UNITAID Impact 2011

Key Performance Indicators

unitaid.eu/kpi

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UNITAID TOP 10 ACHIEVEMENTS 2011

1. Over 65,000 new children on treatment in 2011, **increasing the global coverage of children in need of ART to 25%.** Today, over 400,000 children are on ARV treatment using optimal AZT-based paediatric FDCs.

2. A leading paediatric ARV[1] costs US$130 per patient per year today instead of US$ 252 in 2006, contributing to the overall **price reductions of 80%** achieved by the UNITAID-CHAI partnership.

3. Facilitated access to **ATV/r FDC**, the first heat-stable alternative to LPV/r. **ATV/r FDC costs US$300 per patient per year**, **25% less than LPV/r** and it reduces the pill burden for patients to one pill per day instead of 4 per day for LPV/r.

4. **Stock outs of ARVs avoided** in Benin and Mali through improved coordination within countries and with major global funders[2].

5. **13 low-income, high-burden TB countries now have fully functioning laboratories** using state-of-the-art Line Probe Assay tests to detect patients with MDR-TB.

6. **1,098,959 curative and preventive anti-TB treatments,** cumulatively through end of 2011, provided for children in 57 countries.

7. **Generic manufacturers supply 84% of all ARVs, 73% of all ACTs and 100% of all anti-TB medicines** purchased with UNITAID's funds.

8. **151 million ACTs** delivered to consumers[3], through support to the Affordable Medicines Facility for Malaria (GFATM).

9. **Reduced ACT cost: only between US$ 0.32 and US$ 1.36** for Artesunate/Amodiaquine 100/270 mg[4] (as opposed to US$ 8 to US$10 per treatment).

10. 45 products prequalified, **including 20 UNITAID priority medicines and 10 diagnostic tests.**

[1] AZT + 3TC + NVP (300mg+ 150mg +200mg)

[2] Through ESTHERAID and the Coordinated Procurement Planning Initiative with GFATM, PEPFAR, UNICEF, WHO and SCMS

[3] From GFATM annual report (provided May 2012) to UNITAID on the AMFm

[4] The other common ACT, Artemether/Lumefantrine 10/120 mg costs between US$0.45 and US$ 1.45 per treatment

BACKGROUND

UNITAID makes treatment for HIV/AIDS, tuberculosis (TB), and malaria more accessible to vulnerable populations. We do this by leveraging price reductions for quality diagnostics, medicines, and related products and accelerating the pace at which these are made available to those in need. This document is a review of our performance for the year 2011. It includes our contributions to improving the markets for better-adapted, quality products at lower prices as well as our organizational performance and the performance of our grantees towards saving more lives from HIV, TB and malaria.

UNITAID: SPECIFIC PURPOSE, INNOVATIVE FUNCTION

In 2006, Brazil, Chile, France, Norway, and the United Kingdom created an international drug purchasing facility called UNITAID to increase access to affordable, high-quality products to prevent, diagnose and treat HIV/AIDS, TB, and malaria in low- and middle-income countries. UNITAID is the leading example of an innovative financing mechanism, funded through a combination of government-imposed air ticket levy and multi-year contributions. Established as a partnership hosted by the World Health Organization (WHO), it is supported by both developed and developing countries as well as the Bill & Melinda Gates Foundation. UNITAID leverages its resources to speed the development and evolution of competitive, innovative, and sustainable markets for health products in low-resource countries.

The UNITAID secretariat is small and adopts a partnership approach to reduce transactions costs and ensure optimal use of resources within and across multiple organizations. The cost-savings generated by UNITAID-facilitated market improvements are passed on to national governments and other international funding agencies. UNITAID's projects are carried out by their funded implementing partners who add synergistic benefits by providing their own human, technical, and financial resources. UNITAID currently supports 17 projects with 10 implementing partners, each with a focus on medicines, diagnostic tests, and related products in areas that need support not currently available from other donors. Examples include child-adapted medicines and second-line (2nd line) medicines, the often prohibitively expensive treatments that patients need when their initial first-line (1st line) treatment stops working. Table 1 summarizes the impact of selected UNITAID-funded market interventions on public health.

SUMMARY OF IMPACT FOR SELECTED UNITAID PROJECTS

PROJECT	MARKET INTERVENTION	PUBLIC HEALTH
2nd line ARVs (HIV/AIDS)	• Price negotiation and product procurement (with CHAI); • Support to WHO/UN prequalification programme	More patients treated with quality 2nd line medicines at lower prices
Paediatric ARVs (HIV/AIDS)		More patients started on treatment with quality-assured child-adapted formulations (including FDCs)
PMTCT HIV	Provision of products for PMTCT to integrated programmes in high-burden HIV countries to stop the spread of HIV to children (with UNICEF).	Integrated testing, treatment and support to pregnant women living with HIV and their infants
ESTHERAID	Technical support and training in supply chain management for ARVs and HIV tests	Improved patient care at monitored treatment sites
1st line TB	1st line medicines procured and delivered to prevent stock-outs in countries awaiting additional external funds.	Prevent development of resistant TB by providing patients with uninterrupted quality medicines
Expand TB diagnostics	Provide laboratory infrastructure, training and new tests to build a market for state-of-the-art MDR TB testing	Testing for MDR TB is quicker and more efficient so people can be treated faster to stop the spread of MDR TB
MDR-TB Scale up	• Increase number of quality-assured manufacturers to stabilize the market; • Support to WHO/UN prequalification programme; • Support strategic rotating stockpile to facilitate patient treatment immediately after diagnosis.	Increase patient access to quality treatments and enable patients with MDR strains to be immediately initiated on medication to prevent spread of MDR TB
ACT Scale-up	• Product procurement; • Support to WHO/UN prequalification programme	More patients have better access to ACT to treat malaria. ACTs replace monotherapy, delaying the development of resistance to Artemisinin
Affordable Medicines Facility for Malaria (AMFm)	Reduce prices to end user purchasers of ACTs by providing subsidized ACTs to the private sector	More people can afford ACTs so that these replace ineffective treatments leading to better patient outcomes

KEY PERFORMANCE INDICATORS (KPI) FOR 2011

This document provides an update on UNITAID-funded projects and their achievements for the 2011 annual reporting cycle. The purpose of the document is to highlight new developments and key challenges in the current projects. The UNITAID Secretariat has received all annual reports from implementing partners for 2011 and is able to report on progress achieved towards the KPIs in the areas 1 (the impact of UNITAID on the market for products to treat, diagnose and prevent HIV/AIDS, TB and malaria) and area 3 (grant performance). Indicators related to area 2 (organizational effectiveness) capture how well the UNITAID Secretariat is managing its budget, human resources, staff performance and responsiveness to Board requests.

The Board approved indicators reported here remain standard for the period from 2010-2012, but are subject to annual revision by the Board to ensure that improvements can be made as the funding landscape changes. Targets have been set for the end of 2012 with milestones for the calendar years, 2010 and 2011. Reporting on milestones takes place on 30 June of each calendar year. This date was chosen because it is aligned with the current reporting cycle of implementing partners to the UNITAID Secretariat for each previous calendar year.

UNITAID uses the results of its reports on the KPIs in a variety of ways to improve its overall performance, set standard operating procedures for the Secretariat and improve reporting by implementing partners. For example, the UNITAID Secretariat shares the Board approved KPIs, milestones and targets with all implementing partners to promote a solid understanding of the expectations that UNITAID has for each of its funded projects. These shared expectations are incorporated into the annual reports of all funded projects which in turn, demonstrate the project achievements towards the UNITAID-implementing partner objectives: better, faster and cheaper treatments, tests and related products to support and treat people living with HIV, TB and malaria in low income countries. The results of the analyses of annual project reports are summarized in areas 1 and 3 of the annual KPI Report. Because the indicators have remained relatively stable from 2009 to 2011, UNITAID is now able to report on trends for areas 1, 2, and 3. This now allows us to track achievement over time and to use this information to make changes to current management practices, either within the Secretariat or at the project level and to facilitate Executive Board funding decisions.

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	2009	2010	2011	Milestone 2011	Trend
1	Monitoring the market: UNITAID has systems and reports in place to track the market for UNITAID target products	Market Intelligence Information System tender complete. Project teams selected	Market Dynamics team hired; landscape analyses started	Landscape Reports produced for medicines & diagnostic tests for all three diseases	Routine monitoring report produced annually	
2	Percentage of UNITAID funded projects reporting annually on progress towards well-defined transition plans	NA	50%	50%	100%	

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 of gains made in the market through UNITAID's funding efforts to the global public health sectors more broadly through cost savings on products of public health importance.

In 2011, UNITAID introduced a new tool to provide advice on funding prioritization to the Board, the Advisory Group on Funding Priorities (AGFP). The Advisory Group members were selected in 2011 and will provide high level, independent advice to the Board on the markets for products of public health importance to respond to the three diseases.

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 2011, work continued on the market intelligence information system with four partners in this area, Boston University, ANRS, FIND and WHO. The Market Dynamics unit at UNITAID was also further enhanced and this resulted in the development of the

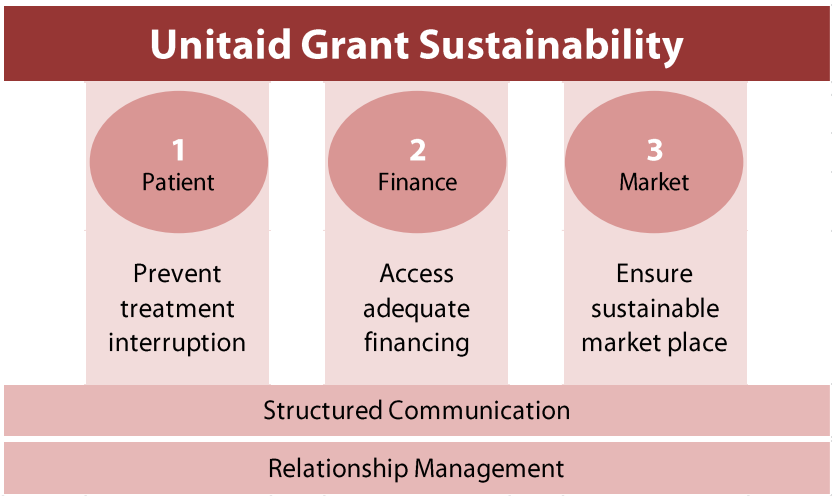
Landscape Analysis Report Series, one for each disease area for medicines as well as diagnostic tests. These reports are intended to provide perspective for UNITAID's priority setting and external Project Review Committee (PRC) as well as the health community. These analyses will provide the evidence with which to launch calls for letters of intent for UNITAID funding.

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. UNITAID projects are time-limited with clear timeframes for closure. Projects require concrete plans to make market and public health gains sustainable through continued support from other funding sources. Providing lasting project sustainability after UNITAID market gains are achieved is critical to maintain the market impact of UNITAID-funded projects. UNITAID has a sustainability framework that explains its approach to grant sustainability. The framework has three pillars (see Figure 1):

- Preventing patient treatment interruption;
- Accessing adequate financing; and
- Sustaining the market place for products of public health importance.

Structured communications and relationship management between UNITAID and partners and across all stakeholders support the three pillars of the framework. To further assess a grants progress towards sustainability, UNITAID has created specific metrics to measure transition actions that support each of the three pillars. The Operations team has focused on understanding the implications of grant sustainability at a project and country level by working with implementing partners to mitigate risks and discuss transition priorities. Detailed transition information has been collected and is not only pro-actively monitored by the Operations team, but is also incorporated into all of the new projects where applicable. All projects providing long term or life-long treatment (i.e. HIV, TB) have a transition plan jointly developed with grantees. Table 12 shows the status of transition by country and project.

Figure 1: Framework for sustaining the impact of UNITAID's grant achievements



CHALLENGES FOR THIS ACTION

Indicator 1:

- Building and maintaining 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. UNITAID's revised Strategy 2013-2016 will address this challenge as a priority for Operations and Market Dynamics;
- 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 diagnose HIV, TB and malaria. Providing regular landscape reports will facilitate rational decision making for UNITAID's investments and also contribute more widely to the community fighting the three diseases as a global public health good. These publications will encourage other donors to include market interventions in their strategies and to align with UNITAID's strategic direction.

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 Advisory Committee to facilitate the continued supply of products generated by successful UNITAID-initiated projects to recipient countries. Sharing UNITAID's approach to grant sustainability with partners and the coordination of activities will serve to promote better planning for medicines and diagnostics to treat and diagnose HIV across all partners and help sustain the achievements of UNITAID's funding in the long term.

ACTION 2: GENERATE LONG-TERM PRICE REDUCTIONS ON MEDICINES AND DIAGNOSTICS

	Indicator	2009	2010	2011	Milestone 2011	Trend
1	Median prices paid for priority UNITAID medicines, diagnostics and related products reported by implementing partners to UNITAID	2nd Line ARVs: 11% and 29% reductions from 2008 prices; Paediatric ARVs: 8% reductions for key AZT and ABC based fixed dose combinations from 2008 prices	2nd Line ARVs: a further 9% and 4% price reduction on regimens from 2009; Paediatric ARVs: 39% reductions for key AZT and ABC based fixed dose combinations from 2009 prices; ACTs: (80% price reduction for ACTs in private sector	2nd Line ARVs: a further 7% and 8% price reduction on regimens from 2010; Paediatric ARVs: 29% reductions for key AZT and ABC based fixed dose combinations from 2010; ACTs: AMFm reported median prices of between US$0.45 to US$1.87 per treatment for artemether/lumefantrine 20/120 mg and between US$0.32 and US$1.33 for Artesunate/Amodiaquine 100/270 mg	Median prices for all UNITAID funded products across all markets held in Market Intelligence Information System	
2	# new manufacturers of priority UNITAID medicines, diagnostics and related products with products available for public procurement	6 new 2nd line ARV suppliers eligible	12 new suppliers for 2nd line ARVs; 4 new suppliers for TB medicines in GDF catalogue	3 new suppliers for 2nd line ARVs plus one new product (ATV/r) and 10 new eligible suppliers for paediatric ARVs; 17 suppliers of quality assured MDR-TB medicines; Master supply Agreement signed with 1 new supplier (QCIL) for artemether/lumefantrine	All partners providing information on new quality suppliers used to UNITAID and the Market Intelligence Information System	
3	Proportion of products in each disease area showing same or lower price than previous 12 months	NA	8 out of 9 2nd Line ARVs decreased in price; 15 out of 16 TB medicines reduced or maintained price.	All ARVs procured by CHAI maintained or lowered prices in 2011; **MDR TB medicine prices** remained constant in 2011	75% of all UNITAID funded products showing the same or lower price than the previous 12 months	

Associated with tables 1 to 4 in the Annex

NARRATIVE EXPLANATION

In 2011, ARVs were still the medicine most amenable to price reductions although progress was also made with 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 described for all indicators in the Annex.

Indicator 3 reflects the need to monitor the market for products not amenable to price reductions in the short term. In 2011, these products were anti-TB medicines to treat children and people with MDR-TB. UNITAID and partners working with these products are trying to contain the costs in the short term by improving forecasting and establishing long term agreements with generic manufacturers. The use of quality assured, generic manufacturers is helping to expand the markets for these products of public health importance.

All implementing partners buying medicines for the three diseases provided median prices with range and interquartile range to UNITAID so that price of UNITAID-funded products can be tracked over time and procurement efficiency can be measured. The collection of this type of price data as well as information on new, quality suppliers used during the year contributes to the milestone for 2011 and represents an improvement in the way data are reported to UNITAID by its implementing partners.

HIV/AIDS and ARVs

Global price reductions on key paediatric fixed dose combinations (FDCs) and 2nd line anti-retrovirals (ARVs) continued in 2011. The inclusion of new manufacturers, including Indian generic manufacturers, in the market contributed to these reductions. In 2011, 84% of all UNITAID-funded ARV medicines were generic products.

Price decreases continue to be made on 2nd line ARVs, consistent with an ever increasing number of 3 more generic manufacturers entering the market in 2011. A further 7% and 8% price reduction in the price per patient per year has been achieved for key 2nd line regimens[5] on top of the reductions shown in 2010. This has been facilitated by 2 additional quality manufacturers making TDF/3TC and TDF/FTC in 2011. Tables of results on all tracked products are shown in the Annex.

Market conditions for paediatric ARVs have improved over the last year with an increasing number of new generic manufacturers making key paediatric products. As a result, price reductions continue to be seen across all recommended products. Tables 1 through 5 show detailed results for all tracked products in Annex.

Malaria and ACTs

The AMFm continued to make progress in 2011. There are 7 generic manufacturers[6] making quality ACTs and 73% of all UNITAID funded ACTs came from generic manufacturers.

[5] TDF/3TC (300/300mg) & LPV/r (200/ 50 mg) and TDF/FTC (300/200 mg) & LPV/r (200/ 50 mg)

[6] Ajanta, Cipla, Ipca, QCIL, Africasoins, Guilin and Sigma-tau

Master supply agreements were signed between the Global Fund and 1 new eligible manufacturer of quality assured ACTs, QCIL, for Artemether/Lumefantrine (AL 20/120mg). Preliminary results from independent surveys[7] conducted in 5 AMFm countries showed that retail prices in the private sector have decreased to between US$0.45 to US$1.45 per treatment course of AL (20/120 mg) and between US$0.32 to US$1.36 for Artesunate/Amodiaquine (100/270 mg). These common products were shown to be widely available in the 5 countries surveyed.

TB and anti-TB medicines

For MDR TB scale up, 17 suppliers are now available in the market[8] for existing medicines and this has improved the sustainability of the market. Prices have been maintained from 2010 to 2011 through negotiations by GDF and long term agreements signed with manufacturers. However, the price of Capreomycin has seen a significant increase in price[9].

