UNITAID

Annual Report 2008

UNITAID ANNUAL REPORT 2008

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Mission

UNITAID's mission is to contribute to scaling up access to treatment for HIV/AIDS, malaria and tuberculosis, primarily for people in low-income countries, by leveraging price reductions for quality diagnostics and medicines and accelerating the pace at which these are made available.

Since UNITAID's overall objective is to serve the needs of the poorest countries and most vulnerable populations, it dedicates at least 85% of its funds to providing health commodities to low-income countries. UNITAID uses less than 10% of its funds to purchase products for lower middle-income countries and less than 5% for upper middle-income countries. These criteria are a key consideration in the decision to fund partner projects.

Photo: © Abby Marie Watson

Message from the Chairman

The world is currently facing an economic downturn of historic proportions. Global GDP for 2009 is expected to contract for the first time since World War II. The economic crisis is also increasingly hitting the developing world, and the consequences for the most vulnerable parts of the world's population are likely to be severe.

This context will reinforce an already severe health crisis in the developing world. Contagious diseases such as malaria, tuberculosis and HIV/AIDS provide a clear illustration of the current state: every year around 300 million people contract malaria and 9 million contract tuberculosis. Across the world about 33 million people are infected by HIV/AIDS, the vast majority of them in developing countries.

In this situation, the topic of innovative financing has received considerable international attention. Already innovative in the way it collects funds (more than 70 percent of our funds are raised through a solidarity tax on airline tickets), UNITAID is also innovative in the way it uses those funds. UNITAID targets specific niches underserved by markets. It therefore complements the work of other entities such as the Global Fund or UNICEF and reinforces their efforts.

In the areas of child-friendly medicines, second-line treatment for HIV/AIDS, not to mention cutting-edge diagnostics and the roll-out of expensive new medicines for multi-drug resistant tuberculosis (MDR-TB), financing the treatments provided to three out of every four children living with HIV/AIDS, UNITAID's achievements are very encouraging.

But much more needs to be done. We cannot afford to be complacent or to waiver from continued commitment to our vital mission. The millions of people whose lives are threatened each year from HIV/AIDS, malaria and tuberculosis, as well as the many millions more who struggle to cope with these three major diseases – including their families and communities – are counting on us.

On behalf of my colleagues on the Executive Board, I express my gratitude to our member countries, donors and partners, as well as to the devoted staff members of the UNITAID Secretariat. We appreciate your past support and encourage you to continue working with us to protect and enhance the lives and health of countless people, particularly the world's poorest, who need UNITAID the most.

Philippe Douste-Blazy

"UNITAID's real success is in the number of lives saved or improved"

Message from the Executive Secretary

The tragic facts and figures surrounding HIV/AIDS, malaria and tuberculosis are by now well known by many. The barriers to accessing treatment for people in developing countries who suffer from these illnesses have also been the subject of many global debates and pronouncements. But there is good news as well. Through the joint efforts of global agencies, countries and civil society, more and more people are accessing treatment and are receiving the chance of a longer, healthy and productive life. I am pleased to say that in its specific area of action, UNITAID has worked hard at finding solutions to make its contribution to scaling up access to medicines and diagnostics.

Since UNITAID's establishment in September 2006, our funding has helped stimulate markets for better medicines and diagnostics, increasing coverage of health commodities and influencing their price and availability. More specifically, UNITAID has continued to invest in niche pharmaceutical markets to address gaps in the availability of treatments suited to different populations and age groups.

Thanks partly to UNITAID, working closely with its partners, today we have more child-friendly medicines than ever before for our target diseases; we have more people on second-line treatments and we are seeing some markets stabilizing, thus benefiting even the countries outside our field of action.

All of this would not be possible without the support of our member countries. Whether through taxes on airline tickets or multi-year contributions, our donors have ensured that UNITAID funding has a real impact on the ground by being sustainable and predictable. It is largely that predictability that has allowed us to influence the production of more and better medicines and the reduction in their prices.

Our Second Annual Report highlights the many results of the past year, and demonstrates our contribution to the global public health response to HIV/AIDS, malaria and tuberculosis. Behind many of those results are the people at the Secretariat and their hard work. I am proud to say that UNITAID truly lives up to its mandate and ideals through the dedication of each and every employee, and our belief that universal access is not only a necessity, but also an achievable goal.

Dr. Jorge Bermudez

"Universal access is not only a necessity, but also an achievable goal"

Executive Summary

In 2008, UNITAID continued to consolidate its role as a vital contributor to scaling up access to medicines and diagnostics for HIV/AIDS, malaria and tuberculosis. The scope of UNITAID's work saw an expansion in the number of countries covered and included novel developments. Some of the achievements were increased coverage of paediatric treatments, continued efforts in driving the development of new medicines and new initiatives to speed up the availability and delivery of medicines to those who need them. UNITAID also reinforced its commitment to quality-assured products by further investing in the prequalification of medicines and diagnostics.

