UNITAID
ACHIEVEMENTS
2010

UNITAID Report
on Key Performance Indicators
2010

UNITAID Top 10 Achievements 2010

1. 49% price reduction from 2008 to 2010 for ABC and AZT based fixed dose combination paediatric medicines and over 70,000 new children living with HIV now accessing quality, child-formulated anti retroviral treatment through UNITAID's support to CHAI for the paediatric ARV treatment programme.

2. 53 % price reduction from 2008 to 2010 for a quality 2nd line treatment regimen[1] and over 113,000 adults living with HIV now receiving quality 2nd line medicines at these lower prices.

3. 4 million pregnant women being tested for HIV and over 500,000 HIV positive pregnant women provided with quality ARV treatment through integrated prevention of mother to child transmission of HIV in 9 high burden countries.

4. Supply chain management support to 5 high burden West African countries to improve access to UNITAID funded medicines and tests for HIV (through ESTHERAID).

5. 15 UNITAID priority medicines (9 for HIV, 5 anti-TB and 1 anti-malarial) available for purchase through the WHO Prequalification programme.

6. 1 new UNITAID priority diagnostic test for malaria available for purchase through WHO prequalification of diagnostics programme.

7. 6 low and middle income countries provided with State of the Art MDR-TB diagnostic facilities, leading to the rapid detection of 4,166 suspected MDR TB cases and treatment of these cases.

8. Almost 150,000 estimated paediatric curative TB treatments provided for children in 22 low and middle income countries as planned with the Stop TB Partnership.

9. 26 metric tons of artemisinin (15% of global demand) secured through contracts between growers and extractors to produce life saving ACTs to cure malaria.

10. Nearly 16 million ACTs provided to 6 low income countries at lower prices for consumers through the Affordable Medicines for Malaria facility (through March 2011).

[1]Emitricitabine 200mg / Tenofovir 300mg (TDF/FTC) & Lopinavir 200mg / Ritonavir 50mg (LPV/r).

Introduction to the UNITAID Key Performance Indicators Report 2010

UNITAID is funded through a combination of airline taxes and multi-year contributions and is supported by founding members Brazil, Chile, France, Norway, the United Kingdom and the Bill & Melinda Gates Foundation[2]. UNITAID's strategy 2010-2012 and subsequent policies aim to make quality medicines and diagnostics quickly available to low income countries. The market changes resulting from UNITAID's investments in key medicines and diagnostics include low, sustainable pricing, quality, fast delivery time and products adapted to the needs of specific populations (i.e. acceptable formulations that are easy to use, promote adherence to treatments and minimize development of resistance). To further complement the work of other global health funders and reduce funding duplication, UNITAID focuses its actions to projects supporting second line medicines, paediatric products, new diagnostic tests, or related complementary actions to build a nascent or failing market. UNITAID's projects are implemented by its partners who provide synergistic benefits through contribution of their own human, technical, and financial resources.

The Key Performance Indicators (KPIs) reported on here measure performance towards UNITAID's strategic objectives in order to promote evidence-based decision-making and shape the development of appropriate policies and best practices within the Secretariat. These indicators have been developed with the help of the Policy and Strategy Committee's sub-committee on KPIs. It follows a standard structure with a summary table, narrative description, bullet points for challenges for each indicator and a summary of lessons learnt for each action in each area. Annex 1 contains supporting analysis of partner reported information and is presented as a series of tables and graphs. The Report is based on implementing partner semi-annual and annual reports for the year 2010. Partners report to UNITAID on a standard set of M&E indicators defined in their project plans and attached to contractual agreements with UNITAID. The data in these reports is collated, analysed and summarized across the relevant project areas and reflects the availability of information in 2010. The report is divided into 3 Areas of work, representing three organizational values of UNITAID: 1) positive market influence on products of public health importance to treat, diagnosis and prevent HIV, TB and malaria, 2) a lean, efficient Secretariat so that the majority of its funds are spent on medicines and diagnostics for people in need and 3) effective in-country partnerships to facilitate treatment, diagnosis and prevention of HIV, TB and malaria. The 3 areas are described as follows:

- **Area 1**: Impact of UNITAID on the market for products to treat, diagnose and prevent HIV/AIDS, TB and malaria;
- **Area 2**: Organizational Effectiveness; and
- **Area 3**: UNITAID Grant Performance.

After approval from its Executive Board, UNITAID shares its KPIs with all implementing partners to promote a solid understanding of the expectations that UNITAID has for reporting on its funding decisions. UNITAID is working with implementing partners to achieve better project planning. It expects that in the future projects will be fully aligned with its strategic objectives, promoting standardized partner reporting on a key set of indicators. The KPI Report for 2010 moves this agenda forward by highlighting challenges for the future and articulating lessons learnt from the implementation of current projects. At this point in time, all implementing partners are in the process of reviewing their indicators as part of an exercise to introduce the logical framework approach to project planning to the work of UNITAID. In addition, UNITAID has commissioned an external mid-term review of 8 of its current projects. Two of the reviews have been completed and are available on the UNITAID website (www.unitaid.eu). The six remaining reviews are expected by mid-July 2011. The reviews will help implementing partners refine and revise their indicators. Improvements in reporting that follow from the reviews will be evident in the KPI report for 2011.

[2] An additional 24 countries are supporting UNITAID. These are Benin, Burkina Faso, Cameroon, Central African Republic, Congo, Cote d'Ivoire, Cyprus, Gambia, Guinea, Jordan, Liberia, Luxembourg, Madagascar, Mali, Mauritius, Morocco, Namibia, Niger, Republic of Korea, Sao Tomé and Principe, Senegal, South Africa, Spain and Togo.

Area 1:
Impact of UNITAID on the market for products to treat, diagnose and prevent HIV/AIDS, TB and malaria

Action 1: The Secretariat monitors achievements of UNITAID's short to medium term funding on the market for products to treat, diagnose and prevent HIV, TB and malaria

Indicator	Milestone 2010	2009	2010	trend
1. Monitoring the market: UNITAID has systems and reports in place to track the market for UNITAID target products	progress report started based on information collected in UNITAID's market Intelligence Information system	Market Intelligence Information System tender complete. Project teams selected.	Market Dynamics team being hired; landscape analyses started	Increasing
2. Percentage of UNITAID funded projects reporting to UNITAID annually on progress towards their well/defined transition plans.	100% of new projects report progress towards transition (where relevant to the project)	N/A	50%[3]	Increasing

Narrative explanation

UNITAID measures its success based on the impact of its project funding choices on the markets for medicines, diagnostics and related products of public health importance to treat HIV/AIDS, TB and malaria. UNITAID monitors how the markets respond to the provision of its additional, secure funding for medicines, diagnostics and related products for HIV, TB and malaria. These two indicators relate to different aspects of market impact. Indicator 1 addresses the need for evidence for decision making and Indicator 2 focuses on the transfer the gains made in the market through UNITAID's funding efforts to the global public health sectors more broadly.

Indicator 1 provides the details of the actions that the UNITAID Secretariat is taking to develop market Intelligence for products to treat, diagnose and prevent the three diseases. In 2010, the UNITAID Market Intelligence Information System moved forward and contracts were signed with four key implementing partners, Boston University, ANRS, FIND and WHO. The Secretariat aims to develop a system that can be used by the global public health community. 2010 also saw the development of the Market Dynamics team at UNITAID. Although not yet fully resourced, a Coordinator and several support staff have been appointed. This has facilitated progress towards a Landscape Analysis Report series, the first of which was produced in March 2011 on the markets for HIV diagnostic tests. These reports are intended to provide perspective for UNITAID's Advisory Group on Funding Priorities (AGFP) and external Project Review Committee (PRC) as well as the global public health community. These analyses may provide the evidence with which to launch calls for proposals for UNITAID funding of projects of market and public health importance.

Indicator 2 addresses the need for UNITAID to make time-limited interventions that shape the market, improving access and availability of medicines and diagnostics over time to the benefit of all in need. Most UNITAID projects are time-limited with clear timeframes for closure. However, 4 out of the

[3] The four projects with expectations of transition in 2010 are: 2nd line and paediatric projects with CHAI, Paediatric TB with GDF and the 2010 extension of PMTCT-1 with UNICEF (for 2011). Out of these 4 projects, only the CHAI funded projects reported on annual progress towards their transition plans, providing the result of 50% for the indicator in 2010.

19 currently funded projects (21%) require concrete plans to make market and public health gains sustainable through continued support from other funding sources. One of these projects, support to UNICEF for prevention of mother to child transmission of HIV in 5 countries officially ended mid-2010. UNITAID's Executive Board agreed to a proposal to support the project throughout 2011 in order to make the gains achieved sustainable in the countries scaling up PMTCT activities. This agreement was signed December 2010 and the proposal includes monitoring of progress towards transition to other funding sources which is expected to be reported in 2011. Two current projects[4] have been monitoring transition and reporting progress regularly to UNITAID.

Challenges for this Action

Indicator 1:

- Building a Market Dynamics team with the capacities to meet all of UNITAID's requirements, including providing Landscape Analyses.
- Developing a Market Intelligence Information system that integrates data contributions from a range of stakeholders in a timely manner;
- Internal use of Landscape Analyses, including by the AGFP and PRC, to craft better decision making and better project planning.

Indicator 2:

- Coordination with other major funders in the areas of HIV, TB and malaria to ensure that UNITAID's gains are acknowledged and used in future funding decisions for these institutions. It has taken some time for the other global health funding organizations to understand UNITAID's business model and to recognize the potential of its innovative and additional funding for HIV, TB and malaria.
- Market changes or delays in project implementation mean that partners are not able to achieve their expected outcomes according to the timeframes in their project plans. For these scenarios, the Secretariat needs to have some flexibility to extend projects, either at no cost or at low cost to ensure that project outcomes are achieved and that sustainability can be planned.

Lessons learnt through monitoring project performance

Coordinating a wide range of stakeholders to build a market intelligence information system has taken more time than expected. This is due to multiple administrative requests from the organizations selected to contribute to this initiative. The Secretariat will work to ensure that both data contributors and users come together and work efficiently to build a dynamic Market Intelligence Information system. The landscape analysis are an excellent way to share the knowledge gained from analyses of data on the markets for the products to treat and diagnosis HIV, TB and malaria. Providing regular landscape reports will facilitate rational decision making for UNITAID's investments.
Sustainability of project outcomes needs to be discussed with other global funders at the time of Board approval for UNITAID funded projects. This will help coordinate UNITAID's actions within the international public health community for the three diseases and highlight the specific business model that UNITAID has to address markets for products of public health importance. It will also ensure that its achievements remain supportive of and additional to the other global players. To this effect UNITAID participates actively in the Coordinated Procurement Planning (CPP) initiative as a founding member along with the United States (US) government, The Global Fund (GF), the World Bank (WB), UNITAID, UNAIDS and WHO. The initiative provides global funding organizations with a forum to join their efforts to improve coordination in procurement and supply management of essential HIV/AIDS medicines. The Global Fund has also initiated a coordination mechanism within its Market Dynamics Committee to facilitate the continued supply of products generated by successful UNITAID-initiated projects to recipient countries. Both of these coordination activities will serve to promote better planning for medicines and diagnostics to treat and diagnosis HIV across all partners and help sustain the achievements of UNITAID's funding in the long term.

[4] UNITAID support to CHAI paediatric and second line medicines programmes

Action 2: Generate long-term price reductions on medicines and diagnostics

Indicator	Milestone 2010	2009	2010	trend
1. Median prices paid for priority UNITAID medicines, diagnostics and related products reported by implementing partners to UNITAID's Market Intelligence Information System	At least 50% reduction from 2008 in median prices paid for key paediatric and 2nd line ARVs[5]	2nd line ARVs: 11% and 29% reductions on key 2nd line regimens[6] from 2008 to 2009 Paediatric ARVs: 8% price reduction for key AZT and ABC based fixed dose combinations[7] (cumulative change 2008-2009)	2nd line ARVs: A further 9% and 4% price reduction on key 2nd line regimens[8] from 2009 to 2010 (53% reduction cumulative 2008-2010) Paediatric ARVs: 39% price reduction for key AZT and ABC based fixed dose combinations from 2009 to 2010 (49% reduction cumulative 2008-2010) ACTs: AMFm negotiates 80% price reduction of private sector ACT prices.	Decreasing prices
2. # new manufacturers of priority UNITAID medicines, diagnostics and related products with products available for public procurement	At least 1 new market entrant with quality ARV participating in the CHAI supplier selection process	6 new ARV suppliers for 2nd line ARVs	ARVs: 12 new suppliers for 2nd line ARVs TB: 4 new suppliers of products in the GDF catalogue	Increasing
3. Proportion of products in each disease area showing same or lower price than previous 12 months	Proportion of products in each disease area showing same or lower prices than last 12 months	N/A	2nd line ARVs: 8 out of 9 medicines[9] showed decreasing prices. 1st line TB medicines (stockpile): 15 out of 16 products reduced or maintained prices from 2009.	N/A

Associated with tables1 through 6 in Annex 1.

Narrative explanation

Different market conditions for the products needed to treat, diagnose and prevent the three diseases dictate the magnitude of price fluctuations, including reductions, for each product type. UNITAID takes action depending on these market conditions and what is known about disease diagnosis and treatment. The timeframes for achieving price change also varies by disease area and product type. ARVs are still the product most amenable to price reduction in 2010. Progress has been achieved and maintained in the 2nd Line ARV market. Another success for indicator 1includes price reductions in the private sector for ACTs driven by the Affordable medicines for malaria facility (AMFm). Most markets have shown some improvements on indicator 2, number of new manufacturers available for public procurement, thanks to the efforts of the UNITAID supported WHO/UN Prequalification programme and UNITAID's implementing partners. Highlights are described in the sections below and more fully presented for all indicators in Annex 1.

[5] The milestone reflects the situation in 2009, where only the market for ARVs was amenable to price reductions. In 2010, the AMFm project run by The Global Fund has achieved preliminary price reductions in private retail sector for ACTs.
[6] TDF+ 3TC (300 mg + 300mg) & LPV/r (200 mg +50 mg) and TDF+ FTC (300 mg + 200mg) & LPV/r (200 mg +50 mg), respectively.
[7] A further 5% price reduction was achieved from 2008 to 2009 on d4T-based fixed dose combinations as reported in the KPI report 2009. These medicines are no longer recommended by the WHO and so are not being tracked by CHAI or UNITAID.
[8] TDF+ 3TC (300 mg + 300mg) & LPV/r (200 mg +50 mg) and TDF+ FTC (300 mg + 200mg) & LPV/r (200 mg +50 mg), respectively.
[9] UNITAID and CHAI track price reductions of key ARVs and regimens that are recommended by WHO and are most frequently ordered by Beneficiary countries.

HIV and ARVs

As in 2009, the ARV market has shown the most progress towards sustainable, global price reductions. In particular, price decreases continue to be made on 2nd line ARVs, consistent with an ever increasing number of generic suppliers entering the market in 2010. For indicator 1, the milestone, at least 50% reduction from 2008 in median prices paid, has been met for 2 key 2nd line ARVs, Tenofovir/Emitricitabine (300mg/ 200mg) (57 % decrease) and Tenofovir 300 mg (60% decrease): Tables of results can be seen in Annex1.
Market conditions for paediatric ARVs have not improved over last year with no entry of new generics manufacturers into production of key paediatric products. As a result, price reductions, while still being achieved for some key fixed dose combinations, have not been as dramatic as those for 2nd Line products. They have remained stable or have increased slightly for the paediatric products monitored from 2008 to date.

Malaria and ACTs

The first major achievement for the AMFm in 2010 was the successful negotiation of ACT manufacturer sales prices to private sector buyers to the same level as for public sector buyers, with price reductions of up to 80 percent. Master supply agreements were signed between the Global Fund and 6 eligible manufacturers of quality assured ACTs. Preliminary results from the AMFm team based on surveys done in chemists in Kenya and Ghana indicate that retail prices in the price sector have decreased by 50% in Kenya and by 89% in Ghana[10]. In addition to the AMFm achievements, a new product, Artesunate powder for injection, manufactured by Guilin Pharmaceutical, was prequalified in 2010. Although not an ACT, this product is needed to successfully treat severe malaria. Improving the stability of the ACT market depends on maintaining a sufficient production of Artemisia to produce the Artemisinin that goes into the last effective treatment for malaria. UNITAID's support to i+ Solutions for the Assured Artemisinin Supply Service project (A2S2) has secured 26 metric Tons of Artemisinin in 2010 through loan agreements with extractors. This represents 15% of the global demand and 65% of the project target of 40 metric Tons which is expected to be exceeded in the coming months. The project is important because it secures a connection between grower, extractor and medicine manufacturer that enables the production of ACTs to cure malaria. The success of the AMFm which aims to replace ineffective anti-malarials with ACTs at lower prices in the private sector retail market also relies on a continuous supply of quality ACTs now facilitated by A2S2.