CHALLENGES FOR THIS ACTION

HIV/AIDS and ARVs

Paediatrics ARVs: The challenge is to keep this market healthy and sustainable. 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. Transition to alternative funding also remains a challenge because of the cancellation of the GFATM round 11 in October 2011. In particular, there is a need to stabilize the paediatric market and to avoid any disruptions to patient treatments. UNITAID may need to persist in this area until the market is stabilized. The paediatric market may require more funding in the future to ensure that short to medium term rising demand for treatment of children is met.

In 2011, the Paediatric Procurement ARV Working group was formed by UNITAID, CHAI, GFATM, UNICEF, MSF and WHO to secure the predictability of funding and procurement ability for the countries as well as for the manufacturers.

2nd Line ARVs: Eighteen out of the 25 original countries in the UNITAID-CHAI 2nd Line ARV project successfully transitioned from the project in 2011 and secured sources of funding for 2nd line ARVs. However,

[7] Surveys conducted by Health Action International are available on the AMFm website: http://www.theglobalfund.org/en/amfm/pricetracking

[8] Macleods, Fatol, Jacobus, Panpharma, Cipla, Lupin, Olainfarm, Medochemie, Chao Centre, Mylan, Akorn, Eli Lily, Meiji, Bayer, Aspen, Remedica, and King Pharma

[9] Capreomycin has gone from $4 per ampoule to $8 following technology transfer from Eli Lilly who subsidized the price of the product to Akorn

countries[10] remain in the project. UNITAID and CHAI have a transition strategy, including maintaining access to high-quality products at affordable and sustainable prices until the end of 2012, combined with identification of other funding sources and technical support for forecasting and improved supply chain management.

TB and anti-TB medicines

Availability of quality assured anti-TB drugs in injectable forms (Kanamycin, Capreomycin and Amikacin) continues to be a major challenge. These medicines are being manufactured and marketed for use in specialized, small markets which means that the prices paid for them remains high. GDF is working with high burden countries including India, Indonesia, China and South Africa and their nascent industries to facilitate inspections and product assessments necessary for alternative manufacturers to become eligible to supply these medicines.

GDF issued a warning regarding shortages of Capreomycin in May 2011. The shortage was the result of the sole eligible manufacturer of the product having limited production capacity. Countries were advised to limit their procurement orders to stock needed for 6 months instead of the usual 12 month period.
Treatment guidelines, including medicine formulations and duration of treatment, have changed for MDR-TB since the beginning of the scale up project. Both high and low range treatment algorithms cost considerably more[11] than they did at the start of the project. In 2011, however, the cost of high range treatment has increased by 8% and the cost of low range treatment has decreased by 4% relative to 2010.

A major challenge for paediatric TB remains the absence of paediatric fixed-dose combinations that are optimally formulated so that they are stable and in line with revised WHO dosing recommendations.

Malaria and ACTs

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.

The current monthly ceiling of US$10 million set for co-payment approvals must be closely monitored by the AMFm working group to avoid shortfalls in funding for the co-payments.

A new product, Dihydroartemisinin plus Piperaquine (DHA/PPQ), the recommended first line treatment for malaria in Cambodia where resistance to ACTs has developed, has been approved for purchase. Cambodia, the first country to sign up for the AMFm, can now start to receive co-paid treatments in 2012.
There is a need to initiate a project to speed up the use of rapid diagnostic tests for malaria in the public sector.

[10] Burundi, Cameroon, DR Congo, Haiti, Mozambique, Uganda and Zimbabwe

[11] Up to 80% more.

LESSONS LEARNT THROUGH MONITORING PROJECT PERFORMANCE

Sustainable price reductions and transition planning

HIV/AIDS

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.

Continued positive market gains for 2nd line ARVs are encouraging further investment in this market from more traditional funders. 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 is working with PEPFAR and GFATM to identify ways to make funding these products more sustainable. Possible solutions include improving yearly forecasts to manufacturers across all disease and product areas and improving access to the new point-of-care diagnostic tests. This in turn 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 in the short to medium term, leading to more competition and better, sustainable prices.

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. Improvement of the Strategic Rotating Stockpile functionality may help to improve access to these vital medicines. A Letter of Intent was submitted to UNITAID from a consortium, including the current implementer, GDF, with a package of interventions designed to reformat the stockpile and improve access to MDR-TB treatment.

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. An external evaluation of phase 1 of the AMFm project is expected in July 2012. This evaluation will be reviewed by the AMFm working group and used as the basis for AMFm's directions in 2013.

ACTION 3: IMPROVE QUALITY OF MEDICINES, DIAGNOSTICS AND RELATED PRODUCTS

	Indicator	2009	2010	2011	Milestone 2011	Trend
1	# of priority UNITAID medicines and diagnostics prequalified annually by niche	18	15	20 medicines (12 HIV, 7 TB and 1 malaria) ; 10 diagnostics (8 HIV and 2 malaria)	Number of UNITAID priority medicines and diagnostics prequalified reported to UNITAID	↑
2	Median number of days taken to prequalify a medicine	752	664	795	Less than 400 days for a medicine with a dossier submitted in 2010	↑
3	Median number of days taken to prequalify a diagnostic test	NA	15	137	Less than 400 days for a diagnostic test with a dossier submitted in 2010	↑

Associated with tables 9-11 in the Annex[12]

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. The PQP Diagnostics programme made progress in 2011 with the prequalification of 10 diagnostic tests, 8 for HIV and 2 rapid tests for malaria. Annex (table 9) presents the PQP dashboard for 2011.

[12] Median number of days taken to prequalify a medicine is broken down by WHO days and manufacturer days as follows: 2009: WHO 276 days, manufacturer 409 days; 2010: WHO 266 days, manufacturer 414 days; 2011: WHO 267 days, manufacturer 514 days

In 2011, the number of prequalified medicines increased to 35 overall, 20 of which were UNITAID priority medicines. Twelve of these products were ARVs, 7 anti-TB medicines and 1 was an ACT.

Indicator 2, the median number of days taken to prequalify a medicine, has increased from 2010 and now exceeds the milestone set for 2011. However, UNITAID and WHO PQP monitor other indicators that describe the efficiency and consistency of the dossier assessment teams. One of these, "median number of days from completion of screening and acceptance of dossier to completion of assessment, minus "stop clock" time", has remained at between 266 and 267 days for 2010 and 2011, indicating that the team is managing optimally. "Stop clock" time indicates time spent waiting for manufacturers to respond to PQP's requests for clarification or additional information. In fact, a breakdown of median days taken during the prequalification process between the WHO Prequalification Programme and manufacturers shows an increase in median number of days taken for manufacturers to respond compared with a decrease in median days taken by the WHO (see footnote 12). Manufacturers' response times are out of the direct control of PQP. Penalties cannot be imposed on manufacturers who do not respond to requests for further information within the requested or a reasonable time frame. However, PQP does investigate and determine whether it can take action to stimulate improvements to manufacturers' response times.

For PQP diagnostics, the first rapid test in 2010 took just 15 days to prequalify once a complete dossier was available for assessment. In 2011 there were 20 tests and the median time to prequalification was 137 days, which fell well under the milestone set for 2011.

CHALLENGES FOR THIS ACTION

For many formulations included on the current invitations to manufacturers to submit an expression of interest for product evaluation, no products have yet been prequalified.

HIV/AIDS

Debate among stakeholders continues regarding whether or not PQP should continue to accept applications for products for which more than three versions have already been prequalified. PQP should continue to work closely with other stringent regulatory agencies, such as the US FDA, to ensure that low income countries continue to have access to quality ARVs.

TB

Many of the applications for evaluation submitted to PQP for anti-TB products continue to be of poor quality for both product dossiers and manufacturing sites. Dossiers often lack key information relating to quality and safety, while serious deficiencies in GMP continue to be observed at manufacturing sites. This situation is exacerbated by the fact that the APIs used to produce anti-TB products are often of poor quality, while the market for good-quality APIs remains monopolized by a few manufacturers.

Malaria

In terms of products under evaluation, malaria remains the smallest therapeutic area for PQP with just 16 products in the pipeline for 2011.

All PQP areas

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.

LESSONS LEARNT THROUGH MONITORING PROJECT PERFORMANCE

UNITAID is working with PQP on procedures for accelerating the approval of prequalified products. Priorities have been identified for prequalification going forward into 2012 and beyond. These are:

- New ARVs for combating resistance;
- New and "missing" paediatric ARVs;
- New TB medicines, particularly paediatric formulations; and
- Active pharmaceutical ingredients (APIs) for anti-TB medicines and anti-malarials.

In addition, PQP plans to create a network of quality control laboratories (QCLs) that are already working with PQP and who can undertake mutual audits, aimed at helping participating QCLs to identify any corrective actions needed, before a WHO inspection is scheduled.

ACTION 4: SHORTEN LEAD TIME FOR DELIVERY OF MEDICINES, DIAGNOSTICS AND RELATED PRODUCTS TO COUNTRIES

	Indicator	2009	2010	2011	Milestone 2011	Trend
1	Manufacturer lead times for key medicines and diagnostics reported to UNITAID	Table 4	Table 4	Table 4	Analysis of manufacturer lead times reported by partners indicates that partners are buying from suppliers who are performing efficiently	
2	Implementing partners are reporting on the percentage of beneficiary country facilities that have experienced a stockout of UNITAID funded products at any point during the annual reporting period for the project	Strategic rotating stockpile reached 5,800 patient treatments for MDR-TB; All 14 suppliers with LTAs for UNICEF ACTs have buffer stock; 100% of LLINs distributed to 9 countries to prevent stock outs	GDF reported a stock out of paediatric anti-TB medicines in Niger	UNITAID support to ESTHER and to the Coordinated Procurement Planning Initiative provides country-level stock out information on ARVs and diagnostic tests for HIV (see Annex 1 for reported stock outs). GDF reports stock outs of Paediatric products in 7 national programmes	Implementing partners report on the percentage of country facilities that have experienced a stockout during the annual reporting period for their project (where relevant to the project)	

Associated with table 5-7 in the Annex

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 reports 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 the Annex (tables 8).

HIV/AIDS

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. ESTHER and UNITAID are working together on ESTHERAID, a project that aims to strengthen supply chain management for the products that UNITAID has purchased in 5 Francophone West African countries[13]. This includes identifying stock outs and shortages in Central and Regional medical stores and at treatment centers throughout the countries. In 2011, ESTHERAID was operational in all 5 countries, assessing stocks, training staff and putting standard operating procedures in place to manage tests and treatments for HIV/AIDs. In assessing stocks, a number of shortages were identified. These are reported in the Annex. ESTHER joined the Coordinated Procurement Planning Initiative (CPP) and is now providing specific information on stock outs to the CPP so that action can be taken to provide needed tests and treatments. UNITAID is working closely with implementing partners and other partnerships to collect better information about what is happening with treatments and tests at the country level. Our partnerships with CPP and ESTHER are examples of this work in action.

TB

In 2011, the strategic rotating stockpile for MDR-TB continued to be used extensively to respond to urgent orders and to rotate stock to guarantee best available shelf life. It operated with the average turnover ratio of 6.3, which translates into a change over every 58 days. All urgent cases were fully or partially supplied from the stockpile with 60 countries receiving deliveries in 2011. The median lead time for emergency and urgent orders was 31 days. This is important because, for anti-TB medicines, delivery lead time is a key factor in the early and continued treatment of patients.

Stock outs were reported in 2011for both MDR-TB products and paediatric TB products. Seven countries[14] reported stock outs of paediatric TB medicines. GDF reports that these stock ruptures were caused by:

- Poor availability of quality assured streptomycin;
- Late disbursement of funds from GDF to countries;
- Poor drug management at country-level;
- Inadequate funding globally; and
- Late delivery on the part of GDF due to supplier delay.

In all cases, GDF responded by redistributing the drugs or procuring them from the local market[15].

[13] Benin, Burkina Faso, Central African Republic, Cameroon and Mali

[14] Eritrea, Kenya, Malawi, Mali, Rwanda, Swaziland and Tanzania

[15] Redistribution and local purchase is not done by GDF on behalf of countries but by National TB Control programmes in countries. UNITAID receives reports from GDF on what actions have been taken to mitigate stock out and shortages.

Malaria

Stock shortages of ACTs in Madagascar and Zambia were reported in late 2011 by UNICEF and GFATM. UNITAID responded by agreeing to the use of remaining project funds in the ACT Scale up project (US$1,752,998) to deliver ACT treatments to three participating grants in Madagascar and Zambia.

CHALLENGES FOR THIS ACTION

TB

The SRS was intended be used to facilitate emergency orders only. It is however being used for off-cycle orders and may represent a disincentive to countries to improve their forecasting. UNITAID and GDF are working to revise the existing stockpile model to better link it to improved country forecasting. A proposal for a revised stockpile model, providing incentives for countries to improve their forecasting, supply chain management and ordering processes is being prepared by GDF and other interested parties.

HIV/AIDS

Availability of ARVs, lab reagents and associated commodities is not guaranteed for low- income countries because funding is in short supply, forecasting is often unreliable, and many countries have poor procurement processes. These problems, combined with supply chain management difficulties, means that treatment centres may not receive products even if they are in central or regional medical stores. UNITAID through its support to ESTHERAID and CPP initiative is helping countries to correct these situations and avoid similar problems in the future.

Malaria

Forecasting remains a problem for ACTs. The future of the AMFm is yet to be determined pending the finding of an independent evaluation of phase 1. This evaluation is due to be released in July 2012.

LESSONS LEARNT THROUGH MONITORING PROJECT PERFORMANCE

HIV/AIDS

Through the efforts of ESTHERAID, UNITAID learnt about stock out situations and imminent shortages of key products to test for and treat HIV/AIDS in West African countries. By connecting ESTHER to the CPP initiative and making sure that they were included in the monthly teleconferences as well as coordination between PEPFAR, GFATM, UNICEF and CHAI, is ensuring that these situations are dealt with as quickly as they are identified. For the future, UNITAID has developed a project with CPP and its managing organization, SCMS, to develop a web-based dashboard for reporting on stock status and impending stock outs of HIV products in all countries at risk. The system will also support the other diseases in the future.

Malaria

UNITAID has supported BCG and associates to make regular global and AMFm-specific ACT demand forecasts. UNITAID has learnt from this process that forecasting is a vital and on-going activity that needs to be re-visited regularly because country situations change.

TB

New quality assured generic manufacturers of MDR-TB medicines are the key to securing the supply of these critical products for countries in need. Improvements in the availability of Capreomycin are expected in 2012 because two new qualified suppliers of the product, Akorn (USA) and Vianex (Greece) recently received stringent national regulatory approval.

ACTION 5: PROMOTE THE DEVELOPMENT OF USER-FRIENDLY DRUGS APPROPRIATE FOR USE IN DEVELOPING COUNTRIES

	Indicator	2009	2010	2011	Milestone 2011	Trend
1	Implementing partners report the number of new paediatric-adapted products for treatment of a) HIV, b) TB and c) malaria.	GDF reported 2 additional paediatric medicines in its catalogue for 2009	a) HIV: no new; b) TB: 1 (Isoniazid) prequalified; c) Malaria: no new	a) HIV: 1 (AZT/3TC 60/30 mg dispersible tablets) ; b) TB: none c) malaria: 3 paediatric	All implementing partners report number of new paediatric-adapted products according to their project types and intended outcomes.	
2	Number of fixed dose combination (FDC) treatments for a) 2nd line products and b) ACTs (malaria) to ensure better patient adherence to treatment.	8 out of 9 prequalified ACTs are FDCs	a) HIV: ATV and ritonavir co-package; b) malaria: Artesunate (injectable)	a) HIV: ATV/r (300/100mg); co-pack of ATV with heat stable Ritonavir and TDF/3TC	All implementing partners report number of new fixed dose combination treatments according to their project types and intended outcomes.	

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 2011, the work of CHAI and UNITAID has been to ensure the availability and accessibility of these FDCs. CHAI has offered paediatric FDCs to all project countries and in 2011, ABC and AZT-based FDCs (dual and triple) have

been ordered by 23 out of 25 countries[16]. During 2011, CHAI has also been successful in replacing syrups and single formulation drugs with FDCs. Today, 98% of children benefiting from the project are on FDCs, up from 85% in 2010, an increase of 50% since 2008[17]. For the 2nd line project, 2011 saw the prequalification of a co-pack of Atazanavir, heat stable Ritonavir, TDF and 3TC prequalified by WHO and the approval by the US FDA of an FDC Atazanavir/heat stable Ritonavir (ATV/r).

The ATV/r FDC[18] was introduced into the project in December and 5 countries[19] have ordered the new formulation. ATV/r replaces LPV/r as the protease inhibitor component of treatment for HIV and lowers the pill burden from 4 a day to one a day.

TB

In December 2010, WHO published the "Rapid Advice" guidelines which recommend higher doses for paediatric treatment than has been historically used. In 2011, the existing formulations and FDCs still do not accommodate these recommendations. 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 and the addition of others in 2011 brings the number of prequalified paediatric products to 13 products consisting of both blister and bulk packaging. Nevertheless, more needs to be done to ensure that manufacturers now start to make paediatric medicines that meet the revised WHO guidelines. A consortium including the WHO Essential Medicines Programme, GDF and WHO Prequalification are preparing a plan for supporting paediatric treatment that takes into account that this is a nascent market (new formulations) and there is a need for on-going treatment while new formulations are being developed.

CHALLENGES FOR THIS ACTION

The paediatric TB project, and the international public health community at large, face a challenge to encourage industry to make additional paediatric products with increased doses to meet the WHO revised targets for paediatric treatment.

Future price reductions for MDR-TB are dependent on WHO and countries ensuring that patients are put onto treatment and that treatment volumes are consolidated. A minimum of 30,000 patient treatments per year is needed in the public sector in order to achieve significant price reductions[20]. In 2010, GDF procured

[16] The remaining two countries are ordering FDCs from another donor as part of their transition from UNITAID-CHAI paediatric funding

[17] % of children on FDCs was 48% in 2008 and 69% in 2009

[18] The product was made by Matrix which was bought by Mylan Laboratories in October 2011. Mylan Laboratories Ltd holds the USA FDA approval status and the WHO Prequalification status which were granted in November 2011

[19] Cameroon, DR Congo, India, Nigeria and Uganda

[20] CHAI estimate, 2011

10,700 treatments. Focus will be on India with a scale up plan anticipating 30,000 patients on treatment by 2015. UNITAID funds the Expand MDR-TB diagnosis project which has built laboratory and technical capacity in countries to do State-of-the-Art testing for MDR-TB. Thirteen countries[21] have used these tests and improved laboratories to detect MDR-TB this year and this will help increase patient numbers to encourage the development of better medicines.

