UNITAID Report on Key Performance Indicators 2009

SUMMARY

AREA1

Key performance indicators related to **Implementation of UNITAID's Strategy**

ACTIONS	DISEASE AREA	INDICATORS	ACHIEVEMENTS	RESULT
1. Implement UNITAID's strategic directions for the next 3 to 5 years to support its mission	**All areas-monitors the markets**	Annual progress report tracking the markets for UNITAID target products and assessing UNITAID's contribution to market development produced.	**1)** Market Intelligence Information System tender complete. Project teams selected.	UNITAID Market Intelligence Information System will provide the data needed to demonstrate UNITAID's market impact by the end of 2010.
2. Generate long-term price reductions on medicines and diagnostics	**2nd line and pediatric ARVs**	**1)** Median prices paid for priority UNITAID medicines, diagnostics and related products tracked annually and reported on for projects able to demonstrate price reductions as per market conditions.	Up to 56% reduction of key 2nd line ARVs[1] Up to 53% price reduction of key paediatric ARV regimens	Price reductions on key 2nd line and paediatric ARVs facilitated the treatment of over **175,000** 2nd line patients and over **250,000** children since 2007.
	2nd line and pediatric ARVs	**2)** # new manufacturers of priority UNITAID medicines, diagnostics and related products with products available for public procurement	6 new ARV suppliers for 2nd line ARVs in partnership with CHAI	New suppliers of key ARVs means an improved market with a better potential for sustainable, fair prices and a subsequent increase in the number of patients treated.
3. Improve quality of medicines, diagnostics and related products	**WHO/UN Prequalification programme-medicines & diagnostics for HIV, TB and malaria**	**1)** # of priority UNITAID medicines and diagnostics prequalified annually by disease area	**1)** 18 UNITAID priority medicines prequalified out of a total of 44 medicines prequalified **2)** 10 ARVs, 3 ACTs and 5 anti-TB medicines[2]	New, quality medicines from generic manufacturers are approved for public procurement so that more people in low income countries have direct access to less expensive quality medicines.
		2) Median number of days taken to prequalify a medicine and a diagnostic test	TBC	Medicine and diagnostic prequalification ensure that low income countries get quality medicines, tests and laboratory services.
4. Shorten lead time for the delivery of medicines, diagnostics and related products to countries	**MDR-TB Malaria HIV**	**1)** Medicines/related products delivery lead times known and monitored by Implementing Partners and reported to UNITAID	**1)** No stock out situations reported from countries to partners or UNITAID; **2)** Manufacturer lead time included as indicator in CHAI supplier selection process; **3)** 80% of LLINs delivered to countries within 12 weeks of purchase order.	**1)** UNITAID funding to partners meant that no patients had to interrupt their treatments on live saving medicines. **2)** Manufacturers know that lead times matter to low income countries and are a factor in whether they are selected to supply medicines to UNITAID partners. **3)** UNITAID support to UNICEF ensured that LLINs deliveries could be completed in 2009 for 9 countries that faced bed net shortages.
		2) Number of stock-outs prevented through the use of strategic stockpiles or planned buffer stocks known and monitored by Implementing Partners and reported to UNITAID	**1)** Strategic rotating stockpile reached 5,800 patient treatments for MDR-TB; **2)** All 14 suppliers with LTAs to for UNICEF ACTs have buffer stocks in place	TB medicines stock piles have reduced the lead time between orders placed and delivery of medicines so that newly identified TB patients can be treated and cured more quickly to stop the spread of TB.
5. Promote the development of user-friendly drugs appropriate for use in developing countries	**HIV, TB and malaria**	**1)** Number of new of paediatric-adapted products for treatment of HIV, TB and malaria	**1)** Proportion of eligible generic suppliers being used in CHAI supplier selection process for paediatric ARV FDCs increased to 84%; **2)** GDF has 2 additional prequalified paediatric medicines on its catalogue	**1)** UNITAID funding to CHAI has created the paediatric ARV market and stabilized this market by encouraging new manufacturers; **2)** UNITAID funding to GDF has generated interest in developing new TB medicines suitable for children. By end 2009, **668,141** quality assured treatments for children (curative and preventive) have been delivered in 58 countries.
		2) Number of fixed dose combination (FDC) treatments for 2nd line products and ACTs (malaria) to ensure better patient adherence to treatment, resulting in improved health outcomes and less disease resistance to treatments	**2)** 8 out of 9 of the prequalified ACTs since 2007 are FDCs	UNITAID funding to TGF and UNICEF has created a market for FDC ACTs which are the only effective treatment for malaria. **16.6 million** ACT treatments have been provided to high burden countries by the end of December 2009. Support to TGF Round 6 has provided ACTs to an additional 2 million people.

[1] Emitricitabine 200 mg/Tenofovir 300 mg (2nd line) and Abacavir 60 mg/Lamivudine 30 mg (Paediatric).
[2] For TB, 2 other products not in the UNITAID priority list for 2009 were also prequalified in 2009: Pyrazinamide 400mg tablets (Micro Labs Limited- 29/06/2009) and Pyrazinamide 500mg tablets (Micro Labs Limited- 29/06/2009).

SUMMARY

AREA 2

Key performance indicators related to **Organizational Effectiveness**

ACTIONS	AREA	INDICATORS	ACHIEVEMENTS	RESULT
1. Monitor UNITAID's compliance with its Constitutional requirement to allocate the majority of its funds to Implementing Partners for projects.	**Finance and Administration**	**1)** Per cent (%) Secretariat costs (US$) relative to disbursements to Implementing Partners (US$)	Secretariat costs are 2.4% of annual disbursements to Implementing Partners	UNITAID has maintained a lean Secretariat and spent 94% of its donor funding on projects through implementing partners
2. Optimize UNITAID Secretariat Performance: Signing of agreements and disbursement speed	**Finance and Administration; Operations**	**1)** Median time between Board approval of project and first disbursement for all projects;	175 days	UNITAID needs to review processes and timelines for project cycles to incorporate lessons learnt from past projects
		2) Median time between Board approval and signing of agreements for all projects;	157 days	Building and maintaining strong partnerships will help to achieve the targets set for this indicator
		3) Median time between signing of agreement and first disbursement for all projects;	18 days	UNITAID is acquiring the staffing levels and skills base needed to maintain its initial speed in implementing Board decisions
3. Optimize UNITAID financial accountability	**Finance and Administration**	**1)** Average variation (%) in budget performance across all results areas relative to Board approved budget (budget performance)	64% of budget for 2009 spent	The Secretariat needs to work on the timing of its budget expenditures to ensure that they fit within the required annual budget cycle.
		2) Per cent total budget allocation per country income classification (as designated by World Bank)	Low income: 87.2% Lower middle income: 9.6% Upper middle income: 3.2%	UNITAID has achieved its target of at least 85% of its budget allocated low income countries.
4. Optimize Staff performance and management	**Finance and Administration**	**1)** Rate of turnover for professional positions	3.5% turnover rate for professional staff	UNITAID is able to retain professional staff and institutional memory
		2) Per cent of Professional posts filled by women	58% of posts filled by women	UNITAID is achieving gender balance in staffing of professional posts
5. Improve UNITAID's resource mobilization efforts to contribute to the sustainability and predictability of its funds	**Finance and Administration**	**1)** Funds collected mid-year as per cent of funds collected annually	17%	Multi-year commitments help UNITAID to maintain the necessary cash flow to fund on-going operations
		2) % of donors who have contributed in the previous year and who continue to contribute in the current year	75%	Donors are recognizing that continued support for UNITAID is a key issue to its financial stability

SUMMARY

AREA 3

Key performance indicators related to **UNITAID's contributions to country health outcomes (transparency)**

ACTIONS	AREA	INDICATORS	ACHIEVEMENTS	RESULT
1. Track treatments, diagnostics and related products delivered and estimated patients treated by UNITAID-funded projects by beneficiary country and over time.	**Operations**	Number of treatments delivered and estimated number of patients treated known for each project on an annual basis	100% of UNITAID-funded projects have partner verified worksheets describing the estimated patients treated by country	*HIV:* **over 600,000** patients treated with ARVs through 2009 in 46 countries[3] *TB:* Nearly **1.5 million** TB treatments purchased to date for 72 countries *Malaria:* almost **19 million** malaria treatments (ACTs) ordered to date for 20 countries (including contributions to TGF Round 6). **20 million** LLINs delivered to 8 countries in 2009
2. Track costs of treatments, diagnostics and related products delivered by UNITAID-funded projects by beneficiary country and over time	**Operations & Finance and Administration**	Costs (US$) of treatments delivered known for each project on an annual basis	100% of UNITAID-funded projects have partner verified worksheets describing the costs (US$) of patients treated by country	*HIV:* approximately **382 million US$** committed to buying products to treat HIV to date in 46 countries . *TB:* approximately **113 million US$** committed to buying medicines and diagnostics to treat and detect TB to date for 73 countries. *Malaria:* approximately **295 million US$** committed to buying medicines and LLINs to treat and prevent malaria date in 28 countries.

[3] Estimate includes all UNITAID funded projects where ARVs are purchased (i.e. CHAI, UNICEF and TGF supported projects).

Area 1: Key performance indicators related to **implementation of UNITAID's strategy**

Action 1: *Implement UNITAID's strategic directions for the next 3 to 5 years.*

Indicator	Baseline 2008/09	Target (Q1 2011)	Key achievements 2009
Annual progress report tracking the markets for UNITAID target products and assessing UNITAID's contribution to market development produced.	No integrated reporting on market conditions	Annual report produced with analysis of markets targeted by UNITAID	Market Intelligence Information System tender complete. Project teams selected.

Narrative explanation

UNITAID's Strategy for 2010-2012 was approved by its Executive Board in December 2009. The strategy document recognizes that UNITAID has a responsibility to measure its success based on its impact on public health and also on the impact of its project funding choices on the markets for medicines, diagnostics and related products to treat HIV/AIDS, TB and malaria. To measure market impact, UNITAID needs to monitor how markets respond to the provision of its additional, secure funding. UNITAID is supporting the development and use of market intelligence information to bring together the information that it needs to monitor its impact on the markets. In 2009, UNITAID raised a request for proposals to produce a Market Intelligence Information System. Eligible proposals have been reviewed and suppliers selected. A system is now being developed that will hold key information on both the supply and demand sides of the markets for medicines and diagnostics for HIV, TB and malaria. The resulting analyses of this information will allow for the products that it funds by Q1 2011.UNITAID to report on the status of each of the markets.