TB and anti-TB medicines

For first line TB, for which UNITAID supports a rotating stockpile of important medicines, 15 products have either decreased in price or remained stable. One product, Streptomycin (1g) has significantly increased in price, resulting from the ineligibility of the generic supplier of this product. An alternative, higher cost product had to be substituted as a result of a breakdown in quality assurance. For MDR TB scale up, the addition of 4 new quality generic suppliers (the CHAO Centre, Olainfarm, Lupin and Meiji) of existing medicines has improved the sustainability of the market for these medicines, and are expected to lead to notable price reduction by the end of 2011.

Challenges for this Action

HIV and ARVs

- Due to the small market size for pediatrics ARVs and the expectation that it may eventually decline with increasing coverage of PMTCT and the need to develop new formulations and dosages of FDCs, the challenge is to keep this market healthy and sustainable. Special attention should be paid during transition of the countries to The Global Fund grants, to secure the predictability of funding and procurement ability for the countries as well as for the manufacturers.
- More time may be needed to secure gains and further reduce prices in the market for paediatric medicines because of the high level of fragmentation in this market. It will be harder to transition this area to other global funders as the gains of the last year have not proved stable. UNITAID may need to persist in this area until the market in stabilized.
- The 2nd line project with CHAI currently represents 77% of the second line ARV demand in generic-accessible low and middle income countries (excluding Argentina, Brazil, China, Mexico

[10] Kenyan results are based on a survey of 270 chemists in Nyanza Province and Ghana results are based on a survey of 808 facilities stocking co-paid ACTs in Ghana as reported in The Global Fund's report to the Ad Hoc Advisory Committee of the AMFm

and South Africa).Therefore, as this project transitions some countries will face difficulty in procuring sustainable, long term sources of funding.

TB and anti-TB medicines

- For anti-TB medicines, rising costs of active pharmaceutical ingredients and oil for the manufacturing process has increased the price of both first and second line treatments.
- A key challenge is maintaining quality assured manufacturers in the market. These medicines are not easy to make as most of the molecules are unstable. When there is a quality assurance problem with a generic manufacturer, the price of the product rises as the product has to be purchased without advanced notice and usually from an originator source (as seen with Streptomycin 1gr).
- Sustainable price reductions will be realized over the course of these projects as long term agreements with manufacturers are made and the sustainability of funding is demonstrated, leading to a more predictable demand that manufacturers can respond to by investing in the production of these medicines and diagnostics.

Malaria and ACTs

- Demonstrating lower prices in the retail sector (private) for ACTs through the AMFm is the key challenge. Preliminary results from Kenya and Ghana indicate that prices have fallen to the level of public sector ACTs where surveys have been conducted.
- A remaining challenge is to ensure that ACTs are provided in preference to non-ACT medicines. To reduce the price to the end user and promote the use of ACTs over ineffective anti-malarials is the goal of AMFm.
- Maintaining the public sector availability of ACTs may be a problem because an increase in orders in the private retail sector have been reported (by The Global Fund) to be accompanied by a decline in public sector orders[11].

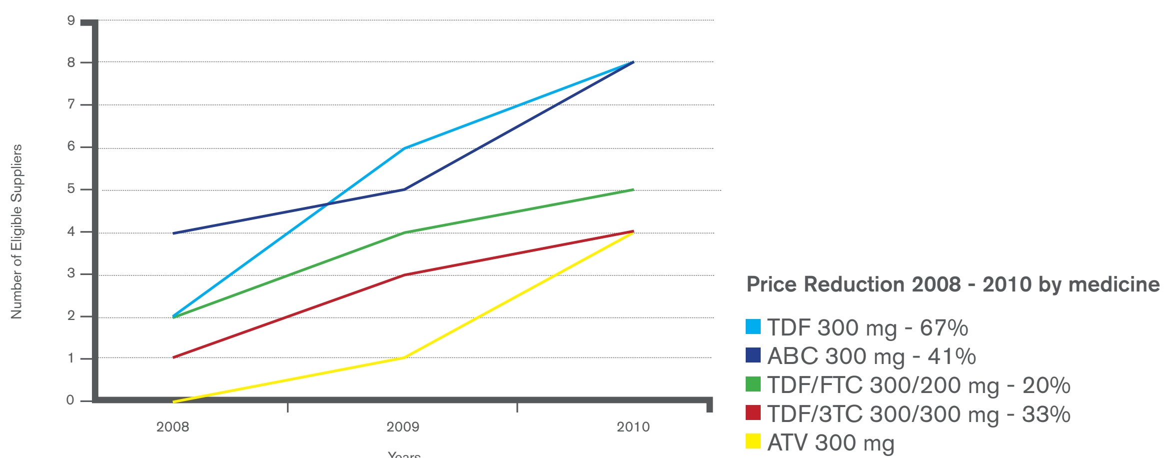
Lessons learnt through monitoring project performance

Sustainable price reductions and transition planning

HIV

In 2010, we learned how difficult it can be to maintain achieved price reductions in the longer term. The successes of the 2nd line ARV project with CHAI have been sustainable and this is clearly related to the number of generic manufacturers still entering the market for these products (Figure 1).

Trends in elegible Suppliers for selected 2nd line ARVs



[11] As reported in the Global Fund's report to the Ad Hoc Advisory Committee of the AMFm.

Positive market gains for 2nd line ARVs are encouraging further investment in this market from more traditional funders. Both PEPFAR and TGF have expressed an interest in the 2nd line ARVs and thereby sustain UNITAID driven market gains into the future. Manufacturers are also anticipating that this is a growing market with more people than ever before having access to first line treatment through the efforts of the international community. There is now a clear need to expand the availability of 2nd line ARVs.
Sustaining gains made with some products in the paediatric ARV project and inducing price reductions in others have been hampered by lack of available quality-assured generic manufacturers with which to negotiate better prices. UNITAID should consider the specific dynamics of this market during the transition period, in particular with the input of The Global Fund. A way to overcome the challenge of sustainable price reductions through time is to improve yearly forecasts to manufacturers across all disease and product areas. For paediatric ARVs, the availability of new point-of-care diagnostic tests may open up the market through faster identification of children in need of treatment. As the forecasts at country level grow, the desire of manufacturers to make key products should increase, leading to more competition and better, sustainable prices. The paediatric project with CHAI may require more funding in the future to ensure that rising demand for treatment of children can be met.

TB

Access to anti-TB medicines remains a challenge, especially for MDR-TB. More and more people are being diagnosed earlier with MDR-TB through the efforts of the UNITAID-funded MDR TB diagnostics project with FIND and GDF. Unfortunately, without better forecasting and planning, they may be unable to access treatment in time to prevent death and further spread of the disease. New evidence suggests that by tackling HIV and TB together through joint screening programmes for HIV and TB, starting ART sooner and providing prophylactic treatment for TB to people living with HIV could save a million people living with HIV[12].

Malaria

The AMFm project, for which UNITAID is a major funder of phase 1, has demonstrated preliminary success in reducing the private sector retail price of ACTs and generating an increasing number of orders for this vital medicine. However, The Global Fund is also reporting that orders placed by public sector suppliers of ACTs have recently dropped, meaning that attention should still be paid to this area to ensure that there are no overall imbalances in the market that may lead to price increases.

[12] Williams B, Dye C et al, Tuberculosis among people living with HIV: is it possible to prevent a million TB deaths by 2015? Unpublished technical report. Personal communication with the authors.

Action 3: Improve quality of medicines, diagnostics and related products

Indicator	Milestone 2010	2009	2010	trend
1. # of priority UNITAID medicines and diagnostics prequalified annually by niche	1) # of medicines and diagnostics prequalified for HIV, TB and malaria reported to UNITAID in interim and annual reports; 2) Target for 2009 (7 for HIV, 7 for TB and 3 for malaria)	1) 18 UNITAID priority medicines prequalified out of a total of 44 medicines prequalified. 2) 10 ARVs, 3 ACTs and 5 anti-TB medicines prequalified[13]	1) 15 UNITAID priority medicines prequalified out of a total of 36 medicines prequalified. 2) 9 ARVs, 5 anti-TB and 1 malaria	Stable
2. Median number of days taken to prequalify a medicine	Less than 547 days for a medicine with a dossier submitted in 2010	736 days	663 days	Decreasing
3. Median number of days taken to prequalify a diagnostic test	Dossiers are assessed by the diagnostics team for first time in 2010	Diagnostic= N/A	15 days	One rapid test for malaria prequalified

Associated with tables 7 and 8 in Annex 1

Narrative explanation

UNITAID's support to the WHO/UN Prequalification programme (PQP) is critical to its mission to improve availability of and access to quality medicines and diagnostics in low and middle income countries for HIV, TB and malaria. A comprehensive and stringent mechanism to assess the quality of pharmaceutical products from generic manufacturers was needed to ensure timely introduction of urgently needed medicines, including new FDCs and new paediatric formulations to the markets. UNITAID support to PQP aims to ensure that its implementing partners can negotiate with a wide range of quality assured manufacturers (generic) and negotiate favourable prices and long term agreements with suppliers of quality medicines and diagnostics. UNITAID initiated support to the area of UNITAID priority diagnostics to improve our ability to accurately detect and treat disease, thereby facilitating the rational use of the medicines that we fund through implementing partners. PQP Diagnostics programme made progress in 2010 with 14 product dossiers currently under review and 1 rapid diagnostic test for malaria prequalified in 2010. Annex 1 (table 7) presents the PQP dashboard for 2010.

Indicator 1 remained relatively stable from 2009 to 2010 with a similar number of prequalified ARVs and ACTs but slightly fewer anti-TB medicines. This reflects the reduction in the number of dossiers submitted for prequalification in 2010. The UNITAID-initiated mid-term review has made suggestions (see below) on ways to improve incentives to manufacturers to submit dossiers.

Indicator 2, the median number of days taken to prequalify a medicine, has decreased from 2009 but not enough to meet the milestone for 2010. This indicates that WHO PQP and UNITAID have set realistic but challenging milestone and targets for the programme. The recommendations of the external mid term review of this project included suggestion for reducing the number of days to prequalify a product , including development of a web-based platform to manage dossiers. However, they also acknowledged that delays in manufacturer responses to requests for clarification or submission of complete dossiers contributed to the time taken for prequalification.

For PQP diagnostics, the first rapid test took 15 days to prequalify once a complete dossier was available for assessment. There are now 14 additional diagnostic tests being assessed and further progress on this indicator will be available in 2011.

[13] Two additional anti-TB medicines not on the UNITAID priority list were prequalified in 2009, bringing the total of prequalified anti-TB medicines to 7 for 2009. These are Pyrazinamide 400mg tablets (Micro Labs Limited- 29/06/2009) and Pyrazinamide 500mg tablets (Micro Labs Limited- 29/06/2009)

Challenges for this Action

HIV and ARVs

- Decreasing number of dossiers received in prequalification from 2008 to 2010. Results of two recent surveys of manufacturers suggest that they are not dissatisfied with the PQP process and see little economic incentive to submit dossiers. Prequalification is a voluntary process for manufacturers; however UNITAID can support PQP being more explicit about the products it is supporting and by promoting its own quality policy.
- The UNITAID quality policy is not always fully respected or copied by other donors (e.g. World Bank) and this can lead to doubts about the benefits of prequalification. Advocacy from UNITAID about it quality policy may improve uptake of prequalification by manufacturers.
- Ensuring that a high level of technical staff is available to both PQP medicines and diagnostic programmes has been difficult in the past for both programmes.
- The UNITAID list of priority products needs to be promoted to all stakeholders to ensure that manufacturers are motivated to submit dossiers for urgently needed medicines, especially FDCs.

Lessons learnt through monitoring project performance

UNITAID commissioned an external mid-term review of the PQP in 2010. The reviewers were from the Agence Européenne pour le Développement et la Santé (AEDES). Their assessment was that WHO-PQP is based on a rational, robust and safe procedure that is well documented and transparent. They noted that because Prequalification is a free and voluntary process for manufacturers, particular attention needs to be paid to improving awareness of the benefits of the procedure to manufacturers through communication and advocacy. They suggest that in some cases the process timeframe may be too long and have made some recommendations about how to improve this aspect of programme efficiency. These include improving the:

- PQP process management, especially the timeframe between expressions of interests for prequalification and availability of prequalified product on the market;
- Recognition of PQP by national regulatory authorities in order to limit duplication and speed up national regulatory processes;
- Communication and information strategies for manufacturers, regulators and procurement agents;
- Capacity building and technical assistance to quality control laboratory prequalification; and
- Incentives to manufacturers to submit dossiers for key products.

UNITAID can help by working harder to make its own quality assurance policy (which highlights prequalification) more widely known to manufacturers, procurement agents and other donors. In addition, UNITAID is working to make its list of priority products for prequalification more specific and the process for creating the list more transparent. This in turn will ensure that more stakeholders can be involved in the selection of critical products for the list, facilitating their timely production by generic manufacturers.

Action 4: Shorten lead time for delivery of medicines, diagnostics and related products to countries

Indicator	Milestone 2010	2009	2010	trend
1. Manufacturer lead times for key medicines and diagnostics reported to UNITAID annually by Implementing Partners.	Manufacturer lead times reported to UNITAID by implementing partners allow for comparisons across medicines and diagnostics manufacturers;	Table 4	Table 9	Meeting milestone
2. Number of stock-outs of UNITAID funded medicines to treat HIV, TB and malaria experienced by developing countries known and monitored by implementing partners and reported to UNITAID	1. Stockpile for MDR-TB medicines functioning at 5,800 treatments; 2. Buffer stock for ACTs in place for all UNICEF approved suppliers with LTAs	1. Strategic rotating stockpile reached 5,800 patient treatments for MDR-TB; 2. All 14 suppliers with LTAs to for UNICEF ACTs have buffer stocks in place; 3. 100% of LLINs distributed to 9 countries facing shortages in 2009.	1. The indicator has changed in 2011 and UNITAID is working with implementing partners to provide up to date country level reporting. 2. GDF reported a stock out of paediatric anti-TB medicines in Niger.	N/A

Associated with table 9 in Annex 1

Narrative explanation

Timely delivery of medicines, diagnostics and related products to beneficiary countries is a key objective of UNITAID. All of UNITAID's implementing partners report on manufacturer lead time (time between placement of an order with the manufacturer to deliver in country) to UNITAID. The results are presented by disease area, product and manufacturer in Annex 1 (table 9).
For ARVs, CHAI includes timeliness of delivery as a decision point when selecting primary, secondary and pool manufacturers for procurement of products for the 2nd Line and paediatric ARV projects. This makes it clear to manufacturers that short lead times are valued by both UNITAID and CHAI.
For anti-TB medicines, manufacturer lead time is an important factor in the timely and continued treatment of patients. Because of the short shelf-life of the product, manufacturers only produce the medicines upon demand, often with a 6 month lag between purchase order and country delivery. The delay is serious for TB suffers and for the transmission of TB, especially MDR TB. The innovative approach of the strategic rotating stockpile (SRS) of TB medicines taken by the Global Drug Facility (GDF) of the Stop TB Partnership with the support of UNITAID has improved the timely delivery of anti-TB medicines to patients and has prevented stock-out situations in which patients must go untreated because of lack of suitable medicines. Three countries (Nepal, Uganda and Zambia) reported a risk of stock out for first line drugs in 2010. UNITAID requested and investigation into the stock out situations from GDF. GDF responded stating that the key factors contributing to the delays were:

- Late disbursement of funds from TGF;
- Delayed periods for the signing of grants and technical agreements; and
- Availability of quality assured Streptomycin.