The landscape analyses will continue to be done for all three diseases to identify 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 three 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 has produced a series of Landscape Analyses. These reports will be updated annually, 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.

[21] Azerbaijan, Cameroon, Ethiopia, Georgia, Haiti, India, Kyrgyzstan, Lesotho, Myanmar, Republic of Moldova, Swaziland, Uganda and Uzbekistan

AREA 2:

ORGANIZATIONAL EFFECTIVENESS

ACTION 1: MONITOR UNITAID'S COMPLIANCE WITH ITS CONSTITUTIONAL REQUIREMENT TO ALLOCATE THE MAJORITY OF ITS FUNDS TO IMPLEMENTING PARTNERS FOR PROJECTS

	Indicator	2009	2010	2011	Milestone 2011	Trend
1	% of Secretariat Costs in US$ relative to disbursement to IPs (excludes GB)	2%	3.5%	10.3%	5.0%	
2	Ratio of annual disbursements to UNITAID full time equivalent staff members	NA	6,474	2,963	2,610	

NARRATIVE EXPLANATION

In the early years of UNITAID, the small size of the Secretariat allowed UNITAID to allocate almost of all its funds to implementing partners to execute UNITAID funded projects in low income countries. UNITAID has relatively low operating costs because it does not have country offices or officers. Because of this, UNITAID set a very specific milestone for 2011 and target for 2012 for indicator 1 of 5% per year. Fluctuating disbursements to partners based on the project life-cycle makes it very difficult to maintain the milestone, even if Secretariat costs remain low.

The 5% milestone set for indicator 1 was exceeded in 2011. By way of explanation, two main changes to how UNITAID conducts its business happened in 2011. First, disbursements to implementing partners were half the amount in 2010, and second, the costs of the Secretariat increased by 40% because the staffing plan (approved by the Board in July 2010) of the Secretariat was implemented at an increased rate over the previous year. Reductions in disbursements to implementing partners occurred for three reasons:

1. No new, large project was approved by the Executive Board for funding in 2010 or 2011;
2. Disbursements for the large HIV /AIDS projects slowed down due to the successful transition of funding in a number of countries; and
3. Disbursements were tightened to ensure they reflected both net short term needs and performance by the partner. This influenced disbursements in the HIV and TB portfolios in particular.

2011 also saw the further development and expansion of the Market Dynamics team and their activities. The target for indicator 1 for 2012[22] will need to be re-visited to reflect both the refinement in UNITAID's standard operating procedures for disbursements and also further improvements in staffing levels and activities accomplished by the Secretariat.

Indicator 2 provides a measure of the appropriateness of the size of the Secretariat for maintaining a lean but efficient operation. In 2010, UNITAID had a relatively high funds-to-staff ratio at US$6.5 million aid dollars per employee, compared to that of several other aid agencies and foundations. For 2011, this funds-to-staff ratio has decreased to slightly around US$3 million aid dollars per employee, the largest factor for this being the drop in transfers to implementing partners. The reasons for this drop are outlined below.

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.

The UNITAID portfolio is evolving and is likely to include smaller and more numerous projects. For example, at least two calls for Letters of Intent (LOIs) will be opened each year.

Indicators do not provide any information on the 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.

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.

[22] Now set at 5% per year

ACTION 2: OPTIMIZE UNITAID SECRETARIAT PERFORMANCE: SIGNING OF AGREEMENTS AND DISBURSEMENT SPEED

	Indicator	2009	2010	2011	Milestone 2011	Trend
1	Median time between Board approval of project and first disbursement for all projects	175	105	115	120	
2	Median time between board approval and signing of agreements for all projects	157	57	69	90	
3	Median time between signing of agreement and first disbursement for all projects	18	48	35	30	
4	Number of Board set deadlines missed by the Secretariat	NA	NA	0	0	

NARRATIVE EXPLANATION

The indicators for this action reflect the timeliness of the Secretariat in implementing Board decisions. Indicator 1 is not equal to the sum of indicators 2 and 3 in 2011 as the Board made funding decisions at the end of 2010 which are not included in the calculation for indicator 2. Indicator 4 reflects the Secretariat's commitment to be responsive to the Executive Board. UNITAID hired a Board Relations Officer in early 2012 and as a result, this indicator will be more rigorously monitored in 2012. The milestones for 2011 have been met.

CHALLENGES FOR THIS ACTION

The process approved by the Board in July 2011 for proposal approval should result in higher quality proposals. The introduction of the Logical Framework Approach to project planning should result in better project plans, with improved programmatic and financial indicators. This higher quality will ultimately decrease the time taken to conclude a grant agreement and make an initial fund transfer. However, three challenges remain that may slow down the process:

The process to finalize the MoU, project plan and first disbursement involves complex negotiations within UNITAID and between partners and WHO as UNITAID's hosting organization.

- The complexity of the projects is increasing;
- A number of new partners are expected and they may require more time as they learn about UNITAID's requirements and procedures; and
- A sufficient amount of time is needed for indicators 1 through 3 in order for UNITAID's review, assessment and approval process can be completed thoroughly.

LESSONS LEARNT IN THIS AREA

The recent appointment of staff to the Operations team has strengthened UNITAID's ability to steer those processes. To improve performance further in this area, UNITAID needs to continue improving its approach to project planning and building strong partnerships both within the teams of the Secretariat and between the Secretariat and its implementing partners.

ACTION 3: OPTIMIZE UNITAID FINANCIAL ACCOUNTABILITY

	Indicator	2009	2010	2011	Milestone 2011	Trend
1	Per cent (%) total budget spent by Secretariat annually	64%	66%	56%	85%	
2	Per cent (%) of cumulative commitment of UNITAID per country in LI, LMI and UMI countries	LI: 87.2%, LMI: 9.6%, UMI 3.2%	LI: 85.9%, LMI:6.9%, UMI 7.6%	LI: 89.4%, LMI: 8.1%, UMI: 2.3%	LI: more than 85%, LMI: less than 10%, UMI: less than 5%	
3	Implementing partners budget variance	NA	15%	30%	10%	

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 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 remains low in 2011. The explanation is two-fold:

1. The large HIV/AIDS projects experienced a faster than expected transition rate and therefore needed less money disbursed; and
2. UNITAID tightened its standard operating procedures for making disbursements in 2011.

This reflects the success of programmatic and financial project management during 2011.

UNITAID has sustained its support to low income countries with 89% of its funds being spent in this income category in 2011. The amount spent in lower middle and upper middle-income countries has decreased for 2011, in line with UNITAID's Constitutional requirement to provide the majority of its funds to support medicines and diagnostics in low income countries.

The 2011 result for indicator 3 is a larger variance in the budget of implementing partners, meaning that partners spent less of their budgets in 2011 than in 2010. This is mostly due to the budget savings on the two large HIV/AIDS project and one TB project where the spending rate was much lower than the approved 2011 budget.

CHALLENGES FOR THIS ACTION

- For Indicator 1, budget performance rests on internal planning processes to some extent (Secretariat costs) and is highly dependent on the level and rate of disbursements to implementing partners;
- Year to year variation in Indicator 2 reflects implementing partner spending or countries transitioning out of a project and thus may fluctuate due to timing of partner expenses, which the Secretariat will have no control over; and
- The challenge for indicator 3 lies around the changing operating environment of the implementing partner and their internal ability to modify budgets. Certain budget flexibility is also necessary for the most innovative projects so that they can be redirected easily to overcome challenges and respond to changing environments.

LESSONS LEARNT IN THIS AREA

As UNITAID refines its standard operating procedures for financial and programmatic management, the following changes are being made:

- Indicator 1. The Secretariat will continue improving its internal planning and budgeting systems.
- Indicator 3. More frequent budget reviews are being built into the new agreements which will lead to the identification of problems with implementing partner budget allocation earlier in the year so that corrective action can be taken by UNITAID and its partners.

ACTION 4: OPTIMIZE STAFF PERFORMANCE AND MANAGEMENT

	Indicator	2009	2010	2011	Milestone 2011	Trend
1	Rate of turnover of professional positions	3.5	6.7	5.3	less than 10%	
2	Percent of staff documented mid-term peformance reviews with Supervisors within the first 9 months of each calendar year	NA	41%	45%	100%	
3	Percent of staff with learning and development plan in place and demonstrated progress towards implementing plan annually	NA	16%	45%	100%	
4	Percent of professional posts filled by women	58	57%	68%	more than 50%	

NARRATIVE EXPLANATION

Staff performance and management is crucial to UNITAID's continued success. As an organization hosted by the WHO, UNITAID staff continue to 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 a fair and comfortable work environment, including gender equality in the work place.

The number of professional staff is rather small and indicator 1 magnifies any staff departure. The results of Indicators 2 and 3 have improved over the 2011 cycle. HR efforts in 2011 were focussed on the implementation of the HR Plan and while a general improvement in the rate of completing 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 2012 as new line managers put into place at the beginning of 2012 work towards making sure that their staff completes the process on time. Many staff members have attended WHO and other training courses and a lot of learning occurs on the job but for 2011, this was not necessarily reflected in predefined learning plans. This practice is also expected to improve in 2012.

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.

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

Performance management at UNITAID has improved in 2011. 2011 was also a year of rapid growth in the staff and change at senior levels. 2012 should be more stable and performance management and development planning should improve as a result.

ACTION 5: IMPROVE UNITAID'S RESOURCE MOBILIZATION EFFORTS TO CONTRIBUTE TO THE SUSTAINABILITY AND PREDICTABILITY OF ITS FUNDS

	Indicator	2009	2010	2011	Milestone 2011	Trend
1	Funds collected mid-year as per cent of funds collected annually	17%	25%	32%	100%	
2	Per cent of donors who have contributed in the previous year and who continue to contribute	75%	75%	100%	75%	
3	Per cent increase in number of new donors to UNITAID annually	NA	0%	17%	20%	

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 and sustained effort. 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-2011. 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 as well as provide the Board with resources to fund new projects.

Indicator 2 is a measure of continued support to UNITAID, a key issue for its financial stability. As of 2011, donors are continuing to contribute either annually or through multi-year commitments. Indicator 3 measures how effective UNITAID's resource mobilization actions have been for the year.

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.
- The indicators for resource mobilization may need to be refined to include one that measures the growth in the amount of funding UNITAID has from year to year. This would allow us to measure not only the number of new donors but also the amount of revenue that is provided to UNITAID over time.

LESSONS LEARNT IN THIS AREA

Resource mobilization is a key area for UNITAID and needs to be resourced appropriately in 2012. UNITAID has made some small improvements in enhancing the staffing in this area in 2012 and improvements made in 2012 will reflect these improvements. As for 2010, multi-year commitments by Brazil, France and the UK and have provided the basis for secure funding for the next 3 years.

ACTION 6: OPTIMIZE UNITAID'S GOVERNANCE

	Indicator	2009	2010	2011	Milestone 2011	Trend
1	Number of Board members who have gone through Board member training within the last three years	NA	none	Introduction of Board induction training	NA	

NARRATIVE EXPLANATION

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 has invested in Board Induction training for new Board members. The first of these was held in 2011. In addition, UNITAID hired a Board Relations Officer in 2012 and now, for the first time, the Board has a point of contact in the Secretariat for its questions, concerns and to provide timely information about UNITAID's on-going activities.

CHALLENGES FOR THIS ACTION

- A Board decision is needed on whether or not the Board indication training meets the requirements of indicator 1; and
- If Board induction training meets the requirement of indicator 1, guidance is needed on the frequency with which this training should be completed by Board members.

LESSONS LEARNT IN THIS AREA

On-going dialogue between the Board, the Governance Committee and the Secretariat has been key to providing strategies for optimizing UNITAID's governance. The Board Relations Officer will provide a secure point of contact between the Board and the Secretariat from 2012 onward.

AREA 3:

UNITAID GRANT PERFORMANCE

ACTION 1: TRACK TREATMENTS, DIAGNOSTICS, RELATED PRODUCTS DELIVERED AND ESTIMATED PATIENTS TREATED BY UNITAID-FUNDED PROJECTS BY BENEFICIARY COUNTRY AND OVER TIME

	Indicator	2009	2010	2011	Milestone 2011	Trend
1	Number of treatments delivered and estimated number of patients treated known for each project on an annual basis	See Annex	See Annex	See Annex	100% of partners report treatments delivered and estimated patients treated	⇔
2	Number of patients treated as percentage of number on treatments planned for the year as per national forecasts shared with Implementing Partners	NA	See Annex	See Annex	no more than 20% variance between country agreed forecasts and project results annually	⇔

See the Annex, Tables 13 & 15 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 data presented in this report are collated and analysed based on reports from implementing partners. The results presented in the table above are cumulative across countries and from the year 2007 to the end of 2011. 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. 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.

UNITAID Secretariat Operations team gather and check implementing partner reported results for completeness and consistency across years. 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, where identified, are fixed. The process of data validation takes time. As a result of our careful checking and consultation with a range of stakeholders,

including at the country-level, there may be slight changes in the data from year to year as we refine project data collection techniques and revise inaccuracies.

Indicator 2 is a new indicator for 2011. Some partners are already providing this type of information. In 2011, for continuing projects in HIV, TB and malaria there was no significant difference between what was planned for the year and deliveries in countries.

CHALLENGES FOR THIS ACTION

- Reconciliation of partner provided data has improved because of better project planning and improved efforts to forecast and work with national governments to match need for treatments and capacity to deliver treatments to the people who need them. This is due to the joint work that the UNITAID Secretariat is doing with implementing partners to provide the most up-to-date numbers. It is a time consuming process but UNITAID has developed a portfolio management system, UNIPRO, which makes the process easier and more manageable.

- All partners now have standard algorithms to translate treatments procured into estimated number of patients on treatment. This is because UNITAID continues to work with all partners to refine their methodology for calculating the estimated number of patients on treatment so that the results are provided in a standard way that is comparable over time.

LESSONS LEARNT THROUGH MONITORING PROJECT PERFORMANCE

UNITAID launched the Logical Framework Approach to project planning with all of its implementing partners in late 2010. In 2011, LogFrames have been refined and provided for all UNITAID-funded projects. 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.

UNIPRO, UNITAID's Project Monitoring System has been used to prepare this KPI report. It now holds all of UNITAID's cleaned and validated partner reported data. The system was built around the Logical Framework 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. The next step is to involve partners in the use of the system, allowing them to input their data directly into the web-based tool, thereby eliminating the need for complicated data tables and annexes in semi-annual and annual reports.

ACTION 2: TRACK COSTS OF TREATMENTS, DIAGNOSTICS AND RELATED PRODUCTS DELIVERED BY UNITAID-FUNDED PROJECTS BY BENEFICIARY COUNTRY AND OVER TIME

	Indicator	2009	2010	2011	Milestone 2011	Trend
1	Costs (US$) of treatments delivered known for each project on an annual basis	HIV: US$285.6 million; TB: US$ 46.5 million; Malaria: US$247.7 million	HIV: US$160 million; TB: US$32.2 million; Malaria: US$57 million	HIV: US$84.6 million; TB US$19.9 million; Malaria: US$158.0 million	no more than 20% difference between annual partner reported results and initial annual project budget	

See the Annex Tables 15 -17

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 more 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 tracks the actual disbursements to implementing partners annually as well as the cumulative disbursements from the start of the project funding. This forms part of the accountability framework of UNITAID and helps us track how much money is going to each partner and monitors that it is aligned with the contractual agreement between the partner and UNITAID. This information is now collected and displayed in the UNIPRO project management tool, providing an additional source of connectivity between the Operations and the Finance teams.

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 12. 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 spend 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.

This year, as reported in Area 2, 89% of UNITAID's funds were spent on products in low income countries, 8.1% were spent on products in lower middle income countries and 2.3% were spent in upper middle income countries.

The values reported for HIV are lower than in 2010 because countries are transitioning out of the UNITAID CHAI paediatric and 2nd line projects to other sources of funding. This is also the case for the TB projects with GDF. The increase in monies spent on malaria products represents the AMFm project that has supplied ACTs to countries through a co-payment scheme to manufacturers to lower prices in the private sector, which is the main source of these products. The milestone was met for 2011 because there were no significant differences between partner reported results and annual project budgets. Where differences did occur, they were cost savings generated by the price reductions achieved by a project. In the case of the CHAI paediatric and 2nd line projects, these "cost savings" are being used to support the transition of countries that will now not be supported by the GFATM due to the cancellation of round 11.

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.
- The tables presented in the Annex represent only the cost of products delivered to the countries. They do not include shipping, customs or other associated charges.

LESSONS LEARNT THROUGH MONITORING PROJECT PERFORMANCE

In 2011, UNITAID's current implementing partners fulfilled UNITAID's requirements for improved forecasting and product delivery at the country level. The introduction of the LogFrame and Finance pro-forma budget templates helped to improve programmatic and financial reporting on activities that implementing partners are doing in countries. The UNIPRO project monitoring system captures both disbursements to partners and the value of treatments delivered to countries, now making it easier to track monetary flows to countries.

ACTION 3: TRACK CUMULATIVE LIVES SAVED AND LIFE YEARS GAINED BY UNITAID-SUPPORTED ARVs, ANTI-TB MEDICINES AND ACTs

	Indicator	2009	2010	2011	Milestone 2011	Trend
1	Estimated number of lives saved as a result of UNITAID funded ARVs, anti-TB medicines and ACTs	NA	Methodology under development	Methodology under development	Calculations performed in a standard way by the UNITAID Secretariat for results from 2011 and 2012	
2	Estimated number of life years gained as a result of UNITAID funded ARVs, anti-TB medicines and ACTs	NA	Methodology under development	Methodology under development	Calculations performed in a standard way by the UNITAID Secretariat for results from 2011 and 2012	

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 UNITAID 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[23] over the

[23] 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 (made

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 experts to measure the impact of its public health initiatives in the area of diagnostics and although results are not currently ready, they are expected by the end of 2012.