Three out of four children on HIV treatment today are accessing medicines thanks to UNITAID funding and market impact

The HIV/AIDS, malaria and tuberculosis (TB) pandemics, while garnering more financial support and global awareness than ever before, still claim 4.4 million lives a year, according to World Health Organization estimates. Slow progress in combating these diseases is partly due to the low availability and high cost of patient appropriate medicines and diagnostics. On the strength of that, a consultative process leading to the UNITAID strategy revision – carried out over the second half of 2008 – gave further emphasis to UNITAID's goal of reaching public health outcomes for these diseases through market impact.

UNITAID and its partners in 2008 continued to work towards the common goal of promoting global health and development. Through sustainable funding and innovative strategic approaches, UNITAID enhanced partners' work while stimulating positive impacts on markets for the products the partners rely on to achieve their mission.

UNITAID funds made tests and medicines available through 16 partner projects in 90 low- and middle-income countries

Several new projects received UNITAID funding, including additional efforts in the prevention of mother-to-child HIV transmission (PMTCT), malaria prevention through the funding of long-lasting insecticide treated bednets, and scale-up of tools against multi-drug resistant tuberculosis (MDR-TB). In each of its target areas, UNITAID worked hard to ensure that the projects it funded identified market failures and promoted interventions to overcome them.

New donor countries in 2008 included Cyprus and Luxembourg, which pledged multi-year financial commitments to UNITAID. The UNITAID commitment marks Cyprus's entry into the international donor community. Jordan joined in late 2008 and declared its intention of introducing the air tax. In addition, two African countries – Kenya and Burkina Faso – pledged their intention of introducing the air tax in the near future.

29 Countries and one foundation supported UNITAID in 2008

Brazil - Chile - Norway - United Kingdom - France - Spain - Korea - Cyprus - Luxembourg - Benin Burkina Faso - Cameroon - Congo - Ivory Coast - Gabon - Guinea - Liberia - Madagascar Mali - Morocco - Mauritius - Namibia - Niger - Central African Republic - Sénégal Sao Tomé & Principe - South Africa - Togo - Jordan - The Bill & Melinda Gates Foundation

2008 also saw the birth of a number of exciting new developments which should come to fruition in 2009. For example, the organization is moving forward with establishing a medicines patent pool to improve access to patents and foster the development and production of life-saving, more affordable, and more suitable medicines. Equally innovative is the Affordable Medicines for Malaria Facility (AMFm) – an initiative aiming to make artemisinin-based combination therapies (ACTs) – the best treatment for malaria today – more affordable and more widely available in high malaria zones. With an investment of US$ 130 million, UNITAID will become the initiative's main stakeholder.

For future action, UNITAID is also exploring ways in which it can contribute to increase access to additional medicines for opportunistic infections for people living with HIV/AIDS, medicines to treat people coinfected with TB and HIV, and female condoms.

UNITAID's partners over the year included the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Stop TB Partnership, the United Nations Children's Fund (UNICEF), the World Health Organization and the William J. Clinton Foundation HIV/AIDS Initiative (CHAI). The Foundation for Innovative New Diagnostics (FIND) came on board as a new partner in July.

An innovative mechanism for innovative action

UNITAID is innovative and UNIQUE in three ways:

1 THE WAY IT COLLECTS FUNDS:

First example of a government-imposed solidarity tax for global health
First example of donor funding from low- and middle-income countries

2 THE WAY IT MAKES THOSE FUNDS WORK:

First example of a global health agency to pursue public health outcomes through market impact

3 THE WAY IT OPERATES:

Lean structure
Channels funds towards strategic gaps in diagnosis and treatment through implementing partners

UNITAID is a critical addition to the fight against HIV/AIDS, malaria and TB and to progress towards achieving the Millennium Development Goals

"Development cooperation is today a priority for the Government of Chile. As our economy grows, so will the resources we devote to solidarity and collaboration with other countries. At the Ministry of Health, we intend to contribute through the exchange of experiences in areas where we have been successful, and we are happy to be part of UNITAID since its inception. Thanks to UNITAID, thousands of men, women and children today are benefiting from effective treatments for HIV/AIDS, malaria and tuberculosis.

As soon as we were able to guarantee our own population's coverage for these diseases, we felt that it was our obligation to contribute in solidarity to those who have fewer resources and are more affected. We welcome the fact that this initiative, founded by France, Brazil, Norway, the United Kingdom and Chile has grown to become an important contributor to the goal, shared with several organizations, of expanding access to treatments for those who most need them. By impacting on the market for HIV/AIDS, malaria and tuberculosis medicines, UNITAID makes it possible to achieve better health for all."