The breakdown in the supply of Streptomycin was due to a revision in the quality criteria for the medicine which meant that the API producer was unable to meet the demand for the active ingredient. UNITAID has requested that GDF identify and report on the steps it is taking to avoid this type of supply disruption in the future. At the time of this report, 4 quality approved suppliers of Streptomycin are available to the market. UNITAID initiated an external mid term review of the strategic rotating

stockpiles with GDF in 2010. The review is being conducted by the Swiss Institute of Tropical medicine and Public Health and the results are expected to be available by the end of July 2011.
GDF reported a stock out of paediatric anti-TB medicines in Niger to UNITAID in its annual report for 2010. The stock out was confirmed to be at the central level in Niger. UNITAID is following up with GDF to understand what actions have been taken to provide paediatric anti-TB medicines to Niger. A review of the paediatric project with GDF is planned for later in 2011.
For the ACTs, UNICEF requires that its suppliers with LTAs maintain a buffer stock at all times. This buffer stock is rotated so that the ACTs have an acceptable remaining shelf life of above 80% always. The buffer stock contributes to shorter lead times at the time of order confirmation for UNICEF because manufacturers factor these stocks into their order planning and ensure that they also have buffer stocks of Artemisinin and appropriate packaging. There were no emergency requests to UNICEF in 2010 that required use of the buffer stock for ACTs.
UNITAID's sub committee on Key Performance Indicators changed indicator 2 in 2010/2011 to make it a more rigorous measure of what is happening at the country level with UNITAID financed medicines and diagnostics. This change was made in response to questions raised by NGOs and Communities living with the three diseases about why UNITAID was not hearing about some of the stock out situations that were being brought to their attention. UNITAID has responded by working more closely with implementing partners to make sure that they are well connected with the relevant Health Authorities within the countries that they are working. We expect to be able to fully report on the success of these actions in the KPI report for 2011.

Challenges for this Action

- UNITAID has initiated a mid term review of the Strategic Rotating Stockpiles with GDF and is awaiting results.
- UNITAID has limited involvement directly with countries so may not hear about stock out situations in a timely manner. UNITAID is working with other partners to improve its intelligence in this area (ESTHER, PEPFAR, SCMS).

Lessons learnt through monitoring project performance

UNITAID has learnt that it needs to take more direct action to monitor stock outs and supply chain functioning in the countries that are receiving its support. To address this area for ARVs, UNITAID initiated a project with ESTHER called ESTHERAID in 2010. The aim of this project is to improve supply chain management and planning for paediatric and 2nd line ARVs in 5 west African countries (Mali, Cameroon, Central African Republic, Benin and Burkina Faso). UNITAID and ESTHER view this collaboration as one that can help identify the potential for stock outs in these countries and mitigate these supply and planning difficulties by building capacity in country for management of existing stocks and forecasting for future need. The Coordinated Procurement Planning initiative of the US government, Global Fund (GF), the World Bank (WB), UNITAID, UNAIDS and WHO has seen the potential of this type of project and is working with both UNITAID and ESTHER to see how this initiative can be duplicated in other countries. UNITAID hopes that these efforts, along with the work it is funding through Boston Consulting Group and MIT in forecasting for ACTs can simplify and harmonize drug management, storage and distribution to country-based health facilities, reducing lead times and ultimately preventing stock outs.

Action 5: Promote the development of user-friendly drugs appropriate for use in developing countries.

Indicator	Milestone 2010	2009	2010	trend
1. Implementing partners report the number of new paediatric-adapted products for treatment of a) HIV, b) TB and c) malaria.	All implementing partners report number of new paediatric-adapted products according to their project types and intended outcomes.	GDF reported 2 additional paediatric medicines in its catalogue for 2009;	a) HIV: no new; b) TB: 1 (Isoniazid) prequalified c) Malaria: no new	Stable
2. Number of fixed dose combination (FDC) treatments for a) 2nd line products and b) ACTs (malaria) to ensure better patient adherence to treatment.	All implementing partners report number of new fixed dose combination treatments according to their project types and intended outcomes.	8 out of 9 of the prequalified ACTs are FDCs	a) 2nd Line: Atazanavir & heat stable ritonavir available as a co-blister; b)ACTs: none	Stable

Narrative explanation

The focus of UNITAID's funding for this objective has been to ensure that paediatric adapted products for the treatment of HIV, and TB are available from quality assured manufacturers. An additional activity is to promote the production and use of fixed dose combinations (FDCs) to improve patient adherence to treatment and thus slow the development of drug resistance. This is particularly important for ARV regimens, paediatric anti-TB medicines and for ACTs, where there is a clear need for FDCs to combat high pill burdens or replace co-blistered products.

HIV/AIDS

Most of the achievements in paediatric formula fixed dose combinations were made in 2008 and 2009. In 2010, the work of CHAI and UNITAID has been to ensure the availability and accessibility of these FDCs. They are now available to all beneficiary countries through the UNITAID funded CHAI Paediatric programme.

TB

In December 2010, WHO published the "Rapid Advice" guidelines which recommend higher doses for paediatric treatment than has been historically used. The existing formulations and FDCs do not accommodate these recommendations. This has serious consequences for the UNITAID supported GDF Paediatric TB project with a need to encourage manufacturers to make these new formulations and get them prequalified as soon as possible to facilitate better treatment of children with TB. Nevertheless, several key paediatric products are available today due to UNITAID funding of the GDF paediatric TB project. One product, Isoniazid (H100 bulk) was prequalified in 2010. This brings the number of prequalified paediatric products to 11 since the project with UNITAID started. More needs to be done to ensure that manufacturers now start to make paediatric medicines that meet the revised WHO guidelines.

The most promising new fixed dose combination product in 2010 was a new 2nd line ARV, Atazanavir which was being developed as an FDC with heat stable Ritonavir. Unfortunately the fixed dose combination product is not currently stable, preventing the mass production of this product for sale to CHAI through UNITAID's support. CHAI is still purchasing the product which is being sold as a co-blister of Atazanavir and Ritonavir. However, concerns have been raised about the suitability of the co-blister as some patients may not fully adhere to the treatment by not taking both pills together, limiting the effectiveness of the treatment and possibly hastening the development of resistance to Atazanavir. UNITAID has expressed concern over this to CHAI and asked WHO for guidance about the acceptability of using this medicine until a stable fixed dose combination can be marketed. WHO has recommended that UNITAID continue to provide support for this co-blistered product until the FDC becomes available.

Challenges for this Action

- The paediatric TB project faces a challenge to encourage industry to make additional paediatric products with increased doses to meet the WHO revised targets for paediatric treatment.
- Support for paediatric and MDR-TB medicines may need to be extended to fully develop sustainable markets for these products.
- A fixed dose combination for Atazanavir and heat stable Ritonavir is urgently needed to improve the treatment options for people living with HIV in low and middle income countries.
- The landscape analyses to be done for all three diseases will investigate new paediatric products and new FDCs that UNITAID can prioritize to support the UNITAID mandate to promote availability and accessibility of better patient adapted medicines, including fixed dose combinations.

Lessons learnt through monitoring project performance

Identifying priorities in paediatric medicines and fixed dose combinations and explicitly communicating these through UNITAID partners, including the WHO Prequalification Programme, will help stimulate manufacturers to invest in producing them. In addition, over the past two years, we have seen that WHO has a major influence on the market for medicines, diagnostics and related products through the development of guidelines and treatment recommendations for countries. For the paediatric TB market, changes to the treatment guidelines from WHO present a challenge to both the demand and supply side of the market (in this case, the UNITAID implementing partner GDF and manufacturers) in producing the required products and prequalifying them in a timely manner.

The markets for medicines and diagnostics are dynamic and changing. UNITAID has responded with its Market Dynamics team which is now producing a series of Landscape Analyses. These reports will be crucial to identifying gaps, and opportunities in markets for medicines and diagnostics that UNITAID can take advantage of by developing calls for proposals that are focused on key public health priorities that have market potential. In this way, UNITAID can remain innovative, flexible and responsive to the needs of its partners and the global public health community in order to improve access to these urgently needed products in low income countries.

Area 2:
Organizational Effectiveness

Action 1: Monitor UNITAID's compliance with its Constitutional requirement to allocate the majority of its funding to Implementing partners for projects

Indicator	Calculation notes	Milestone 2010	2009	2010	Trend
1. Per cent (%) Secretariat costs (US$) relative to direct project costs for funded projects (US$)	Secretariat costs exclude project specific expenses and expenses related to market dynamics; Implementing partners exclude Millennium Foundation and Medicines patent Pool.	Secretariat costs are less than 5% of annual direct project costs for funded projects	2.4%	3.5%	Increasing
2. Ratio of annual disbursements to UNITAID full time equivalent (FTE) staff members	Annual disbursements exclude Millennium Foundation and Medicines patent Pool	2010 sets the benchmark	N/A	US$ 6,473,829	N/A

Narrative explanation

The small size of the Secretariat is central to UNITAID's mandate to allocate the majority of its funds to implementing partners to execute UNITAID funded projects in low income countries. UNITAID has no country offices or officers and so these type of costs do not contribute to Secretariat costs.
For Indicator 1, the overall percentage has remained less than 5% of annual direct project costs for all funded projects, meeting the milestone for 2010 and 2011 and on track for the target for 2012. The increase is due to a 26% decrease in the level of disbursements to partners while Secretariat expenses only increased by 10%. The lower level of disbursements was mainly due to the peak in 2009 created by the Bednet projects. UNITAID has strengthened its disbursement policy and this has resulted in the withholding of some scheduled payments.
Indicator 2 provides a measure of the appropriateness of the size of the Secretariat for maintaining a lean but efficient operation. This is a newly reported indicator for 2010. UNITAID has a relatively high funds-to-staff ratio at $6.5 million aid dollars per employee, compared to that of several other aid agencies and foundations. For example the Global Fund spent $5 million aid dollars per employee (2005) and DFID reports $4.4 million aid dollars per employee[14].

Challenges for this Action

- Fluctuating disbursement levels to partners based on the life-cycle of the project and also on progress of project implementation may influence UNITAID's performance on indicator 1 over time.
- Indicators do not provide any indication of quality of project management. Quality and oversight may be compromised if the Secretariat is too small to monitor the performance of implementing partners, especially with regard to tracking partner performance in countries.

[14] Rhetoric versus Reality: The Best and Worst of Aid Agency Practices, 2011. Easterly, W & Williamson CR. World Development, Special Issue.

Lessons learnt in this area

UNITAID requires a minimum infrastructure within the Secretariat to function as an Organization. For this reason, Secretariat costs are fixed and comparatively small. Project costs, on the other hand, are variable and large. The challenge for UNITAID is to balance these changeable, large project costs within the framework of a small but functional Secretariat.

Action 2: Optimize UNITAID Secretariat Performance: Signing of agreements and disbursement speed.

Indicator	Calculation notes	Milestone 2010	2009	2010	Trend
1. Median time between Board approval of project for funding and first disbursement for all projects;	Includes new projects only	10% reduction from baseline	175	105	Decrease
2. Median time between Board approval and signing of agreements for all projects;	Includes Board approvals that have resulted in an agreement in reporting year	10% reduction from baseline	157	57	Decrease
3. Median time between signing of agreement and first disbursement for all projects;	Includes new projects which require first disbursements to start work	10% reduction from baseline	18	48	Increase

Narrative explanation

The UNITAID Secretariat focuses on operational activities, especially providing funds to implementing partners to do time limited procurement of medicines, diagnostics and related products for HIV, TB and malaria. These indicators reflect the timeliness of the Secretariat in implementing Board decisions. Indicator 1 is the sum of indicators 2 and 3 and provides the overall performance related to Board approval of projects and first disbursement to implementing partners. UNITAID concluded a very small number of grants in 2010. The increase in time between signing of agreement and first disbursement (indicator 3) reflects the delays in a specific case from the implementing partner in requesting funds to start work.

Challenges for this Action

- A fully staffed Secretariat is crucial to support implementation of Board decisions;
- The Legal position was staffed in 2010;
- Operations, Finance and Administration and Market Dynamics were not fully staffed in 2010.

Lessons learnt in this area

The newly proposed process of project proposal review and partner assessment by the Secretariat will greatly decrease the time needed to convert a proposal into an MoU. It should also be noted that the time needed to sign the agreement cannot be compressed much further given the approval processes both within the partner organization and WHO/UNITAID.
The successful appointment of staff to the Operations and Market Dynamics team will improve UNITAID's ability to assess project risks and plan for appropriate responses to these risks. This will help to speed up the signing of new project agreements. In 2010, UNITAID acquired additional staff and skills base needed to perform its operations with speed and ease. Dedicated legal support was added due to the recognized need to finalize the development of agreements in a timely manner.
To improve performance further in this area, UNITAID needs to focus on developing policies and processes that support the project planning stage and that enable strong partnerships both within the teams of the Secretariat and between the Secretariat and its implementing partners.

Action 3: Optimize UNITAID financial accountability

Indicator	Calculation notes	Milestone 2010	2009	2010	Trend
1. Per cent (%) of total budget spent by Secretariat annually (budget performance)	Uses an arithmetical formula using budget approved by the Board in its June meeting	At least 70% of the Board approved budget is spent by the Secretariat annually	64% of overall budget for 2009 spent by the Secretariat	66%	Increasing
2. Per cent (%) budget allocations per country income classifications (as designated by World Bank)	Calculated based on partner project spending annually	Low income: at least 85%; Lower middle income: less than 10%; Upper middle income: less than 5%	Low income: 87.2%; Lower middle income: 9.6%; Upper middle income: 3.2 %	Low income: 85.9 %, Lower middle income: 6.9 %; Upper Middle income: 7.6 %	Stable
3. Per cent (%) of actual expenses of implementing partners compared to the latest UNITAID approved budget for a financial year for each UNITAID funded project.	Only grants with annual budgets included here	Baseline is reported in 2010 report	N/A	85%	N/A

Narrative explanation

These indicators are proxy measures of the effectiveness of UNITAID's budget planning and monitoring process. They are an element of monitoring the financial accountability of the Secretariat. Indicator 1 measures Secretariat compliance with the Board approved budget. Indicator 2 measures the Secretariat's adherence to its constitutional mandate to work in low income countries and to allocate its financial resources accordingly. Indicator 3, new for 2010, monitors to what extent implementing partners are spending UNITAID funds in accordance with their project plans and contractual agreements with UNITAID.

UNITAID's budget performance has improved in 2010 but remains rather low. This is due in part to the large, sporadic nature of disbursements made to partners. Progress is being made towards the 2010 milestone of at least 70% of the total budget spent by the Secretariat annually in close collaboration with its implementing partners. UNITAID has sustained its support to low income countries with nearly 86% of its funds being spent in this income category in 2010. The amount spent in lower middle income countries has declined for 2009 values and the amount spent in upper middle income countries has increased slightly in 2010, reflecting work done by FIND/GDF to provide the laboratory infrastructure to countries able to scale up the detection of MDR TB using state-of-the-art diagnostic tests.

The 2010 result for indicator 3 sets the baseline for the indicator at 85%. This was achieved in great part thanks to the good performance on HIV/AIDS project budgets. Although not all projects could be included due to data availability (e.g. AMFM), this shows that partners have been able to achieve their plans to a great extent but also shows that they have all come under plan in 2010.

Challenges for this Action

- For Indicator 1, budget performance rests on internal planning processes to some extent (Secretariat costs or 4% of expenses) and on the ability of partners to plan their needs and absorb the additional work load related to the project.
- Year to year variation in Indicator 2 reflects implementing partner spending and thus may fluctuate due to timing of partner expenses, which the Secretariat will have no control over;
- For Indicator 3, the milestone for 2011 and target for 2012 requires that the implementing partners budget implementation rate does not vary by more than 10% annually.

Lessons learnt in this area

Indicator 1. A new budgeting process based on more robust unit work plans has been developed for the Secretariat. Budgeting for project disbursements has also been made tighter. While this learning process will take a few years to bear fruit, improvements are expected for 2011.
Indicator 3. More frequent budget reviews are being built into the new agreements. This should logically lead to a high ratio as well but as projects become more diverse and complex, achieving a high overall rate may be more challenging.

Action 4: Optimize staff performance and management

Indicator	Calculation notes	Milestone 2010	2009	2010	Trend
1. Rate of turnover for Professional positions	Percent of number of fixed term staff leaving annually/ by number of fixed term staff employed at 31 December of each year	Less than 10%	3.5%	6.7%	Increasing
2. Per cent (%) staff with learning and development plan in place and demonstrated progress towards implementing this plan annually.	based on WHO e-work system	100%	N/A	41%	Increasing
3. Per cent (%) of actual expenses of implementing partners compared to the latest UNITAID approved budget for a financial year for each UNITAID funded project.	based on WHO e-work system	100%	N/A	[15]	
4. Per cent of Professional posts filled by women	Percent of number of fixed term professional staff/ total number of professional fixed term staff	At least 50% of Professional posts filled by women	58%	57%	

Narrative explanation

Staff performance and management is crucial to UNITAID's continued success. As an organization hosted by the WHO, UNITAID staff use the WHO performance management and development system (PMDS) to plan their work, track and improve performance. In addition, there are two other indicators for this action. These are related to turnover of professional staff and % of professional posts filled by women. The objective of these indicators is to monitor the UNITAID work environment and to ensure that UNITAID makes strides towards gender equality in the work place.

The HR plan was not fully implemented in 2010 and the number of fixed term staff employed during this period was relatively small. As a result, indicator 1 is high in 2010.