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 based on assumptions, many of which are uncertain, and therefore, may not reflect a true measure of UNITAID's impact on public health. In addition, many implementing partners are concerned that a focus on this type of measurement will detract from their overall project achievements, all of which have substantial benefits to global public health.

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.

by the GFATM, 2010) 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.

ACTION 4: IDENTIFY THE SOURCES OF SUPPORT FOR OPERATIONAL COSTS IN EACH BENEFICIARY COUNTRY AT THE START OF EACH PROJECT

	Indicator	2009	2010	2011	Milestone 2011	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	NA	HIV: CHAI spent US$13 million on complementary funding in UNITAID supported countries; TB: FIND raised US$4.2 million additional funds for Expand TB diagnostics; Malaria: US$86 million were contributed by DFID and Gates Foundation to AMFm phase 1	HIV: CHAI spent US$10 million on complementary funding in UNITAID supported countries; TB: FIND reports having approx. US$205 million of support "in kind" for Expand TB diagnostics; Malaria: US$86 million were contributed by DFID and Gates Foundation to AMFm phase 1	100% of operational costs for UNITAID funded commodities projects funded by implementing partners	

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 affected 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

All partners have reported the additional financial support that they or other stakeholders provide to the UNITAID-funded commodity component of these projects. For the majority of the projects, UNITAID is the primary or sole funder for the projects. In the LogFrame template now provided to new implementing partners, UNITAID requires partners to identify up-front the inputs, including financial resources that will be provided by the partner or others to increase the chance of a successful project outcome. This type of information will increase the chances that UNITAID achieves value for money for its projects into the future.

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	2009	2010	2011	Milestone 2011	Trend
1	Per cent (%) of UNITAID implementing partners that have signed MOUs with all national governments before start of projector within Q1 of project year	25%	81%	100%	100% of new partners with new projects sign MoUs with beneficiary country national governments by Q1 of the project start year	

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 was the implementing partner that had difficulties achieving the milestone for this indicator in 2010. In 2011, CHAI was able to finalize MoUs with all countries benefiting from the project.

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. UNITAID is working on ways to institutionalize this requirement so that it becomes a routine condition of our contractual agreements with partners.

ANNEX

Table 1: Prices and % difference for selected WHO recommended 2nd Line ARVs, 2008, 2009, 2010 & 2011

Variation in price per patient per year of key formulations, median (interquartile range)

Project Year 2011	2008	2009	2010	2011	2008-2011	2010-2011
Product Code (2nd Line ARVs)	**Generic**	**Generic**	**Generic**	**Generic**	**% difference**	**% difference**
ABC 300mg	335 (314-389)	228 (228-276)	202 (192-228)	$174	-48	-14
ATV 300 mg				$250		
TDF 300mg	207 (151-208)	99 (99-149)	84 (82-84)	75 (74.4-75.6)	-64	-11
TDF/FTC (300/200mg)	319 (251-319)	141 (141-205)	138 (138-141)	115.2 (115.2-121)	-64	-17
TDF/3TC (300/300mg)	$158	138 (120-171)	107 (1)	96.2 (96.2-98)	-16	-6
LPV/r (200/50 mg)	496 (496-569)	441 (441-567)	420 (420-441)	396 (396-420)	-20	-6
ATV/r (300/100mg)				$300		
TDF/3TC (300mg/300 mg) & LPV/r (200/50 mg)	$654.00	579 (561-738)	527 (526-548)	$492	-25	-7
TDF/FTC (300mg/200 mg) & LPV/r (200/50 mg)	815 (747-915)	582 (582-772)	558 (558-561)	$511	-37	-8

*Note: Median price analysis based on Low Income countries only; interquartile range shown only when greater than zero.

Table 2: Approved suppliers[24,25] by year for 2nd Line ARVs

Project Year 2011	Approved Suppliers				
Product Code (2nd Line ARVs)	**2008**	**2009**	**2010**	**2011**	**New suppliers 2011**
ABC 300 mg	Aurobindo, Cipla, Matrix, GSK	Aurobindo, Cipla, Matrix, GSK, Ranbaxy	Aurobindo, Cipla, Matrix, GSK, Ranbaxy, Hetero, Strides, Invagen Pharms	Aurobindo, Cipla, Matrix, Ranbaxy, Hetero, Strides, Invagen Pharms, Viiv (GSK)	0
ATV 300 mg		BMS	BMS, Matrix, Cipla, Emcure	BMS, Matrix, Cipla, Emcure	0
LPV/r 200/50 mg	Abbott	Abbott, Matrix, Aurobindo, Cipla, Hetero	Abbott, Matrix, Aurobindo, Cipla, Hetero	Abbott, Matrix, Aurobindo, Cipla, Hetero	0
TDF 300mg	Gilead, Matrix	Gilead, Matrix, Aurobindo, Cipla, Ranbaxy, Hetero	Gilead, Matrix, Aurobindo, Cipla, Ranbaxy, Hetero, Invagen Pharms, Strides	Gilead, Matrix, Aurobindo, Cipla, Ranbaxy, Hetero, Invagen Pharms, Strides, Aspen	1
TDF/FTC (300/200mg)	Gilead, Matrix, Aspen, IDS	Gilead, Matrix, Aurobindo, Cipla,	Gilead, Matrix, Aurobindo, Cipla, Strides	Gilead, Matrix, Aurobindo, Cipla, Strides, Aspen	1
TDF/3TC (300/300mg)	Matrix	Matrix, Hetero, Cipla	Aurobindo, Matrix, Hetero, Cipla	Aurobindo, Matrix, Hetero, Cipla	0
ATV/r (300/100mg)				Matrix	1
Total number of new suppliers for 2nd Line ARVs in 2011					**3**

[24] Includes suppliers who were eligible to supply a product in a specified year according to UNITAID's quality assurance policy and not only suppliers who put in a tender for the CHAI projects in the specified year.

[25] Mylan Laboratories Ltd bought Matrix in October 2011

Table 3: Prices and % difference for selected WHO recommended Paediatric ARVs, 2008, 2009, 2010 & 2011

Variation in price per patient per year of key formulations (median and interquartile range)

Project Year 2011	2008	2009	2010	2011	2008-2011	2010-2011
Product Code (Pediatric ARVs)	**Generic**	**Generic**	**Generic**	**Generic**	**% difference**	**% difference**
AZT/3TC/NVP (60/30/50 mg)	$108	$108	$106	$105	-3	-1
AZT/3TC (60/30 mg)	$85	$84	$81	$75	-12	-8
AZT/3TC/NVP (300/150/200 mg)	$150 ($133-154)	$147	$136 ($136-137)	$134 ($133 - $134)	-11	-1
AZT/3TC (300/150 mg)	$114	$113	$103	$105 ($105 - $106)	-8	2
ABC/3TC (60/30 mg)	$193	$182	$172	$163	-16	-6
NVP (50 mg)				$61	0	0
NVP (200 mg)	$40 ($35 - $40)	$35	$32	$32	-20	0
LPV/r (80/20 mg/ml) (brand price only)	$206	$206	$181	$169	-18	-7

*Note: Median price analysis based on Low Income countries only; interquartile range shown only when greater than zero.

Table 4: Approved suppliers[26],[27] by year for paediatric ARVs

Project Year 2011	Approved Suppliers in market				
Product Code (Pediatric ARVs)	**2008**	**2009**	**2010**	**2011**	**New suppliers 2011**
AZT/3TC/NVP (60/30/50 mg)	Matrix	Matrix	Matrix	Matrix	0
AZT/3TC (60/30 mg)	Matrix	Aurobindo, Matrix	Aurobindo, Matrix	Matrix, Cipla Aurobindo	1
AZT/3TC (60/30 mg)-dispersible tablets				Ranbaxy	1
AZT/3TC/NVP (300/150/200 mg)	Cipla, Hetero, Aurobindo, Apotex	Cipla, Hetero, Matrix, Aurobindo, Apotex	Cipla, Hetero, Matrix, Aurobindo, Apotex	Cipla, Hetero, Aurobindo, Strides, Matrix, Apotex	1
AZT/3TC (300/150 mg)	GSK, Aurobindo, Cipla, Ranbaxy, Strides	Hetero, Matrix, GSK, Aurobindo, Cipla, Ranbaxy, Strides	Hetero, Matrix, GSK, Aurobindo, Cipla, Ranbaxy, Strides	Hetero, Cipla, Macleods, Aurobindo, Micro Labs, Matrix, Strides, Viiv (GSK)	1
ABC/3TC (60/30 mg)	Aurobindo	Aurobindo, Matrix	Aurobindo, Matrix	Aurobindo, Matrix	0
NVP (50 mg)				Aurobindo	1
NVP (200 mg)	Aurobindo, Cipla, Ranbaxy, Strides, Boerhinger Ingelheim	Aurobindo, Cipla, Ranbaxy, Huahai, Hetero, Boerhinger Ingelheim	Aurobindo, Cipla, Ranbaxy, Huahai, Hetero, Boerhinger Ingelheim	Hetero, Aurobindo, Macleods, Strides, Cipla, Matrix, Boehringer Ingelheim	2
LPV/r (80/20 mg/ml)	Abbott	Abbott	Abbott	Abbott, Aurobindo, Matrix, Cipla	3
Total number of new suppliers for paediatric products in 2011					**10**

[26] Includes suppliers who were eligible to supply a product in a specified year according to UNITAID's quality assurance policy and not only suppliers who put in a tender for the CHAI projects in the specified year

[27] Mylan Laboratories Ltd bought Matrix in October 2011

Table 5: Summary of shortages[28] and stock out reported by ESTHERAID for the 2011 calendar year

Country	Items	Duration of stock out (months unless noted)	Location of stock-out	Reason for stock out or shortage
Benin	Didanosine 200 mg caps B/60	4	Central Medical store	Weakness in forecasting and in-between rounds, transition of GFATM support
	Didanosine 200 mg caps B/30	3	Central Medical store	
	Didanosine 400 mg caps	5	Central Medical store	
	Lamivudine/Stavudine/Nevirapine 30/6/50 caps	3	Central Medical store	
	Stavudine 1 mg/ml syrup	2	Central Medical store	
	Tenofovir 300 mg caps	4	Central Medical store	
Burkina Faso	Tenofovir/Emtricitabine 300/200 mg	3	Central Medical store	Weakness in forecasting, GFATM contribution decreased, now covers only 70% of needs in round 10
Cameroon	Zidovudine/Lamivudine 300/150 mg	15 days	Eastern Regional Medical stores	Blackout on stock data from CENAME reported in 2011
	Zidovudine/Lamivudine/Nevirapine 60/30/50 mg	6	Eastern Regional Medical stores	
	Tenofovir 300 mg caps	7	Eastern Regional Medical stores	
	Efavirenz 200 mg	6	Eastern Regional Medical stores	
	Lopinavir/ritonavir 200/50 mg	3 days	Eastern Regional Medical stores	
	Tenofovir/Emtricitabine 300/200 mg	1	Eastern Regional Medical stores	
	Lamivudine 50mg/5cc	1.5	Eastern Regional Medical stores	
	Lamivudine 150 mg	1.5	Eastern Regional Medical stores	

[28] Shortages are defined as less than 2 months of supply of product.

	HIV screening tests	NA	Treatment centres	
Central African Republic	Efavirenz 600 mg	NA	Central Medical store	Interruption in GFATM funding support
	Wide spread stock outs of adult formulations	Q1 2011	Central Medical store	
	CD4 reagents	NA	Central Medical store	
Mali	Efavirenz 30mg/ml	1	Central Medical store	GFATM suspended round 8
	Tenofovir/Emtricitabine 300/200 mg	shortage	Central Medical store	
	Tenofovir/Lamivudine 300/300 mg	shortage	Central Medical store	
	Tenofovir/Emtricitabine/Efavirenz 300/200/600 mg	shortage	Central Medical store	
	Efavirenz 600mg	shortage	Central Medical store	
	CD4 and viral load tests	10	Central Medical store	poor forecasting and quantification; CHAI provided CD4 tests in November 2011
	Nevirapine 200mg	shortage	Central Medical store	

Table 6: Summary of Countries at high risk[29] of stock out in 2011 from the Coordinated Procurement Planning initiative

Country	Stock out reported	Comments
Mozambique	NA	GFATM round 9 on hold; risks of stock expiry Q4 2011 and Q1 2012
Malawi	Central medical store unable to report stock outs	formal emergency request from MoH for most essential medicines
Cameroon	See ESTHERAID reporting	funding gap of 1.4 million US$ remains
Côte d'Ivoire	07-Mar-11	PEPFAR and MOH doing quantification
DR Congo	NA	Phase 2 funds form GFATM round 8
Angola	17-Nov-11	PSM transition delayed for UNITAID/CHAI transition
Swaziland	10-Feb-11	May need up to US$6 million for ARVs
Central African Republic	Stocked out of CD4 in 2011	funded only by GFATM round 7 and small UNITAID/UNICEF fund
Togo	NA	GFATM round 8 frozen
Burkina Faso	See ESTHERAID reporting	No funds secured for UNITAID/CHAI transition
Mali	See ESTHERAID reporting	GFATM disbursement delayed

[29] High risk countries are defined as those who had the greatest risk of stock out in the first 6 to 9 months of 2011.

Table 7: Stock outs reported for Paediatric TB products in 2011

Percentage of time that paediatric TB drugs are not available by eligible countries

Between January and December 2011, GDF served 79 programs with paediatric and/or adult first line drugs.

During this period, the following programs had a rupture in the stock supply of paediatric medicines: Eritrea, Kenya, Malawi, Mali, Rwanda, Swaziland, and Tanzania.

The Table below shows the stock-outs for paediatric drugs as verified in the GDF mission report.

Country	Location of stock out	Duration	Reasons	Actions taken by GDF/NTP to rectify
Eritrea	Central	15 Days	Expiry of RH 60/30	Treatment Redistribution New order (DP) already initiated on 05/09/11
Kenya	District level (RHZ 60/30/150 and RH 60/30)	A few weeks	Poor drug management, as paediatric drugs were distributed separately and not enough resources for transportation	Better drug management following the incident.
Malawi	All levels (E100 and RH 60/30)	2 weeks	Supplier delay, and poor drug management	Redistribution at treatment centers
Mali	Central	Stock out of approx 120 days of paediatric drugs	Not provided	Redistribution of stock among regions to ensure more accurate quantities of drugs according to the demand
Rwanda	Central	N/A	Mismanagement of RHZ 60/30/150	Large quantities were supplied to Dispensaries and Health facilities depleting the stocks at central level NTP staff gave a briefing on need for calculation and order form usage
Swaziland (August 2011)	Central	A few weeks	RHZ 60/30/150 Increase in case detection and treatment	
Tanzania	Central (Zanzibar) Health facilities (Coastal region)	6 weeks	Expiry of RHZ 60/30/150 and RH 60/30	New order in the pipeline as approved by TRC (October 2011)

Notes:

GDF does not redistribute drugs on behalf of countries. Redistribution happens internally within the country and is managed by the National TB Programs. As the drugs stay within the NTP, there is no double debiting.

Table 8: WHO Prequalification Programme Dashboard of UNITAID priority medicines prequalified from 2007 to 2011[30] (WHO PQP Annual Report to UNITAID, 2011)

Summary	Submissions	Stage 1	Stage 2	Stage 3
Second-line anti-retrovirals	42	42	37	28
Paediatric anti-retrovirals	8	8	8	7
1st-line anti-tuberculosis products	17	17	13	2
2nd-line anti-tuberculosis products	29	29	28	8
Paediatric anti-tuberculosis products	11	11	10	4
Anti-malarials	32	32	24	8
TOTAL	**139**	**139**	**120**	**57**

Key

STAGE 1: Accepted dossiers awaiting assessment as of date of this report
STAGE 2: Dossier assessment started
STAGE 3: Prequalification complete

[30] 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 9: WHO Prequalification- Summary of priority products (20) prequalified in 2011 by disease area

9.1. HIV[31,32] (Adult)

Adult products			
Dossier	**Medicine**	**Status**	**Manufacturer**
HA472	Didanosine, capsule, 200 mg	Prequalified, 1 September 2011	Mylan Laboratories Ltd.
HA473	**Didanosine, capsule, 200 mg**	**Prequalified, 1 September 2011**	**Mylan Laboratories Ltd.**
HA474	**Didanosine, capsule, 200 mg**	**Prequalified, 1 September 2011**	**Mylan Laboratories Ltd.**
HA439	Tenofovir + emtricitabine, tablet, 300mg + 200mg	Prequalified, 5 October 2011	Cipla Ltd.
HA448	Tenofovir + emtricitabine, tablet, 300mg + 300mg	Prequalified, 1 September 2011	Hetero Labs Ltd.
HA489	Tenofovir + emtricitabine, tablet, 300mg + 300mg	Prequalified, 5 October 2011	Cipla Ltd.
HA500	Tenofovir + efavirenz + emtricitabine, tablet, 300 mg + 600 mg + 200 mg	Prequalified, 8 December 2011	Cipla Ltd.
HA507	Atazanavir + ritonavir, capsule, 300 mg + 100 mg	Prequalified, 28 November 2011	Mylan Laboratories Ltd.

9.2. HIV (Children)

[31] Note manufacturer of ATV/r (300/100mg) is listed as Mylan Laboratories Ltd. Mylan Laboratories Ltd. bought Matrix in October 2011. The product was approved by the USA FDA and the WHO Prequalification Programme in November 2011

[32] **Blue**= products that were included in the original priority list as described in the project agreement but are no longer in the updated priority list (as of June 2010). **Red**= products that were not included in the original priority list as described in the project agreement but are now included in the updated priority list (as of July 2010).