Dr. Alvaro Erazo, Minister of Health, Chile

UNITAID represents governments' commitment to financing for global health as a national priority requiring international collaboration

29 countries currently support UNITAID

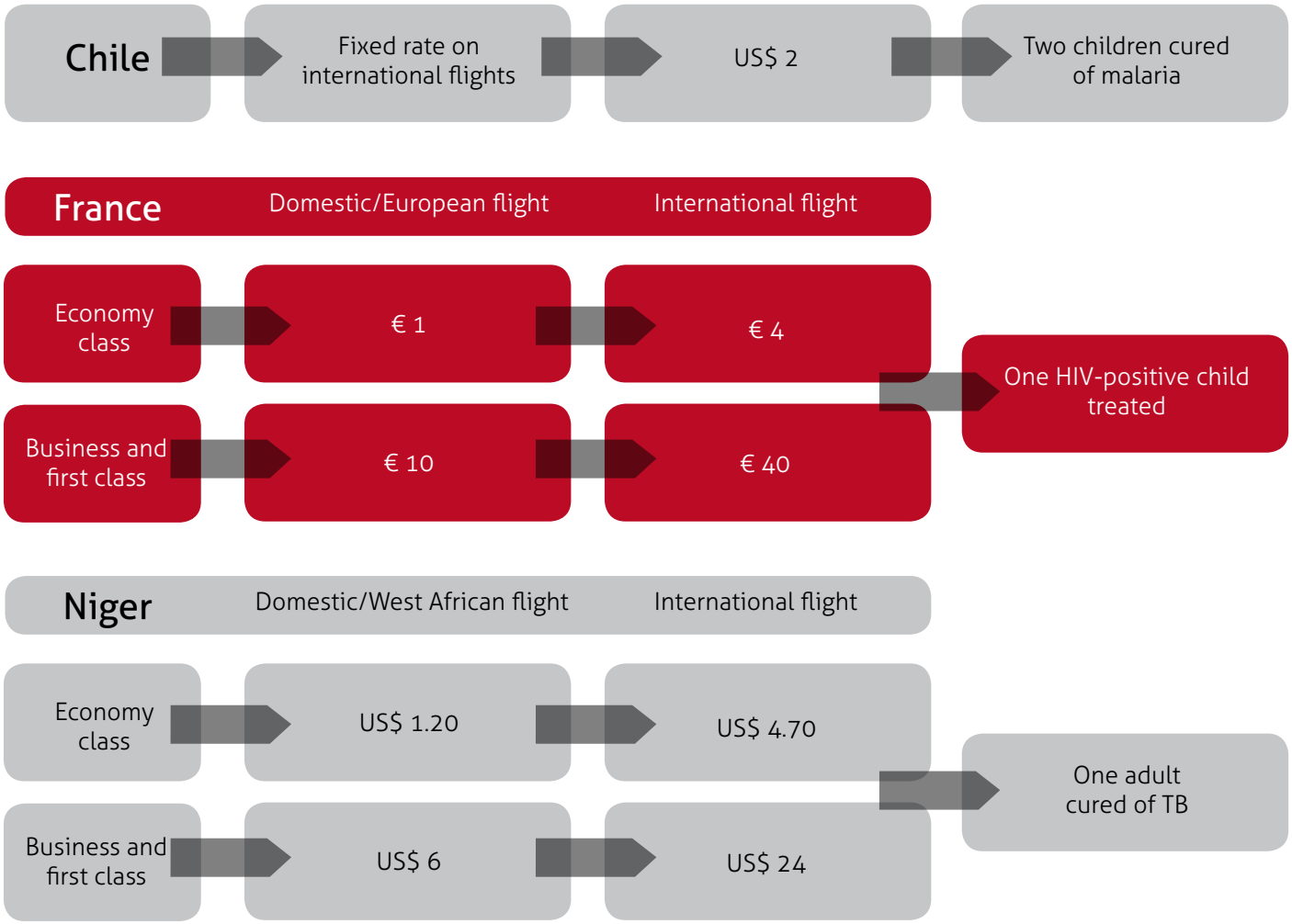
7 apply the air tax

The **air tax supplies over 70%** of our finances

More are in the process of introducing it

The others give us money through multi-year contributions

EXAMPLES OF COUNTRIES' AIR TAX TRANSLATED INTO BENEFITS



UNITAID... is not only purchasing large quantities of interventions. It is already showing additional benefits arising from the guarantee of a large and predictable market. UNITAID has provided an incentive for product improvements, including paediatric formulations for AIDS and TB drugs.

Margaret Chan, Director-General, World Health Organization, January 2008

Thanks to a flexible financing model, UNITAID is able to:

Commit funds over the long term for sustainable action

Impact on the market for medicines, diagnostics and other commodities by reducing prices and pushing up volume of production

Drive the development of new and necessary medicine formulations by creating a predictable market for them

Promote quality of medicines and diagnostics by investing in long-term technical assistance through the World Health Organization's (WHO's) Prequalification Programme.

Photo: © MHallahan/Sumitomo Chemical - Olyset® Net

UNITAID AT WORK

STRENGTHENING the GLOBAL EFFORT against HIV/AIDS, MALARIA and TUBERCULOSIS

Photo: © Hugh Sitton/Zefa/Corbis

Scaling Treatment UP

UNITAID

AIDS

Pushing Prices DOWN

HIV/AIDS: Scaling Treatment UP, Pushing Prices DOWN

Much Progress on Access to Antiretroviral Treatment, but Major Challenges Remain

The global HIV/AIDS pandemic continues to demand urgent attention, despite significant progress in scaling up treatment over the last several years. An estimated 33 million people are living with HIV/AIDS today, and of the approximately ten million in need of antiretroviral treatment (ART), roughly three million are receiving it[1]. While this represents a ten-fold increase over the last six years, more than six million people are still in urgent need of treatment, but lack access. Meanwhile, the virus continues to take its toll, particularly in developing countries, where 95% of those infected live. An estimated two million people died of AIDS in 2007, including 270 000 children[2].