Indicators 2 and 3 are disappointingly low. HR efforts in 2010 were focussed on the design and implementation of the HR Plan and while a general improvement in the rate of filling and discussing the yearly PMDS was observed, the Secretariat is still not generally carrying out its mid term reviews in time. This should markedly improve in 2011.

By the same token, while staff have attended WHO-offered training courses, supervisors and staff members have not developed actual learning plans. This should also improve in 2011 and be generalized in 2012 once the team is complete.

Indicator 4, per cent of professional posts filled by women is an indicator of how well UNITAID is able to achieve gender balance in the workplace and the percentage remains strong.

[15] The learning plan is already incorporated into the performance management plan but HR was unable in 2010 to access the quality of these plans and to provide relevant learning opportunities.

Challenges for this Action

- UNITAID's Secretariat is quite small and as a result, small changes in staffing result in large turnover rates so care must be taken when interpreting this rate.
- Interpretation of Indicator 4, per cent of professional posts filled with women, is also effected by the small size of the organization and care must be taken when examining these results.

Lessons learnt in this area

UNITAID has integrated well into the WHO Host environment and 2010 has seen an uptake of the management systems of the WHO, including the PMDS, Global Learning and Performance Management support system and the WHO GSM. UNITAID and WHO's Performance Management and Learning team have signed an agreement which means that all WHO courses are accessible to UNITAID staff. The HR unit has worked on an approach to staff development within UNITAID that has been reviewed by the Senior Management Group of the Secretariat and will be implemented starting in 2011.

Action 5: Improve UNITAID's resource mobilization efforts to contribute to the sustainability and predictability of its funds

Indicator	Calculation notes	Milestone 2010	2009	2010	Trend
1. Funds collected mid-year as per cent of funds collected annually	Includes only monies released from donors by 30 June in each calendar year.	25%	17%	25%	Increasing
2. Per cent (%) of donors who have contributed in previous year and who continue to contribute.	Calculated over two calendar years (i.e. 2009 for previous years contribution compared to 2010 for continued contributions)	75%	75%	75%	stable
3. Per cent (%) increase in number of new donors to UNITAID annually	Measured over the calendar year	10%	N/A	0%	Stable

Narrative explanation

Sustainable, predictable funding is at the heart of UNITAID's commitment to increased access to treatments, diagnostics and prevention products for HIV, TB and malaria in low income countries. The innovative nature of UNITAID and its ability to have an impact on the markets for medicines, diagnostics and related products is jeopardized if its funding base is insecure because market impact takes time. The indicators for this action monitor the security of UNITAID's funding annually. If funding is not sustainable, then cash flow also becomes a problem for the organization.

Indicator 1 monitors per cent of funds received within the calendar year to facilitate timely expenditure of UNITAID's budget. There was a significant increase in the per cent of funds available to UNITAID in mid-2010. More funds collected mid-year means more stability for UNITAID and its implementing partners because it will be easier for UNITAID to ensure partners of a stable cash flow.
Indicator 2 is a measure of continued support to UNITAID, a key issue for its financial stability. As of 2010, donors are continuing to contribute whether annually or through multi-year commitments.
Indicator 3 is a new indicator for 2010 and measures how effective UNITAID's resource mobilization actions have been for the year. No new donors contributed to UNITAID in 2010.

Challenges for this Action

- UNITAID faces a challenge to increase its resource mobilization efforts so that it can maintain the necessary revenue stream and cash flow to fund its on-going operations.

Lessons learnt in this area

Resource mobilization is a key area for UNITAID and needs to be resourced appropriately in 2011. Multi-year commitments by Brazil, France and the UK and have provided the basis for secure funding for the next 3 years.

Action 6: Optimizing UNITAID's Governance

Indicator	Calculation notes	Milestone 2010	2009	2010	Trend
1. Number of Board members who have gone through Board member training within the last 3 years.	Cannot be measured until plans for training are developed and approved.	Board member training process developed and implemented	N/A	None	N/A

Narrative explanation

UNITAID's Executive Board has created a Governance Committee to provide guidance to the Board on how UNITAID's overall governance can be improved. UNITAID is an innovative organization and requires best practice from Board governance. This is because the UNITAID Secretariat depends on its Board to set its strategic directions and key policies. A well-informed Board is essential to UNITAID continued success. To ensure that these decisions are evidence-based and implemented in a decisive and timely manner, UNITAID should invest in Board Member training.

Challenges for this Action

- A Board decision is needed on how and when to take action on this indicator.

Lessons learnt in this area

On-going dialogue between the Board, the Governance Committee and the Secretariat is needed to provide strategies for optimizing UNITAID's governance.

Area 3:
UNITAID Grant Performance

Action 1: Track treatments, diagnostics and related products delivered and estimated patients treated by UNITAID funded projects by beneficiary country and over time.

Indicator	Notes on calculations	Milestone 2010	2009	2010[16]	Trend
1. Number of treatments delivered and estimated number of patients treated known for each project on an annual basis	These are estimates based on implementing partner reporting	100% of UNITAID-funded projects have partner verified worksheets describing the estimated patients treated by country available on the UNITAID web site and updated by Q2 of the following year	HIV: **over 600,000** ARV treatments delivered to 44 countries TB: **424,543** TB treatments delivered in 2009 to 64 countries Malaria: nearly **19 million** malaria treatments (ACTs) delivered to date for 16 countries **13.5 million** LLINs delivered to 8 countries in 2009	HIV: **over 700,000** ARV treatments delivered to 52 countries[17] TB: **over 250,000** TB treatments delivered in 2010 to 68 countries. Malaria: over **17.6 million** malaria treatments (ACTs delivered for 32 countries. **6.5 million** LLINs delivered to 1 country in 2010	Stable
2. Number of patients treated as percentage of number on treatments planned for the year as per national forecasts shared with Implementing Partners	These are calculations done by the Secretariat based on implementing partner reporting and contractual agreements for 2010	Partners report % of patients treated relative to number of planned treatments based on annual agreed forecasts with beneficiary country government.	N/A	Reported for HIV projects (paediatric, 2nd line and PMTCT)	

See Annex 1, Table 10 and 12 by disease area and project

Narrative explanation

UNITAID's implementing partners report on the number of treatments and/or patients treated in countries as a result of their UNITAID-funded projects. The results presented in the table above are cumulative across countries and from the year 2007 to the end of 2010. A summary of treatments provided by year and disease area is presented in table 12. Results by country and product type (treatment, diagnostic, or prevention) are presented in table 10. This information is important because it is one of the ways that UNITAID measures its impact on public health. UNITAID aims to support access to treatment and diagnosis for people in low income countries so that they can be provided with life-saving care.
Cumulative increases in treatments provided are evident across all disease areas. This is due to successes in treatments provided to countries from CHAI and UNICEF for HIV/AIDS, GDF for TB and the start of AMFm for malaria. The data presented in this report are collated and analysed based

[16] For 2010 and based on the Secretariat's reconciliation of data presented in the 2010 annual reports submitted by implementing partners

[17] Plus an additional 1 million ARV treatments delivered for HIV positive pregnant women to prevent transmission of the disease to their children.

on reports from implementing partners. UNITAID Secretariat staff gather and check these results for consistency across years and completeness. These are then verified by implementing partners. Where external information is available to check the reliability of the results, the UNITAID Secretariat uses this information and then works with implementing partners to ensure that inaccuracies are identified and fixed. This process takes time. As a result, there may be slight changes in the data from year to year as we refine project data collection techniques and revise any inaccuracies.
Indicator 2 is a new indicator for 2010. Some partners are already providing this type of information. For other projects, this reporting will be available in the KPI report for 2011.

Challenges for this Action

- Reconciliation of partner provided data is improving due to the joint work that the UNITAID Secretariat is doing with implementing partners to provide the most up to date numbers. However this is a time consuming process and will need to be streamlined in the future.
- Not all partners have standard algorithms to translate treatments procured into estimated number of patients on treatment. UNITAID is working with all partners to refine their methodology for calculating the estimated number of patients on treatment so that this result can be provided routinely in the future. This data is an input into the calculation of Action 3, Track cumulative lives saved and life years gained by UNITAID supported ARVs, anti-TB medicines and ACTs. Action 3 measures UNITAID's contribution to public health so it is important to have a standard, replicable methodology for producing this data.

Lessons learnt through monitoring project performance

UNITAID launched the Logical Framework Approach to project planning with all of its implementing partners in late 2010. To date, the Secretariat has developed a UNITAID logframe template to facilitate consistent indicator development and promote better reporting. Additionally, UNITAID's KPIs have also been shared with partners so that they can see what expectations UNITAID has about the types of information that are important to its Board and other Stakeholders. UNITAID has also developed a project Monitoring System that is now in the Beta testing phase. The design of this system uses a logframe approach to make it easier for partners to put in their goals, objectives, outputs and activities and the indicators associated with each of these levels.

Action 2: Track costs of treatments, diagnostics and related products delivered by UNITAID-funded projects by beneficiary country and over time.

Indicator	Notes on calculations	Milestone 2010	2009[18]	2010[19]	Trend
Costs (US$) of treatments delivered known for each project on an annual basis	Provided by implementing partners in 2010 annual reports	100% of UNITAID-funded projects have partner verified worksheets describing the costs (US$) of patients treated by country available on the UNITAID web site and updated by Q2 of the following year	HIV: **US$285,649,351** spent on products delivered to countries. . TB: **US$ 46,502,271** spent on anti-TB medicines and diagnostics. Malaria: **US$ 247,649,174** spent by partners on Malaria actions.	HIV: **US$ 160 million.** TB: **US$ 32.2 million.** Malaria: **US$ 57 million**	In accordance with project plans

See Annex 1, Table 11 and 13

Narrative explanation

Monitoring the value of treatments and related products in countries is an element of measuring the value for money of UNITAID. In addition, this information is useful to the broader public health community in order to track where resources are currently being spent and where they may be needed in the future.

Partners report on the US$ value of medicines provided to beneficiary countries as a result of project agreements with UNITAID. There are two types of numbers that are tracked within the UNITAID Secretariat. The Finance and Administration team track the actual disbursements to implementing partners annually as well as the cumulative disbursements from the start of project funding. This forms part of the accountability framework of UNITAID and helps us to track how much money is going to each partner and to monitor that it is aligned with the contractual agreement between the partner and UNITAID.

Implementing partners also report to UNITAID on how much money they have spent on medicines and diagnostics in each beneficiary country. Cumulative results by country and product type (treatment, diagnostic, or prevention) are presented in table 11. A summary of treatments provided by year and disease area are presented in table 13. The data are essential for monitoring whether or not partners are providing value for money through use of UNITAID's funds. UNITAID also needs to track this information to ensure that its funds are being spent according to its constitutional requirement to spent greater than 85% of its annual budget in low income countries, less than 10% in lower middle income countries and less than 5% in upper middle income countries.

Challenges for this Action

- UNITAID does not have country offices or work directly with countries and it relies on its implementing partners to provide timely and accurate information about the cost of products delivered to countries.
- Actual disbursements are the easiest type of costs to report for each disease area but they do not reflect the reality of partner spending by country;

[18] The results presented in the table above are cumulative across countries and from the year 2007 to the end of 2009.

[19] Represents actual disbursements in 2010 for projects with procurement budgets and is a greater value than that of the value of treatments delivered for each country, which may be less because of the costs of shipping, clearance, insurance and some other programmatic costs agreed between UNITAID and the implementing partner.

- The tables in Annex 1 report the implementing partner spending on products per country but the data are not necessarily comparable across disease areas or project types. The main limitation is that some partners are still reporting the cost of treatments including shipping and procurement costs while others only report the cost of products. UNITAID is working with implementing partners to improve the consistency of reporting across all areas.

Lessons learnt through monitoring project performance

Implementing partners are starting to have a better understanding of UNITAID's requirements for forecasting and product delivery at the country level. The UNITAID Secretariat has implemented both an M&E logframe template and a Finance pro-forma budget template to facilitate better financial reporting that is linked directly to the activities that partners are doing in countries. These templates are being incorporated in the new Project Monitoring System and this will make the process of tracking monetary flows to countries easier.

Action 3: Track cumulative lives saved and life years gained by UNITAID supported ARVs, anti-TB medicines and ACTs

Indicator	Notes on calculations	Milestone 2010	2009	2010	Trend
1. Estimated number of lives saved as a result of UNITAID funded ARVs, anti-TB medicines and ACTs.	Methodology under development	1st analysis completed based on partner results for 2010	N/A	Consultant working on partner submitted data	N/A
2. Estimated number of life years gained as a result of UNITAID funded ARVs, anti-TB medicines and ACTs.	Methodology under development	1st analysis completed based on partner results for 2010	N/A	Consultant working on partner submitted data	N/A

Narrative explanation

These indicators are an attempt to measure the impact of UNITAID's funding support on global public health outcomes. UNITAID has a very specific mandate and mission. Its focus is on increasing access to and availability of products of public health importance to treat, diagnose and prevent HIV, TB and malaria. UNITAID focuses its support in low income countries, where the diseases are of highest burden already. This means that its is already doing invaluable work that is additional to the efforts of other global public health initiatives. These indicators are important proxy indicators for the contributions that UNITAID funding makes to global public health.

The distinctiveness of UNITAID lies not just in its ability to make a public health impact but also in its focus on stimulating the markets for products. UNITAID's role in building or fixing markets for medicines and diagnostics makes many life saving products available to people who would not have had access to them, either because the cost was too great or because the product would not have been produced. UNITAID and its partners focus on specific, needed products to generate sufficient demand so that more generic manufacturers enter these markets. The result of these actions is to reduce the price of these products and accelerate the introduction of other important new products. This strategy has been used in the UNITAID funded CHAI project for second line ARVs where it is expected to generate a global cost savings of at least US$600 million[20] over the next 3 years. The value for money generated by UNITAID's support to this market helps not only global initiatives like the Global Fund and PEPFAR but also the countries themselves to procure affordable, quality medicines and diagnostics.

Challenges for this Action

- The results that will be presented here must be based on sound partner reported data. The challenge is still to produce timely partner-reported data to develop the methodology for estimating lives saved and life years gained.
- UNITAID is working with an expert on measuring the impact of public health initiatives and although results are not currently ready, they are expected before the end of 2011 and will be made public on the UNITAID website.

[20] Cost savings is derived from the price difference between the average market price in 2008. In addition, CHAI's 2011 price ceilings were multiplied by the anticipated demand for Tenofovir (TDF) and Atazanavir (ATV) over the next 3 years. The US$ 600 million savings estimate conservatively assumes no scale up in the total number of patients being treated with ARVs but assumes that product preferences in existing patients will shift towards TDF for first line treatment and ATV for second line treatment.

Lessons learnt through monitoring project performance

The data used to calculate number of lives saved and life years gained are estimated number of patients treated or diagnosed derived from the number of treatments and diagnostics procured by each UNITAID funded project. These estimates are uncertain and many implementing partners are concerned about whether this uncertainty will detract from their overall project achievements. Measuring UNITAID's impact based on these two indicators alone may discount the value of UNITAID's support to market dynamics. UNITAID and its partners are working on additional indicators that use UNITAID's unique focus on the market for products of public health importance. These will include measures of cost savings generated over time and into the future.

Action 4: Identify the sources of support for operational costs in each beneficiary country at the start of each project

Indicator	Baseline 2009	Milestone 2010	2009	2010	Trend
1. Per cent (%) of UNITAID funded projects that have a costing (US$) for operational costs and the sources of operational costs provided at the start of project funding.	N/A	Partners report source and amounts of operational costs to UNITAID annually	N/A	HIV: CHAI reports contributing US$ 13 million to complementary programmatic work in UNITAID funded countries Malaria: US$ 86 million are contributed by the UK (DFID) and the Gates Foundation for phase 1 of AMFm TB: FIND reports raising US$ 4.2 million funds for category 1 countries and US $1.3 million for category 2 countries	Increasing

Narrative explanation

UNITAID expects that its implementing partners will provide funds to support the programmatic work that they are doing in countries as a result of UNITAID's funding of the procurement costs for the project. The global financial crisis has effected some partners' abilities to generate programmatic support externally. Both CHAI and GDF have requested that UNITAID provide support for some additional programmatic activities related to their UNITAID funded projects, including provision of monies for staff costs.

Challenges for this Action

- Some implementing partners are reluctant to report this information as it was not a part of their previous contractual agreement with UNITAID.

Lessons learnt through monitoring project performance

This is a new indicator for 2010. More information on lessons learnt will be available in the KPI Report for 2011.