Challenges for this Action

A range of stakeholders, both data contributors and users, need to come together and work efficiently to build a dynamic Market Intelligence Information system. UNITAID has taken the first step by identifying the stakeholders that are needed to make the activity happen and providing them with the resources to build a quality information system. The project will take time to set up and will require careful management and leadership from within UNITAID.

Another key issue for the implementation of UNITAID's strategy is to identify potential areas for new *calls for proposals*. Key priority areas for new proposals should be aligned with UNITAID's Strategy 2010-2012. A process is needed now to identify these priorities and recommend them to the Board for action. The recent request for proposals (RfPs) focusing on viral

load is an example of how RfPs could promote strong partnerships in identified priority areas. This RfP was issued in 2009 with the outcome presented to the Board at EB11 in December 2009. The Board requested that the applicants work together to produce a coordinated proposal with the help of the interim external advisory group (iEAG) and the Secretariat. A collaborative approach ensures that one viral load project incorporating all applicants is funded to the appropriate level and that UNITAID's funding does not duplicate the work of other institutions.

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

Indicator	Baseline 2008	Target 2009	Key achievements 2009
1. Median prices paid for priority UNITAID medicines, diagnostics and related products tracked annually and reported on across each niche	2008 median prices paid for key paediatric and 2nd line ARVs	At least 50% reduction from 2008 in median prices paid for key paediatric and 2nd line ARVs	1. Up to 88% reduction of key 2nd line ARV regimens (see Annex 1)
2. # new manufacturers of priority UNITAID medicines, diagnostics and related products with products available for public procurement	Number of new market entrants making key paediatric and 2nd line ARVs in 2008	At least 1 new market entrant with quality ARV participating in the CHAI supplier selection process	2. 6 new ARV suppliers for 2nd line ARVs in partnership with CHAI

Associated with tables 1, 2, 3 & 4 in Annex 1.

Narrative explanation

Different market conditions for the products needed to treat, diagnose and prevent the three diseases means that expectations for achieving price reductions are different for each product type and the timeframes for achieving these reductions also vary. In 2009, the market for anti-retroviral medicines to treat HIV was the most amenable to sustainable price reductions. Several factors contributed to this outcome, including the pre-qualification of new generic ARVs, and the work of UNITAID's implementing partner, CHAI, in negotiating with manufacturers and implementing open supplier selection processes.

Indicator 1

UNITAID has facilitated access to medicines (anti-retrovirals, ARVs), diagnostics and related products to treat and diagnose HIV/AIDS in three strategic areas, paediatric medicines and related products, 2nd line medicines and integrated prevention of mother to child transmission (PMTCT) of HIV. Since inception in 2006, UNITAID supported partnerships have successfully built the market for paediatric ARVs and provided support for integrated PMTCT, including the development of the innovative mother and baby pack to ease the burden of care on mothers in rural and remote areas. In 2009, UNITAID funded projects provide 100% of the market for most Paediatric FDC ARVs[4] .

UNITAID's funding support to CHAI, starting in late 2006, has also built the generic market for 2nd line ARVs. UNITAID support represents 50% of the demand for 2nd line ARVs[5] . Prices have been reduced so that other donors and national governments can continue to treat patients who need

[4] Except for Lopinavir/ritonavir, for which UNITAID provides 82% of the market volume.
[5] Generic manufacturer accessible demand, excluding Argentina, Brazil, China and Mexico.

to switch to 2nd line treatment. The prices of key regimens have been reduced by more than 50% from 2006 to 2009 (Table 1). Key results related to indicator 1 for 2nd line and paediatric ARVs are shown in Tables 1 & 2.

Indicator 2

Another mechanism for reducing prices is increasing the number of quality suppliers/manufacturers for UNITAID priority medicines. The CHAI supplier selection process in 2009 provided an increase in the number of approved suppliers for key 2nd line and paediatric products since the 2008 tender. Six of these were for 2nd line ARVs (see Table 1, Annex 1). UNITAID also provides significant financial support to the WHO Prequalification Programme to facilitate the availability of good quality UNITAID priority medicines and diagnostics. The results of this collaboration are shown in Tables 3 &4.

Challenges for this Action

TB and malaria markets

The markets for TB medicines and ACTs to treat malaria are quite different than the markets for ARVs and HIV-related products. For anti- TB medicines, rising costs of active pharmaceutical ingredients and oil for the manufacturing process has increased the price of both first and second line treatments. Nonetheless, UNITAID's partnership with the Global Drug Facility of the Stop TB Partnership has led to cost containment of under US$ 20 per treatment for the adult formulated first line anti-TB medicines. The median treatment cost for a 6 month course of treatment for TB is US$ 18.65. An additional change in the market for paediatric anti-TB medicines has been facilitated by the partnership between GDF and UNITAID. GDF reports that the prices of 4 key paediatric anti-TB medicines have been reduced between 10 and 30% of their costs at the end of 2009. UNITAID support to the Global Drug Facility of the Stop TB Partnership (GDF) is working to stabilize the supplier base for the TB medicines markets. Sustainable price reductions will be realized over the course of these projects as long term agreements with manufacturers are made and the sustainability of funding from UNITAID is demonstrated, leading to a more predictable demand that manufacturers can respond to by investing in the production of these medicines and diagnostics.

For malaria, the price of ACTs has fallen over the last few years so that the main challenge is no longer one of reducing the price but making sure that these life-saving drugs are widely available

in countries, in both the public and private sectors. The market for ACTs remains primarily private sector driven, so while the cost of making medicines is not high, the fact that the end user buys them from a private source means that they can and do pay high prices for ACTs. The consumers of anti-malarials are poor, and because most of them self-medicate, there is consumer demand not only for the right drugs, but for cheap drugs which work or seem to work. Therefore, the challenge remains 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, UNITAID is supporting the Affordable Medicines for Malaria Facility (AMFm) of TGFATM.

Sustainable price reductions

The challenge across all disease areas will be to maintain any achieved price reductions in the longer term. This is particularly important because of UNITAID's principle that its projects should transition to alternative, more traditional funding sources once their key market and public health objectives have been accomplished and within a 3 to 5 year time period. A way to overcome the challenge of sustainable price reductions through time is to improve yearly forecasts to manufacturers across all disease and product areas. This is difficult because the ability to treat patients depends on country capacity to scale up and to deliver which in turn effects how much medicines/diagnostic tests can be ordered by a country at any point in time. Much of the current treatment forecasting considers the large number of patients needing treatment. Unfortunately these forecasts are often not backed up by country purchase orders because of low country capacity to deliver treatment. The process, if unmanaged, leads to manufacturers with raised expectations that may ultimately loose interest in making a medicine because their expectations of a market share are not realized. UNITAID seeks a mechanism for generating manufacturer engagement in a realistic but optimistic manner. Investigating ways in which UNITAID can help implementing partners to improve country capacity to deliver treatment is an area for expansion in the future.

Lessons learnt through monitoring project performance

Supplier selection for ARVs

Lessons learnt from the CHAI supplier selection process over the past two years has led to changes in selection criteria for primary, secondary and pool allocated suppliers as well as the volumes of products that are allocated to these supplier categories. For example, supplier selection criteria have been expanded to include not only the price offered by the supplier but also additional

information about product delivery times to countries (from time of purchase order to delivery in country) and supplier moves to register their products in beneficiary countries. The intention behind these changes is to encourage an open market that includes quality generic products that are acceptable to beneficiary countries.

Retention of paediatric patients on treatment

CHAI has also informed UNITAID that retention of paediatric patients on treatment is an area that needs improvement. Further work will be needed to support countries in collecting and maintaining data records so that problems can be identified and solutions found quickly. This will also help facilitate better forecasting for manufacturers, an area that also needs improvement. UNITAID has been discussing ways to move forward in these areas with the Children's Investment Fund Foundation (CIFF) which has provided CHAI with the financing to support the programmatic component of the paediatric project.

Transition planning

Transitioning from UNITAID support to other funders will be difficult for all projects and the need for better transition planning in the wake of the global financial crisis has been highlighted by all UNITAID partners. UNITAID has an example of successful transition in its support to GDF for the provision of first line TB medicines. All countries requiring urgent first line TB medicines have now transitioned to traditional funding sources as envisioned at the start of the project. However, for other projects and disease areas, UNITAID should be aware that bridge funding may be requested from some partners to prevent breaks in patient treatments. UNITAID needs to plan for this in its budget and Board funding decisions.

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

Indicator	Baseline 2008	Target 2009	Key achievements 2009
# of priority UNITAID medicines and diagnostics prequalified annually by niche	2008:8 for HIV, 7 for TB and 3 for malaria.	1) # of medicines and diagnostics prequalified for HIV, TB and malaria reported to UNITAID in interim and annual reports; 2) Target for 2009 (7 for HIV, 7 for TB and 3 for malaria)	1. 18 UNITAID priority medicines prequalified out of a total of 44 medicines prequalified 2. 10 ARVs, 3 ACTs and 5 anti-TB medicines prequalified[6]
Median number of days taken to prequalify a medicine and a diagnostic test	Medicine=>774 days (2008); Diagnostic= TBC	Medicine=>730 days; Diagnostic= TBC	Medicine= 736 days, range (64-2323 days), IQR (395-1092); Diagnostic= TBC

Associated with tables 3 & 4 in Annex 1

Narrative explanation

UNITAID supports the WHO/UN Prequalification programme in order to increase the number of new, high quality manufacturers of pre-existing medicines and to facilitate the timely introduction of new quality assured medicines, including FDCs and paediatric formulations. The support provided aims to ensure that our implementing partners can negotiate with a wide range quality assured manufacturers (generic) and negotiate favourable long term agreements with quality suppliers of medicines, diagnostics and related products. 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. Regular reporting on project indicators for the prequalification of diagnostics will begin in 2010.

Indicator 1

In 2009, 44 medicines for the treatment of HIV, TB, malaria, maternal health conditions and influenza were prequalified by the WHO/UN Prequalification programme. 18 of these products were UNITAID priority medicines (10 HIV, 3 malaria and 5 TB, see Table 4 in Annex 1 for specific medicines and manufacturers by year).