Access to appropriate and adapted paediatric antiretroviral medicines (ARVs), as well as to newer and more potent 'second-line' ARVs remains a major challenge, as does tackling transmission of the virus from expectant mothers to their babies – the primary cause of child infection.

UNITAID has made these challenges the focus of its HIV/AIDS effort, and together with its partners the William J. Clinton Foundation HIV/AIDS Initiative (CHAI), UNICEF and the World Health Organization (WHO), UNITAID is helping address them in crucial ways by:

Helping increase access to appropriate and adapted treatment for children, while supporting the development and roll-out of child-friendly ARVs and ensuring that prices come down;

Helping expand access to second-line treatment and lower prices for second-line ARVs by ensuring that more producers are encouraged to enter the market – competition being the tried and tested way to bring prices down; and

Supporting the scale-up of Prevention of Mother-to-Child Transmission (PMTCT) programmes with an emphasis on implementing optimal treatment protocols, in order to reduce the number of child HIV infections; and ensuring PMTCT efforts are linked to paediatric HIV/AIDS care, as well as family-inclusive services.

1 UNAIDS, 2008 Report on the global AIDS epidemic
2 Ibid

Photo: © Giacomo Frigerio/Unitaid

Paediatric HIV/AIDS

Expanding Treatment While Driving the Development of Affordable Child-friendly Medicines

UNITAID and its partners' efforts to expand paediatric treatment had reached over 170 000 children by the end of 2008. The goal is to reach an additional 100 000 children per year in 2009 and 2010, amounting to almost 400 000 children receiving treatment through UNITAID by the end of 2010.

The overwhelming majority of children with HIV/AIDS are infected through the preventable transmission of the virus from mother to child. In stark contrast to developing countries, successful Prevention of Mother-to-Child Transmission (PMTCT) programmes in wealthy countries have led to paediatric HIV/AIDS becoming extremely rare in the North. Consequently, with little market incentive in the North for companies to invest in paediatric HIV/AIDS, the development of child-appropriate ARVs has consistently lagged behind. It took a full six years longer to develop a three-in-one fixed-dose combination (FDC) pill for children than it did for adults[3]. Until then, the only option for children was to take large amounts of often foul-tasting syrups, or even small amounts of crushed adult tablets, which is complicated for caregivers to administer and carries a risk of over- or under-dosing.

UNITAID's 2008 efforts on paediatric HIV/AIDS focused on:

- Contributing to the scale-up of FDC formulations and to the availability of new quality FDCs and other appropriate medicines for HIV;
- Scaling up access to reach close to 100 000 more children with paediatric ARVs in 2008, and an additional 100 000 per year until 2010, to reach an intended total of 400 000 by the end of the decade;
- Scaling up availability and price reduction of diagnostic and monitoring tests; and
- Providing an integrated package of care

Scaling up Paediatric Treatment

In total, UNITAID in 2008 disbursed approximately US$ 52.1 million to CHAI to purchase quality-assured and affordable paediatric ARVs, diagnostics and other products needed for renourishment and to stave off opportunistic infections. The partnership has reached more than 170 000 children in 38 countries across Africa, Asia, Latin America and the Caribbean since its inception in late 2006[4]. The goal is to reach at least an additional 100 000 children in both 2009 and 2010, leading to a cumulative goal of providing treatment to close to 400 000 children by the end of the decade.

UNITAID funding also enabled projects receiving grants from the Global Fund to Fight AIDS, TB and Malaria to purchase quality-assured paediatric HIV treatments for eight countries in Africa, Asia and Europe[5].

3 "Untangling the Web of ARV Price Reductions", 11th edition, Médecins Sans Frontières, July 2008

4 Angola, Antigua & Barbuda, Benin, Botswana, Burkina Faso, Burundi, Cambodia, Cameroon, China, Côte d'Ivoire, Dominica, Dominican Republic, Democratic Republic of Congo, Ethiopia, Grenada, Guyana, India, Jamaica, Kenya, Lesotho, Liberia, Malawi, Mali, Mozambique, Namibia, Nigeria, Papua New Guinea, Rwanda, Senegal, St. Kitts & Nevis, St. Lucia, St. Vincent and the Grenadines , Swaziland, United Republic of Tanzania, Uganda, Vietnam, Zambia and Zimbabwe

5 Burkina Faso, Guinea, India, Lao People's Democratic Republic, Morocco, Mozambique, Senegal and Serbia

Increasing Paediatric Treatment Options

UNITAID and CHAI have contributed significantly to the availability of several paediatric FDCs today by providing the predictable funding needed to encourage generic manufacturers to enter the market. The simplification achieved by combining several medicines into one pill makes it easier for children to adhere to their treatment, thus slowing the development of resistance. However, treatment options for children continue to be limited compared to those for adults: of the 22 individual AIDS medicines approved by the United States Food and Drug Administration and currently available, six are not approved for paediatric use and seven do not have paediatric formulations.