Child products			
Dossier	**Medicine**	**Status**	**Manufacturer**
HA454	**Staduvine + Lamivudine, tablet 6 mg + 30 mg**	**Prequalified, 8 February 2011**	**Cipla Ltd.**
HA455	**Staduvine + Lamivudine, tablet 6 mg + 30 mg**	**Prequalified, 8 February 2011**	**Cipla Ltd.**
HA463	Zidovudine + Lamivudine, tablet 60 mg + 30 mg	Prequalified, 29 September 2011	Ranbaxy Laboratories Ltd.
HA471	Didanosine, capsule, 125 mg	Prequalified, 1 September 2011	Mylan Laboratories Ltd.

9.3. TB

TB products			
Dossier	**Medicine**	**Status**	**Manufacturer**
TB205	Levofloxacin, tablet, 250 mg	Prequalified, 22 December 2011	Cipla Ltd.
TB215	Ethionamide, tablet, 250 mg	Prequalified, 22 December 2011	Cipla Ltd.
TB224	Ofloxacin, tablet, 200mg	Prequalified, 22 December 2011	Cipla Ltd.
TB225	**Ofloxacin, tablet, 200mg (?400)**	**Prequalified, 22 December 2011**	**Cipla Ltd.**
TB227	Levofloxacin, tablet, 500 mg	Prequalified, 22 December 2011	Cipla Ltd.
TB229	P-aminosalicylic acid, granulés, 4g	Prequalified, 22 March 2011	OlainFarm JSC
TB217	Amikacin injectable, vial, 500 mg/2ml	Prequalified, 14 January 2011	Cipla Ltd.

9.4. Malaria

Malaria products			
Dossier	**Medicine**	**Status**	**Manufacturer**
MA074	Artesunate + amodiaquine, tablet, 50 mg + 153 mg	Prequalified, 22 December 2011	Strides Arcolab Ltd.

Table 10: WHO Prequalification of diagnostics programme / Summary of priority tests prequalified in 2011

Product Name	Manufacturer	Type of assay	Date prequalified
HIV			
NucliSENS EasyQ® HIV-1 v2.0 (Automated)	bioMérieux SA	Virological technologies	23-Dec-11
NucliSENS EasyQ® HIV-1 v2.0 (Semi-Automated)	bioMérieux SA	Virological technologies	20-Dec-11
Alere Determine HIV-1/2	Alere Medical Co. ltd	HIV RDT	25-Nov-11
Alere Determine HIV-1/2	Alere Medical Co. ltd	HIV RDT	25-Nov-11
HIV 1/2 STAT-PAK® Dipstick	Chembio Diagnostic Systems Inc	HIV RDT	25-Nov-11
Pima CD4 Test	Alere Technologies GmbH	CD4 technologies	25-Nov-11
Abbott RealTime HIV-1 (Manual)	Abbott Molecular	Virological technologies	17-Oct-11
Abbott RealTime HIV-1 (m2000sp)	Abbott Molecular	Virological technologies	17-Oct-11
Abbott RealTime HIV-1 (m24sp)	Abbott Molecular	Virological technologies	17-Oct-11
Malaria			
IMMUNOQUICK® Malaria Falciparum	Biosynex	Malaria RDT	18-Oct-11

Table 11: Area 1, Action 4: Selected delivery lead time achievements from partners

11.1. Paediatric HIV (with CHAI 2011)

Manufacturer	Status	Average lead time (days)*
Strides Arcolab	Generic	56
Hetero Drugs	Generic	67
Abbott	Originator	69
Matrix	Generic	105
Aurobindo	Generic	107
BMS	Originator	109
Cipla	Generic	122
MSD	Originator	122
GSK	Originator	125

*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.

11.2. 2nd Line HIV (with CHAI 2011)

Manufacturer	Status	Average lead time (days)*
Hetero	Generic	70
Abbott	Originator	81
Emcure	Generic	82
Cipla	Generic	85
Aurobindo	Generic	152
Matrix	Generic	177

* 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.

11.3. TB

Product line	Number of orders placed	Number of orders delivered	Actual median lead time (days*)
MDR-TB	41	41	See lead time by manufacturer below
MDR-TB rotating stock pile**	20	20	31
Paediatric TB	33	45	132

*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 Drug Facility for urgent and emergency orders in 2011. In total, 60 countries received deliveries from the stockpile in 2011, but only 20 countries were served based on emergency requests.

11.4. MDR-TB

Average lead time by manufacturer of MDR TB medicines for orders placed in the MDR-TB Scale up project in 2011
(= difference in days between orders placed to first delivery per programme supported)

Product Manufacturer	Cost Exworks (US$)	Average lead time in days
Akorn Inc.	347,416	204
Aspen	242,361	209
B. Braun Melsungen	24,918	63
Bayer Europe	5,674	63
Becton Dickenson International	7,024	63
Cadila	2,805	189
Cipla	298,240	135
Eli Lilly	639,667	65
Fatol Arzneimittel	224,062	187
Jacobus Pharmaceutical Company Inc.	1,079,312	114
Lupin	273,661	98
McLeods	6,787,637	102
Medochemie	103,612	115
Meiji Seika Kaisha Ltd.	2,914,620	87
Micro Labs Ltd. (Brown and Burk)	19,855	133
Micro Labs Ltd. Veerasandra	418,210	95
Panpharma	5,456	18

11.5. Malaria; ACT Scale up

Manufacturer	Status	Product	Average Lead Time (days)*
Guillin Pharmaceutical	generic	Artesunate 100mg+SP525mg tabs/6+3/PAC-25	NA
		Artesunate 50mg+SP525mg tabs/6+2/PAC-25	NA
Novartis Pharma AG	originator	Artemeth 20mg+Lumef120mg disp tabs/6/PAC-30	101.7
		Artemeth 20mg+Lumef120mg disp tabs/12/PAC-30	120
		Artemeth20mg+Lumefan120mg tabs/18/PAC-30	95.6
		Artemeth20mg+Lumefan120mg tabs/24/PAC-30	106.8
Africasoins	generic	Amodiaquine67.5 mg+Arte25mg tabs/3/PAC-25	92
		Amodiaquine 135mg+Arte 50mg tabs/3/PAC-25	92
		Amodiaquine 270mg+Arte 100mg tabs/3/PAC-25	92

* Analysis done at UNITAID from UNICEF supplied UNICEF Order Status Table of May 2012 for the year 2011 only. Calculation done on delivery lead time from date of purchase order issued to actual arrival in country, includes only 2011 procurements.

Table 12: Transition status by country and project

COUNTRY	PAEDS	2L	ESTHERAID	MDR TB	PAEDS TB	MDR/ DIAG	AMFM	QA DIAG
Afghanistan					GDF 2nd term Grant			
Angola	GF (R4 COS) 2011							
Azerbaijan				GF R7 & R9		2013		
Bangladesh					GDF 2nd term Grant	2013		
Belarus						2013		
Benin	GF R9 2012	GF R5	2013		TBD			
Botswana	MoH / PEPFAR 2011	PEPFAR / MOH						
Burkina Faso	GF R10 2012		2013	GF R8	TBD			2013
Burundi	GF R8 Ph2 2012	GF R8 2			GDF 2nd term Grant			
Cambodia	GF (R7 2 / R9) 2010	GF R7 P2/R9		GF R7 & R9	GDF Emergency/ 2nd term Grant			
Cameroon	GF R10	GF R10 / GOC	2013		TBD	2013		
CAR			2013					
Cape Verde					GDF 2nd term Grant			
Chad		GF R8 2						
China	MoH 2010							2013
Congo					TBD (grant suspended after year 1)			
Cote d'Ivoire	GF R9 & PEPFAR 2012	PEPFAR			GF	2013		2013
Djibouti					GDF Emergency / 2nd term Grant	2013		
DR	GF (R2 RCC) 2010							
DPR Korea					GDF 2nd term Grant			
DRC	GF R8 Ph 2	GF R8 P2		GF R9		2013		
Egypt					KFW/CIDA 2nd term grant			
Eritrea					GF			
Ethiopia	GF R2RCC 2011	GF R2 RCC			TBD	2013		
Gambia					GF			
Georgia					TBD	2013		
Ghana		GF Prev / PEPFAR					GF/RBM	
Guinea					GDF 2nd term Grant			
Guinea Bissau					GF			
Guyana	PEPFAR 2010							
Haiti	GF R1RCC/ PEPFAR 2012	GF R1 RCC / PEPFAR				2013		
India	GF R4RCC / W.Bank	GF R4 RCC		GF R9		2013		
Indonesia					MoH - TBC	2013		

COUNTRY	PAEDS	2L	ESTHERAID	MDR TB	PAEDS TB	MDR/ DIAG	AMFM	QA DIAG
Iraq					Government			
Jamaica	GF R7							
Jordan					TBD			
Kazakhstan					TBD	2013		
Kenya	GF R10	GF R10 / PEPFAR		GF R9	GDF 2nd term Grant	2013	GF/RBM	
Kiribati					TBD			
Kyrgyzstan				GF R9	GDF 2nd term Grant	2013		
Lebanon					GDF 2nd term Grant			
Lesotho	GF R7 Ph 2			GF R8	GDF 2nd term Grant	2013		
Liberia	GF R6/R8							
Macedonia					Plans to apply for 2nd term Grant			
Madagascar					GDF 2nd term Grant		GF/RBM	
Malawi	No funding secured 2013	GF R1 RCC		GF R7	TBD			
Mali*	GF R8 Ph2	GF R8 P1	2013		GF			
Mauritania					TBD			
Moldova				GF R8 & R9		2013		
Mongolia					GDF 2nd term Grant			
Morocco					GDF 2nd term Grant			
Mozambique	No funding secured 2013	GF R9 / PEPFAR		GF R7	TBD			
Myanmar				GF R9	GDF 2nd term Grant	2013		
Namibia		PEPFAR / MOH						
Nepal				GFR7	GDF 2nd term Grant			
Niger					TBD		GF/RBM	
Nigeria	No funding secured 2013	GF R9 / PEPFAR			TBD		GF/RBM	
OECS								
Pakistan					KFW			
Peru						2013		
Philippines					No grant completed			
PNG					TBD			
Rwanda		GF R6/R7/NSA / PEPFAR			GDF 2nd term Grant			
Senegal	GF R8 / MoH	GF R9 / MOH			TBD	2013		
Sierra Leone					GDF 2nd term Grant			
Somalia					GDF 2nd term Grant			

COUNTRY	PAEDS	2L	ESTHERAID	MDR TB	PAEDS TB	MDR/ DIAG	AMFM	QA DIAG
South Africa								2013
South Sudan					GDF 2nd term Grant			
Sri Lanka					GDF 2nd term Grant			
Sudan					GDF 2nd term Grant			
Swaziland	No funding secured 2013				TBD	2013		
Tajikistan					GDF 2nd term Grant	2013		
Tanzania	GF R8 Ph2 & PEPFAR	GF R8 / PEPFAR			TBD	2013	GF/RBM	2013
Thailand					TBD			
Timor-Leste				GF R7				
Togo	GF R8 Ph 2	GF R8 Ph1 & Ph2			TBD			
Turkmenistan					TBD			
Uganda	No funding secured 2013	GF R7 / PEPFAR / GOU				2013	GF/RBM	
Uzbekistan				GF R8		2013		
Viet Nam	PEPFAR 2010					2013		
Yemen					GDF 2nd term Grant			
Zambia	GF R10	GF R10			GDF 2nd term Grant	2013		
Zimbabwe	No funding secured 2013	Zimbabwe						

*Mali may require additional support in 2012 for the Paediatric and Second Line (2L) projects due to political instability.

Colours: **Green** means funding has been secured, **Yellow** means funding to be secured in 2012-2013 and **Red** means no funding has been secured. All transition sources of funding are provided by implementing partners as of 27 June 2012. We expect an update mid-summer 2012 from GDF with regards to the Paediatric TB project transition. Updates with regards to the planned transition to Global Fund for the Paediatric and Second Line (2L) are on-going between the Global Fund and CHAI.

Table 13 (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

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

Country	WB Income group	WHO Region	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[4]		UNICEF (PMTCT I)	UNICEF (PMTCTII)[3]	UNICEF (PMTCTI)	UNICEF (PMTCT II)[3]	
Benin	LI	AFRO			1,632		1,632					
Botswana	UMI	AFRO			9,623		9,623					
Burkina Faso	LI	AFRO	258				258	7,082		3,557		10,639
Burundi	LI	AFRO			5,919		5,919					
Cambodia	LI	WPRO			4,896		4,896					
Cameroon	LI*	AFRO	411		8,542		8,953	18,879		18,484		37,363
Central African Republic	LI	AFRO		507			507		18,199		2,643	20,842
Chad	LI	AFRO			1,537		1,537					
China	LMI	WPRO		0			0		0		514	514
Côte d'Ivoire	LI	AFRO	8112		1,122		9,234	17,969		19,201		37,170
DR Congo	LI	AFRO			4,192		4,192					
Djibouti	LMI	EMRO				839	839					
Ethiopia	LI	AFRO			5,179		5,179					
Ghana	LI	AFRO			210		210					
Haiti	LI	AMRO		759	2,723		3,482		4,998		6,492	11,490
India	LI	SEARO	0		7,615		7,615	25,253		0		25,253
Kenya	LI	AFRO			45,571		45,571					
Laos ¢	LI	WPRO				1,145	1,145					
Lesotho	LMI	AFRO		0			0		19,165		0	19,165
Liberia	LI	AFRO				2501	2,501					
Malawi	LI	AFRO	2885		1,991		4,876	34,760		0		34,760
Mali	LI	AFRO			5,375		5,375					
Moldova, Republic of	LMI	EURO				1,047	1,047					
Mozambique	LI	AFRO			6,741		6,741					
Myanmar	LI	SEARO		630			630		4,636		821	5,457
Namibia	LMI	AFRO			7,743		7,743					
Nigeria	LI**	AFRO		7,067	53,230		60,297		123,549		18,173	141,722
Rwanda	LI	AFRO	3813		2,321		6,134	19,295		22,545		41,840
Senegal	LI	AFRO			2,218		2,218					
Swaziland	LMI	AFRO		3,812			3,812		21,818		6,755	28,573
Tanzania, United Republic of	LI	AFRO	6549		6,749	1,584	14,882	32,537		4,566		37,103
Togo	LI	AFRO			5,426		5,426					
Tunisia	LMI	EMRO				361	361					
Uganda	LI	AFRO		5,849	155,471		161,320		104,117		58,661	162,778
Zambia	LI	AFRO	9225		187,777		197,002	41,472		31,421		72,893
Zimbabwe	LI	AFRO		15,000	9,550		24,550		318,242		3,257	321,499
TOTAL			**31,253**	**33,624**	**543,353**	**7,477**	**615,707**	**197,247**	**614,724**	**99,774**	**97,316**	**1,009,061**

Updated: As of Dec 2011

(1) Includes Tenofovir ordered as first line treatments for Namibia (2007,2008), Uganda and Zambia (2008, 2009, 2010, 2011) , as per country request to CHAI.

(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, patient estimates were calculated based on the number of patients that could be reasonably treated from the volumes ordered.

(3) Based on reports submitted by UNICEF to UNITAID: First Annual Report 2009; Interim Report 2010 and Annual Report 2010

(4) Based on May 2012 analysis submitted by Global Fund

¢ Patient numbers for Laos are presented only under adult as these were not broken down by paediatric and adult treatments

* Cameroon is classified as a Low Income Country in the CHAI 2nd line project only. For all other projects, it is classified as an LMI because of its changed status at the time of signing of the MoU

** Nigeria is classified as an LMI in the PMTCT projects and as an LI in the CHAI 2nd line project

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

Country	WB Income group	WHO Region	Cumulative Treatments - Children		Total	Cumulative Prevention - Children[1]			Total
			Treatments-ARVs children			Prevention-RuTF and Cotrimoxazole[2]			
Lead Recipient			CHAI[3]	GF-Round6[4]		UNICEF (PMTCTI)	UNICEF (PMTCTII)	UNICEF (PMTCTIII)	
Angola	LMI	AFRO	609		609				
Benin	LI	AFRO	1,237		1,237				
Botswana	UMI	AFRO	9,182		9,182				
Burkina Faso	LI	AFRO	1,593	1,373	2,966	2,046			2,046
Burundi	LI	AFRO	1,927		1,927				
Cambodia	LI	WPRO	4,439		4,439				
Cameroon	LMI	AFRO	4,440		4,440	11,548			11,548
Central African Republic	LI	AFRO					3,405		3,405
China	LMI	WPRO	1,849		1,849		625		625
Côte d'Ivoire	LI	AFRO	5,938		5,938	9,219			9,219
DR Congo	LI	AFRO	5,684		5,684				
Dominican Republic	LMI	AMRO	950		950				
Ethiopia	LI	AFRO	14,504		14,504				
Guinea	LI	AFRO		6,866	6,866				
Guyana	LMI	AMRO	195		195				
Haiti	LI	AMRO	1,714		1,714		3,093		3,093
India	LI	SEARO	27,587	15,000	42,587	18,244			18,244
Jamaica	LMI	AMRO	313		313				
Kenya	LI	AFRO	48,546		48,546				
Laos ¢	LI	WPRO			0				
Lesotho	LMI	AFRO	5,779		5,779		0		0
Liberia	LI	AFRO	570		570				
Malawi	LI	AFRO	32,319		32,319	24,184		18,784	42,968
Mali	LI	AFRO	1,442		1,442				
Morocco	LMI	EMRO		2,614	2,614				
Mozambique	LI	AFRO	23,049		23,049				
Myanmar	LI	SEARO			0		997		997
Namibia	LMI	AFRO	9,346		9,346				
Nigeria	LI**	AFRO	35,535		35,535		9,299		9,299
OECS*	UMI	AMRO	20		20				
Papua New Guinea	LI	WPRO	447		447				
Rwanda	LI	AFRO	7,644		7,644	12,358		44,207	56,565
Senegal	LI	AFRO	900	6,109	7,009				
Serbia	LMI	EURO		8	8				
Swaziland	LMI	AFRO	6,567		6,567		9,416		9,416
Tanzania, United Republic of	LI	AFRO	31,653		31,653	1,582		11,612	13,194
Togo**	LI	AFRO	1,700		1,700				
Uganda	LI	AFRO	27,085		27,085		13,289		13,289
Viet Nam	LI	WPRO	3,276		3,276				
Zambia***	LI	AFRO	30,700		30,700	8,083		0	8,083
Zimbabwe	LI	AFRO	41,441		41,441		0		0
TOTAL			**390,180**	**31,970**	**422,150**	**87,264**	**40,124**	**74,603**	**201,991**

Updated: As of Dec 2011

*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). Breakdown of treatments by country was not provided by CHAI

**Togo was added to the UNITAID pediatric programme in 2009

*** Does not include the charge of clearing/additional shipping disbursed for Zambia 2009

¢ Patient numbers for Laos are presented under adults as these were not broken down by Pediatric and Adult treatments.