In addition to reporting on the indicators identified as key performance indicators by UNITAID, the WHO/UN Prequalification Programme (PQP) also produces a dashboard describing the progress of products under evaluation since UNITAID support began in January 2007. This is attached as Table 3 in Annex 1.

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

Indicator 2

From the annual report of the program to UNITAID in 2008, the lead time from receipt of complete dossier to prequalification for these products ranged from 106 days (3.4 months) to 2323 days (6.4 years).

The median for this indicator in 2008 was 774 days (25.2 months), taking into account all products prequalified, not just the UNITAID priority medicines. For generic products only it was 820 days (27 months). These median figures were negatively influenced by a number of products for which the lead times were exceptionally long (between 27 months and 6.4 years). The "stop the clock time" for these products (i.e. the time taken by manufacturers to respond to PQP's requests for further information) was considerable. PQP could have decided to reject these dossiers given the delays generated by the manufacturers slow responses, but instead it remained committed to moving forward with the dossiers to prequalification. Updated figures for 2009 were reported from PQP to UNITAID in the WHO PQP Annual Report to UNITAID. The result was a median of 736 days, 6 days short of the target set for 2009, demonstrating that WHO PQP and UNITAID had set realistic but challenging targets for the programme.

Challenges for this Action

WHO prequalification reported to UNITAID in its annual report that it faced challenges with maintaining enough staff to support the assessment of dossiers, completion of inspections and implementation of training programmes because of difficulties with the WHO contract system.

As a result of challenges faced in 2008 with the visibility of the PQP with manufacturers, PQP has appointed a supplier liaison officer to liaise directly with manufacturers to ensure that they fully understand requests from PQP for additional information during the process of dossier evaluation. PQP has also institutionalized two consultations per year during the Copenhagen assessment sessions to enable manufacturers to consult directly with assessors on prequalification issues. Since manufacturers often need convincing that participating in the PQP will result in increased purchase of their products, PQP has distributed additional information on the programme to WHO disease programmes so that they can help to promote the benefits of prequalification to manufacturers. UNITAID has helped with the need to increase the visibility of PQP by ensuring that

all of its implementing partners know about the program, its importance to UNITAID's mission and have indicators linked to increasing the generic manufacturing base as part of their project plans and legal agreements with UNITAID.

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

Indicator	Baseline 2008	Target 2009	Key achievements 2009
Medicines/related products delivery lead times known and monitored by Implementing Partners and reported to UNITAID	Partners reporting delivery lead times to UNITAID annually	1. UNITAID informed about suppliers with long delivery lead times; 2. UNITAID informed about stock out situations in countries; 3. Manufacturer lead time included as decision point in CHAI supplier selection process for ARVs	1. No stock out situations reported from countries to partners or UNITAID[7]; 2. Manufacturer lead time included as indicator in CHAI supplier selection process; 3. 80% of LLINs delivered to countries within 2 weeks of purchase order.
Number of stock-outs prevented through the use of strategic stockpiles or planned buffer stocks known and monitored by Implementing Partners and reported to UNITAID	1. GDF stockpile for MDR-TB medicines at 800 treatments and stockpile for 1st line TB medicines developed; 2. UNICEF developing requirements for suppliers with long term agreements (LTAs) to maintain buffer stock for ACTs	1. Stockpile for MDR-TB medicines functioning at 5,800 treatments; 2. Buffer stock for ACTs in place for all UNICEF approved suppliers with LTAs	1. Strategic rotating stockpile reached 5,800 patient treatments for MDR-TB; 2. All 14 suppliers with LTAs to for UNICEF ACTs have buffer stocks in place; **3.** 100% of LLINs distributed to 9 countries facing shortages in 2009.

Associated with table 5 in Annex 1

Narrative explanation

The main actions facilitated by UNITAID for this activity are to decrease drug delivery lead times and prevent stock-outs through the use of strategic stockpiles or planned buffer stocks. In addition, UNITAID has examined the challenging areas of improved demand forecasting and pooled procurement processes. There have also been discussions with Supply Chain Management Systems (SCMS), managers of the PEPFAR procurements, around tools developed by SCMS to manage the interface between forecasts and in-country supply chain management (i.e. QUANTIMED and PIPELINE). UNITAID is a member of the Country Procurement Partnership (CPP) led by PEPFAR which also includes TGF, PMI (President's Malaria Initiative)and others. CPP aims to address field-based supply chain initiatives to simplify and harmonize drug management, storage and distribution to country-based health facilities.

[7] Specifically no stock-outs were reported for beneficiary countries using the UNITAID funded strategic rotating stockpiles for MDR-TB and 1st line TB medicines.

Timely delivery of medicines, diagnostics and related products to beneficiary countries is a keep objective in UNITAID's strategic plan. It is particularly important for the treatment of TB patients, especially MDR-TB patients, who find themselves in the difficult position of immediately (once diagnosed) needing 24 month treatment using medicines with a shelf-life of less than 36 months. What this means for the country programmes is that as soon as they identify a case, they need to order the medicines to treat the patient to prevent further transmission of the disease. Unfortunately, because of the short shelf-life of the product, manufacturers only produce the medicines upon demand, often with a 6 month lag between purchase order and country delivery. The delay is serious for the patient and for the transmission of MDR TB. Therefore, the innovative approach of the strategic rotating stockpile (SRS) of TB medicines taken by the Global Drug Facility (GDF) of the Stop TB Partnership with the full support of UNITAID has improved the timely delivery of anti-TB medicines to patients and has prevented stock-out situations in which patients must go untreated because of lack of suitable medicines. As a result, the main achievements in the area of improved delivery to prevent stock outs in 2009 have been for the UNITAID funded TB projects including those for 1st line TB medicines and MDR TB medicines.

There have also been substantial achievements related to shortening lead time for delivery of ACTs and long lasting insecticide treated bed nets (LLINs) in UNITAID funded projects with UNICEF as implementing partner.

Indicator 1

All implementing partners report on the manufacturer and/or delivery lead times for the products that they procure for UNITAID-funded projects annually. Key results are reported by project and disease area in Annex 1, Table 5.

Indicator 2

In the first quarter of 2009, the strategic rotating stockpiles were scaling up to reach their full potentials in the 1st line and MDR TB projects to facilitate timely treatment of patients and prevent stock outs. This means that the full 5,800 treatments were available for the MDR TB stockpile and that country programme requested packages were being pulled together for 1st line TB medicines. UNITAID support to both the 1st line and MDR-TB medicines stockpiles are complementary actions because 1st line treatment interruption is a risk factor for the development of drug resistant TB. The rotating stock piles are a truly innovative way to address the need to initiate patients onto treatment quickly once they are diagnosed with TB or MDR-TB.

For the ACT Scale up, UNICEF requirements for suppliers with LTAs to maintain buffer stock and to rotate the stock so that acceptable remaining shelf life (above 80%) is always available were maintained. These actions are in place for the 14 LTAs that UNICEF has with suppliers for artemisinin based formulations.

UNITAID support to UNICEF ensured the delivery of the 20 million LLINs (100% of required LLINs) to 8 countries (and 9 programmes) which faced bed net shortages in 2009. UNICEF reports that 40% of LLINs are now in households in the beneficiary countries and that 80% of the deliveries to countries were made within a 12 week period after submission of purchase order. The distribution of LLINS in countries for this project is the responsibility of UNICEF which has mobilized US$ 23 million from other partners and its own funds for this purpose.

Challenges for this Action

In 2010 an external evaluation of the set up and implementation of SRSs will be undertaken in order to learn more about the success factors and to identify areas for improvement in the management and organization of the SRS.

Considerable efforts will need to be made by GDF and its partners to improve forecasting of demand for 1st line adult, child and MDR-TB, i.e. realistic quarterly order schedules based on firmer patient enrolment figures versus GLC/GF approved treatment targets: (i) for industry to be incentivized further with respect to prequalification; and (ii) to improve production planning for optimal delivery lead-times, and better aggregation of scaled-up demand is required.

Lessons learnt through monitoring project performance

The establishment of Strategic Rotating Stockpiles is an effective mechanism for preventing stock outs and should be explored for other disease areas and suitable products.

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

Indicator	Baseline 2008	Target 2009	Key achievements 2009
Number of new of paediatric-adapted products for treatment of HIV and TB	• Proportion of eligible generic suppliers being used in CHAI supplier selection process for paediatric ARV FDCs process for paediatric FDCs at 75%; • WHO paediatric TB guidelines revised in 2009	• Proportion of eligible generic suppliers being used in CHAI supplier selection process for paediatric ARV FDCs increased to at least 85% by 2009; • GDF has at least 1 new manufacturer of paediatric FDC in its catalogue	• Proportion of eligible generic suppliers being used in CHAI supplier selection process for paediatric ARV FDCs increased to 84%; • GDF has 2 additional prequalified paediatric medicines on its catalogue
Number of fixed dose combination (FDC) treatments to ensure better patient adherence to treatment, resulting in improved health outcomes and less disease resistance to treatments	• No heat stable Atazanavir/ritonavir (ATV/r) available for purchase; • 1 ACT FDC prequalified and available for purchase	• ATV/r available by Q3 or 4 2009; • At least 2 additional ACT FDCs prequalified in 2009 and available for purchase	• 8 out of 9 of the prequalified ACTs are FDCs

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 and prequalified 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.

Indicator 1

HIV/AIDS

Paediatric FDCs are now available to all beneficiary countries through the UNITAID funded CHAI Paediatric programme. For the paediatric HIV project, new suppliers are providing more adapted paediatric formulations, including FDCs. In fact, AZT-based paediatric FDCs (both dual and triple) have been ordered for 30 of the beneficiary countries and proportion of eligible generic suppliers being used in the supplier selection process for these Paediatric FDCs has increased from 75% in 2007 to 84% in 2009.

TB

A major change was made in May 2009 to the WHO recommendations for the treatment of paediatric TB. The main outcome is that WHO recommended higher doses for paediatric formulations. This has serious consequences for the UNITAID supported GDF Paediatric TB project with a need to encourage manufacturers to make these new formulations and get them prequalified as soon as possible to facilitate better treatment of children with TB. Nevertheless, several key paediatric products are available today due to UNITAID funding of the GDF paediatric TB project. During the first two quarters of 2009 GDF maintained the number of suppliers (4) available for the currently listed paediatric anti-TB medicines in the GDF catalogue, while securing a second manufacturer for the fix-dose combinations (FDC) – RH60/30mg and RHZ60/30/150mg – in blister packaging. 7 different paediatric formulations and 13 products consisting of both blister and bulk packaging are available. In quarter 1 2009, 2 additional paediatric TB drugs (Rifampicin + Isoniazid mg (60/30) and Rifampicin + Isoniazid + Pyrazinamide mg (60/30/150) were prequalified.