In 2008, UNITAID and its partner CHAI worked to ensure the development of six new better-adapted and more-affordable ARV formulations for children, including a new fixed-dose combination that contains zidovudine (AZT). This FDC presents treatment providers with an alternative to the combination containing the less tolerated stavudine (d4T) – a drug from which the World Health Organization has recommended countries start to consider moving away, because of the significant side effects it can cause[6]. Once the new FDC became available in April 2008, UNITAID funding enabled CHAI to purchase and provide it to seven countries[7].

Paediatric care and treatment has come a long way ... We have tripled the number of children on treatment in just two years.
I am proud that our foundation's partnership with UNITAID is responsible for three quarters of the more than 200,000 children on treatment today.

President Bill Clinton, International AIDS Conference, Mexico, August 2008

Pushing Prices Down

Since its inception in 2006, UNITAID and CHAI's partnership on paediatric HIV/AIDS has resulted in cumulative price reductions for paediatric ARVs of an average 60% in low-income countries. The partnership was also able to provide a new fixed-dose combination containing lamivudine/nevirapine/zidovudine (AZT) at the price of US$ 66 per child per year. This price is 66% down from the price of standard paediatric treatment in 2006.

UNITAID's partner CHAI has negotiated agreements for preferred pricing for products with UNITAID's resources. On average, prices paid for paediatric ARVs were lower than those reported by both generic and originator manufacturers to Médecins Sans Frontières for its publication *Untangling the Web of ARV Price Reductions* (September 2008 update). In addition, CHAI has negotiated long-term agreements with suppliers on behalf of UNITAID and beneficiary countries. Ten generic manufacturers are competing for this market; in 2008, CHAI signed long-term agreements with four of them.

Providing an Integrated Package of Care

Many children living with HIV in developing countries suffer from malnutrition, which reduces their ability to absorb treatment. Through UNITAID, children receiving treatment are also accessing highly-nutritious food for increased therapeutic effect, antibiotics and other medicines needed to stave off opportunistic infections.

6 World Health Organization, "Antiretroviral therapy for HIV infection in adults and adolescents, Recommendations for a public health approach" (2006 revision)
7 Dominican Republic, Lesotho, Nigeria, PNG, Senegal, Uganda and Zimbabwe

Seabata's story

A nine-year-old orphan from Lesotho, Seabata was forced to miss one year of school because of repeated bouts of HIV-related illnesses. When he first enrolled in Mafeteng General Hospital, Seabata had symptoms of full-blown AIDS. After being initiated on antiretroviral treatment, his condition improved dramatically. These days, he returns to the hospital for regular check-ups with his grandmother, who says Seabata reminds her that he needs to take his medications each day, even before she gets a chance to remind him. Seabata has responded well to treatment, and is excited to be returning to school.

Photo: © CHAI

"Thanks to UNITAID support, Kenyan medical professionals can now diagnose newborns with HIV in the first six weeks after birth. This will enable us to avert more than 10 000 deaths. UNITAID funding has also equipped three Kenyan laboratories with the capacity to conduct HIV tests on infants less than 18 months old."

Honourable Beth Mugo, Minister of Public Health, Kenya

Srey's story

Srey arrived at the Maryknoll orphanage in Cambodia in October 2004. She was three years old and severely undernourished. Srey's mother, who was very sick, brought her to the orphanage and never returned. At the time, Srey was suffering from HIV, tuberculosis and malnutrition, which was so severe that several hospitals refused to treat her. Srey today receives paediatric HIV treatment and care. She is now a healthy eight-year old, and among the tallest children of her age in the orphanage.

Photo: © CHAI

Second-line antiretrovirals

Increasing Access and Reducing Prices through Market Expansion

UNITAID disbursed US$ 88.2 million to CHAI to purchase quality-assured and affordable second-line antiretrovirals (ARVs) in 2008. The partnership reached an estimated 46 000 people with second-line medicines in 24 countries across Africa, Asia and the Caribbean[8]. UNITAID funding also enabled projects receiving grants from the Global Fund to Fight HIV, TB and Malaria to increase access to second-line ARVs in seven countries across Africa, Asia and Europe[9].

A Rapidly Growing Need for Newer ARVs

HIV/AIDS is a life-long disease, and people on antiretroviral treatment (ART) need access to newer and more potent ARV combinations when they become resistant to their initial set of medicines over time, or when they develop side effects. While today the vast majority of patients on ART are still on their first line of treatment, the need for access to newer medicines – known as second-line – is growing at a rapid pace, as people have been on their initial drug combinations for several years.

Because of a lack of adequate diagnostic tools to monitor treatment in resource-limited settings, such as viral load testing, it is difficult to ascertain the scope of the need for second-line treatment. Although only 4% of patients on antiretroviral therapy in 23 countries surveyed by WHO were on second-line regimens in 2006 (WHO, 2007a), the need for second-line therapies will grow over time. An estimated 3% of patients on first-line antiretroviral drugs—or approximately 180 000 individuals in 2008—need to switch to second-line regimens each year[10].