Action 5: : UNITAID implementing partners sign MoUs with national governments to commit long term support, align technologies and protocols for working with Ministries of Health.

Indicator	Baseline 2009	Milestone 2010	2009	2010	Trend
1. Per cent (%) of UNITAID implementing partners that have MoUs signed with all national governments before start of the project or within Q1 of the project start year.	All partners have a requirement for an MoU arrangement with national governments but only 25% sign all agreements before the start of the project or by Q1 of the project start year.	100% of new partners with new projects sign MoUs with beneficiary country national governments by Q1 of the project start year.	25%	81% [21]	Increasing

Narrative explanation

UNITAID expects implementing partners to work within the existing national health frameworks in the countries for which treatments and diagnostics are being procured. One way of ensuring the visibility of UNITAID through its funding of implementing partners is through the use of Memoranda of Understanding with national governments which describe the projects fully, including UNITAID as the source of the funding. This provides governments with the information that they need to more easily align the projects with existing national initiatives so as not to duplicate resources or add an additional reporting burden.

For most of UNITAID's partners, including UNICEF, GDF and ESTHER, MoUs with Ministries of Health are routinely created and finalized. CHAI has found it difficult to finalize MoUs in some countries, although they have made progress in 2010. For the 2nd Line project, CHAI reports that 67% of countries[22] have signed MoUs. For the paediatric project, CHAI reports that 65% of countries have signed in 2010[23].

Challenges for this Action

- Signature of MoUs before the start of projects is a requirement of UNITAID funding and needs to be enforced in the case of non compliance.

Lessons learnt through monitoring project performance

In general, most partners are working within the frameworks of national government and are succeeding in getting support for their work from national governments. UNIATID is working on ways to institutionalized this requirement so that it becomes a routine condition of our contractual agreements with partners.

[21] In 2010, CHAI reports 67% of MoUs signed for the 2nd line project and 65% signed for the paediatric project.

[22] Cameroon, Chad, Kenya, Mozambique and Uganda had not signed MoUs with CHAI for the 2nd Line project in 2010.

[23] Cameroon, China, Cote d'Ivoire, Ethiopia, Malawi, Dominican Republic, Kenya and Lesotho had not signed MoUs with CHAI for 2010.

ANNEX 1

Table 1. Prices for 2nd line ARVs, 2008, 2009 and 2010

	MEDIAN[24] PRICE PER PATIENT PER YEAR (US$)				
	2008	2009		2010	
ARV name	**Generic (interquartile range)**	**Brand (interquartile range)**	**Generic (interquartile range)**	**Brand (interquartile range)**	**Generic (interquartile range)**
Abacavir 300 mg (ABC)	335 (314-389)	n/a	228 (228-276)	n/a	202 (192-228)
Didanosine 250 mg (DDI-ec)	n/a	220	156 (156-170)	220	156 (156-170)
Didanosine 400 mg (DDI-ec)	288 (286-288)	284	240 (240-266)	284	264 (240-264)
Emitricitabine 200mg / Tenofovir 300mg (TDF/FTC)	319 (251-319)	496 (362-630)	141 (141-205)	315 (upper middle income)	138 (138-141)
Lamivudine 300 mg / Tenofovir 300 mg (TDF/3TC)	158	n/a	138 (120-171)	n/a	107 (106-107)
Lopinavir 200mg / Ritonavir 50mg (LPV/r)	496 (496-569)	493	441 (441-567)	434 (434-493)	420 (420-441)
Tenofovir 300 mg (TDF)	207 (151-208)	204 (204-469)	99 (99-149)	n/a	84 (82-84)
Atazanavir 300 mg (ATV)	-	-	-	n/a	247 (0)
Ritonavir hs 100 mg (RTV)	-	-	-	82	357 (lower middle income)
Regimens					
TDF + 3TC (300 mg + 300 mg) & LPV/r (200 mg + 50 mg)	654	n/a	579 (561-738)		527 (526-548)
TDF+ FTC (300 mg + 200 mg) & LPV/r (200 mg + 50 mg)	815 (747-915)	989 (855-1123)	582 (582-772)	749 (upper middle income)	558 (558-561)

[24] Median price analysis based on low income country orders only. Interquartile ranges shown only when greater than zero.

Table 2. Per cent change in price reductions 2nd line ARVs 2008-2010.

	2008-2009	2009-2010	2008-2010
ARV name	**% change[25]**	**% change**	**% change**
Abacavir 300mg (ABC)	-32	-11	-43
Didanosine 250 mg (DDI-ec)	na	0	na
Didanosine 400 mg (DDI-ec)	-17	+10	-7
Emitricitabine 200 mg / Tenofovir 300 mg (TDF/FTC)	-56	-2	-58
Lamivudine 300 mg / Tenofovir 300 mg (TDF/3TC)	-13	-22	-35
Lopinavir 200 mg / Ritonavir 50 mg (LPV/r)	-11	-5	-16
Tenofovir 300 mg (TDF)	-52	-15	-67
Atazanavir 300 mg (ATV)	-	-	-
Ritonavir hs 100 mg RTV)	-	-	-
Regimens			
TDF + 3TC (300 mg + 300mg) & LPV/r (200 mg + 50 mg)	-11	-9	-20
TDF+ FTC (300 mg + 200 mg) & LPV/r (200 mg +50 mg)	-29	-4	-33

[25] Analysis has been done for generic products only. Minus (-) indicates per cent reduction; plus (+) indicates per cent increase.

Table 3. Approved suppliers by year for 2nd line ARVs

	2008	2009	2010	Number of new suppliers in 2010
ARV name				
Abacavir 300 mg (ABC)	Aurobindo, Cipla, Matrix, GSK	Aurobindo, Cipla, Matrix, GSK, Ranbaxy	Aurobindo, Cipla, Matrix, GSK, Ranbaxy, Hetero, Strides, Invagen Pharms	3
Atazanavir 300 mg (ATV)	na	BMS	BMS, Matrix, Emcure, Cipla	3
Ritonavir Heat Stable 100 mg (RTV)	na	na	Abbott, Matrix	2
Lopinavir 200 mg/ Ritonavir 50mg (LPV/r)	Abbott, Matrix, Aurobindo, Cipla	Abbott, Matrix, Aurobindo, Cipla, Hetero	Abbott, Matrix, Aurobindo, Cipla, Hetero	0
Didanosine 250 mg (DDI-ec)	BMS, Barr, Aurobindo	BMS, Barr, Aurobindo, Matrix, Cipla	BMS, Barr, Aurobindo, Matrix, Cipla	0
Didanosine 400 mg (DDI-ec)	BMS, Barr, Aurobindo	BMS, Barr, Aurobindo, Matrix, Cipla	BMS, Barr, Aurobindo, Matrix, Cipla	0
Tenofovir 300mg (TDF)	Gilead, Matrix	Gilead, Matrix, Aurobindo, Cipla, Ranbaxy, Hetero	Gilead, Matrix, Aurobindo, Cipla, Ranbaxy, Hetero, Invagen Pharms, Strides	2
Tenofovir 300 mg/ Emitricitabine 200 mg (TDF/FTC)	Gilead, Matrix	Gilead, Matrix, Cipla, Aurobindo	Gilead, Matrix, Cipla, Aurobindo, Strides	1
Tenofovir 300 mg/ Lamivudine 300 mg (TDF/3TC)	Matrix	Matrix, Hetero, Cipla	Matrix, Hetero, Cipla, Aurobindo	1

Table 4. Prices for selected, WHO recommended Paediatric ARVs, 2008, 2009 and 2010.

	MEDIAN[26] PRICE PER PATIENT PER YEAR (US$)					
	2008		2009		2010	
ARV name	**Brand (interquartile range)**	**Generic (interquartile range)**	**Brand (interquartile range)**	**Generic (interquartile range)**	**Brand (interquartile range)**	**Generic (interquartile range)**
Lopinavir 80 mg/ Ritonavir 20 mg per ml (Syrup) (LPV/r)	206	na	206	na	181	na
Regimens[27]						
Lamivudine 30 mg/Zidovudine 60 mg / Nevirapine 50mg (3TC/AZT/NVP)	na	108	na	108	na	106
Lamivudine 150 mg/ Zidovudine 300 mg/ Nevirapine 200mg (3TC/AZT/NVP)	na	150 (133-154)	na	147	na	136 (136-137)
Lamivudine 30 mg/Zidovudine 60 mg (3TC/AZT)	na	85	na	84	na	81
Lamivudine 150 mg/ Zidovudine 300 mg (3TC/AZT)	na	114	na	113	na	103
Abacavir 60 mg/ Lamivudine 30 mg (3TC/ABC)	na	193	na	182		172

[26] Median price analysis based on low income country orders only. Interquartile ranges shown only when greater than zero.

[27] Regimens were selected based on consumption patterns in countries and the need for these regimens in low income country settings. 3TC+NVP+d4T (60 mg+100 mg+ 12mg) and 3TC + NVP + AZT (30 mg +50 mg + 60 mg) are no longer recommended by WHO because of the toxicity of d4T and so CHAI reports that it has discontinued use of these products.

Table 5. Per cent change in price reductions for paediatric ARVs in 2008, 2009 & 2010

	2008-2009	2009-2010	2008-2010
ARV name	**% change[28]**	**% change**	**% change**
Lopinavir 80 mg/ Ritonavir 20 mg per ml (Syrup) (LPV/r)	0	-12	-12
Lamivudine 30 mg/Zidovudine 60 mg/Nevirapine 50mg (3TC/AZT/NVP)	0	-2	-2
Lamivudine 150 mg/Zidovudine 300 mg/ Nevirapine 200mg (3TC/ AZT/ NVP)	-2	-7	-9
Lamivudine 30 mg/Zidovudine 60 mg (3TC/AZT)	-1	-4	-5
Lamivudine 150 mg/ Zidovudine 300 mg (3TC/AZT)	-1	-9	-10
Abacavir 60 mg/ Lamivudine 30 mg (3TC/ABC)	-6	-5	-11

[28] Analysis has been done for generic products only. Minus (-) indicates per cent reduction; plus (+) indicates per cent increase.

Table 6. Approved suppliers by year for paediatric ARVs

	2008	2009	2010	Number of new suppliers in 2010
ARV name				
Abacavir 60 mg/ Lamivudine 30 mg (ABC/3TC)	Aurobindo	Aurobindo, Matrix	Matrix	-1
Lopinavir 80 mg/ Ritonavir 20 mg per ml (Syrup) (LPV/r)	Abbott	Abbott	Abbott	0
Lamivudine 30 mg + Zidovudine 60 mg (3TC/AZT)	Matrix	Aurobindo, Matrix	Aurobindo, Matrix	0
Lamivudine 150 mg + Zidovudine 300 mg (3TC/ AZT)	Matrix	Hetero, Matrix	Hetero, Cipla	0
Lamivudine 30 mg/Zidovudine 60 mg/Nevirapine 50mg (3TC/AZT/NVP)	Matrix	Matrix	Matrix	0
Lamivudine 150 mg/ Zidovudine 300 mg/ Nevirapine 200mg (3TC/AZT /NVP)	Cipla, Aurobindo	Hetero, Matrix	Cipla, Hetero	0

Table 7. WHO Prequalification Programme Dashboard of UNITAID priority medicines prequalified from 2007 to 2010[29].

(WHO PQP Annual Report to UNITAID, 2010)

SUMMARY	NUMBER	STAGE 1	STAGE 2	STAGE 3
Second-line anti-retrovirals	36	36	31	19
Paediatric anti-retrovirals	7	7	7	4
1st-line anti-tuberculosis products	17	17	16	3
2nd-line anti-tuberculosis products	19	19	18	1
Paediatric anti-tuberculosis products	10	10	10	4
Anti-malarials	28	28	22	7
TOTAL	**117**	**117**	**104**	**38**

Key

Stage 1: Accepted dossiers awaiting assessment as of date of this report
Stage 2: dossier assessment started
Stage 3: prequalification complete

[29] Analysis Including UNITAID priority products under assessment as at 31 December 2010 for dossiers accepted in 2007. For dossiers accepted before 2007 and from 2007 to 2010 a total of 51 UNITAID priority products have been prequalified.

Table 8. UNITAID priority medicines prequalified from 2007 to 2010

UNITAID priority medicines prequalified in 2007						
Disease area		Medicine	formulation	dosage	manufacturer	date of prequalification
HIV	2nd line	Lopinavir + Ritonavir	tablets	200mg + 50mg	Abbott Laboratories	06/06/2007
			tablets	300mg + 600mg +200mg	Merck Sharp & Dohme	21/12/2007
TB	1st line	Ethambutol + Isoniazid	tablets	400 mg + 150 mg	Macleods Pharmaceuticals Ltd	23/03/2007
	Peds.	Ethambutol, tablet	tablets	400 mg	Macleods Pharmaceuticals Ltd	23/03/2007
	MDR	Cycloserine	capsules	250 mg	Macleods Pharmaceuticals Ltd	23/03/2007
		Ethionamide		250 mg	Macleods Pharmaceuticals Ltd	21/12/2007
Malaria	ACT	Artesunate	tablets	50 mg	Ipca Laboratories Ltd	30/08/2007

UNITAID priority medicines prequalified in 2008						
Disease area		Medicine	formulation	dosage	manufacturer	date of prequalification
HIV	2nd line	Lopinavir + Ritonavir	tablets	100 mg + 25 mg	Abbott Laboratories	25/07/2008
	Peds.	Stavudine + Lamivudine + Nevirapine	tablets	6 mg + 30 mg + 50 mg	Cipla Ltd	23/04/2008
TB	1st line	Isoniazid + Rifampicin	tablets	75mg + 150mg	Macleods Pharmaceuticals Ltd	07/03/2008
		Ethambutol + Isoniazid + Rifampicin	tablets	275mg +75mg +150mg	Macleods Pharmaceuticals Ltd	22/10/2008
		Ethambutol (hydrochloride) + Isoniazid + Pyrazinamide + Rifampicin	tablets	250mg +75 mg +400 mg +150 mg	Macleods Pharmaceuticals Ltd	07/03/2008
	Peds.	Isoniazid	tablets	100 mg	Macleods Pharmaceuticals Ltd	23/04/2008
Malaria	ACT	Artemether + Lumefantrine	tablets	20 mg +120 mg	Ajanta Pharma Ltd	16/12/2008
		Artesunate + Amodiaquine	tablets	50 mg +153 mg (or 200 mg as hydrochloride	Ipca Laboratories Ltd Cipla Ltd	23/04/2008 11/11/2008
		Artesunate + Amodiaquine	tablets	67.5 mg+25 mg	Sanofi-Aventis	11/11/2008
		Artesunate + Amodiaquine	tablets	135 mg+50 mg	Sanofi-Aventis	14/10/2008

UNITAID priority medicines prequalified in 2009						
Disease area		**Medicine**	**formulation**	**dosage**	**manufacturer**	**date of prequalification**
HIV	2nd line	Abacavir (as sulfate)	tablets	60 mg	Matrix Laboratories Ltd	26/10/2009
		Tenofovir (disoproxil fumarate)	tablets	300 mg	Cipla Ltd Matrix Laboratories Ltd Ranbaxy Laboratories Ltd	30/06/2009 27/10/2009 16/12/2009
		Lopinavir + Ritonavir	tablets	200 mg + 50 mg	Matrix Laboratories Ltd	19/02/2009
		Lopinavir + Ritonavir	tablets	100 mg + 25 mg	Matrix Laboratories Ltd	25/05/2009
	Peds.	Zidovudine + Lamivudine + Nevirapine	tablets	60 mg + 30 mg + 50 mg	Matrix Laboratories Ltd	26/10/2009
		Zidovudine + Lamivudine	tablets	60 mg + 30 mg	Matrix Laboratories Ltd	25/05/2009
		Abacavir (as Sulfate) + Zidovudine + Lamivudine	tablets	60 mg + 60 mg + 30 mg	Matrix Laboratories Ltd	25/05/2009
		Abacavir (as Sulfate) + Lamivudine	tablets	60 mg + 30 mg	Matrix Laboratories Ltd	26/10/2009
TB	Peds.	Isoniazid + Rifampicin	dispersible tablets	60 mg + 60 mg	Macleods Pharmaceuticals Ltd	09/11/2009
		Isoniazid + Rifampicin	dispersible tablets	30 mg + 60 mg	Macleods Pharmaceuticals Ltd	03/03/2009
		Isoniazid + Pyrazinamide + Rifampicin	dispersible tablets	30 mg + 150 mg + 60 mg	Macleods Pharmaceuticals Ltd	03/03/2009
	MDR	Cycloserine	capsules	250 mg	Aspen Pharmacare Ltd	19/06/2009
		P-aminosalicylic sodium	granules	100 g	Macleods Pharmaceuticals Ltd	14/12/2009
Malaria	ACT	Artemether + Lumefantrine	tablets dispersible tablets	20 mg + 120 mg 20 mg + 120 mg	Cipla Ltd Ipca Laboratories Ltd Novartis Pharma	22/05/2009 15/12/2009 27/02/2009

UNITAID priority medicines prequalified in 2010						
Disease area		Medicine	formulation	dosage	manufacturer	date of prequalification
HIV	2nd line	Atazanavir	capsule	300 mg	Matrix Laboratories	25/10/2010
		Ritonavir	Tablet (heat stable)	100 mg	Matrix Laboratories	14/12/2010
		Ritonavir	Tablet (heat stable)	100 mg	Abbott Laboratories	02/06/2010
		Efavirenz	Tablets (scored)	200 mg	Cipla Ltd	14/12/2010
		Tenofovir + emitricitabine	tablets	300 mg + 200 mg	Matrix Laboratories	20/08/2010
		Tenofovir + Lamivudine	tablet	300 mg + 300 mg	Matrix Laboratories	30/06/2010
		Tenofovir + Efavirenz + emitricitabine	tablet	300 mg + 600 mg + 200 mg	Matrix Laboratories	25/10/2010
		Tenofovir + Efavirenz+ Lamivudine	tablet	300 mg + 600 mg + 300 mg	Matrix Laboratories	25/10/2010
	Peds.	Abacavir	tablet	60 mg	Cipla ltd.	20/08/2010
TB	1st line	High dose Isoniazid	Tablet (loose + blister pack)	300 mg	Micro labs	01/11/2010
		Ethambutol + isoniazid	Tablet	400 mg +150 mg	Cadila Pharmaceuticals Ltd	28/04/2010
		Ethambutol hydrochloride	tablet	400 mg	Lupin Ltd	08/04/2010
	Paediatric	Isoniazid	Tablet (breakable)	100 mg	Micro labs	01/11/2010
	MDR	Moxifloxacin (moved to first line)	tablet	400 mg	Cipla Ltd	01/11/2010
Malaria	ACT	Artesunate	Powder for injections	60 mg (vial)	Guilin Pharmaceuticals Ltd	05/11/2010

Table 9. Area 1, Action 4: Selected delivery lead time achievements from partners.