Indicator 2
Malaria

Since 2007, the ACT scale up project has generated a lot of interest from manufacturers for the production of FDC ACTs. Out of the 9 prequalified ACTs to date, 8 of them are FDCs. One FDC of Artemether+Lumefantrine 20mg+120mg formulation (Novartis Pharma) has been made available in dispersible tablets, which, among others, presents a comparative advantage over the non-dispersible tablets in ease of oral consumption, storage and transportation. UNITAID funding to TGF and UNICEF has created a market for FDC ACT which are the preferred treatment for malaria in all high burden countries. To date, 16.5 million ACT treatments have been provided to high burden countries as a direct result of UNITAID's support to TGF and UNICEF. Over 2 million more people have also been treated with ACTs as a result of UNITAID's support to round 6 of TGF.

Challenges for this Action

HIV/AIDS

The 2nd line project has faced a serious set back with a technical difficulty with the formulation development of the generic heat stable ATV/r FDC. This has jeopardized UNITAID's ability to achieve an objective, to place this life-saving drug and formulation in low income countries at reasonable cost in 2009. The current expectation is that the product will be available for

purchase in the 2nd quarter of 2010. This means that beneficiary countries of the UNITAID-funded CHAI 2nd line project will be able to purchase this key product by the end of 2010.

TB

As previously mentioned, the paediatric project faces a challenge to encourage industry to make additional paediatric products with increased doses to meet the WHO revised targets for paediatric treatment. In addition, since UNITAID is also helping to develop nascent markets in TB, particularly for paediatric and MDR-TB medicines, the timeframe for funding these projects to fully develop sustainable markets also needs to be established.

Lessons learnt through monitoring project performance

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 demand and supply side of the market (in this case UNITAID implementing partner GDF and manufacturers) in producing the required products and prequalifying them in a timely manner. UNITAID will help facilitate discussions with WHO/UN prequalification programme about prioritizing some of the needed products (i.e., Paediatric TB medicines) that now become priorities for prequalification because of changes to the guidelines. It is important to realize that the markets for medicines and diagnostics are dynamic and changing. UNITAID needs to remain flexible and responsive to the needs of its partners in order to improve access to these products in low income setting.

Area 2: Key performance indicators related to **Organizational Effectiveness**

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

Indicator	Baseline 2008	Target 2009	Key achievements 2009
Per cent (%) Secretariat costs (US$) relative to direct project costs for funded projects (US$)	Secretariat costs were 2.4% of 2008 direct project costs for funded projects	Secretariat costs are less than 5% of annual direct project costs for funded projects	Secretariat costs are 2.4% of 2009 direct project costs for funded projects

Narrative explanation

The UNITAID secretariat remains lean with an orientation towards facilitating operational activities and building collaborative relationships with implementing partners as per the decisions of its Executive Board. There are no UNITAID country offices or officers and UNITAID does not fund countries. This indicator measures how well UNITAID can manage the balance between its Secretariat costs relative to direct project costs for funded projects.

Indicator 1

Indicator 1 is aligned with UNITAID's constitutional requirement to allocate the majority of its funds to Implementing Partners for projects. UNITAID has calculated this figure by including all project management costs in the Secretariat costs, including the entire administrative fee of the WHO and the work on the Strategic Plan. UNITAID has succeeded in allocating 94% of its donor funding to implementing partners on the basis on project plans and legal agreements.

Challenges for this action

UNITAID has been missing a key team from its functional structure, the Market Dynamics team. This area is key to UNITAID's success in achieving market impact as a result of its project funding. Key positions and resources will need to be provided to this team in order for it to function at the highest level of capacity quickly.

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

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

Indicator	Baseline 2008	Target 2009	Key achievements 2009
1) Median time between Board approval of project for funding and first disbursement for all projects;	359	Less than 130 days elapsed time	175
2) Median time between Board approval and signing of agreements for all projects;	303	less than 100 days elapsed time	157
3) Median time between signing of agreement and first disbursement for all projects;	20	less than 20 days elapsed time	18

Narrative explanation

The UNITAID Secretariat focuses on operational activities. Therefore it is important that the secretariat take stock of and report on its success in implementing these activities. Identifying potential projects and implementing partners is the start of the process of project management. Having the procedures and resources to rapidly identify new project areas and partners is crucial to then ensuring that Board decisions are implemented in a timely manner. The indicators provided here form the basis for monitoring the operational activities of the UNITAID Secretariat.

Indicator 1

This indicator describes the total amount of time needed from Board approval of a project to first disbursement to an implementing partner. The indicator is calculated based on the time taken from approval to disbursement for each project approved in the reporting calendar year. The median is used because of the nature of the metric, i.e. the times will not be normally distributed and so no distribution can be assumed. The total amount of time needed from Board approval of a project to first disbursement has certainly decreased from 2008 to 2009. However, it should be noted here that the total median time for projects approved in 2007 was 101 days, albeit for fewer projects than in 2008. Improvement is still needed in order to maintain the initial speed in implementing Board approved actions.

Indicator 2

This indicator describes the time taken to sign a legal agreement with an implementing partner after the Board has approved a project. The time here includes working with the implementing partner to finalize a project plan complete with M&E indicators, a schedule for reporting results to UNITAID and a disbursement schedule. It is clear from the results that most of

the time spent by the Secretariat and implementing partners is at this stage. The baseline (2008) is high because there were more project plans that needed to be finalized in this year and UNTIAD had not yet acquired the necessary level of staffing to complete the work quickly.

Indicator 3

This indicator describes the time taken to make a disbursement after a legal agreement has been signed with the partner. From the above data, this is the quickest phase of project implementation and yet judging from the 2007 results (a median time of 14 days) there is still improvement to be made in this area.

Challenges for this action

To improve its performance in this critical action area requires that UNITAID focus on developing strong partnerships. Strong partnerships will also facilitate timely identification and reporting of project achievements and lead to the strengthening of project areas that may need further support. In addition, all areas of UNITAID's work, Operations, Finance and Administration, and Legal, need to be fully staffed in order to support each other as necessary for each project approved.

Lessons learnt in this area

UNITAID needs to refine its processes and timelines for its project cycles to incorporate lessons learnt from past projects. Clear processes and timelines will facilitate the achievement of the targets set in the years to come. UNITAID is now acquiring the staff and skills base needed for each of these stages to be performed with speed and ease. In particular, dedicated legal support has been added due to the recognized need to finalize the development of agreements in a timely manner.

Action 3: *Optimize UNITAID financial accountability*

Indicator	Baseline 2008	Target 2009	Key achievements 2009
1) Per cent (%) of Board approved budget spent by the Secretariat annually (budget performance)	TBD	> than 90% of the Board approved budget is spent by the Secretariat annually	64% of overall budget for 2009 spent by the Secretariat
2) Per cent (%) budget allocations per country income classifications (as designated by World Bank)	Low income: 85.6%; Lower middle income: 10%; Upper middle income: 5 %	Low income: 85%; Lower middle income: less than 10%; Upper middle income: less than 5%	Low income: 87.2%; Lower middle income: 9.6%; Upper middle income: 3.2 %

Narrative explanation

These indicators are quick measures of UNITAID's budget planning intended to monitor how the UNITAID Secretariat performs with regards to financial accountability. The first measures how well the Secretariat has been able to comply with its plan of action as translated into the Board approved budget. The second relates to UNITAID's constitutional mandate to work in low income countries. Variation in this second indicator may be related to both internal or external factors, some of which the Secretariat will have little or no control over.

Indicator 1

This indicator tracks the extent to which UNITAID's spending conforms to its approved budget in a given year. UNITAID will present a revised budget at every Board meeting starting in June 2010. UNITAID, together with its partners, should plan effectively so that it knows ahead of time what its level and type of expenditures will be and when these expenditures will be made. This indicator is designed to measure UNITAID's ability to plan, use and monitor its budget and to ensure its accountability to its Board over its financial expenditures.

Indicator 2

This indicator is calculated by including all project expenditures tallied by country and country income group as set by the World Bank in July of each calendar year. Because World Bank income categories change over time, projects will be held accountable to the classification designated in the calendar year in which the legal agreement with UNITAID was first signed. On this basis, UNITAID has met its target for project funding in 2009.

Challenges for this action

Presenting a budget that is realistic not only for needed expenditures but also for the timing of these expenditures is essential to improving ability to meet the target annual budget expenditure of 90% for indicator 1.

***Action 4:** Optimize staff performance and management*

Indicator	Baseline 2008	Target 2009	Key achievements 2009
1) Rate of turnover for Professional positions	N/A	No more than 6% (2 positions)	3.5%
2) Per cent of Professional posts filled by women	N/A	At least 50% of Professional posts filled by women	58% (average of three points in time for 2009, 01 January, 30 June and 31 December)

Narrative explanation

Staff performance and management is a critical factor for UNITAID's success. As an organization hosted by the WHO, UNITAID staff use the WHO performance management and development system (PMDS) to plan their work, track and improve performance. However, indicators related to the PMDS are under discussion with the Board and will be presented from 2010 onward. In addition, there are two other indicators for this action. These are related to turnover of professional staff and % of professional posts filled by women. The objective of these indicators is to monitor the UNITAID work environment and to ensure that UNITAID makes strides towards gender equality in the work place.

Indicator 1

Organizations need to have some turnover in positions to keep growing and moving forward. A healthy staff turnover rate would show that an organization is able to provide work challenges and a general work environment that suits each individual's expectations and abilities. 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.

Indicator 2

Per cent of professional posts filled by women is an indicator of how well UNITAID is able to achieve gender balance in the workplace.

Challenges for this action

Our main challenge for both of these indicators is that the Secretariat team is very small. The Human Resources plan has 36 professional staff so one person represents 3% of the total staff. For the turnover rate, if three people leave (a realistic possibility for one year) then the turnover rate for that year becomes 9%, which is quite high. The situation will be similar for the per cent of professional posts filled with women. Therefore, care must be taken when examining these results.