However, newer medicines used in second-line treatment cost much more than drugs used in first-line combinations. While competition among generic manufacturers has helped bring the price of first-line ARVs down by more than 99% – from $10 000 per patient per year in 2000 to approximately $80 today, as negotiated by the UNITAID-CHAI partnership – newer second-line medicines have remained much more expensive. This is due primarily to less competition and to the perception that the market remains small, as well as to patent barriers – two factors that serve as a disincentive for manufacturers to invest in their production. Without urgent action to bring prices down, national treatment programmes will be faced with massive cost increases – indeed a second wave of the ARV access crisis initially seen earlier in the decade.

UNITAID's 2008 efforts on Second-line ARVs focused on:

Influencing the market for ARVs to further reduce the price of priority second-line drug regimens; and

Scaling up access to second-line ARVs to reach an additional 60 000 people in 2008

8 "Benin, Botswana, Burundi, Cambodia, Cameroon, Chad, Democratic Republic of Congo, Ethiopia, Ghana, Haiti, India, Kenya, Malawi, Mali, Mozambique, Namibia, Nigeria, Rwanda, Senegal, United Republic of Tanzania, Togo, Uganda, Zambia, and Zimbabwe

9 Djibouti, Laos, Liberia, Moldova, Mozambique, Tunisia and Zanzibar (United Republic of Tanzania)

10 UNAIDS, 2008 Report on the global AIDS epidemic

Responding to High Drug Prices and Expanding Treatment

UNITAID, through its support of CHAI, has been addressing the high price of newer ARVs by influencing the market in order to encourage price reductions. Stimulating competition and providing incentives to encourage new manufacturers to enter the market has resulted in considerably lower prices for second-line ARVs. Following negotiations with leading manufacturers of generic medications, in May 2007 CHAI and UNITAID announced steep price reductions on seven different formulations of second-line antiretroviral drugs. As a result, the price of the WHO recommended second-line antiretroviral regimen came down by 50%, from US$ 1 500 in 2006 to less than US$ 700 in 2008.

The World Health Organization (WHO) in its revised adult antiretroviral treatment guidelines of 2006 recommended that treatment providers slowly begin moving away from stavudine (d4T), a drug contained in the most commonly used first-line regimen in developing countries[11]. Stavudine is rarely prescribed any longer in wealthy countries due to side effects. In its place, WHO suggests the option to use tenofovir (TDF) as part of an alternative first-line regimen. The price of tenofovir, however, has long remained too high for treatment providers in developing countries to be able to consider it as feasible.

CHAI, through UNITAID support, provided an estimated 88 000 people with tenofovir in Namibia, Uganda and Zambia at the price of US$ 149 per patient per year, a considerable reduction from the widely reported price of US$ 200 to US$ 207. UNITAID's funding of first-line tenofovir until 2009 is intended to send a signal to manufacturers of the longer-term needs for the drug, and encourage them to enter the market. This, in turn, should foster the market competition that can bring prices down even further.

Additionally, UNITAID funding of the World Health Organization's Prequalification Programme also enabled CHAI to purchase seven new quality-assured second-line antiretroviral products and make them available in 24 countries.

11 World Health Organization, "Antiretroviral therapy for HIV infection in adults and adolescents, Recommendations for a public health approach" (2006 revision)

Photo: © Giacomo Frigerio/Unitaid

Improving Prevention of Mother-to-Child Transmission (PMTCT)

and Scale-Up of Linkages to Paediatric HIV Care and Treatment

Through UNITAID's partnership with the World Health Organization (WHO) and UNICEF, an estimated 820 000 pregnant women were tested and 95 000 women and 43 000 infants were treated for HIV/AIDS in eight countries across Asia and Africa[12].

UNITAID's 2008 efforts on PMTCT focused on:

- Accelerating the scale-up of provider-initiated HIV testing and counselling in antenatal, maternity and postpartum services;
- Reducing the proportion of infants born with HIV through the provision of more efficacious ARV regimens, including ART, to women and their newborns;
- Accelerating early access of young HIV-infected infants to paediatric ART treatment through optimized identification strategies, such as Early Infant Diagnosis;
- Reducing morbidity and mortality among HIV-infected pregnant women, mothers and their infants through the provision of co-trimoxazole prophylaxis for the prevention of opportunistic infections; and
- Increasing access to ART for eligible HIV-infected women.

In 2008 UNITAID started its work with UNICEF and WHO to support the global scale-up of national Prevention of Mother-to-Child Transmission (PMTCT) programmes. The main goal was to increase access to HIV treatment and tests for HIV-infected pregnant women and their infants, and to fill the existing gap in the provision of quality medicines, diagnostics and family-inclusive services. The collaboration has already led to the development of four new diagnostic packs, containing easy to use testing equipment, and the identification of six new suppliers of ARVs.

UNITAID, UNICEF and WHO, together with technical partners, are building the necessary in-country coordination to effectively deliver PMTCT commodities and related capacity. The project represents a holistic, family-centred approach that is making an important contribution to reducing the proportion of infants newly infected with HIV and improving maternal and child health.

The project is promoting the implementation of the most recent WHO PMTCT guidelines, which now recommend that all HIV-positive pregnant women receive triple antiretroviral therapy throughout pregnancy and the breastfeeding period, as opposed to the previous recommendation of providing a single dose of the ARV nevirapine around the birth.