Paediatric HIV (with CHAI 2010)		
Manufacturer	**Status**	**Average lead time (days)***
Abbott	Originator	55.2 (50% decrease from 2009)
Strides Arcolab	Generic	66.8
Cipla	Generic	72.3
Matrix	Generic	86.8
Aurobindo	Generic	96.5
BMS	Originator	111.3
Hetero Drugs	Generic	114.8

* Refers to average number of days between the date a purchase order is confirmed and the date products are ready EX factory per manufacturer of ARVs.

2nd Line HIV (with CHAI, 2010)		
Manufacturer	**Status**	**Average lead time (days)***
BMS	Originator	20.6
Hetero	Generic	42.8
Emcure	Generic	44.5
Cipla	Generic	75.2
Abbott	Originator	78.4
Matrix	Generic	101.6
Aurobindo	Generic	104.8

* Refers to average number of days between the date a purchase order is confirmed and the date products are ready EX factory per manufacturer of ARVs.

Table 9 continued

TB			
	Number of orders placed	**Number of orders delivered**	**Actual average lead time (days*)**
MDR-TB	N/A	N/A	102
MDR-TB stock pile**	20	20	42
Paediatric TB	40#	N/A	77
1st Line TB	30	N/A	55
1st Line stockpile***	41	37	56

*lead time is calculated as the number of calendar days from firm order placement with procurement agent to the actual delivery in country since order placed until delivery in country programmes.
**Reported by the Global Fund for urgent and emergency orders in 2010.
*** Orders placed to 1st Line stockpile to meet urgent or emergency needs for treatment in 2010.
#Based on interim report GDF in 2010. Not reported in annual report 2010.

Table 9 continued

Malaria ACT Scale up			
Manufacturer	**Status**	**Product**	**Average lead time (days)***
Guillin Pharmaceutical	Generic	Artesunate 100 mg + SP5 25 mg tabs/6+3/PAC - 25	116
		Artesunate 50 mg + SP 525 mg tabs/6+2/PAC - 25	116
Novartis Pharma AG	Originator	Artemeth 20mg + Lumef 120 mg disp tab/6/PAC - 30	50
		Artemeth 20mg + Lumef 120 mg disp tab/12/PAC - 30	50
		Artemeth 20 mg + Lumefan 120 mg tab/18/PAC - 30	51
		Artemeth 20 mg + Lumefan 120 mg tab/24/PAC - 30	47
		Artemeth 20 mg + Lumefan 120 mg tab/18/PAC - 30	50
		Artemeth 20 mg + Lumefan 120 mg tab/24/PAC - 30	54
Africasoins	Generic	Amodiaquine 67.5 mg + Arte 25 mg tab/3/PAC - 25	13
		Amodiaquine 135 mg + Arte 50 mg tab/3/PAC - 25	13

* Analysis done at UNITAID from UNICEF supplied annual procurement report for 2010, Annex 7, Procurement Report. Calculation done on delivery lead time from date of purchase order issue to actual arrival in country, includes only 2010 procurements.

Table 10: (Action 1, Area 3) Track treatments, diagnostics and related products delivered and estimated patients treated by UNITAID funded projects by beneficiary country and over time.

Treatments and Prevention supported by UNITAID across HIV/AIDS niches : Adults

Country	**Cumulative Treatments** - Adults				**Total**	**Cumulative Prevention** - Adults				**Total**
	Treatments - ART for HIV positive pregnant women		**Treatments** ARVs 2nd Line Adults			**Prevention -** ARVs to prevent mother to child transmission		**Prevention -** Cotrimoxazole provided to HIV+ women		
Lead Recipient	**UNICEF (PMTCT I)**	**UNICEF (PMTCTII)[3]**	**CHAI[1,2]**	**GF: Round 6**		**UNICEF (PMTCT I)**	**UNICEF (PMTCTII)[3]**	**UNICEF (PMTCTI)**	**UNICEF (PMTCT II)[3]**	
Benin			3,723		3,723					
Botswana			7,768		7,768					
Burkina Faso	258				258	7,082		3,557		10,639
Burundi			4,355		4,355					
Cambodia			4,896		4,896					
Cameroon	411		3,894		4,305	18,879		18,484		37,363
Central African Republic		507			507		18,199		2,643	20,842
Chad			1,289		1,289					
China		0			0		0		514	514
Côte d'Ivoire	8112		1,032		9,144	17,969		19,201		37,170
Djibouti			0	839	839					
Ethiopia			3,958		3,958					
Ghana			2,760		2,760					
Haiti		759	1,192		1,951		4,998		6,492	11,490
India	0		3,320		3,320	25,253		0		25,253
Kenya			43,365		43,365					
Laos			0	2,129	2,129					
Lesotho		0			0		19,165		0	19,165
Liberia			0	2501	2,501					
Malawi	2885		3,005		5,890	34,760		0		34,760
Mali			2,355		2,355					
Moldova			0	1,047	1,047					
Mozambique			6,798		6,798					
Myanmar		630			630		4,636		821	5,457
Namibia			7,441		7,441					
Nigeria		7,067	33,010		40,077		123,549		18,173	141,722
République démocratique du Congo			2,781		2,781					
Rwanda	3813		2,359		6,172	19,295		22,545		41,840
Senegal			4,631		4,631					

Swaziland		3,812			3,812		21,818		6,755	28,573
Tanzania	6549		4,490	1,584	12,623	32,537		4,566		37,103
Togo			26,181		26,181					
Tunisia			0	361	361					
Uganda		5,849	99,339		105,188		104,117		58,661	162,778
Zambia	9225		148,970		158,195	41,472		31,421		72,893
Zimbabwe		15,000	3,300		18,300		318,242		3,257	321,499
TOTAL	**31,253**	**33,624**	**426,212**	**8,461**	**499,550**	**197,247**	**614,724**	**99,774**	**97,316**	**1,009,061**

[1]Includes Tenofovir ordered as first line treatments for Namibia (2008), Uganda and Zambia (2008, 2009, 2010)
[2] For many countries, patients treated estimates are based on patient data or estimates provided by the country Ministries of Health and/or treatment partners. In cases where patient figures were not provided or were not in line with actual volumes ordered
[3] Based on reports submitted by UNICEF to UNITAID: First Annual Report 2009; Interim Report 2010 and Annual Report 2010 and Updated by Email Correspondence on 14 June 2011.

Treatments and Prevention supported by UNITAID across HIV/AIDS niches : Children

Country	Cumulative Treatments - Children		Total	Cumulative Prevention - Children[1]			Total
	Treatments - ARVs children			Prevention - RuTF and Cotrimoxazole[2]			
Lead Recipient	CHAI[3]	GF-Round6		UNICEF (PMTCTI)	UNICEF (PMTCTII)	UNICEF (PMTCTIII)	
Angola	830		830				
Benin	1,179		1,179				
Botswana	8,698		8,698				
Burkina Faso	1,399	1,373	2,772	2,046			2,046
Burundi	2,218		2,218				
Cambodia	4,134		4,134				
Cameroon	3,994		3,994	11,548			11,548
Central African Republic			0		3,405		3,405
China	1,900		1,900		625		625
Côte d'Ivoire	3,443		3,443	9,219			9,219
Dominican Republic	950		950				
Ethiopia	14,019		14,019				
Guinea		6,866	6,866				
Guyana	272		272				
Haiti	715		715		3,093		3,093
India	23,017	15,000	38,017	18,244			18,244
Jamaica	471		471				
Kenya	39,254		39,254				
Laos		1,145	1,145				
Lesotho	4,316		4,316		0		0
Liberia	366		366				
Malawi	25,028		25,028	24,184		18,784	42,968
Mali	1,392		1,392				
Morocco		2,614	2,614				
Mozambique	17,395		17,395				
Myanmar			0		997		997
Namibia	9,346		9,346				
Nigeria	37,758		37,758		9,299		9,299
OECS*	21		21				
Papua New Guinea	426		426				
République démocratique du Congo	4,925		4,925				
Rwanda	7,644		7,644	12,358		44,207	56,565
Senegal	713	4,199	4,912				

Serbia		0	0				
Swaziland	6,275		6,275		9,416		9,416
Tanzania	29,173		29,173	1,582		11,612	13,194
Togo**	737		737				
Uganda	22,434		22,434		13,289		13,289
Viet Nam	2,672		2,672				
Zambia***	25,855		25,855	8,083		0	8,083
Zimbabwe	29,278		29,278		0		0
TOTAL	**332,999**	**31,197**	**364,196**	**87,264**	**40,124**	**74,603**	**201,991**

*OECS = Organization of Eastern Caribbean States with 6 countries: Antigua and Barbuda (UMI), Dominica (UMI), Grenada (UMI), St. Kitts and Nevis (UMI), St. Lucia (UMI) and St. Vincent and Grenadines (LMI).
**Togo was added to the UNITAID pediatric programme in 2009
*** Does not include the charge of clearing/additional shipping disbursed for Zambia 2009
[1] Does not include CHAI
[2] HIV exposed infants receiving Cotrimoxazole at 3 months and 2 years combined
[3] Estimate of new patients treated updated as of 31 December 2010. Cumulative figures are aggregate from 2007 to 31 December 2010 and represent estimated number of patients on ART as a result of the project.

HIV Testing supported by UNITAID across HIV/AIDS niches : Mothers

Country	**Cumulative Tests** - Adults				**Total**
	pregnant women **HIV tests**		HIV positive pregnant women **CD4 tests**		
Lead Recipient	**UNICEF (PMTCTI)**	**UNICEF (PMTCTII)**[1]	**UNICEF (PMTCTI)**	**UNICEF (PMTCTII)**[1]	
Burkina Faso	241,610		2,600		244,210
Cameroon	285,055		48,800		333,855
Central African Republic		56,117		249,200	305,317
China		1,447,125		12,000	1,459,125
Côte d'Ivoire	344,725		24,400		369,125
Haiti		2,805		2,400	5,205
Lesotho		0		0	0
Malawi	708,210		184,250		892,460
Myanmar		143,217		800	144,017
Nigeria		483,293		56,800	540,093
Rwanda	168,190		26,600		194,790
Swaziland		0		0	0
Tanzania	108,244		45,000		153,244
Uganda		3,300,219		101,500	3,401,719
Zambia	367,780		30,200		397,980
Zimbabwe		355,088		4,050	359,138
TOTAL	**2,223,814**	**5,787,864**	**361,850**	**426,750**	**8,800,278**

[1] Based on reports submitted by UNICEF to UNITAID: First Annual Report 2009; Interim Report 2010 and Annual Report 2010 and Updated by Email Correspondence on 14 June 2011

HIV Testing supported by UNITAID across HIV/AIDS niches : Children

Country	Cumulative Tests - Children			Total
	tests - HIV for Early Infant Diagnosis			
Lead Recipient	CHAI[1]	UNICEF (PMTCTI)[2]	UNICEF (PMTCTII)[3]	
Angola	18,170			18,170
Benin	35,536			35,536
Botswana	177,652			177,652
Burkina Faso	363,586	1152		364,738
Burundi	11,371			11,371
Cambodia	50,404			50,404
Cameroon	60,387	1728		62,115
Central African Republic			0	0
China	2,592		8,928	11,520
Côte d'Ivoire	36,800	10368		47,168
Dominican Republic	21,128			21,128
DR Congo	176,271			176,271
Ethiopia	61,224			61,224
Guyana	3,324			3,324
Haiti	0		4,320	4,320
India	10,013	12096		22,109
Jamaica	5,504			5,504
Kenya	256,381			256,381
Lesotho	262,708		0	262,708
Liberia	65,283			65,283
Malawi	412,526	1920		414,446
Mali	53,652			53,652
Mozambique	504,957			504,957
Myanmar			288	288
Namibia	129,262			129,262
Nigeria	1,063,598		0	1,063,598
OECS*	1,628			1,628
Papua New Guinea	2,592			2,592
Rwanda	1,522,315	576		1,522,891
Senegal	30,928			30,928
Swaziland	84,801		0	84,801
Tanzania	273,375	7200		280,575
Togo**	25,267			25,267
Uganda	756,756		0	756,756
Vietnam	78,880			78,880
Zambia	686,742	2592		689,334
Zimbabwe	522,966		11,520	534,486
TOTAL	**7,768,579**	**37,632**	**25,056**	**7,831,267**

*OECS = Organization of Eastern Caribbean States with 6 countries: Antigua and Barbuda (UMI), Dominica (UMI), Grenada (UMI), St. Kitts and Nevis (UMI), St. Lucia (UMI) and St. Vincent and Grenadines (LMI).
**Togo was added to the UNITAID pediatric program in 2009
[1] Tests are based on the information provided in the Order Tracker and the 2010 Annual Report submitted by CHAI
[2] Based on Annual Reports submitted by UNICEF; the reports follow the grant year which are then converted to produce treatment numbers for the calendar year
[3] Based on reports submitted by UNICEF to UNITAID: First Annual Report 2009; Interim Report 2010 and Annual Report 2010 and Updated by Email Correspondence on 14 June 2011

Malaria treatments supported by UNITAID: Adults and Children

Country	Cumulative Treatments				Total
Lead Recipient	ACT Scale up-GF&UNICEF[1]	GF	AMFM GF[2,3]	A2S2 i+solutions	
Bangladesh		121,325			121,325
Burundi[4]	722,953				722,953
Cambodia	295,850	141,755	0		437,605
China		91,861			91,861
Cote d'Ivoire		274,086			274,086
Djibouti		4,105			4,105
Eritrea		43,136			43,136
Ethiopia	3,999,990	0			3,999,990
Gambia		210,962			210,962
Ghana	2,790,020		1,910,620		4,700,640
Guinea		440,878			440,878
Guinée Bissau		103,065			103,065
Indonesia	139,350				139,350
Kenya			2,397,770		2,397,770
Liberia[4]	678,275	0			678,275
Madagascar	2,889,805	0	21,600		2,911,405
Mali		683,798			683,798
Mauritania		61,741			61,741
Mozambique	9,500,940				9,500,940
Namibia		362,161			362,161
Niger			0		0
Nigeria		0	0		0
Somalia		111,779			111,779
Sudan *	3,009,425				3,009,425
Tanzania		0	210,000		210,000
Uganda		0	0		0
Zambia	5,089,890	0			5,089,890
TOTAL	**29,116,498**	**2,650,652**	**4,539,990**	**n/a**	**36,307,140**