(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 2011. Cumulative figures are aggregate from 2007 to 31 December 2011

(4) Based on May 2012 analysis submitted by Global Fund

** Nigeria is classified as an LMI in the PMTCT projects and as an LI in the CHAI peds project, reflecting its changed status when MoU was signed with UNICEF.

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

Country	WB Income group	WHO Region	**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	LI	AFRO	241,610		2,600		244,210
Cameroon	LMI	AFRO	285,055		48,800		333,855
Central African Republic	LI	AFRO		56,117		249,200	305,317
China	LMI	WPRO		1,447,125		12,000	1,459,125
Côte d'Ivoire	LI	AFRO	344,725		24,400		369,125
Haiti	LI	AMRO		2,805		2,400	5,205
India	LI	SEARO	0		87,000		87,000
Lesotho	LMI	AFRO		0		0	0
Malawi	LI	AFRO	708,210		184,250		892,460
Myanmar	LI	SEARO		143,217		800	144,017
Nigeria	LMI	AFRO		483,293		56,800	540,093
Rwanda	LI	AFRO	168,190		26,600		194,790
Swaziland	LMI	AFRO		0		0	0
Tanzania, United Republic of	LI	AFRO	108,244		45,000		153,244
Uganda	LI	AFRO		3,300,219		101,500	3,401,719
Zambia	LI	AFRO	367,780		30,200		397,980
Zimbabwe	LI	AFRO		355,088		4,050	359,138
TOTAL			**2,223,814**	**5,787,864**	**448,850**	**426,750**	**8,887,278**

Updated: As of Dec 2011

(1) Based on reports submitted by UNICEF to UNITAID: First Annual Report 2009; Interim Report 2010 and Annual Report 2010

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

Country	WB income group	WHO Region	**Cumulative Tests** - Children			Total
			Tests-HIV for Early Infant Diagnosis			
Lead Recipient			**CHAI**[1]	**UNICEF (PMTCTI)**[2]	**UNICEF (PMTCTII)**[3]	
Angola	LMI	AFRO	674			674
Benin	LI	AFRO	1,400			1,400
Botswana	UMI	AFRO	73,074			73,074
Burkina Faso	LI	AFRO	2,030	1,152		3,182
Burundi	LI	AFRO	1,997			1,997
Cambodia	LI	WPRO	2,903			2,903
Cameroon	LMI	AFRO	36,293	1,728		38,021
Central African Republic	LI	AFRO			0	0
China	LMI	WPRO	2,329		8,928	11,257
Côte d'Ivoire	LI	AFRO	4,289	10,368		14,657
DR Congo	LI	AFRO	10,561			10,561
Dominican Republic	LMI	AMRO	429			429
Ethiopia	LI	AFRO	45,009			45,009
Guyana	LMI	AMRO	625			625
Haiti	LI	AMRO	3,148		4,320	7,468
India	LI	SEARO	22,554	12,096		34,650
Jamaica	LMI	AMRO	877			877
Kenya	LI	AFRO	211,103			211,103
Lesotho	LMI	AFRO	16,763		0	16,763
Liberia	LI	AFRO	726			726
Malawi	LI	AFRO	74,203	1,920		76,123
Mali	LI	AFRO	1,732			1,732
Mozambique	LI	AFRO	114,611			114,611
Myanmar	LI	SEARO			288	288
Namibia	LMI	AFRO	34,947			34,947
Nigeria	LI***	AFRO	133,881		0	133,881
OECS*	UMI	AMRO	86			86
Papua New Guinea	LI	WPRO	1,286			1,286
Rwanda	LI	AFRO	32,682	576		33,258
Senegal	LI	AFRO	613			613
Swaziland	LMI	AFRO	26,892		0	26,892
Tanzania, United Republic of	LI	AFRO	87,339	7,200		94,539
Togo**	LI	AFRO	4,033			4,033
Uganda	LI	AFRO	175,232		0	175,232
Viet Nam	LI	WPRO	3,610			3,610
Zambia	LI	AFRO	144,119	2,592		146,711
Zimbabwe	LI	AFRO	68,672		11,520	80,192
TOTAL			**1,340,722**	**37,632**	**25,056**	**1,403,410**

Updated: As of Dec 2011

*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). Breakdown of tests by country were not provided by CHAI
**Togo was added to the UNITAID pediatric program in 2009

*** Nigeria is classified as an LMI in the PMTCT projects and as an LI in the CHAI peds project, reflecting its changed status when

(1) Information on EID tests represent a revision of figures submitted by CHAI in August 2012 with number of tests for 2007 - 2009 based on volumes procured and number of tests in 2010 - 2011 based on country reporting.

(2) Based on Annual Reports submitted by UNICEF; the reports follow the grant year which was then converted to tests/treatments by 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

13.5. Patients treated and treatments delivered across Malaria niches

Country	WB income group	WHO Region	Cumulative Treatments				Total
Lead Recipient			ACTScale up-GF & UNICEF[1]	GF Round 6[5]	AMFm GF[2,3]	A2S2 I+ solutions	
Bangladesh	LI	SEARO		121,325			121,325
Burundi[4]	LI	AFRO	722,953				722,953
Cambodia	LI	WPRO	295,850	141,755	0		437,605
China	LMI	WPRO		91,861			91,861
Cote d'Ivoire	LI	AFRO		456,891			456,891
Djibouti	LMI	EMRO		4,105			4,105
Eritrea	LI	AFRO		43,136			43,136
Ethiopia	LI	AFRO	10,241,820	0			10,241,820
Gambia	LI	AFRO		210,962			210,962
Ghana	LI	AFRO	2,790,020		22,763,106		25,553,126
Guinea	LI	AFRO		440,878			440,878
Guinée Bissau	LI	AFRO		103,065			103,065
Indonesia	LMI	SEARO	139,350				139,350
Kenya	LI	AFRO			26,058,868		26,058,868
Liberia[4]	LI	AFRO	678,275				678,275
Madagascar	LI	AFRO	3,194,805		1,666,578		4,861,383
Mali	LI	AFRO		683,798			683,798
Mauritania	LI	AFRO		61,741			61,741
Mozambique	LI	AFRO	9,500,940				9,500,940
Namibia	LMI	AFRO		362,161			362,161
Niger	LI	AFRO			2,225,120		2,225,120
Nigeria	LI	AFRO			57,772,801		57,772,801
Somalia	LI	EMRO		111,779			111,779
Sudan	LI	EMRO	1,434,425				1,434,425
South Sudan	LI	EMRO	399,875				
Tanzania, United Republic of	LI	AFRO			13,070,695		13,070,695
Uganda	LI	AFRO			28,226,700		28,226,700
Zambia	LI	AFRO	5,089,890				5,089,890
TOTAL			**34,488,203**	**2,833,457**	**151,783,868**	**n/a**	**189,105,528**

Updated: As of Dec 2011

(1) All figures are based on the latest Annual Report submitted by GFATM on 31st May 2012

(2) Based on latest 2011 Annual Report

(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 33,086,975 (=34,488,203-722,953(Burundi)-678,275(Liberia))

(5) Based on May 2012 figures submited by Global Fund

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

Country	WB Income group	WHO Region	Cumulative Prevention LLINs
Lead Recipient			**UNICEF**
Angola	LMI	AFRO	850,000
Central African Republic	LI	AFRO	1,100,000
Congo Brazaville	LMI	AFRO	470,000
DR Congo	LI	AFRO	5,500,000
Guinea	LI	AFRO	1,300,000
Nigeria	LI	AFRO	6,500,000
Sudan *	LI	EMRO	3,850,000
Zimbabwe	LI	AFRO	430,000
TOTAL			**20,000,000**

Updated: As of Dec 2011

* Treatments for Sudan and South Sudan have been combined

13.7. Patients treated and treatments delivered across TB niches: Adults

Country	WB income group	WHO Region	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	LMI	EURO		1,201			1,201
Bangladesh	LI	SEARO	147,450				147,450
Belarus	LMI	EURO			200		200
Benin	LI	AFRO			13		13
Bosnia Herzegovina	LMI	EURO	3,727				3,727
Bhutan	LI	SEARO			19		19
Bulgaria	LMI	EURO			40		40
Burkina Faso	LI	AFRO	8,500	57			8,557
Cambodia	LI	WPRO		169			169
Cameroon	LI	AFRO	51,806				51,806
Cote d'Ivoire	LI	AFRO	42,476				42,476
DR Congo	LI	AFRO		455			455
Dominican Republic	LMI	AMRO		324			324
Egypt	LMI	EMRO			89		89
Gambia	LI	AFRO	3,524				3,524
Georgia	LMI	EURO			739		739
Guatemala	LMI	AMRO			50		50
Guinea	LI	AFRO	18,847	29			18,876
Haiti	LI	AMRO		233			233
India[3]	LMI	SEARO		4,850	0		4,850
Iraq	LMI	EMRO	4,820				4,820
Kazahkstan[3]	LMI	EURO			381		381
Kenya	LI	AFRO	128,508	309			128,817
Kyrgystan	LI	EURO		505	550		1,055
Lesotho	LI	AFRO		640			640
Madagascar	LI	AFRO	45,456				45,456
Malawi	LI	AFRO		0			0
Mali	LI	AFRO	10,842				10,842
Moldova, Republic of[3]	LMI	EURO		155	717		872
Mozambique	LI	AFRO	23,439	104			23,543
Myanmar	LI	SEARO	114,627	199			114,826
Nepal	LI	SEARO		625			625
Niger	LI	AFRO	9,679				9,679
Nigeria	LI	AFRO	110,542				110,542
Rwanda	LI	AFRO	10,144		172		10,316
Sri Lanka	LMI	SEARO			10		10
Syrian Arab Republic	LMI	EMRO			30		30
Tajikistan	LI	EURO	16,202		42		16,244

Country	WB income group	WHO Region	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	
Tanzania, United Republic of	LI	AFRO			15		15
Timor-Leste	LI	SEARO		22			22
Togo	LI	AFRO	3,824				3,824
Uganda	LI	AFRO	30,667				30,667
Uzbekistan	LI	EURO		614			614
Viet Nam	LI	WPRO			101		101
TOTAL			**785,080**	**10,491**	**3,168**	**5,800**	**804,539**

Updated: As of Dec 2011

(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) Based on May 2012 analysis submitted by Global Fund

(3) For Round 6 project with GFATM, these countries were categorized as LI

13.8. Patients treated and treatments delivered across TB niches: Children

Country	WB Income Group	WHO Region	Cumulative Treatments - Children		Total
			Patient **treatments** delivered[1]	TB **prophylaxis treatments** delivered[1]	
Lead Recipient			**GDF/STOP TB**	**GDF/STOP TB**	
Afghanistan	LI	EMRO	13,738	133,033	146,771
Bangladesh	LI	SEARO	18,942	7,667	26,609
Benin	LI	AFRO	422	7,355	7,777
Burkina Faso	LI	AFRO	483	4,190	4,673
Burundi	LI	AFRO	1,306	0	1,306
Cambodia	LI	WPRO	11,792	7,917	19,709
Cameroon	LMI	AFRO	3,174	24,342	27,516
Cape Verde	LMI	AFRO	103	529	632
Congo	LMI	AFRO	398	0	398
Cote d'Ivoire	LI	AFRO	3,352	40,478	43,830
Djibouti	LMI	EMRO	1,252	439	1,691
DPR Korea	LI	SEARO	16,304	0	16,304
Egypt	LMI	EMRO	1,550	9,360	10,910
Eritrea	LI	AFRO	795	2,360	3,155
Ethiopia	LI	AFRO	28,281	3,603	31,884
Gambia	LI	AFRO	566	292	858
Georgia	LMI	EURO	641	4,567	5,208
Guinea	LI	AFRO	2,680	22,057	24,737
Guinea Bissau	LI	AFRO	505	289	794
Indonesia	LMI	SEARO	12,000	0	12,000
Iraq	LMI	EMRO	2,585	31,622	34,207
Jordan	LMI	EMRO	406	1,372	1,778
Kazakhstan	UMI	EURO	7,041	31,522	38,563
Kenya	LI	AFRO	20,400	0	20,400
Kiribati	LMI	WPRO	126	311	437
Kyrgyzstan	LI	EURO	2,743	4,366	7,109
Lebanon	UMI	EMRO	120	318	438
Lesotho	LMI	AFRO	3,792	2,956	6,748
Macedonia	LMI	EURO	174	875	1,049
Madagascar	LI	AFRO	6,300	3,814	10,114
Malawi	LI	AFRO	11,072	9,917	20,989
Mali	LI	AFRO	569	18,267	18,836
Mauritania	LI	AFRO	301	180	481
Mongolia	LMI	WPRO	1,165	466	1,631
Morocco	LMI	EMRO	7,853	0	7,853
Mozambique	LI	AFRO	6,640	8,640	15,280
Myanmar	LI	SEARO	98,114	0	98,114
Nepal	LI	SEARO	10,107	3,003	13,110
Niger	LI	AFRO	2,292	4,086	6,378
Nigeria	LI	AFRO	21,932	14,016	35,948

Country	WB Income Group	WHO Region	Cumulative Treatments - Children		Total
			Patient **treatments** delivered[1]	TB **prophylaxis treatments** delivered[1]	
Lead Recipient			**GDF/STOP TB**	**GDF/STOP TB**	
Pakistan	LI	EMRO	66,736	72,496	139,232
Papua New Guinea	LI	WPRO	2,634	0	2,634
Rwanda	LI	AFRO	1,290	3,739	5,029
Senegal	LI	AFRO	1,533	10,590	12,123
Sierra Leone	LI	AFRO	4,241	3,460	7,701
Somalia	LI	EMRO	4,941	18,359	23,300
Sri Lanka	LMI	SEARO	1,279	0	1,279
North Sudan	LI	EMRO	9,851	49,003	58,854
South Sudan	LI	EMRO	2,139	2,572	4,711
Swaziland	LMI	AFRO	2,445	1,298	3,743
Tajikistan	LI	EURO	1,908	22,340	24,248
Tanzania, United Republic of	LI	AFRO	12,123	5,135	17,258
Thailand	LI	SEARO	3,606	25,202	28,808
Togo	LI*	AFRO	302	2,115	2,417
Turkmenistan	LMI	EURO	486	5,512	5,998
Yemen	LI	EMRO	1,165	11,375	12,540
Zambia	LI	AFRO	14,835	8,024	22,859
TOTAL			**453,530**	**645,429**	**1,098,959**

Updated: As of Dec 2011

Philippines was removed from the list as this project is not being conducted in this country

(1) Patient treatments based on the 2011 Annual Report submitted by GDF

*Togo was incorrectly classified as an LMI in the original agreement. It has been changed to LI

13.9. Case detection of MDR TB in UNITAID supported countries

Country	WB Income Group	WHO Region	Cumulative Number of Cases detected MDR TB[1]
Lead Recipient			**GDF/FIND/GLI**
Azerbaijan	LMI	EURO	115
Bangladesh	LI	SEARO	
Belarus	LMI	EURO	
Cameroon	LMI	AFRO	10
Cote d'Ivoire	LI	AFRO	
Djibouti	LMI	AFRO	
Ethiopia	LI	AFRO	544
Georgia	LMI	EURO	804
Haiti	LI	AMRO	61
India	LMI	SEARO	4187
Indonesia	LMI	SEARO	
Kazahkstan	UMI	EURO	
Kenya	LI	AFRO	
Kyrgyz Republic	LI	EURO	50
Lesotho	LMI	AFRO	392
Moldova, Republic of	LMI	EURO	420
Mozambique	LI	AFRO	
Myanmar	LI	SEARO	572
Peru	LMI	AMRO	
Rwanda	LI	AFRO	
Senegal	LI	AFRO	
Swaziland	LMI	AFRO	369
Tajikistan	LI	EURO	
Tanzania, United Republic of	LI	AFRO	
Uganda	LI	AFRO	202
Uzbekistan	LI	EURO	3166
Viet Nam	LI	WPRO	
Total			**10,892**

Updated: As of Dec 2011

Democratic Republic of Congo and Zambia withdrew from the project and are being replaced by Rwanda and Mozambique

(1) Countries where no data was reported are either in transition (requiring laboratory infrastructure, laboratory assessments, needing essential equipment, validation of diagnostic algorithms and training, or MoUs need to be signed for Peru and Mozambique. Rwanda was signed in May 2012

Table 14 (Action 2, Area 3): Track costs of treatments, diagnostics and related products delivered by UNITAID-funded projects by beneficiary country and over time