In 2008, UNITAID announced additional funding support of around US$ 55 million for PMTCT to extend the ongoing Project to approximately nine further countries[13] and to address nutritional problems that impact negatively on PMTCT outcomes in four initial countries through the provision of testing for anaemia and of nutritional supplements[14].

In collaboration with Ministries of Health, WHO played a strong role to ensure that expansion of PMTCT programmes, use of ARVs, and procurement of treatment and diagnostics followed global guidelines and recommendations.

12 Burkina Faso, Cameroon, Côte d'Ivoire, India, Malawi, Rwanda, United Republic of Tanzania and Zambia

13 UNITAID support is expected to result in: testing of close to 10 million pregnant women and the delivery of 285 000 more efficacious ARV regimens to both mother and child and to women in need of treatment for their own health; provision of preventive and antiretroviral treatments during pregnancy, continuing for up to one year after delivery or until the patients can be absorbed by national treatment programmes; testing of 150 000 children born to HIV-infected mothers at four to six weeks to confirm HIV diagnosis; and co-trimoxazole preventive treatment for close to 300 000 of the children born to HIV-infected mothers.

14 UNITAID support is expected to result in: anaemia screening of 206 826 pregnant women; treatment for severe malnutrition for 16 793 HIV-infected pregnant; anaemia screening of 38 093 children; and re-nourishment for 32 330 children with severe malnutrition.

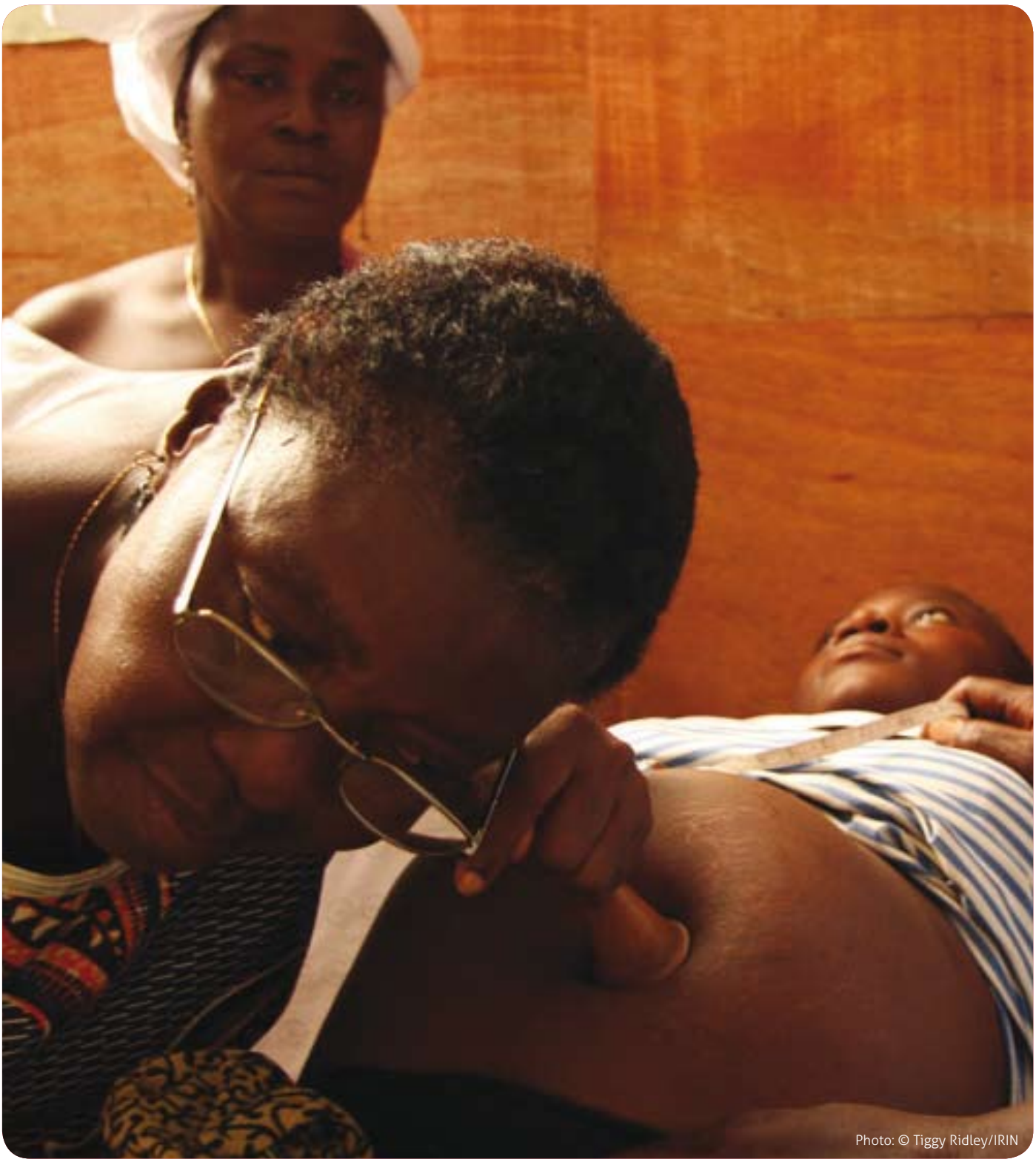


Photo: © Tiggy Ridley/IRIN

UNITAID's PATH FORWARD FOR HIV/AIDS

UNITAID is considering novel initiatives to support the fight against the HIV/AIDS pandemic in 2009 and beyond. These include:

- Working to establish a patent pool to increase the availability and affordability of new and better patient-adapted ARVs and other medicines to treat people living with HIV/AIDS;
- Investigating the possibility of funding diagnostic tests for monitoring the development of resistance to antiretroviral therapy;
- Potentially investing in sustainable local production of ready-to-use therapeutic food for use in HIV/AIDS care; and
- Supporting the greater availability of female condoms.