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

Indicator	Baseline 2008	Target 2009	Key achievements 2009
1) Funds collected mid-year as per cent of funds collected annually	20%	40%	17%
2) % of donors who have contributed in previous year and who continue to contribute in the current year.	66%	At least 80% of donors who have contributed in previous year an who continue to contribute in the current year	75% (9 out of 12 on the basis of the official revenue figure)

Narrative explanation

One element at the core of the creation of UNITAID was that its funding would be sustainable. Maintaining continuity of funding is very important to UNITAD, its implementing partners and the sufferers of HIV, TB and malaria in all beneficiary countries. The very innovative nature of UNITAID and its ability to have an impact on the markets for medicines, diagnostics and related products is jeopardized if its funding base is insecure because market impact takes time. The indicators for this action relate to how secure UNITAID's funding is in a given year. If funding is not sustainable, then cash flow also becomes a problem for the organization.

Indicator 1

This indicator monitors whether or not UNITAID is receiving funds from donors in a timely manner after donor commitments are reported to UNITAID's Board. If most of the funds are available by mid-year in a given calendar year, then UNITAID's Board has a better indication of how many projects can be approved and for what amounts of money. 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. The result for 2009 is slightly lower than for 2008 and indicates that no change has been made in ensuring a stable cash flow for UNITAID.

Indicator 2

Continuing support to UNITAID is a key issue for its financial stability. This indicator shows donor loyalty to UNITAID. Donors continuing to contribute whether annually or through multi-year commitments mean more stability for UNITAID and its implementing partners. A slight increase in 2009 relative to 2008 indicates that donors are recognizing that continued support for UNITAID is a key issue for its financial stability.

Challenges for this action

UNITAID faces a challenge to increase its resource mobilization efforts so that it can maintain the necessary cash flow levels to fund its on-going operations. This challenge is demonstrated by the 4 multi-year commitments that UNITAID has now and the recognition that 3 of them will lapse in within the next two years. The Board has acknowledged this challenge by agreeing to the principle of multi-year commitments.

In calculating results for indicator 2, it was noted that the practice of recording income received from donors has changed. The change means that 2 pledges which were recorded in 2008 would now have been recorded in 2009. Had UNITAID maintained this recording of income, only one donor would be recorded as having dropped out this year (1 out of 12) which would result in 90% of donors who contributed last year continuing with contributions this year as opposed to the lower figure reported here as 75%.

Area 3: Key performance indicators related to UNITAID's contributions to country health outcomes.

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

Indicator	Baseline 2008	Target 2009	Key achievements to end 2009
Number of treatments delivered and estimated number of patients treated known for each project on an annual basis	NA	100% of UNITAID-funded projects have partner verified worksheets describing the estimated patients treated by country available on the UNITAID web site and updated by Q2 of the following year	*HIV:* **over 600,000** patients treated with ARVs to date in 44 countries *TB:* Nearly **1.5 million** TB treatments purchased to date for 64 countries *Malaria:* nearly **19 million** malaria treatments (ACTs) purchased to date for 16 countries **20 million** LLINs delivered to 9 countries in 2009

See Annex 1, Table 6 and Table 8

Narrative explanation

The public health benefit of UNITAID's actions derive from making sure that people in low income countries, who may otherwise go without needed treatment or even diagnosis of their illnesses, are identified and provided with life-saving care. Keeping track of the number of patients that could be and are treated with UNITAID supplied products is key information needed to demonstrate UNITAID's impact in the public health arena.

<u>Indicator 1</u>

Implementing partners report to UNITAID on the progress that they are making with getting treatments into beneficiary countries so that more patients in low income countries can have access to life saving medicines, diagnostic tools and related products. Partners report these figures as required under contractual agreement with UNITAID as part of the monitoring and evaluation plans for projects twice a year.

Challenges for this Action

There are two main challenges for this action. The first is that reconciliation of figures that are reported by a partner from a projects' inception through each semi-annual reporting period is complicated by the inevitable changes that are made to the project (i.e. beneficiary countries dropping out, changing orders or non-delivery of expected orders). The second is that partners do

not all report to UNITAID on the estimated patients treated by UNITAID supplied monies. Some partners provide UNITAID with the volume of products procured per country. In some cases, the estimated number of patients treated with the provided medicines differs from the volume of product procured due to treatment duration, patient weight classes, and use of different defined daily doses (DDD). Some partners have been reluctant to provide figures on estimated patients treated with the medicines procured because of the uncertainty inherent in these numbers.

Lessons learnt through monitoring project performance

To ensure consistent and timely reporting on this action, providing partners with a spreadsheet (filled or empty) that captures the required information succinctly has proven to be a successful strategy. Partners are able to check and confirmed UNITAID's version of what has been delivered or provide their data directly to UNITAID through the spreadsheets. Partners will, in future, be required to enter this information directly into UNITAID's project monitoring system after which verification will be done by the Secretariat with clarifications, as necessary, from the partners.

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

Indicator	Baseline 2008	Target 2009	Key achievements to end 2009
Costs (US$) of treatments delivered known for each project on an annual basis	NA	100% of UNITAID-funded projects have partner verified worksheets describing the costs (US$) of patients treated by country available on the UNITAID web site and updated by Q2 of the following year	*HIV:* approximately **382 million US$** committed to buying products to date in 46 countries. US$285,649,351 spent on products delivered to countries. . *TB:* approximately **113 million US$** committed to buying medicines and diagnostics to date for 73 countries. US$ 46,502,271 spent on anti-TB medicines and diagnostics. *Malaria:* approximately **295 million US$** committed to buying medicines and LLINs to date in 28 countries. US$ 247,649,174 spent by partners on Malaria actions.

See Annex 1, Table 7 and Table 9

Narrative explanation

As with Action 1, understanding and tracking the US$ value of treatments and related products in countries is an element of measuring and evaluating the impact of UNITAID. In addition, this information is useful to the broader public health community in tracking where resources are currently being spent and where they may be needed in the future.

Indicator 1

Partners report the US$ value of medicines provided to beneficiary countries as a result of project agreements with UNITAID. Tracking this information is essential to monitoring project performance, particularly for reporting on the overall per cent of UNITAID's funding commitments to low income countries (>85%), lower middle income countries (<10%) and upper middle income countries (<5%).

Challenges for this Action

There are two sets of numbers related to cost of products in countries that the UNITAID Secretariat tracks. The first is the monies (US$) committed to buying products in each beneficiary country by implementing partners as part of their project plans in the legal agreements with

UNITAID. This is a reporting of how partners plan to spend UNITAID funds in countries. The second is the monitoring (or tracking), through partner progress reports, of how much of the budgeted monies (US$) was spent (with products either ordered or delivered) in beneficiary countries annually. Changes naturally occur over the course of projects and these changes need to be captured so that final outcomes can be attributed by country. Because UNITAID does not work directly in countries, it relies on its implementing partners to forecast and budget as accurately as possible for health products in specified countries. Implementing partners are starting to have a better understanding of UNITAID's requirements for forecasting and product delivery at the country level.

Lessons learnt through monitoring project performance

A project monitoring system that allows implementing partners to directly enter their treatment targets and budgets per country will help make the process of tracking monetary flows to countries easier.

ANNEX 1

Table 1. Price reductions and new market entrants for 2nd line ARVs, 2009

	MEDIAN PRICE PER PATIENT PER YEAR (US$) 2008*	MEDIAN PRICE PER PATIENT PER YEAR (US$) 2009*		APPROVED SUPPLIERS 2008	APPROVED SUPPLIERS 2009	NEW SUPPLIERS 2009
ARV name	**Generic (interquartile range)**	**Brand (interquartile range)**	**Generic (interquartile range)**			
Abacavir 300mg (ABC)	335 (314-389)	n/a	228 (228-276)	Aurobindo, Cipla, Matrix, GSK	Aurobindo, Cipla, Matrix, GSK, Ranbaxy	Ranbaxy
Didanosine 250mg (DDI-ec)	n/a	220	156 (156-170)	BMS, Barr, Aurobindo	BMS, Barr, Aurobindo	
Didanosine 400mg (DDI-ec)	288 (286-288)	284	240 (240-266)	BMS, Barr, Aurobindo	BMS, Barr, Aurobindo	
Emitricitabine 200mg / Tenofovir 300mg (TDF/FTC)	319 (251-319)	496 (362-630)	141 (141-205)	Gilead, Matrix	Gilead, Matrix, Cipla, Aurobindo	Cipla, Aurobindo
Lamivudine 300mg / tenofovir 300mg (TDF/3TC)	158	n/a	138 (120-171)	Matrix	Matrix Hetero	Hetero
Lopinavir 200mg / Ritonavir 50mg (LPV/r)	496 (496-569)	493	441 (441-567)	Abbott, Matrix, Aurobindo, Cipla	Abbott, Matrix, Aurobindo, Cipla	
Tenofovir 300mg (TDF)	207 (151-208)	204 (204-469)	99 (99-149)	Gilead, Matrix	Gilead, Matrix, Aurobindo, Cipla	Aurobindo, Cipla
Regimens						
TDF+ 3TC (300 mg + 300mg) & LPV/r (200 mg +50 mg)	654	n/a	579 (561-738)	as above for individual ARVs	as above for individual ARVs	
TDF+ FTC (300 mg + 200mg) & LPV/r (200 mg +50 mg)	815 (747-915)	989 (855-1123)	582 (582-772)	as above for individual ARVs	as above for individual ARVs	

Table 2. Price reductions and new market entrants for paediatric ARVs, 2009

Updated using CHAI's Annual Report to UNITAID 2009.

	MEDIAN[8] PRICE PER PATIENT PER YEAR (US$) 2008	MEDIAN PRICE PER PATIENT PER YEAR (US$) 2009		APPROVED SUPPLIERS 2008	APPROVED SUPPLIERS 2009	NEW SUPPLIERS 2009
ARV name	**Generic (interquartile range)**	**Brand (interquartile range)**	**Generic (interquartile range)**			
Lopinavir 80 mg/ Ritonavir 20 mg per ml (Syrup)	n/a	206	n/a	Abbott	Abbott	
Regimens[9]						
Lamivudine 30 mg /Nevirapine 50 mg/ Stavudine 6 mg	61 (53-61)	n/a	60	Cipla	Cipla	
Lamivudine 60 mg /Nevirapine 100mg/ Stavudine 12 mg	58 (50-58)	n/a	56	Cipla	Cipla	
Lamivudine 30 mg /Nevirapine 50mg/ Zidovudine 60 mg	109	n/a	108	Matrix	Matrix	
Abacavir 60 mg/ Lamivudine 30 mg	193	n/a	91	Aurobindo	Aurobindo, Matrix	Matrix

[8] Median price analysis based on low income country orders only.