14.1. Monies Spent on HIV Treatments in Adults

			CumulativeTreatment Values (US$)		
Country	**WB Income group**	**WHO Region**	**Treatments** : ARVs 2nd Line Adults		**Total**
Lead Recipient			**CHAI**[1,2]	**GF: Round 6**[3]	
Benin	LI	AFRO	292,346		292,346
Botswana	UMI	AFRO	11,968,710		11,968,710
Burundi	LI	AFRO	2,980,841		2,980,841
Cambodia	LI	WPRO	2,927,334		2,927,334
Cameroon	LI	AFRO	7,769,873		7,769,873
Chad	LI	AFRO	1,140,465		1,140,465
Côte d'Ivoire	LI	AFRO	1,590,609		1,590,609
DR Congo	LI	AFRO	2,919,123		2,919,123
Djibouti	LMI	EMRO		74,088	74,088
Ethiopia	LI	AFRO	3,787,369		3,787,369
Ghana	LI	AFRO	134,964		134,964
Haiti	LI	AMRO	1,704,060		1,704,060
India	LI	SEARO	5,838,879		5,838,879
Kenya	LI	AFRO	28,245,110		28,245,110
Laos[4]	LI	WPRO		12,183	12,183
Liberia	LI	AFRO		240,529	240,529
Malawi	LI	AFRO	1,101,251		1,101,251
Mali	LI	AFRO	2,992,215		2,992,215

Country	WB Income group	WHO Region	CumulativeTreatment Values (US$)		Total
			Treatments : ARVs 2nd Line Adults		
Lead Recipient			**CHAI**[1,2]	**GF: Round 6**[3]	
Moldova, Republic of	LMI	EURO		732,283	732,283
Mozambique	LI	AFRO	6,086,225		6,086,225
Namibia	LMI	AFRO	1,465,037		1,465,037
Nigeria	LI	AFRO	27,649,005		27,649,005
Rwanda	LI	AFRO	2,148,750		2,148,750
Senegal	LI	AFRO	1,489,134		1,489,134
Tanzania, United Republic of	LI	AFRO	3,441,117	13,109	3,454,226
Togo	LI	AFRO	2,721,691		2,721,691
Tunisia	LMI	EMRO		252,270	252,270
Uganda	LI	AFRO	38,108,531		38,108,531
Zambia	LI	AFRO	40,438,053		40,438,053
Zimbabwe	LI	AFRO	4,040,739		4,040,739
TOTAL			**202,981,430**	**1,324,462**	**204,305,892**

(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, 2010 and 2011 Annual Reports

(3) Cumulative values based on 2012 May Analysis submitted by Global Fund

(4) Results for Laos for Global Fund Roud 6 are combined for pediatric and second line ARVs to avoid double counting

14.2. Monies Spent on HIV Treatments in Children

			Cumulative Values (US$)						
Country	**WB Income group**	**WHO Region**	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]	**Total**
Lead Recipient			**CHAI**	**CHAI**	**CHAI**	**CHAI**	**CHAI**	**GF: Round 6**	
Angola	LMI	AFRO	167,687	90,430	63,579	368,295	689,991		689,991
Benin	LI	AFRO	407,729	193,867	125,336	0	726,932		726,932
Botswana	UMI	AFRO	4,235,687	530,995	1,190,445	366,853	6,323,980		6,323,980
Burkina Faso	LI	AFRO	690,995	624,727	460,829	0	1,776,552	600,000	2,376,552
Burundi	LI	AFRO	795,613	150,079	48,414	0	994,107		994,107
Cambodia	LI	WPRO	1,029,896	188,553	211,841	151,126	1,581,415		1,581,415
Cameroon	LMI	AFRO	2,230,107	904,310	335,776	296,123	3,766,316		3,766,316
China	LMI	WPRO	1,668,759	38,847	70,575	0	1,778,181		1,778,181
Côte d'Ivoire	LI	AFRO	1,105,055	167,599	47,118	0	1,319,772		1,319,772
DR Congo	LI	AFRO	2,313,890	952,121	479,106	10,527	3,755,644		3,755,644
Dominican Republic	LMI	AMRO	508,510	77,355	113,956	17,907	717,729		717,729
Ethiopia	LI	AFRO	4,844,025	1,326,264	482,580	2,227,477	8,880,347		8,880,347
Guinea	LI	AFRO					0	66,000	66,000
Guyana	LMI	AMRO	120,718	46,573	21,000	0	188,291		188,291
Haiti	LI	AMRO	128,697	86,498	51,734	496,800	763,729		763,729
India	LI	SEARO	6,602,394	2,868,507	1,026,630	0	10,497,531	4,444,445	14,941,976
Jamaica	LMI	AMRO	55,603	40,916	47,656	10,069	154,245		154,245
Kenya	LI	AFRO	16,995,463	3,008,244	1,309,243	207,760	21,520,710		21,520,710
Laos[7]	LI	WPRO					0		0
Lesotho	LMI	AFRO	1,968,183	1,323,681	1,302,440	403,350	4,997,654		4,997,654
Liberia	LI	AFRO	230,300	61,756	71,375	0	363,432		363,432
Malawi	LI	AFRO	5,156,627	4,367,482	1,789,205	4,015,139	15,328,453		15,328,453
Mali	LI	AFRO	1,135,637	45,233	107,769	0	1,288,639		1,288,639
Morocco	LMI	EMRO					0	37,200	37,200
Mozambique	LI	AFRO	5,917,328	4,755,609	2,772,630	3,658,274	17,103,841		17,103,841
Namibia	LMI	AFRO	1,138,775	820,497	492,277	190,182	2,641,731		2,641,731
Nigeria	LI	AFRO	11,371,932	2,391,839	2,157,708	1,892,615	17,814,093		17,814,093
OECS[3]	UMI	AMRO	94,017	15,984	30,898	0	140,898		140,898
Papua New Guinea	LI	WPRO	125,941	197,609	89,438	46,993	459,981		459,981
Rwanda	LI	AFRO	2,569,845	634,643	717,707	1,158,446	5,080,641		5,080,641
Senegal	LI	AFRO	457,813	34,737	62,840	14,816	570,206	271,200	841,406
Serbia	LMI	EURO					0	104,000	104,000
Swaziland	LMI	AFRO	2,254,460	1,198,029	334,692	169,341	3,956,523		3,956,523
Tanzania, United Republic of	LI	AFRO	6,036,793	3,322,337	834,620	572,792	10,766,542		10,766,542
Togo[1]	LI	AFRO	298,045	332,032	14,664	0	644,741		644,741
Uganda	LI	AFRO	11,548,326	8,495,601	1,714,666	1,880,351	23,638,944		23,638,944
Viet Nam	LI	WPRO	1,309,698	186,364	112,467	1,671	1,610,200		1,610,200

			Cumulative Values (US$)						Total
Country	**WB Income group**	**WHO Region**	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: Round 6**	
Zambia[2]	LI	AFRO	4,813,125	6,019,186	2,326,703	2,581,705	15,740,719		15,740,719
Zimbabwe	LI	AFRO	6,535,229	4,340,203	1,505,005	3,394,098	15,774,535		15,774,535
TOTAL			**106,862,903**	**49,838,709**	**22,522,922**	**24,132,711**	**203,357,245**	**5,522,845**	**208,880,090**

(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 extraneous 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 May 2012 analysis submitted by Global Fund

(7) Results for Laos for Global Fund Round 6 are combined for pediatric and second line ARVs to avoid double counting. They are presented in the values for adult treatments

14.3. Monies Spent on HIV treatments in Pregnant Women and in Children

			Cumulative Values (US$)			
Country	**WB Income group**[7]	**WHO Region**	Value of **product** expenditure[1,5]	Value of **product** expenditure[2,6]	Value of **product** expenditure[3,4]	**Total**
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	LI	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	LMI	AFRO		2,838,264		2,838,264
Rwanda	LI	AFRO	1,233,388		173,086	1,406,474
Swaziland	LMI	AFRO		826,751		826,751
Tanzania, United Republic of	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

(7) Income status of countries was based on an analysis of information presented in the annual report and year of MoU

14.4. 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[5]**	
Bangladesh	LI	SEARO		315,875			315,875
Burundi*	LI	AFRO	376,731				376,731
Cambodia	LI	WPRO	962,773	888,143	0		1,850,916
China	LMI	WPRO		179,100			179,100
Côte d'Ivoire	LI	AFRO		325,463			325,463
Djibouti	LMI	EMRO		7,456			7,456
Eritrea	LI	AFRO		577,978			577,978
Ethiopia	LI	AFRO	11,501,700				11,501,700
Gambia	LI	AFRO		3,428,900			3,428,900
Ghana	LI	AFRO	1,697,690		26,431,494		28,129,184
Guinea	LI	AFRO		2,224,750			2,224,750
Guinea Bissau	LI	AFRO		661,911			661,911
Indonesia	LMI	SEARO	134,255				134,255
Kenya	LI	AFRO			24,980,279		24,980,279
Liberia*	LI	AFRO	428,609				428,609
Madagascar	LI	AFRO	833,388		959,434		1,792,822
Mali	LI	AFRO		748,016			748,016
Mauritania	LI	AFRO		230,076			230,076
Mozambique	LI	AFRO	9,164,821				9,164,821
Namibia	LMI	AFRO		1,087,500			1,087,500
Niger	LI	AFRO			1,939,296		1,939,296
Nigeria	LI	AFRO			61,003,326		61,003,326
Somalia	LI	EMRO		31,062			31,062
Sudan	LI	EMRO	1,128,964				1,128,964
South Sudan	LI	EMRO	235,856				235,856
Tanzania, United Republic of	LI	AFRO			13,742,434		13,742,434
Uganda	LI	AFRO			26,388,431		26,388,431
Zambia	LI	AFRO	5,262,036				5,262,036
TOTAL			**31,726,823**	**10,706,230**	**155,444,693**	**9,280,000**	**207,157,746**

*Liberia and Burundi received treatments only for 2007/2008. Note: They are not part of the ACT Scale-up project

** Sudan and South Sudan have been combined as one country

(1) Country information received from GFATM on 31st May 2012

(2) Cumulative values based on 2012 May Analysis by the GFATM

(3) Cumulative values based on updated figures sent by AMFm project team on 22 May 2012

(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

(5) MoU Ceiling for this project is US$ 9,280,000 with US$ 8,400,000 available as a revolving fund to extractors. As per the 2011 Annual Report, a loan amount totalling US$6,450,000 was approved but only US$ 4,850,000 was actually disbursed to extractors as of December 2011

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

			Cumulative Values (US$)
Country	**WB Income group**	**WHO Region**	**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
DR Congo	LI	AFRO	23,450,583
Guinea	LI	AFRO	6,616,339
Nigeria	LI	AFRO	30,524,550
Sudan*	LI	EMRO	16,763,500
Zimbabwe	LI	AFRO	2,064,000
TOTAL			**90,753,692**

Project completed in 2010

*Sudan and South Sudan have been combined

(1) Value of LLINs in US$ excluding costs of freight, insurance, quality assurance & handling fees

14.6. Monies spent on Treatment of Tuberculosis in Adults

Country	WB Income group	WHO Region	Cumulative Values of Treatments (US$)				Total
			Value of **treatments - 1st Line**	Value of treatments - **MDR TB**		**MDR TB** SRS	
Lead Recipient			**GDF/STOP TB**[1]	**GLC/GDF/GF**[2]	**GF Round 6**[3]	**GDF/STOP TB**[5]	
Azerbaijan	LMI	EURO		3,966,044			3,966,044
Bangladesh	LI	SEARO	2,671,881				2,671,881
Belarus	LMI	EURO			549,720		549,720
Benin	LI	AFRO			20,478		20,478
Bosnia Herzegovina	LMI	EURO	63,232				63,232
Bhutan	LI	SEARO			99,000		99,000
Bulgaria	LMI	EURO			201,912		201,912
Burkina Faso	LI	AFRO	157,585	133,762			291,347
Cambodia	LI	WPRO		363,065			363,065
Cameroon	LMI	AFRO	1,236,650				1,236,650
Côte d'Ivoire	LI	AFRO	792,541				792,541
DR Congo	LI	AFRO		710,004			710,004
Dominican Republic	LMI	AMRO		614,493			614,493
Egypt	LMI	EMRO			522,000		522,000
Gambia	LI	AFRO	68,836				68,836
Georgia	LMI	EURO			1,836,800		1,836,800
Guatemala	LMI	AMRO			55,707		55,707
Guinea	LI	AFRO	370,769	37,098			407,867
Haiti	LI	AMRO		625,038			625,038
India[4]	LMI	SEARO		13,777,317	958,126		14,735,443
Iraq	LMI	EMRO	106,422				106,422
Kazahkstan[4]	LMI	EURO			332,000		332,000
Kenya	LI	AFRO	2,265,596	601,732			2,867,328
Kyrgyz Republic	LI	EURO		1,274,607	2,501,651		3,776,258
Lesotho	LI	AFRO		2,527,264			2,527,264
Madagascar	LI	AFRO	952,686				952,686
Malawi	LI	AFRO		0			0
Mali	LI	AFRO	218,279				218,279
Moldova, Republic of[4]	LMI	EURO		310,175	1,264,958		1,575,133
Mozambique	LI	AFRO	549,004	233,615			782,619
Myanmar	LI	SEARO	2,782,168	748,032			3,530,200
Nepal	LI	SEARO		1,061,081			1,061,081
Niger	LI	AFRO	208,328				208,328
Nigeria	LI	AFRO	2,029,255				2,029,255
Rwanda	LI	AFRO	208,166		326,749		534,915
Sri Lanka	LMI	SEARO			55,518		55,518
Syrian Arab Republic	LMI	EMRO			180,082		180,082
Tajikistan	LI	EURO	360,672		126,000		486,672
Tanzania, United Republic of	LI	AFRO			126,000		126,000
Timor-Leste	LI	SEARO		40,803			40,803

			Cumulative Values of Treatments (US$)				
Country	**WB Income group**	**WHO Region**	Value of **treatments - 1st Line**	Value of treatments - **MDR TB**		**MDR TB** SRS	**Total**
Lead Recipient			**GDF/STOP TB[1]**	**GLC/GDF/GF[2]**	**GF Round 6[3]**	**GDF/STOP TB[5]**	
Togo	LI	AFRO	96,315				96,315
Uganda	LI	AFRO	506,120				506,120
Uzbekistan	LI	EURO		2,464,426			2,464,426
Viet Nam	LI	WPRO			823,381		823,381
TOTAL			**15,644,504**	**29,488,556**	**9,980,082**	**9,985,937**	**65,099,079**

(1) Exworks values of products procured; based on 2011 Annual Report

(2) Cumulative figures since project inception till Dec 2011: Based on 2011 Annual Report from GDF

(3) Cumulative values based on 2012 May analysis submitted by the Global Fund

(4) For Round 6 project with GFATM, these countries were categoriesed as LI

(5) The MOU allocated USD11.4 million for the Strategic Rotating Stockpile of which USD 9.9 million was budgeted for purchase of MDR TB drugs; Values for MDR TB SRS is based on Annex 3 of the Financial Section of the 2011 Annual Report

14.7. Monies spent on Treatment of Tuberculosis in Children

			Cumulative values of treatments (US$)
Country	**WB Income group**	**WHO Region**	ExWorks Value of **treatments and prophylaxis treatments** delivered
Lead Recipient			**GDF/STOP TB**
Afghanistan	LI	EMRO	337,813
Bangladesh	LI	SEARO	245,760
Benin	LI	AFRO	13,283
Burkina Faso	LI	AFRO	10,932
Burundi	LI	AFRO	13,446
Cambodia	LI	WPRO	112,689
Cameroon	LMI	AFRO	78,811
Cape Verde	LMI	AFRO	1,825
Congo	LMI	AFRO	7,544
Cote d'Ivoire	LI	AFRO	53,391
Djibouti	LMI	EMRO	21,209
DPR Korea	LI	SEARO	129,224
Egypt	LMI	EMRO	29,569
Eritrea	LI	AFRO	10,786
Ethiopia	LI	AFRO	479,649
Gambia	LI	AFRO	6,086
Georgia	LMI	EURO	9,859
Guinea	LI	AFRO	48,069
Guinea Bissau	LI	AFRO	5,420
Indonesia	LMI	SEARO	89,349
Iraq	LMI	EMRO	79,139
Jordan	LMI	EMRO	6,257
Kazakhstan	UMI	EURO	88,560
Kenya	LI	AFRO	328,218
Kiribati	LMI	WPRO	2,759
Kyrgyzstan	LI	EURO	36,948
Lebanon	UMI	EMRO	2,088
Lesotho	LMI	AFRO	76,902
Macedonia	LMI	EURO	3,089
Madagascar	LI	AFRO	103,131
Malawi	LI	AFRO	192,131
Mali	LI	AFRO	24,710
Mauritania	LI	AFRO	4,233
Mongolia	LMI	WPRO	21,642
Morocco	LMI	EMRO	88,454
Mozambique	LI	AFRO	128,662
Myanmar	LI	SEARO	1,033,541
Nepal	LI	SEARO	136,542
Niger	LI	AFRO	35,988

			Cumulative values of treatments (US$)
Country	**WB Income group**	**WHO Region**	ExWorks Value of **treatments and prophylaxis treatments** delivered
Lead Recipient			**GDF/STOP TB**
Nigeria	LI	AFRO	340,793
Pakistan	LI	EMRO	654,393
Papua New Guinea	LI	WPRO	39,366
Philippines**	LMI	WPRO	
Rwanda	LI	AFRO	24,158
Senegal	LI	AFRO	25,877
Sierra Leone	LI	AFRO	53,847
Somalia	LI	EMRO	73,950
Sri Lanka	LMI	SEARO	13,369
Sudan*	LI	EMRO	241,457
Swaziland	LMI	AFRO	33,165
Tajikistan	LI	EURO	56,279
Tanzania, United Republic of	LI	AFRO	149,087
Thailand	LI	SEARO	104,369
Togo	LI**	AFRO	6,606
Turkmenistan	LMI	EURO	8,762
Yemen	LI	EMRO	25,724
Zambia	LI	AFRO	140,376
TOTAL			**6,089,286**

**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

(1) Based on 2011 Annual Report (Annex 1, Indicator P.1.1, Table 2) submitted to UNITAID from GDF: These figures represent ex-works values

*Value of treatments for Sudan were not available separately for Sudan and South Sudan