* Treatments for North and South Sudan have been added
[1] All figures based on Annual Reports submitted and confirmed by UNICEF on 10 June 2011
[2] Figures recalculated by Global Fund for calendar year 2010 as report received covered the period until March 2011; values were confirmed by the Global Fund on 10 June 2011
[3] The AMFM project also included Benin, Senegal and Rwanda. Benin and Senegal were not successful with their grants to the Global Fund; Rwanda declined the grant
[4] Liberia and Burundi were exceptionally financed by UNITAD in 2007 for procurement of ACT drugs and are not part of the ACT Scale up programme. The number of treatments under the ACT Scale up project should exclude Liberia and Burundi and should read as 27,715,270 (=29,116,498-722,953-678,275)

Prevention (Long Lasting Insecticide Treated Bednets) supported by UNITAID for Malaria

Country	Cumulative Prevention LLINs
Lead Recipient	**UNICEF**
Angola	850,000
Central African Republic	1,100,000
Congo Brazaville	470,000
Guinée	1,300,000
Nigeria	6,500,000
République démocratique du Congo	5,500,000
Sudan *	3,850,000
Zimbabwe	430,000
TOTAL	**20,000,000**

* Treatments for North and South Sudan have been combined

Patients treated and treatments delivered across TB niches: Adults

Country	Cumulative Treatments - Adults				Total
	Treatments - 1st Line TB	Treatments - MDR TB		MDR TB - SRS	
Lead Recipient	GDF/STOP TB	GLC/GDF/GF[1]	GF Round 6[2]	GDF	
Azerbaijan		649			649
Bangladesh	147,450				147,450
Belarus			200		200
Benin			16		16
Bosnia Herzegovina	3,727				3,727
Bhutan			19		19
Bulgaria			40		40
Burkina Faso	8,500	20			8,520
Cambodia		128			128
Cameroon	51,806				51,806
Cote d'Ivoire	42,476				42,476
Dominican Republic		288			288
Egypt			89		89
Gambia	3,524				3,524
Georgia			739		739
Guatemala			50		50
Guinea	18,847	19			18,866
Haiti		236			236
India			0		0
Iraq	4,820				4,820
Kazahkstan			381		381
Kenya	128,508	109			128,617
Kyrgystan		347	550		897
Lesotho		521			521
Madagascar	45,456				45,456
Malawi		0			0
Mali	10,842				10,842
Moldova		155	717		872
Mozambique	23,439	104			23,543
Myanmar	114,627	168			114,795
Nepal		410			410
Niger	9,679				9,679
Nigeria	110,542				110,542
République démocratique du Congo		317			317
Rwanda	10,144		224		10,368
Sri Lanka			10		10

Syrian Arab Republic			30		30
Tajikistan	16,202		42		16,244
Tanzania			15		15
Timor-Leste		9			9
Togo	3,824				3,824
Uganda	30,667				30,667
Uzbekistan		481			481
Viet Nam			101		101
TOTAL	**785,080**	**3,961**	**3,223**	**5,800**	**798,064**

[1] Treatment numbers reported were cumulative; treatments by calendar year were recalculated by UNITAID based on cumulative figures since inception of the project available from annual reports submitted
[2] Treatments for Round 6 based on Annual Report submitted by Global Fund: Annex 2 “Programmatic Data”

Patients treated and treatments delivered across TB niches: Children

Country	**Cumulative Treatments** - Children		**Total**
	Patient **treatments** delivered[1]	TB **prophylaxis treatments** delivered[1]	
Lead Recipient	**GDF/STOP TB**	**GDF/STOP TB**	
Afghanistan	10,581	95,746	106,327
Bangladesh	18,942	7,667	26,609
Benin	422	7,355	7,777
Burkina Faso	187	595	782
Burundi	1,177	0	1,177
Cambodia	11,792	7,917	19,709
Cameroon	1,891	23,074	24,965
Cape Verde	79	453	532
Congo	398	0	398
Cote d'Ivoire	1,720	22,609	24,329
Djibouti	1,234	439	1,673
DPR Korea	8,970	0	8,970
Egypt	1,888	5,960	7,848
Eritrea	628	1,779	2,407
Ethiopia	15,614	3,603	19,217
Gambia	566	292	858
Georgia	641	4,567	5,208
Guinea	2,680	22,057	24,737
Guinea Bissau	458	0	458
Indonesia	12,000	0	12,000
Iraq	2,585	31,622	34,207
Jordan	406	1,372	1,778
Kazakhstan	5,647	5,213	10,860
Kenya*	5,976	0	5,976
Kiribati	97	311	408
Kyrgyzstan	1,910	2,223	4,133
Lebanon	120	318	438
Lesotho	2,813	11	2,824
Macedonia	141	529	670
Madagascar	4,330	3,600	7,930
Malawi	5,280	9,600	14,880
Mali	312	14,664	14,976
Mauritania	158	180	338
Mongolia	568	212	780
Morocco	5,327	0	5,327
Mozambique	4,092	8,640	12,732
Myanmar	98,114	0	98,114

Nepal	10,107	3,003	13,110
Niger	1,852	2,610	4,462
Nigeria	15,205	7,877	23,082
Pakistan	66,736	72,496	139,232
Papua New Guinea	2,634	0	2,634
Rwanda	1,022	2,400	3,422
Senegal	903	6,000	6,903
Sierra Leone	4,241	3,460	7,701
Somalia	4,941	18,359	23,300
Sri Lanka	829	0	829
Sudan*	8,500	43,812	52,312
Swaziland	748	1,298	2,046
Tajikistan	1,356	16,004	17,360
Tanzania	12,123	5,135	17,258
Thailand	3,606	25,202	28,808
Togo	120	2,115	2,235
Turkmenistan	486	5,512	5,998
Yemen	756	6,000	6,756
Zambia	14,835	30,724	45,559
TOTAL	**380,744**	**534,615**	**915,359**

*For Kenya 2007, only one drug for the continuation phase of TB treatment was supplied. As per GDF method for treatment calculation, no full treatment has been supplied.
**South Sudan combined with Sudan
Philippines was removed from the list as this project is not being conducted in this country
[1] Patient treatments come from Annual Reports of GDF to UNITAID (Annex 2) 2007, 2008, 2009 and 2010.

Case detection of MDR TB in UNITAID supported countries

Country	Cumulative Number of Cases detected MDR TB[1]
Lead Recipient	GDF/TGF/GLC
Azerbaijan	
Bangladesh	
Belarus	
Cameroon	
Cote d'Ivoire	
Djibouti	
Ethiopia	443
Georgia	
Haiti	
India	740
Indonesia	
Kazahkstan	
Kenya	
Kyrgystan	
Lesotho	274
Moldova	
Myanmar	90
Peru	
Senegal	
Swaziland	
Tajikistan	
Tanzania	
Uganda	110
Uzbekistan	2509
Viet Nam	
TOTAL	**4,166**

Democratic Republic of Congo and Zambia withdrew from the project

[1] Countries where no data was reported are in either in transition (requiring laboratory infrastructure, laboratory assessments, needing essential equipment, validation of diagnostic algorithms and training; Belarus, Kazakhstan and Viet Nam require MoUs for signature

Table 11: (Action 2, Area 3) Track costs of treatments, diagnostics and related products delivered by UNITAID-funded projects by beneficiary country and over time.

Monies Spent on HIV Treatments in Adults

Country	WB Income group	WHO Region	Cumulative Treatment Values (US$)		Total
			treatments : ARVs 2nd Line Adults		
Lead Recipient			CHAI[1,2]	GF: Round 6 [3]	
Benin	LI	AFRO	274,857		274,857
Botswana	UMI	AFRO	11,968,710		11,968,710
Burundi	LI	AFRO	2,156,665		2,156,665
Cambodia	LI	WPRO	2,927,334		2,927,334
Cameroon	LMI	AFRO	4,391,419		4,391,419
Chad	LI	AFRO	1,140,465		1,140,465
Côte d'Ivoire	LI	AFRO	1,590,609		1,590,609
Djibouti	LMI	EMRO		614,700	614,700
Ethiopia	LI	AFRO	3,787,369		3,787,369
Ghana	LI	AFRO	134,964		134,964
Haiti	LI	AMRO	1,104,504		1,104,504
India	LI	SEARO	1,365,131		1,365,131
Kenya	LI	AFRO	28,245,110		28,245,110
Laos	LI	WPRO		15,078	15,078
Liberia	LI	AFRO		10,275,870	10,275,870
Malawi	LI	AFRO	1,101,251		1,101,251
Mali	LI	AFRO	2,635,355		2,635,355
Moldova	LMI	EURO		2,203,061	2,203,061
Mozambique	LI	AFRO	4,046,106		4,046,106
Namibia	LMI	AFRO	1,465,037		1,465,037
Nigeria	LI	AFRO	17,478,684		17,478,684
République démocratique du Congo	LI	AFRO	1,486,633		1,486,633
Rwanda	LI	AFRO	2,148,750		2,148,750
Senegal	LI	AFRO	1,489,134		1,489,134
Tanzania	LI	AFRO	3,441,117	NA	3,441,117
Togo	LI	AFRO	2,611,099		2,611,099
Tunisia	LMI	EMRO		177,636	177,636
Uganda	LI	AFRO	29,929,828		29,929,828
Zambia	LI	AFRO	37,035,669		37,035,669
Zimbabwe	LI	AFRO	3,302,540		3,302,540
TOTAL			**167,258,339**	**13,286,345**	**180,544,684**

[1] Reflects values of medicines invoiced (paid for) during the reporting period; excludes shipping and CSD;
[2] Financial Figures are based on 2007, 2008, 2009 and 2010 Annual Reports
[3] Cumulative values based on Annex 3 "Procurement : cumulative procurement update from 1 May 2007 to 30 June 2010" of Annual Report for Round 6 submitted by the Global Fund

Monies Spent on HIV Treatments in Children

Country	WB Income group	WHO Region	Cumulative Treatment Values (US$)						Total
			Value of ARVs purchased	Value of Diagnostics purchased	Value of Opportunistic Infections Medicines purchased	Value of RUTF purchased	Total Value of products purchased[4,5]	Value of ARVs purchased[6]	
Lead Recipient			CHAI	CHAI	CHAI	CHAI	CHAI	GF: Round6	
Angola	LMI	AFRO	149,529	78,974	62,572	368,295	659,371		659,371
Benin	LI	AFRO	385,708	156,947	125,336		667,991		667,991
Botswana	UMI	AFRO	4,004,046	412,723	1,190,445	240,220	5,847,434		5,847,434
Burkina Faso	LI	AFRO	375,385	355,797	359,294		1,090,476	714,344	1,804,820
Burundi	LI	AFRO	444,157	105,153	25,399		574,710		574,710
Cambodia	LI	WPRO	1,029,896	184,857	211,841	151,126	1,577,719		1,577,719
Cameroon	LMI	AFRO	1,813,407	557,712	317,506	296,123	2,984,748		2,984,748
China	LMI	WPRO	1,668,759	38,847	70,575		1,778,181		1,778,181
Côte d'Ivoire	LI	AFRO	735,649	99,733	47,118		882,500		882,500
Dominican Republic	LMI	AMRO	508,510	77,355	113,956	17,907	717,729		717,729
Ethiopia	LI	AFRO	4,381,321	892,888	482,580	2,227,477	7,984,267		7,984,267
Guinea	LI	AFRO						70,398	70,398
Guyana	LMI	AMRO	120,718	46,573	21,000		188,291		188,291
Haiti	LI	AMRO	75,057	25,273	33,584	198,720	332,634		332,634
India	LI	SEARO	3,505,827	886,723	265,284		4,657,834	NA	4,657,834
Jamaica	LMI	AMRO	55,603	40,916	47,656	10,069	154,245		154,245
Kenya	LI	AFRO	12,395,824	2,142,276	1,309,243	207,760	16,055,103		16,055,103
Laos	LI	WPRO						16,394	16,394
Lesotho	LMI	AFRO	1,798,242	1,323,681	1,251,095	403,350	4,776,368		4,776,368
Liberia	LI	AFRO	230,300	61,756	71,375		363,432		363,432
Malawi	LI	AFRO	2,077,362	2,469,467	1,605,296	3,965,683	10,117,809		10,117,809
Mali	LI	AFRO	1,122,437	45,233	107,769		1,275,439		1,275,439
Morocco	LMI	EMRO						35,265	35,265
Mozambique	LI	AFRO	3,861,123	2,399,635	1,453,779	2,604,203	10,318,740		10,318,740
Namibia	LMI	AFRO	1,138,775	820,497	492,277	190,182	2,641,731		2,641,731
Nigeria	LI	AFRO	9,572,492	1,057,487	2,157,708	1,892,615	14,680,302		14,680,302
OECS[3]	UMI	AMRO	94,017	15,984	30,898		140,898		140,898
Papua New Guinea	LI	WPRO	125,941	197,609	89,438	46,993	459,981		459,981
République démocratique du Congo	LI	AFRO	1,638,915	603,088	455,856	10,527	2,708,387		2,708,387
Rwanda	LI	AFRO	2,569,845	634,643	717,707	1,158,446	5,080,641		5,080,641
Senegal	LI	AFRO	411,268	34,737	62,840	14,816	523,661	5,894,602	6,418,263
Serbia	UMI	EURO						31,367	31,367
Swaziland	LMI	AFRO	1,514,426	856,338	297,456	157,756	2,825,976		2,825,976

Tanzania	LI	AFRO	5,501,711	2,031,653	834,620	572,792	8,940,775		8,940,775
Togo[1]	LI	AFRO	259,795	290,613	14,664		565,072		565,072
Uganda	LI	AFRO	7,942,748	5,153,328	1,543,722	1,880,351	16,520,149		16,520,149
Viet Nam	LI	WPRO	1,036,145	156,677	108,467	1,671	1,302,960		1,302,960
Zambia[2]	LI	AFRO	4,091,566	4,415,988	2,227,677	2,101,705	12,836,936		12,836,936
Zimbabwe	LI	AFRO	3,742,193	3,626,012	1,505,005	3,394,098	12,267,309		12,267,309
TOTAL			**80,378,699**	**32,297,174**	**19,711,038**	**22,112,886**	**154,499,797**	**6,762,370**	**161,262,167**

[1] Togo was added to the UNITAID pediatric program in 2009
[2] Does not include the charge of clearing/additional shipping disbursed for Zambia 2009.
[3] OECS = Organization of Eastern Caribbean States with 6 countries: Antigua and Barbuda (UMI), Dominica (UMI), Grenada (UMI), St. Kitts and Nevis (UMI), St. Lucia (UMI) and St. Vincent and Grenadines (LMI).
[4] Includes ARVs, Diagnostics, OI drugs and RUTF.
[5] Excludes the following other charges: Laboratory equipment, advance orders, estimated freight on unpaid orders, advance payments, procurement/QA/QC cost, CSD Support to CHAI
[6] Cumulative values based on Annex 3 “Procurement : cumulative procurement update from 1 May 2007 to 30 June 2010” of Annual Report for Round 6 submitted by the Global Fund

Monies Spent on HIV treatments in Pregnant Women and in Children

Country	WB Income group	WHO Region	Cumulative Treatment Values (US$)			Total
			Value of **product** expenditure[1,5]	Value of **product** expenditure[2,6]	Value of **product** expenditure[3,4]	
Lead Recipient			**UNICEF (PMTCTI)**	**UNICEF (PMTCTII)**	**UNICEF (PMTCTIII)**	
Burkina Faso	LI	AFRO	402,756			402,756
Cameroon	LMI	AFRO	1,074,825			1,074,825
Central African Republic	LI	AFRO		286,084		286,084
China	LMI	WPRO		1,808,609		1,808,609
Côte d'Ivoire	LI	AFRO	1,662,182			1,662,182
Haiti	LI	AMRO		317,484		317,484
India	LMI	SEARO	1,150,123			1,150,123
Lesotho	LMI	AFRO		276,832		276,832
Malawi	LI	AFRO	3,089,730		151,822	3,241,552
Myanmar	LI	SEARO		303,752		303,752
Nigeria	LI	AFRO		2,838,264		2,838,264
Rwanda	LI	AFRO	1,233,388		173,086	1,406,474
Swaziland	LI	AFRO		826,751		826,751
Tanzania	LI	AFRO	2,126,579		103,137	2,229,716
Uganda	LI	AFRO		8,109,540		8,109,540
Zambia	LI	AFRO	3,300,437		39,659	3,340,096
Zimbabwe	LI	AFRO		5,176,773		5,176,773
TOTAL			**14,040,021**	19,944,089	467,704	**34,451,814**