[9] Regimens were selected based on consumption patterns in countries and the need for these regimens in low income country settings.

Table 3. WHO Prequalification Programme Dashboard of UNITAID specific medicines prequalified from 2007 to 2009[10]. (WHO PQP Annual Report to UNITAID, 2009)

SUMMARY	NUMBER	STAGE 1	STAGE 2	STAGE 3
Second-line anti-retrovirals	29	0	29	10
Paediatric anti-retrovirals	7	0	7	5
1st-line anti-tuberculosis products	12	0	12	5
2nd-line anti-tuberculosis products	11	0	11	4
Paediatric anti-tuberculosis products	11	0	11	6
Anti-malarials	17	0	17	9
TOTAL	**87**	**0**	**87**	**39**

Key

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

[10] Including UNITAID priority products under assessment as at 2 June 2010 for dossiers accepted before 2007

Table 4. UNITAID priority medicines prequalified from 2007 to 2009

UNITAID priority medicines prequalified in 2007

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

UNITAID priority medicines prequalified in 2008

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

UNITAID priority medicines prequalified in 2009

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

Table 5. Area 1, Action 4: Selected delivery lead time achievements from partners.

Paediatric HIV (with CHAI, quarters 1 &2 2009)

Manufacturer	Status	Average lead time (days)*
Ranbaxy	Generic	212
GSK	Originator	157
BMS	Originator	103
Abbott	Generic	101
Cipla	Generic	99
Matrix	Generic	98
Strides Arcolab	Generic	96
Aurobindo	Generic	68
Hetero Drugs	Generic	48

* Refers to cumulative weighted average number of days between the date of the purchase order and the date of the invoice for 2009 per manufacturer of ARVs.

2nd Line HIV (with CHAI, quarters 1 & 2 2009)

Manufacturer	Status	Average lead time (days)*
Aurobindo	Generic	58
Cipla	Generic	60
GSK	Originator	62
Matrix	Generic	64
Aspen Pharmacare	Generic	70
Abbott Logistics	Generic	93
BMS	Originator	135

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

Table 5 continued

TB

	Number of orders placed	Number of orders delivered	Actual average lead time (days*)
MDR-TB	10	11	228[11]
Paediatric TB	44	15	90[12]
1st Line TB	20	20	35[13]

*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.

Malaria

ACT Scale up

Manufacturer	Status	Product	Average lead time (days)*
Ipca Laboratories	generic	Artesun50+Amod153 co-bl.,tabs/3+3/PAC-10	109
Guillin Pharmaceutical	generic	Artesun50+Amod153 co-bl.,tabs/3+3/PAC-25	28
		Artesunate 50mg+SP525mg tabs/6+2/PAC-25	73.5
Strides Arco Lab	generic	Artesun50mg+Amod153mg co-bl.,tabs/3+3	202
Novartis Pharma AG	originator	Arteme.+Lumefan,20+120mg tab,6x1/PAC-180	65
Cipla LTD	generic	Artesun50mg+Mefloq250mg co-bl.,tabs/3+1	93
Activa Pharmaceuticals	generic	Artesun50+Amod153 co-bl.,tabs/3+3/PAC-10	98

* Analysis done at UNITAID from UNICEF supplied annual procurement report for 2009, Annex 8. Calculation done on delivery lead time from date of purchase order issue to actual arrival in country, includes 2008 and 2009 procurements combined.

[11] 3 orders (Myanmar, Kyrgyzstan and Azerbaijan) contributed to long lead times because they were placed far in advance of preferred delivery dates. Registration difficulties in Kyrgyzstan also delayed delivery.

[12] Reduced from 103 calendar days in 2008 to 90 calendar days in Q1/2 2009 due to more reliable forecasts and closer monitoring.

[13] Note this is the average lead time for the 1st line TB stockpile and the 20 orders that accessed the stockpile in Q1/Q2 2009. 9 of these orders were emergency orders and the lead times for these alone were reduced to an average of 30 days.

Table 6: (Action 1, Area 3)

Patients treated and treatments delivered by country across HIV/AIDS niches

Recipient country	WHO Region	WB Income category at time of MoU	Pediatric ARV		2nd line ARV		PMTCT	PMTCT
Lead recipient			CHAI[1]	Round 6/ TGFATM[4]	CHAI[2]	Round 6/ TGFATM[4]	WHO/ UNICEF[3]	WHO/ UNICEF[3]
			patients	patients	patients	patients	ARV treatments provided to HIV positive Mothers	Tests (HIV and CD4) provided to mothers and infants)
Angola	AFR	LMI	830					
Benin	AFR	LI	798		1,204			
Botswana	AFR	UMI	7,321		7,623			
Burkina Faso	AFR	LI	1,354	1,178	na		1,628	84,776
Burundi	AFR	LI	1,844		2,383			
Cambodia	WPR	LI	3,638		3,492			
Cameroon	AFR	LMI	3,114		2,970		5,098	33,858
Central African Republic	AFR	LI						
Chad	AFR	LI			957			
China	WPR	LMI	1,805					
Côte d'Ivoire	AFR	LI	2,993		1,122		6,931	154,152
Djibouti	AFR	LMI				839		
Dominican Republic	AMR	LMI	873					
Ethiopia	AFR	LI	10,020		5,179			
Ghana	AFR	LI			210			
Guinea	AFR	LI		5,879				
Guyana	AMR	LMI	272					
Haiti	AMR	LI			547			
India	SEAR	LI	18,371	15,000	570		0	0
Jamaica	AMR	LMI	435					
Kenya	AFR	LI	30,520		27,579			
Laos	WPR	LI		1145*		1,145		
Lesotho	AFR	LMI	3,683					
Liberia	AFR	LI	292			2,501		
Malawi	AFR	LI	18,842		1,991		12,260	436,000
Mali	AFR	LI	1,150		2,508			
Moldova	EUR	LMI				1,047		
Morocco	EMR	LMI		2,614				
Mozambique	AFR	LI	13,505		3,313			
Myanmar	SEAR	LI						
Namibia	AFR	LMI	8,837		7,743			
Nigeria	AFR	LI	29,409		21,079			
OECS[14]	AMR	UMI	18					
Papua New Guinea	WPR	LI	253					
République démocratique du Congo	AFR	LI	4,676		792			
Rwanda	AFR	LI	6,676		2,321		10,683	133,016
Senegal	AFR	LI	517	4,199	1,579			
Serbia	EUR	UMI		0				
Swaziland	AFR	LMI	4,772					
Tanzania	AFR	LI	21,627		6,749	1,584	7,164	64,950
Togo	AFR	LI	401		2,586			
Tunisia	EMR	LMI				361		
Uganda	AFR	LI	19,164		71,303			
Vietnam	WPR	LI	2,010					
Zambia	AFR	LI	21,104		133,567		0	50,372
Zimbabwe	AFR	LI	20,349		2,953			
Total			**261,473**	**28,870**	**312,320**	**7,477**	**43,764**	**957,124**

(1) From annual report of CHAI to UNITAID for 2009.

(2) From annual report of CHAI to UNITAID for 2009. UNITAID funded volume orders for the 2008 CHAI 2nd line project include 2nd line treatment for an estimated 46,107 patients. In Namibia, Uganda and Zambia, the project also supplied TDF formulations for use in first line treatment for an estimated 87,216 patients. In 2009 the project included 2nd line treatment for an estimated 67,490 patients. In Uganda and Zambia, the project included TDF formulations for use in first line treatment for an estimated 49,834 patients.

(3) From Annex 3 of UNICEF Annual Report to UNITAID as of 31 December 2008. Treatments by country for 2009 pending data from UNICEF.

(4) Estimated patients treated in Phase 1 of the Global Fund's Round 6.

Patients treated and treatments delivered by country across Malaria niches

Recipient country	WHO Region	WB Income category at time of MoU	ACT			LLINs	AMfM**	Malaria
Lead recipient			ACT Scale up UNICEF[1]	UNICEF/ WHO[2]	Round 6/ TGFATM[4]	UNICEF[3]	TGFATM	A2S2
			treatments	treatments	patients	bed nets	n/a	
Angola	AFR	LMI				850,000		
Bangladesh	SEAR	LI			121,325			
Benin	AFR	LI					*	
Burundi	AFR	LI		722,953				
Cambodia	WPR	LI	295,850		32,638		*	
Central African Republic	AFR	LI				1,100,000		
China	WPR	LMI			91,861			
Congo Brazzaville	AFR	LMI				470,000		
Côte d'Ivoire	AFR	LI			274086			
Djibouti	AFR	LMI			2,430			
Eritrea	AFR	LI			43,136			
Ethiopia	AFR	LI	0					
Gambia	AFR	LI			210,962			
Ghana	AFR	LI	2,790,020				*	
Guinea	AFR	LI			154,340	1,300,000		
Guinée Bissau	AFR	LI			103,065			
Indonesia	SEAR	LMI	139,350					
Kenya	AFR	LI					*	
Liberia	AFR	LI		678,275				
Madagascar	AFR	LI	2,789,805				*	
Mali	AFR	LI			582,547			
Mauritania	AFR	LI			0			
Mozambique	AFR	LI	9,500,940					
Namibia	AFR	LMI			327,758			
Niger	AFR	LI					*	
Nigeria	AFR	LI				6,500,000	*	
République démocratique du Congo	AFR	LI				5,500,000		
Rwanda	AFR	LI					*	
Senegal	AFR	LI					*	
Somalia	AFR	LI			111,779			
Sudan	EMR	LI	1,434,425			3,850,000		
Tanzania	AFR	LI					*	
Uganda	AFR	LI					*	
Zambia	AFR	LI	2,028,570					
Zimbabwe	AFR	LI				430,000		
Total			**18,978,960**	**1,401,228**	**2,055,927**	**20,000,000**	**n/a**	**n/a**

(1) Updated April 2010 from Annex 8, Procurement and Pricing report, Annual Report to UNITAID from UNICEF (2009). Contains some

(2) From final project report, "WHO assessment of UNITAID supply of ACT to Burundi and Liberia, Summary Report". Updated by email correspondence from UNICEF and WHO on 10 March 2009.