**Togo was incorrectly classified as an LMI in the original agreement. It has been changed to LI

14.8. Monies spent on detection of MDR-TB

			Cumulative Values (US $)
Country	**WB Income Group**	**WHO Region**	**Total Product Costs (Orders Paid cumulatively) Expand TB[1]**
Lead Recipient			**GDF/FIND/GLI**
Azerbaijan	LMI	EURO	77,099
Bangladesh	LI	SEARO	
Belarus	LMI	EURO	
Cameroon	LMI	AFRO	243,372
Côte d'Ivoire	LI	AFRO	182,400
Djibouti	LMI	AFRO	274,928
Ethiopia	LI	AFRO	680,106
Georgia	LMI	EURO	354,316
Haiti	LI	AMRO	219,366
India	LMI	SEARO	3,498,674
Indonesia	LMI	SEARO	
Kazahkstan	UMI	EURO	
Kenya	LI	AFRO	39,319
Kyrgyz Republic	LI	EURO	338,786
Lesotho	LMI	AFRO	119,206
Moldova, Republic of	LMI	EURO	108,714
Mozambique	LI	AFRO	
Myanmar	LI	SEARO	633,194
Peru	LMI	AMRO	
Rwanda	LI	AFRO	

Senegal	LI	AFRO	
Swaziland	LMI	AFRO	112,192
Tajikistan	LI	EURO	141,504
Tanzania, United Republic of	LI	AFRO	119,073
Uganda	LI	AFRO	116,358
Uzbekistan	LI	EURO	176,659
Viet Nam	LI	WPRO	
Total			**7,435,264**

(1) Includes Equipment costs, consumables and re-agents and essential supplies; excludes freight and insurance and pre-shipment inspection; based on the 2011 Annual Report, spreadsheet "Schedule C2 GDF Cumulative" in workbook "Monitoring and Financial Tables EXPANDTB 3rd Annual Report January - December 2011

Note: DR Congo and Zambia withdrew from the project and are being replaced by Rwanda (MOU signature is imminent) and Mozambique (MoU signed in May 2012)

Table 15: Summary of treatments provided by year and by disease area

15.8. HIV

HIV / AIDS (Treatments, Tests and Prevention)						
Year	**2007**	**2008**	**2009**	**2010**	**2011**	**Total***
Treatments: ART for HIV positive pregnant women (PMTCT I, II)		5,948	45,611	13,318		**64,877**
Treatments: ARVs children (CHAI & GFATM R6) [1]	134,677	55,995	60,014	73,578	65,916	**422,150**
Treatments: ARVs 2nd line adults (CHAI & GFATM R6) [1,3]	61,674	133,322	117,324	113,892	117,141	**550,830**
Tests: pregnant women HIV tests (PMTCT I, II)		819,860	3,105,442	4,086,376		**8,011,678**
Tests: HIV + pregnant women CD4 tests (PMTCT I, II)		129,200	336,200	410,200		**875,600**
Tests: HIV for Early Infant Diagnosis (CHAI & PMTCT I, II)[4]	75,115	176,187	332,146	397,866	422,096	**1,403,410**
Prevention: ARVs to prevent mother-to-child transmission (PMTCTI,II)		43,764	227,494	540,713		**811,971**
Prevention: Cotrim provided to HIV+ women (PMTCT I,II III)		48,802	109,633	38,655		**197,090**
Prevention: RuTF and Cotrim provided to children (PMTCT I,II,III)[2]		35,187	65,366	101,438		**201,991**

(1) Treatments by project year for Round 6 have not been validated by GFATM; the cumulative total has been added to the row total for ARV treatments

(2) Excludes the CHAI project

(3) Includes Tenofovir ordered as first line treatments for Namibia, Uganda and Zambia

(4) Information on EID tests represent a revision of figures submitted by CHAI in August 2012 with 2007 - 2009 volumes based on procurement and 2010 - 2011 based on country reporting.

* Row totals do not necessarily add up as cumulative totals have been added for projects that did not have annual breakdowns:
GFATM Round 6 treatments (31,970) has been added to the cumulative total for ARVs for children
GFATM Round 6 treatments (7,477) has been added to the cumulative total for ARVs for adults

15.2. Malaria

Malaria (Treatments and Prevention)						
Year	**2007**	**2008**	**2009**	**2010**	**2011**	**Total***
Treatments : ACT Scale-up[1] (UNICEF, GFATM R6, AMFm)	1,401,228	8,200,280	6,961,150	15,918,705	153,790,708	**189,105,528**
Prevention: (LLINs)[3]			13,500,000	6,500,000		**20,000,000**

Note: This table excludes the indirect effects of the A2S2 project which provided a loan to manufacturers for the production of ACTs and was not tied to specific treatment deliveries
(1) ACT treatments were funded for patients in Liberia and Burundi in 2007 only
(2) Treatments by project year for Round 6 have not been validated by GFATM; the cumulative total (2,883,457) has been added to the row total for ACT treatments
(3) The project ended in 2010
* Row totals do not necessarily add up as cumulative totals have been added for projects that did not have annual breakdown; GFATM Round 6 treatments (2,883,457) has been added to the cumulative total for ACT treatments

15.3. TB

Tuberculosis (Treatments and Tests)						
Year	**2007**	**2008**	**2009**	**2010**	**2011**	**Total***
Treatments: first line (GDF)	197,584	545,793	41,703	0	0	**785,080**
Treatments: MDR TB (GDF & GFATM R6)[1]	0	1,543	1,535	845	6,568	**13,659**
Strategic Rotating stockpile: **Treatments** for MDR TB (GDF)		800	5,000			**5,800**
Treatments: children curative (GDF)	52,128	81,053	145,709	117,211	57,429	**453,530**
Treatments: children preventive (GDF)	60,626	91,995	229,884	173,620	89,304	**645,429**
Diagnostic **tests** (for MDR-TB)			1,810	2,356	6,726	**10,892**

1 Treatments by project year for Round 6 have not been validated by GFATM; the cumulative total has been added to the row total for MDR TB treatments

* Row totals do not necessarily add up as cumulative totals have been added for projects that did not have annual breakdown; GFATM Round 6 treatments (3,168) has been added to the cumulative total for MDR TB treatments

Table 16: Summary of monies spent (US$) on products purchased by year and by disease area

16.1. HIV

HIV ($ Investments)						
Year	**2007**	**2008**	**2009**	**2010**	**2011**	**Total**
Treatments: ARVs children (CHAI)	20,178,638	25,889,011	16,370,168	17,940,882	26,484,204	**106,862,903**
Treatments: ARVs children (GFATM R6)[1]			5,522,845			**5,522,845**
Treatments: ARVs 2nd Line Adults (CHAI)	20,741,509	48,917,770	60,634,919	36,964,141	35,723,091	**202,981,430**
Treatments: ARVs 2nd Line Adults (GFATM R6)[1]			1,324,462			**1,324,462**
Tests: HIV for Early Infant Diagnosis CHAI	1,823,495	2,773,175	13,411,220	14,289,285	17,541,535	**49,838,710**
Combined: PMTCT (I,II & III) UNICEF[2]		4,004,541	16,449,724	13,997,550		**34,451,814**
Prevention: RuTF and Opportunistic Infections in Children (CHAI)	12,046,854	14,854,684	8,582,912	6,339,474	4,831,709	**46,655,633**
Total	**54,790,496**	**96,439,182**	**122,296,250**	**89,531,332**	**84,580,539**	**447,637,798**

(1) Based on latest available data received in May 2012 from the Global Fund for Round 6

(2) Includes values for testing, treatments and prevention related products: 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

16.2. Malaria

MALARIA ($ Investments)						
Year	**2007**	**2008**	**2009**	**2010**	**2011**	**Total**
Treatments: ACTs[1] (UNICEF, GFATM R6, AMFm)	805,340	6,504,601	16,375,042	16,186,917	158,005,846	**197,877,746**
Prevention: LLINs[2] (UNICEF)			90,753,692			**90,753,692**

(1) Includes Liberia and Burundi for 2007 only which was a time limited project

(2) Project completed in 2010

16.3. Tuberculosis

TUBERCULOSIS ($ Investments)						
Year	**2007**	**2008**	**2009**	**2010**	**2011**	**Total***
Treatments: first line drugs (GDF)[1]	Refer to footnote 1	Refer to footnote 1	Refer to footnote 1	Refer to footnote 1	Refer to footnote 1	**15,644,503**
Treatments: MDR TB [2, 3, 4] (GDF, GFATM R6)	0	9,985,937	9,980,082	0	13,394,530	**49,454,575**
Treatments: children (curative and preventive)[5]	244,980	934,993	2,290,403	1,501,681	1,117,228	**6,089,285**
Expand TB (MDR-TB **cases detected)**[6]					5,372,799	**7,435,264**
Total	**244,980**	**10,920,930**	**12,270,485**	**1,501,681**	**19,884,557**	**78,623,627**

(1) Only cumulative total of ExWorks Value of treatments is available; Annual breakdowns are available with all charges included which includes both product and non-product related expenditure (e.g. insurance and shipping fees)

(2) Includes values from the MDR TB Strategic Rotating Stockpile project: The MOU allocated USD11.4 million for the Strategic Rotating Stockpile of which USD 9.9million was budgeted for purchase of MDR TB drugs in 2008

(3) Values for MDR TB SRS is based on Annex 3 of the Financial Section of the 2011 Annual Report

(4) Cumulative values for MDR TB Scale up are available till 2010 ($16,094,026) followed by an annual figure for 2011; to arrive at the total value of treatments for MDR TB the cumulative total of $16,094,026 has been added to the values for the MDR TB SRS amd GFATM Round 6.

(5) ExWorks values

(6) Only cumulative values for Expand TB are available with an annual breakdown for 2011

* Row totals do not necessarily add up as cumulative totals have been added for projects that did not have annual breakdowns

Table 17. Summary of monies spent (US$) on commodities by disease area and country to end of 2011

Country	HIV	Malaria	TB	Grand Total
Afghanistan	0	0	337,813	337,813
Angola	689,991	3,697,500	0	4,387,491
Azerbaijan	0	0	4,043,143	4,043,143
Bangladesh	0	315,875	2,917,641	3,233,516
Belarus	0	0	549,720	549,720
Benin	1,019,278	0	33,761	1,053,038
Bhutan	0	0	99,000	99,000
Bosnia Herzegovina	0	0	63,232	63,232
Botswana	18,292,690	0	0	18,292,690
Bulgaria	0	0	201,912	201,912
Burkina Faso	2,779,308	0	302,280	3,081,588
Burundi	3,974,948	428,609	13,446	4,417,003
Cambodia	4,508,749	1,850,916	475,754	6,835,419
Cameroon	12,611,013	0	1,558,833	14,169,846
Cape Verde	0	0	1,825	1,825
Central African Republic	286,084	5,444,520	0	5,730,604

Country	HIV	Malaria	TB	Grand Total
Chad	1,140,465	0	0	1,140,465
China	3,586,790	179,100	0	3,765,890
Congo	0	2,192,700	7,544	2,200,244
Côte d'Ivoire	4,572,563	325,463	1,028,331	5,926,358
Djibouti	74,088	7,456	296,138	377,682
Dominican Republic	717,729	0	614,493	1,332,222
DPR Korea	0	0	129,224	129,224
DR Congo	6,674,767	23,450,583	710,004	30,835,355
Egypt	0	0	551,569	551,569
Eritrea	0	577,978	10,786	588,764
Ethiopia	12,667,715	11,501,700	1,159,754	25,329,170
Gambia	0	3,428,900	74,922	3,503,822
Georgia	0	0	2,200,975	2,200,975
Ghana	134,964	28,129,183	0	28,264,147
Guatemala	0	0	55,707	55,707
Guinea	66,000	8,841,089	455,937	9,363,026
Guinea Bissau	0	661,911	5,420	667,331

Country	HIV	Malaria	TB	Grand Total
Guyana	188,291	0	0	188,291
Haiti	2,785,273	0	844,404	3,629,678
India	21,930,978	0	18,234,117	40,165,095
Indonesia	0	134,255	89,349	223,604
Iraq	0	0	185,561	185,561
Jamaica	154,245	0	0	154,245
Jordan	0	0	6,257	6,257
Kazakhstan	0	0	420,560	420,560
Kenya	49,765,821	24,980,279	3,234,865	77,980,965
Kiribati	0	0	2,759	2,759
Kyrgyz Republic	0	0	4,151,992	4,151,992
Laos	12,183	0	0	12,183
Lebanon	0	0	2,088	2,088
Lesotho	5,274,486	0	2,723,372	7,997,858
Liberia	603,961	376,731	0	980,692
Macedonia	0	0	3,089	3,089
Madagascar	0	1,792,822	1,055,816	2,848,638

Country	HIV	Malaria	TB	Grand Total
Malawi	19,671,256	0	192,131	19,863,387
Mali	4,280,854	748,016	242,989	5,271,859
Mauritania	0	230,076	4,233	234,309
Moldova, Republic of	732,283	0	1,683,847	2,416,130
Mongolia	0	0	21,642	21,642
Morocco	37,200	0	88,454	125,654
Mozambique	23,190,066	9,164,821	911,281	33,266,167
Myanmar	303,752	0	5,196,935	5,500,687
Namibia	4,106,767	1,087,500	0	5,194,267
Nepal	0	0	1,197,623	1,197,623
Niger	0	1,939,296	244,315	2,183,611
Nigeria	48,301,362	91,527,876	2,370,048	142,199,286
OECS	140,898	0	0	140,898
Pakistan	0	0	654,393	654,393
Papua New Guinea	459,981	0	39,366	499,348
Peru	0	0	0	0
Rwanda	8,635,865	0	559,073	9,194,938

Country	HIV	Malaria	TB	Grand Total
Senegal	2,330,541	0	25,877	2,356,417
Serbia	104,000	0	0	104,000
Sierra Leone	0	0	53,847	53,847
Somalia	0	31,062	73,950	105,012
Sri Lanka	0	0	68,887	68,887
Sudan	0	18,128,320	241,457	18,369,777
Swaziland	4,783,274	0	145,357	4,928,631
Syrian Arab Republic	0	0	180,082	180,082
Tajikistan	0	0	684,455	684,455
Tanzania, United Republic of	16,450,484	13,742,434	394,160	30,587,078
Thailand	0	0	104,369	104,369
Timor-Leste	0	0	40,803	40,803
Togo	3,366,432	0	102,920	3,469,352
Tunisia	252,270	0	0	252,270
Turkmenistan	0	0	8,762	8,762
Uganda	69,857,015	26,388,431	622,478	96,867,924
Uzbekistan	0	0	2,641,085	2,641,085

Country	HIV	Malaria	TB	Grand Total
Viet Nam	1,610,200	0	823,381	2,433,581
Yemen	0	0	25,724	25,724
Zambia	59,518,868	5,262,036	140,376	64,921,280
Zimbabwe	24,992,047	2,064,000	0	27,056,047
Grand Total	**447,637,796**	**288,631,437**	**68,637,691**	**804,906,925**

LIST OF ACRONYMS AND ABBREVIATIONS

3TC	**Lamivudine, Epivir**
ABC	**Abacavir**
ACT	**Artemisinin-based combination therapy**
AFRO	**Regional Office for Africa (WHO)**
AGFP	**Advisory Group on Funding Priorities**
AIDS	**Acquired Immune Deficiency Syndrome**
AMFm	**Affordable Medicines Facility for malaria**
AMRO	**Regional Office for the Americas (WHO)**
ANRS	**The French National Research Agency on AIDS**
API	**Active Pharmaceutical Ingredient**
ART	**Anti-retroviral treatment for HIV/AIDS**
ARV	**Anti-retroviral medicine for HIV/AIDS**
ATV	**Atazanavir, anti-retroviral medicine of the protease inhibitor class**
AZT	**Azidothymidine (Zidovudine), anti-retroviral medicine**
BCG	**Boston Consulting Group**

CHAI	**Clinton Health Access Initiative**
CPP	**Coordinated Procurement Planning Initiative**
EMRO	**Regional Office for Eastern Mediterranean**
ESTHER	**Ensemble pour une Solidarité Thérapeutique Hospitalière En Réseau**
FDA	**Food and Drug Administration**
FDC	**Fixed-dose combination**
GDF	**Global Drug Facility of the Stop TB Partnership**
GFATM	**The Global Fund to fight AIDS, TB and malaria**
GMP	**Good manufacturing practice**
HIV	**Human Immunodeficiency Virus**
LLIN	**Long-Lasting Insecticide-Treated bed Net**
LOI	**Letter of Intent**
LPV/ r	**Lopinavir/ritonavir**
MDR-TB	**Multi-drug resistant TB**
MoU	**Memorandum of Understanding**
MSF	**Médecins sans frontières**

NVP	**Nevirapine**
PEPFAR	**The United States President's Emergency Plan for AIDS Relief**
PMDS	**Performance Management and Development System of WHO**
PMTCT	**Prevention of Mother-to-Child Transmission (of HIV)**
PMTCT	**Preventing mother to child transmission (PMTCT) of HIV**
PQP	**Prequalification of Medicines Program**
PRC	**Project Review Committee**
QCLS	**Quality Control Laboratories**
RDT	**Rapid Diagnostic Test**
RHZ	**Rifampicin + Isoniazid + Pyrazinamide**
RUTF	**Ready-to-use therapeutic food**
SCMS	**Supply Chain Management System**
SEARO	**Regional Office for South-East Asia (WHO)**
SRS	**Strategic Rotating Stockpile for anti-TB medicines**
TB	**Tuberculosis**
TDF	**Tenofovir- antiretroviral medicine known as a nucleotide analogue reverse transcriptase inhibitor (NRTI)**

UN	**United Nations**
UNAIDS	**The United Nation's Agency for HIV/AIDS**
UNICEF	**United Nations Children's Fund**
UNIPRO	**UNITAID Portfolio Management System**
UNITAID	**United Nations International Drug Purchase Facility**
WB	**World Bank**
WHO	**World Health Organization**

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