[1] Based on 2008 (Annex 3 Order Status) and 2009 Annual Report submitted by UNICEF to UNITAID
[2] Based on reports submitted by UNICEF to UNITAID: First Annual Report 2009; Interim Report 2010 and Annual Report 2010 and Updated by Email Correspondence on 14 June 2011
[3] Includes values of RUTF and hemocue products
[4] Values are for adults (mothers) and children combined; not available separately
[5] Includes values for testing of pregnant women for HIV, CD4 tests for HIV+ pregnant women, efficacious ARVs and ART for pregnant women, Cotrimoxazole treatments for HIV+ mothers, HIV exposed infants accessing PCR and Cotrimoxazole treatments for infants
[6] Includes values for rapid tests, CD4 tests for ART eligibility, more efficacious ARV treatments for PMTCT, treatments for HIV+ mothers for their own health, Cotrimoxazole treatments for mothers, DBS/PCR tests for Infants born to HIV+ mothers, and Cotrimoxazole treatments for infants

Monies Spent on ACT Treatments for Malaria

Country	WB Income group	WHO Region	Cumulative Value of Treatments (US$)				Total
			Value of **Treatments - ACTs**				
Lead Recipient			**ACTScale up-GF&UNICEF[1]**	**GF Round 6[2]**	**AMFM GF[3,4]**	**A2S2 i+ solutions**	
Angola	LMI	AFRO					0
Bangladesh	LI	SEARO		384,475			384,475
Benin	LI	AFRO					0
Burundi*	LI	AFRO	428,609				428,609
Cambodia	LI	WPRO	962,773	NA	0		962,773
China	LMI	WPRO		82,856			82,856
Cote d'Ivoire	LI	AFRO		NA			0
Djibouti	LI	EMRO		6,226			6,226
Eritrea	LI	AFRO		NA			0
Ethiopia	LI	AFRO	4,411,193				4,411,193
Gambia	LI	AFRO		2,378,740			2,378,740
Ghana	LI	AFRO	1,697,689		1,927,650		3,625,340
Guinea	LI	AFRO		1,894,217			1,894,217
Guinea Bissau	LI	AFRO		1,017,247			1,017,247
Indonesia	LMI	SEARO	134,255				134,255
Kenya	LI	AFRO			2,460,847		2,460,847
Liberia*	LI	AFRO	376,731				376,731
Madagascar	LI	AFRO	711,891		17,053		728,944
Mali	LI	AFRO		NA			0
Mauritania	LI	AFRO		391,692			391,692
Mozambique	LI	AFRO	9,164,821				9,164,821
Namibia	LMI	AFRO		774,788			774,788
Niger	LI	AFRO			0		0
Nigeria	LI	AFRO			0		0
Somalia	LI	EMRO		20,012			20,012
Sudan**	LMI	EMRO	2,381,719				2,381,719
Tanzania	LI	AFRO			245,300		245,300
Uganda	LI	AFRO			0		0
Zambia	LI	AFRO	5,262,036				5,262,036
TOTAL			**25,531,716**	**6,950,253**	**4,650,851**	**9,280,400**	**46,413,220**

*Liberia and Burundi received treatments only for 2007/2008
** North and South Sudan have been combined as one country
[1] All values confirmed by UNICEF on 10 June 2011
[2] Cumulative values based on Annex 3 "Procurement : cumulative procurement update from 1 May 2007 to 30 June 2010" of Annual Report for Round 6 submitted by the Global Fund
[3] Values recalculated calendar year 2010 as report received covered the period until March 2011; values were also confirmed by the Global Fund
[4] The AMFM project also included Benin, Senegal and Rwanda. Benin and Senegal were not successful with their grants to the Global Fund; Rwanda declined the grant

Monies Spent on Prevention (Long lasting Insecticide Treated Nets) for Malaria

Country	WB Income group	WHO Region	Cumulative Values (US$) Prevention: LLINs Supply Value[1]
Lead Recipient			**UNICEF**
Angola	LMI	AFRO	3,697,500
Central African Republic	LI	AFRO	5,444,520
Congo Brazaville	LMI	AFRO	2,192,700
République démocratique du Congo	LI	AFRO	23,450,583
Guinée	LI	AFRO	6,616,339
Nigeria	LI	AFRO	30,524,550
Sudan*	LMI	EMRO	16,763,500
Zimbabwe	LI	AFRO	2,064,000
TOTAL			**90,753,692**

*North and South Sudan have been combined
[1] Value of LLINs in US$ excluding costs of freight, insurance, quality assurance & handling fees

Monies spent on Treatment of Tuberculosis in Adults

Country	WB Income group	WHO Region	Cumulative Values of Treatments (US$) - Adults				Total
			Value of **treatments - 1st Line**	Value of treatments - **MDR TB**		**MDR TB** SRS	
Lead Recipient			**GDF/STOP TB**	**GLC/GDF/ GF**[1]	**GF Round 6**[2]	**GDF/STOP TB**	
Azerbaijan	LMI	EURO	0	1,872,422			1,872,422
Bangladesh	LI	SEARO	3,000,000				3,000,000
Belarus	LMI	EURO	0		294,358		294,358
Benin	LI	AFRO	0		NA		0
Bosnia Herzegovina	LMI	EURO	84,577				84,577
Bhutan	LMI	SEARO	0		NA		0
Bulgaria	UMI	EURO	0		87,381		87,381
Burkina Faso	LI	AFRO	180,451	37,366			217,817
Cambodia	LI	WPRO	0	301,416			301,416
Cameroon	LI	AFRO	1,516,020				1,516,020
Cote d'Ivoire	LI	AFRO	1,000,000				1,000,000
Dominican Republic	LMI	AMRO	0	589,194			589,194
Egypt	LMI	EMRO	0		374,946		374,946
Gambia	LI	AFRO	91,272				91,272
Georgia	LMI	EURO	0		970,024		970,024
Guatemala	LMI	AMRO	0		180,702		180,702
Guinea	LI	AFRO	502,891	22,951			525,842
Haiti	LI	AMRO	0	495,370			495,370
India	LMI	SEARO	0	5,389,364	NA		5,389,364
Iraq	LMI	EMRO	156,035				156,035
Kazahkstan	UMI	EURO	0		960,199		960,199
Kenya	LI	AFRO	2,420,655	127,531			2,548,186
Kyrgystan	LI	EURO	0	1,068,253	1,020,467		2,088,720
Lesotho	LMI	AFRO	0	2,125,521			2,125,521
Madagascar	LI	AFRO	1,197,565				1,197,565
Malawi	LI	AFRO	0	0			0
Mali	LI	AFRO	245,946				245,946
Moldova	LMI	EURO	0	310,175	1,817,260		2,127,435
Mozambique	LI	AFRO	662,511	130,351			792,862
Myanmar	LI	SEARO	2,850,000	412,371			3,262,371
Nepal	LI	SEARO	0	625,078			625,078
Niger	LI	AFRO	289,354				289,354
Nigeria	LI	AFRO	2,700,000				2,700,000
République démocratique du Congo	LI	AFRO	0	439,431			439,431

Rwanda	LI	AFRO	257,066		111,444		368,510
Sri Lanka	LMI	SEARO	0		13,648		13,648
Syrian Arab Republic	LMI	EMRO	0		38,019		38,019
Tajikistan	LI	EURO	402,913		NA		402,913
Tanzania	LI	AFRO	0		71,990		71,990
Timor-Leste	LI	SEARO	0	17,974			17,974
Togo	LI	AFRO	127,584				127,584
Uganda	LI	AFRO	583,271				583,271
Uzbekistan	LI	EURO	0	2,129,258			2,129,258
Viet Nam	LI	WPRO	0		481,814		481,814
TOTAL			**18,268,111**	**16,094,026**	**6,422,252**	**11,458,000**	**52,242,389**

[1] Cumulative figures since project inception till Dec 2010: Based on 2010 Annual Report from GDF, Financial overview, Section C, Schedule C2.2
[2] Cumulative values based on Annex 3 "Procurement : cumulative procurement update from 1 May 2007 to 30 June 2010" of Annual Report for Round 6 submitted by the Global Fund

Monies spent on Treatment of Tuberculosis in Children

Country	WB Income group	WHO Region	Cumulative values of treatments (US$) - Children Value of **treatments and prophylaxis treatments** delivered[1]
Lead Recipient			GDF/STOP TB
Afghanistan	LI	EMRO	342,081
Bangladesh	LI	SEARO	317,325
Benin	LI	AFRO	36,122
Burkina Faso	LI	AFRO	9,959
Burundi	LI	AFRO	20,097
Cambodia	LI	WPRO	158,802
Cameroon	LMI	AFRO	92,177
Cape Verde	LMI	AFRO	9,790
Congo	LMI	AFRO	11,642
Cote d'Ivoire	LI	AFRO	58,537
Djibouti	LMI	EMRO	40,615
DPR Korea	LI	SEARO	92,120
Egypt	LMI	EMRO	58,951
Eritrea	LI	AFRO	21,978
Ethiopia	LI	AFRO	316,202
Gambia	LI	AFRO	19,694
Georgia	LMI	EURO	27,522
Guinea	LI	AFRO	101,904
Guinea Bissau	LI	AFRO	20,025
Indonesia	LMI	SEARO	108,234
Iraq	LMI	EMRO	136,709
Jordan	LMI	EMRO	30,727
Kazakhstan	UMI	EURO	65,509
Kenya*	LI	AFRO	149,615
Kiribati	LMI	WPRO	8,685
Kyrgyzstan	LI	EURO	48,224
Lebanon	UMI	EMRO	14,579
Lesotho	LI	AFRO	72,329
Macedonia	LMI	EURO	12,425
Madagascar	LI	AFRO	103,356
Malawi	LI	AFRO	111,294
Mali	LI	AFRO	37,213
Mauritania	LI	AFRO	8,686
Mongolia	LI	WPRO	20,677
Morocco	LMI	EMRO	85,114
Mozambique	LI	AFRO	126,073
Myanmar	LI	SEARO	1,244,230
Nepal	LI	SEARO	189,049

Niger	LI	AFRO	44,558
Nigeria	LI	AFRO	302,575
Pakistan	LI	EMRO	779,740
Papua New Guinea	LI	WPRO	111,317
Philippines**	LMI	WPRO	0
Rwanda	LI	AFRO	25,496
Senegal	LI	AFRO	22,262
Sierra Leone	LI	AFRO	89,471
Somalia	LI	EMRO	120,808
Sri Lanka	LMI	SEARO	14,982
Sudan***	LI	EMRO	273,213
Swaziland	LMI	AFRO	19,838
Tajikistan	LI	EURO	90,339
Tanzania	LI	AFRO	182,135
Thailand	LMI	SEARO	138,100
Togo	LI	AFRO	10,293
Turkmenistan	LMI	EURO	27,380
Yemen	LI	EMRO	30,935
Zambia	LI	AFRO	316,329
TOTAL			**6,928,042**

*For Kenya 2007, only one drug for the continuation phase of TB treatment was supplied. As per GDF method for treatment calculation, no full treatment has been supplied.
**Philippines: this grant had not been effective due to registration issues at country-level and the National Tuberculosis Control Program cancelled the grant after the official release of the new dosing recommendations by WHO
***North and South Sudan are combined as one country
[1] Based on 2010 Annual Report (Annex1, 1b and 1c) submitted to UNITAID from GDF: The figures are submitted by Grant Year which are then recalculated by calendar year

Table 12: Summary of treatments provided by year and by disease area.

HIV

Actual disbursements 2010	Cumulative disbursements 2006-2010				
$160,013,772	$498,846,915				
Year	**2007**	**2008**	**2009**	**2010**	**Total**
treatments - ART for HIV positive pregnant women	0	5,948	45,611	13,318	**64,877**
treatments ARVs children*	134,677	76,466	80,345	72,708	**364,196**
treatments ARVs 2nd Line Adults *	62,876	138,056	121,051	113,892	**not cumulative**
pregnant women HIV tests	0	819,860	3,105,442	4,086,376	**8,011,678**
HIV positive pregnant women - CD4 tests	0	129,200	336,200	410,200	**875,600**
tests-HIV for Early Infant Diagnosis	3,727,896	2,575,924	1,129,581	397,866	**7,831,267**
prevention - ARVs to prevent mother to child transmission	0	43,764	227,494	579,368	**850,626**
prevention RuTF and Cotrim (not including CHAI) - women	0	48,802	109,633	38,655	**197,090**
prevention RuTF and Cotrim (not including CHAI) - children	0	35,187	65,366	101,438	**201,991**

*Includes TGF round 6 and CHAI treatment programmes

Malaria

Actual disbursements 2010	Cumulative disbursements 2006-2010				
$56,591,576	$277,709,736				
Year	**2007**	**2008**	**2009**	**2010**	**Total**
treatments (ACTs)*	1,401,228	8,903,671	8,320,539	17,681,702	**36,307,140**
Prevention (LLINs)	0	0	13,500,000	6,500,000	**20,000,000**

*includes TGF round 6, ACT Scale up & AMFm

Tubercolosis

Actual disbursements 2010	Cumulative disbursements 2006-2010				
$32,248,264	**$121,879,895**				
Year	**2007**	**2008**	**2009**	**2010**	**Total**
treatments-first line	197,584	545,793	41,703	0	785,080
treatments MDR-TB*	55	2,331	3,880	918	7,184
Strategic Rotating stockpile - treatments for MDR TB	0	800	5,000	0	5,800
treatments - children curative	52,128	81,053	145,691	101,872	380,744
treatments-children preventive	60,626	91,995	228,269	153,725	534,615
Cases Detected (for MDR-TB)	0	0	1,810	2,356	4,166

*Includes Global Fund Round 6

Table 13 : Summary of monies spent (US$) on products purchased by year and by disease area

HIV

Year	2007	2008	2009	2010	Total
treatments ARVs children - CHAI	19,167,718	24,496,876	15,815,315	17,940,882	**77,420,791**
treatments ARVs children - GF	NA	NA	NA	NA	**6,762,370**
treatments ARVs 2nd Line Adults - CHAI	20,741,509	48,917,770	60,634,919	36,964,141	**167,258,339**
treatments ARVs 2nd Line Adults - GF	NA	NA	NA	NA	**13,286,345**
tests-HIV for Early Infant Diagnosis - CHAI	1,442,608	1,838,132	12,703,429	12,686,992	**28,671,162**
PMTCT (I,II & III) - UNICEF*	-	4,004,541	16,449,724	13,997,550	**34,451,814**
prevention RuTF and Opportunistic Infections in Children - CHAI	10,912,072	13,287,333	7,393,446	5,331,970	**36,924,821**

*Includes values for testing of pregnant women for HIV, CD4 tests for HIV+ pregnant women, efficacious ARVs and ART for pregnant women, Cotrimoxazole treatments for HIV+ mothers, HIV exposed infants accessing PCR and Cotrimoxazole treatments for infants; rapid tests, CD4 tests for ART eligibility, more efficacious ARV treatments for PMTCT, treatments for HIV+ mothers for their own health, DBS/PCR tests for Infants born to HIV+ mothers

Malaria

Year	2007	2008	2009	2010	Total
treatments (ACTs)[1,2]		7,309,940	4,706,039	17,203,816	**46,413,220**
Prevention (LLINs)			90,753,692		**90,753,692**

[1] Includes TGF round 6, ACT Scale up & AMFm & i+ solutions
[2] Values from the A2S2 project led by i+solutions are added to the cumulative total as these monies were not targetted towards procurement but towards a loan to ACT manufacturers

Tubercolosis

Year	2007	2008	2009	2010	Total
treatments - first line	4,920,679	12,499,221	848,211	0	**18,268,111**
treatments MDR-TB1,2	-	-	-	-	**52,242,389**
treatments - children curative and preventive	646,754	1,289,450	3,080,674	1,911,164	**6,928,042**
Cases Detected (for MDR-TB)	NA	NA	NA	NA	**NA**

*Includes values for testing of pregnant women for HIV, CD4 tests for HIV+ pregnant women, efficacious ARVs and ART for pregnant women, Cotrimoxazole treatments for HIV+ mothers, HIV exposed infants accessing PCR and Cotrimoxazole treatments for infants; rapid tests, CD4 tests for ART eligibility, more efficacious ARV treatments for PMTCT, treatments for HIV+ mothers for their own health, DBS/PCR tests for Infants born to HIV+ mothers

UNITAID Secretariat
World Health Organization
Avenue Appia 20
CH-1211 Geneva 27
Switzerland
T +41 22 791 55 03
F +41 22 791 48 90
unitaid@who.int
www.unitaid.eu

UNITAID is hosted and administered by the World Health Organization

© 2011 World Health Organization
(Acting as the host Organization for the Secretariat of UNITAID)
The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.