(3) All LLINS have been delivered to countries. Final distribution to programmes is expected to be complete by June 2010.

(4) Estimated patients treated in Phase 1 of the Global Fund's Round 6.

Patients treated and treatments delivered by country across TB niches

Recipient country	WHO Region	WB Income category at time of MoU	1st line TB	MDR-TB		Pediatric TB	Diagnostics	Rotating Stockpile
Lead recipient			GDF	GLC - GDF/ GFATM	Round 6/ TGFATM[6]	GDF/ Stop TB	GDF/FIND	GDF
			treatments[2]	treatments[3]	patients	treatments[4]	tests[5]	treatments
Afghanistan	EMR	LI				106,327		
Azerbaijan	EUR	LMI		315			803,891	
Bangladesh	SEAR	LI	147,450			19,946	1,482,381	
Belarus	EUR	LMI			200			
Benin	AFR	LI			5	3,207		
Bhutan	WPR	LMI			15			
Bosnia & Herzegovina	EUR	LMI	3,727					
Bulgaria	EUR	UMI			40			
Burkina Faso	AFR	LI	8,500	0		716		
Burundi	AFR	LI				1,177		
Cambodia	WPR	LI		82		19,709		
Cameroon	AFR	LMI	51,806			2,220		
Cap Verde	AFR	LMI				532		
Congo Brazzaville	AFR	LMI				398		
Côte d'Ivoire	AFR	LI	42,476			24,329	544,369	
Democratic People's Republic of Korea	SEAR	LI				8,970		
Djibouti	AFR	LMI				1,673		
Dominican Republic	AMR	LMI		242				
Egypt	EMR	LMI			51	4,608		
Eritrea	AFR	LI				2,407		
Ethiopia	AFR	LI				19,217	1,582,406	
Gambia	AFR	LI	3,524			438		
Georgia	EUR	UMI			739	5,208	600,446	
Guatemala	AMR	LMI			46			
Guinea	AFR	LI	18,847	10		23,253		
Guinée Bissau	AFR	LI				458		
Haiti	AMR	LI		236				
India	SEAR	LI			0			
Indonesia	SEAR	LMI				12,000	2,306,766	
Iraq	EMR	LMI	4,820			19,505		
Jordan	EMR	UMI				706		
Kazakhstan	EUR	UMI			381	10,860	2,160,934	
Kenya	AFR	LI	128,508	85		5,976		
Kiribati	WPR	LI				121		
Kyrgyzstan	EUR	LI		188	550	4,133	814,562	
Lebanon	EMR	UMI				257		
Lesotho	AFR	LMI		481		2,824	426,501	
Macedonia	EUR	LMI				670		
Madagascar	AFR	LI	45,456			7,930		
Malawi	AFR	LI		0		14,880		
Mali	AFR	LI	10,842			14,976		
Mauritania	AFR	LI				338		
Moldova	EUR	LMI		155	717		763,655	
Mongolia	WPR	LI				780		
Morocco	EMR	LMI				2,948		
Mozambique	AFR	LI	23,439	120		12,732		
Myanmar	SEAR	LI	114,627	81		63,490	1,046,201	
Nepal	SEAR	LI		330		8,137		
Niger	AFR	LI	9,679			2,280		
Nigeria	AFR	LI	110,542			13,548		
Pakistan	EMR	LI				81,871		
Papua New Guinea	WPR	LI				1,339		
Philippines	WPR	LMI				0		
République démocratique du Congo	AFR	LI		317			1,318,549	
Rwanda	AFR	LI	10,144		158	3,422		
Senegal	AFR	LI				6,903		
Sierre Leone	AFR	LI				5,651		
Somalia	AFR	LI				23,300		
Sri Lanka	SEAR	LMI			8	829		
Sudan	EMR	LI				15,532		
Swaziland	AFR	LMI				2,046		
Syrian Arab Republic	EMR	LMI			30			
Tajikistan	EUR	LI	16,202		42	17,360	1,236,127	
Tanzania	AFR	LI			8	7,200		
Thailand	SEAR	LMI				28,808		
Timor-Leste	WPR	LI		9				
Togo	AFR	LI	3,824			2,235		
Turkmenistan	EUR	LMI				2,614		
Uganda	AFR	LI	30,667					
Ukraine	EUR	UMI					3,939,371	
Uzbekistan	EUR	LI		481			2,941,519	
Vietnam	WPR	LI			101		822,813	
Yemen	EMR	LI				6,756		
Zambia	AFR	LI				18,391		
Zimbabwe[1]	AFR	LI						
Total			**785,080**	**3,132**	**3,091**	**668,141**	**22,790,491**	**n/a**

[1]Zimbabwe has not been approved for paediatric TB project

(2) One off treatments provided to countries to prevent stock outs of key anti-TB medicines starting in 2007. All treatments have now been delivered.

(3) Number of treatments delivered for UNITAID funded MDR-TB project in 2008 and 2009.

(4) Data taken from: UNITAID Paediatric TB Project, Annual Programmatic Progress Report, 01 January 31 December 2009. Patient treatments come from Annex 2: Patient treatments per Calendar year.

(5) Number of tests expected per country by end of project, not yet delivered to date. Countries are now in the process of building laboratory capacity to perform state of the art tests for MDR-TB.

(6) Estimated patients treated in Phase 1 of the Global Fund's Round 6.

Table 7: (Action 2, Area 3)

Monies spent by country across HIV/AIDS niches

Recipient country	WHO Region	WB Income category at time of MoU	Pediatric ARV		2nd line ARV		PMTCT-1[14]	PMTCT-2 (extention 2010-2011)[13]	PMTCT-Nutrition initiative	Facilitating distribution of HIV tests and medicines*	All HIV/AIDS projects
Lead recipient			CHAI[1]	Round 6 / TGFATM **	CHAI [1]	Round 6 / TGFATM**	WHO / UNICEF[3]	WHO / UNICEF[3]	WHO / UNICEF[3]	ESTHERAID[6]	Countries total across niches
			(US$)	(US$)	(US$)	(US$)	(US$)	(US$)	(US$)	(US$)	(US$)
Angola	AFR	LMI	597,035								597,035
Benin	AFR	LI	246,745		216,878						463,623
Botswana	AFR	UMI	4,798,919		6,493,631						11,292,550
Burkina Faso	AFR	LI	883,598	3,658,600	na		402,756				4,944,954
Burundi	AFR	LI	369,304		1,419,454						1,788,758
Cambodia	WPR	LI	1,398,430		2,791,553						4,189,983
Cameroon	AFR	LMI	2,234,427		2,743,756		1,074,825				6,053,008
Central African Republic	AFR	LI						0			0
Chad	AFR	LI			775,750						775,750
China	WPR	LMI	1,539,158					0			1,539,158
Côte d'Ivoire	AFR	LI	725,068		1,590,609		1,662,182				3,977,859
Djibouti	AFR	LMI				117,600					117,600
Dominican Republic	AMR	LMI	672,678								672,678
Ethiopia	AFR	LI	6,241,578		3,228,712						9,470,290
Ghana	AFR	LI			134,964						134,964
Guinea	AFR	LI		66,000							66,000
Guyana	AMR	LMI	174,793								174,793
Haiti	AMR	LI			624,345			0			624,345
India	SEAR	LI	4,174,069	4,444,445	1,043,671		1,150,123				10,812,308
Jamaica	AMR	LMI	140,436								140,436
Kenya	AFR	LI	11,404,158		23,607,077						35,011,235
Laos	WPR	LI		1,651		10,532					12,183
Lesotho	AFR	LMI	3,806,426					0			3,806,426
Liberia	AFR	LI	306,084			341,483					647,567
Malawi	AFR	LI	6,280,996		1,101,251		3,089,730		0		10,471,977
Mali	AFR	LI	856,361		2,265,162						3,121,523
Moldova	EUR	LMI				732,283					732,283
Morocco	EMR	LMI		587,155							587,155
Mozambique	AFR	LI	6,702,255	6,450,000	2,670,394	7,329,958					23,152,607
Myanmar	SEAR	LI						0			0
Namibia	AFR	LMI	2,328,557		1,370,471						3,699,028
Nigeria	AFR	LI	13,117,720		10,983,871			0			24,101,591
OECS	AMR	UMI	119,675								119,675
Papua New Guinea	WPR	LI	316,085								316,085
République démocratique du Congo	AFR	LI	1,732,532		1,163,227						2,895,759
Rwanda	AFR	LI	4,362,399		2,148,750		1,233,388		0		7,744,537
Senegal	AFR	LI	247,767	774,795	1,118,415						2,140,977
Serbia	EUR	UMI		104,000							104,000
Swaziland	AFR	LMI	2,076,243					0			2,076,243
Tanzania	AFR	LI	6,363,366		3,441,117	13,109	2,126,579		0		11,944,171
Togo	AFR	LI	315,632		1,269,037						1,584,669
Tunisia	EMR	LMI				252,270					252,270
Uganda	AFR	LI	11,026,965		24,587,824			49,469			35,664,258
Vietnam	WPR	LI	1,006,033								1,006,033
Zambia	AFR	LI	10,491,439		31,072,665		3,300,437		0		44,864,541
Zimbabwe	AFR	LI	8,873,227		2,431,615						11,304,842
Total			115,930,156	16,086,646	130,294,199	8,797,235	14,040,020	49,469	0	451,626	285,649,351

Monies spent by country across Malaria niches

Recipient country	WHO Region	WB Income category at time of MoU	ACT			LLINs	AMfM**	Support to Artemisinin Suppliers	All Malaria projects
Lead recipient			ACT Scale up UNICEF[2]	UNICEF/ WHO[15]	Round 6/ TGFATM**	UNICEF[5]	TGFATM	i+ Solutions[9]	Countries total across niches
			(US$)	US$	(US$)	(US$)	(US$)	(US$)	(US$)
Angola	AFR	LMI				3,697,500			**3,697,500**
Bangladesh	SEAR	LI			0				**0**
Benin	AFR	LI					*		**0**
Burundi	AFR	LI		428,609					**428,609**
Cambodia	WPR	LI	962,773		0		*		**962,773**
Central African Republic	AFR	LI				5,444,520			**5,444,520**
China	WPR	LMI			0				**0**
Congo (Brazzaville)	AFR	LMI				2,192,700			**2,192,700**
Côte d'Ivoire	AFR	LI			0				**0**
Djibouti	AFR	LMI			0				**0**
Eritrea	AFR	LI			0				**0**
Ethiopia	AFR	LI							**0**
Gambia	AFR	LI			0				**0**
Ghana	AFR	LI	1,697,690				*		**1,697,690**
Guinea	AFR	LI			657,743	6,616,339			**7,274,082**
Guinée Bissau	AFR	LI			574,396				**574,396**
Indonesia	SEAR	LMI	134,255						**134,255**
Kenya	AFR	LI					*		**0**
Liberia	AFR	LI		376,731					**376,731**
Madagascar	AFR	LI	675,515				*		**675,515**
Mali	AFR	LI			0				**0**
Mauritania	AFR	LI			0				**0**
Mozambique	AFR	LI	9,164,821						**9,164,821**
Namibia	AFR	LMI			0				**0**
Niger	AFR	LI					*		**0**
Nigeria	AFR	LI				30,524,550	*		**30,524,550**
République démocratique du Congo	AFR	LI				23,450,584			**23,450,584**
Rwanda	AFR	LI							**0**
Senegal	AFR	LI					*		**0**
Somalia	AFR	LI			0				**0**
Sudan	EMR	LI	1,128,964			16,763,500			**17,892,464**
Tanzania	AFR	LI					*		**0**
Uganda	AFR	LI					*		**0**
Zambia	AFR	LI	1,813,584						**1,813,584**
Zimbabwe	AFR	LI				2,064,000			**2,064,000**
Total			**15,577,602**	**805,340**	**1,232,139**	**90,753,693**	**130,000,000**	**9,280,400**	**247,649,174**

Monies spent by country across TB niches

Recipient country	WHO Region	WB Income category at time of MoU	1st line TB	MDR-TB		Pediatric TB	Diagnostics	Rotating Stockpile	All TB projects
Lead recipient			GDF	GLC - GDF/ GFATM	Round 6/ TGFATM	GDF/ Stop TB	GDF/FIND	GDF	Countries total across niches
			(US$)	(US$)	(US$)	(US$)	(US$)	(US$)	(US$)
Afghanistan	EMR	LI				342,081			342,081
Azerbaijan	EUR	LMI					803891*		0
Bangladesh	SEAR	LI	3,000,000			135,643	1482381*		3,135,643
Belarus	EUR	LMI			127,261				127,261
Benin	AFR	LI			0	19,518			19,518
Bhutan	WPR	LMI			0				0
Bosnia & Herzegovina	EUR	LMI	84,577						84,577
Bulgaria	EUR	UMI			95,559				95,559
Burkina Faso	AFR	LI	180,451			6,752			187,203
Burundi	AFR	LI				20,097			20,097
Cambodia	WPR	LI				158,802			158,802
Cameroon	AFR	LMI	1,516,020			45,808			1,561,828
Cap Verde	AFR	LMI				9,790			9,790
Congo (Brazzaville)	AFR	LMI				11,642			11,642
Côte d'Ivoire	AFR	LI	1,000,000			58,537	544369*		1,058,537
Democratic People's Republic of Korea	SEAR	LI				92,120			92,120
Djibouti	AFR	LMI				40,615			40,615
Egypt	EMR	LMI			108,106	30,162			138,268
Eritrea	AFR	LI				21,978			21,978
Ethiopia	AFR	LI				316,202	1582406*		316,202
Gambia	AFR	LI	91,272			8,107			99,379
Georgia	EUR	UMI			257,595	27,522	600446*		285,117
Guatemala	AMR	LMI			0				0
Guinea	AFR	LI	502,891			66,759			569,650
Guinée Bissau	AFR	LI				14,120			14,120
Haiti	AMR	LI							0
India	SEAR	LI			0				0
Indonesia	SEAR	LMI				108,234	2306766*		108,234
Iraq	EMR	LMI	156,035			71,120			227,155
Jordan	EMR	UMI				14,880			14,880
Kazakhstan	EUR	UMI			380,050	65,509	2160934*		445,559
Kenya	AFR	LI	2,420,655			149,615			2,570,270
Kiribati	WPR	LI				6,408			6,408
Kyrgyzstan	EUR	LI			175,767	48,224	814562*		223,991
Lebanon	EMR	UMI				10,655			10,655
Lesotho	AFR	LMI				72,329	426501*		72,329
Macedonia	EUR	LMI				12,425			12,425
Madagascar	AFR	LI	1,197,565			103,356			1,300,921
Malawi	AFR	LI				111,294			111,294
Mali	AFR	LI	245,946			37,213			283,159
Mauritania	AFR	LI				8,686			8,686
Moldova	EUR	LMI			0		763655*		0
Mongolia	WPR	LI				20,667			20,667
Morocco	EMR	LMI				35,473			35,473
Mozambique	AFR	LI	662,511			126,073			788,584
Myanmar	SEAR	LI	2,850,000			858,881	1046201*		3,708,881
Nepal	SEAR	LI				88,014			88,014
Niger	AFR	LI	289,354			27,766			317,120
Nigeria	AFR	LI	2,700,000			145,216			2,845,216
Pakistan	EMR	LI				437,640			437,640
Papua New Guinea	WPR	LI				35,609			35,609
Philippines[1]	WPR	LMI				0			0
République démocratique du Congo	AFR	LI					1318549*		0
Rwanda	AFR	LI	257,066		63,955	25,496			346,517
Senegal	AFR	LI				22,262			22,262
Sierre Leone	AFR	LI				50,508			50,508
Somalia	AFR	LI				120,808			120,808
Sri Lanka	SEAR	LMI			0	14,982			14,982
Sudan	EMR	LI				111,045			111,045
Swaziland	AFR	LMI				19,838			19,838
Syrian Arab Republic	EMR	LMI			16,313				16,313
Tajikistan	EUR	LI	402,913		0	90,339	1236127*		493,252
Tanzania	AFR	LI			54,066	74,179			128,245
Thailand	SEAR	LMI				138,100			138,100
Togo	AFR	LI	127,584			10,293			137,877
Turkmenistan	EUR	LMI				11,850			11,850
Uganda	AFR	LI	583,271						583,271
Ukraine	EUR	UMI					3939371*		0
Uzbekistan	EUR	LI					2941519*		0
Vietnam	WPR	LI			0	0	822813*		0
Yemen	EMR	LI				30,935			30,935
Zambia	AFR	LI				274,700			274,700
Zimbabwe[1]	AFR	LI							0
Total			18,268,111	7,087,273	1,278,670	5,016,877	3,393,340	11,458,000	46,502,271

[1]Not yet approved for paediatric TB project

*Awaiting clarification on expenditures per country from FIND/GDF/GLI

Table 8: Summary of treatments provided by year and by disease area.

HIV

	CHAI PEDS	CHAI_2ND_LINE[1]	PMTCT-I[2]	TGF_R6	Total
2007	134,677	61,674	NA		196,351
2008	60,430	133,322	49,712	na	243,464
2009	66,366	117,324	184,170	36,347	404,207
TOTAL	261,473	312,320	233,882	36,347	844,022

[1]Reflects estimated second-line patients treated as of 31 December in each year, including first-line patients on tenofovir in Namibia, Uganda and Zambia for 2008 and first-line patients on tenofovir for Uganda and Zambia (only) for 2009.

[2] Only numbers of HIV+ Pregnant women receiving ARVs and/or ART. Cotrim. is also provided to HIV + pregnant women and their infants. HIV testing is also provided to pregnant women and infants born to HIV + women from this project.

Malaria

	ACT SCALE-UP	Liberia and Burundi	TGF R6	LLIN	Total
2007	4,280,115	NA	na	NA	4,280,115
2008	8,722,815	722,953	na	NA	9,445,768
2009	5,976,030	678,275	2,055,927	20,000,000	28,710,232
TOTAL	18,978,960	1,401,228	2,055,927	20,000,000	42,436,115

NA= not applicable
na=not available

TB

	1ST LINE	PEDS-TB[1]	MDR-TB	TB-DIAGNOSTICS	TGF R6	Total
2007	197,584	112,754		NA	na	310,338
2008	545,793	181,427	1,673	NA	na	728,893
2009	41,703	373,960	2,920	NA	3,091	421,674
TOTAL	785,080	668,141	3,132	na	3,091	1,459,444

[1] Curative and preventive treatments combined

Table 9: Summary of monies spent (US$) on products purchased by year and by disease area.

HIV

	CHAI PEDS*	CHAI_2ND_LINE**	PMTCT-I	TGF_R6**	Total
2007	34,229,127	20,741,509	0	na	54,970,636
2008	44,702,791	48,917,770	4,004,541	na	97,625,103
2009	41,713,927	17,392,287	10,035,480	8,481,721	77,623,415
TOTAL	120,645,845	87,051,566	14,040,021	8,481,721	230,219,154

**Reflects annual report from CHAI
***Reflects cost of pediatric and 2nd line projects only, not procurement of CSD costs

Malaria

	ACT scale up*	Liberia and Burundi**	TGF R6	LLIN***	Total
2007	1,990,116	NA	na	NA	1,990,116
2008	8,250,152	805,340	na	NA	9,055,492
2009	5,337,334	NA	1,232,139	90,753,692	97,323,165
TOTAL	15,577,602	805,340	1,232,139	90,753,692	108,368,773

*UNICEF has reporting schedules are not calendar years. The structure is Year 1 (Q4 2007-June 2008), Year 2 (July 2008-June 2009), Year 3 (July 2009-June 2010). Year 3 expenditures are not yet confirmed by UNICEF.
**Project was completed in 2008.
***Product delivery has been completed
NA= not applicable
na=not available

TB

	1ST LINE	PEDS-TB	MDR-TB	TB-diagnostics	TGF R6	Total
2007	4,920,679	646,754	NA	NA	na	5,567,433
2008	12,499,221	1,289,450	1,967,172	NA	na	15,755,843
2009	848,211	3,080,674	5,038,828	2,676,340.00	1,278,670	12,922,723
TOTAL	18,268,111	5,016,878	7,087,273	2,676,340.00	1,278,670	34,327,272