Taking the Plunge: UNITAID moves towards a "Patent Pool" for medicines

"Patent pools are increasingly seen as a useful tool in tackling barriers to access to medicines in developing countries. Sharing knowledge and technologies and putting them at the service of global health is key to truly expanding treatments for all populations."

Philippe Douste-Blazy, Chair of UNITAID's Executive Board

UNITAID's Executive Board in July 2008 took initial steps to establish an international system to boost the availability and affordability of new and more patient-friendly medicines for people in developing countries – a 'patent pool.'

Widespread patenting represents a significant barrier to access to essential medicines for people in developing countries. Through a collective management structure for HIV medicines patents, known as a patent pool, UNITAID seeks to foster in particular the development of products for HIV/AIDS that are lacking, such as fixed-dose combinations (FDCs) of newer AIDS medicines and child-friendly formulations; and products for which there are not enough producers to create economies of scale. This would mark the first time such a system is applied to medicines.

The international public health community has long been worried about the affordability and accessibility of newer medicines in developing countries. For example, second-line AIDS medicines have increased the survival and quality of life for many people living with HIV/AIDS in wealthy countries, yet because of their considerably higher cost, few people in developing

countries can afford them.

The establishment of UNITAID led the international medical humanitarian organization Médecins Sans Frontières (MSF) and Knowledge Ecology International (KEI) to propose that UNITAID's Executive Board explore the possibility of a patent pool for medicines as one potential solution to overcome barriers to access to essential medicines.

The Medicines Patent Pool will depend on patent holders' willingness to put their patents in the pool. Generic manufacturers, for example, will be able to make use of the patents to produce needed products, in exchange for paying a royalty to the pool. This system rewards pharmaceutical companies for their investment into research and development, while at the same time allowing generic manufacturers to make use of intellectual property more swiftly, resulting in more affordable and faster provision of needed medicines to people in developing countries. UNITAID will also aim to ensure that producers using the pool meet agreed quality standards.

While the patent pool will initially focus on HIV/AIDS, it could also be applied to further areas of need for other diseases in the future.

The next steps undertaken by UNITAID will be to develop an operational plan for the creation of the patent pool.

Civil society comment on the HIV Medicines Patent Pool

The Medicines Patent Pool is a creative initiative to increase access to HIV medicines by overcoming patent barriers to generic production and to the development of adapted formulations such as fixed dose combinations and medicines for children.

A patent pool is a simple centralized licensing system through which patent-owners allow the use of their patents by others. Companies that make generic drugs and researchers that want to use the patents to develop new versions of existing medicines can access patents in the Pool in exchange for paying a fair royalty to the patent owners. The Pool acts as a 'one-stop shop' for managing the negotiations and receiving and paying the royalties. The pool will be open to all companies and will therefore enable market competition to bring prices down and increase access to medicines.

Civil society organizations on the UNITAID board and outside strongly support the establishment of an HIV patent pool.

Photo: © Giacomo Frigerio/Unitaid

U N I T

ACTing Urgently to Save Lives by Scaling up the Best Treatment and Investing in Prevention

MALARIA AID

ACTing Urgently to Save Lives

by Scaling up the Best Treatment and Investing in Prevention

In a joint effort that included UNICEF and the Global Fund to Fight HIV, TB and Malaria, UNITAID disbursed approximately **US$ 14 million** to UNICEF to purchase more than eight million artemisinin-based combination therapy (ACT) malaria treatments for eight countries in Africa and Asia[15]. Projects receiving Global Fund grants were also able to increase access to ACTs in 13 malaria-endemic countries across Africa and Asia in 2008 through UNITAID's support of US$ 21.5 million[16]. Additionally, UNITAID approved US$ 109.2 million to UNICEF in 2008 for the purchase and distribution of 20 million bednets in eight high-burden countries over 2009-2010.

Nearly One Million Deaths per Year despite an Effective Cure

Malaria is a potentially deadly disease that is transmitted through the bites of mosquitoes. Half of the world's population – or approximately 3.3 billion people in more than 100 countries or territories – are at risk of contracting malaria, with nine in ten cases occurring in sub-Saharan Africa[17]. The World Health Organization (WHO) estimates that in 2006, there were nearly a quarter of a billion malaria infections, and nearly 900 000 people – 85% of whom were children under the age of five – died of malaria[18]. The disease kills more than 2 000 children under five years of age per day – roughly one every 30 seconds.

Although malaria is entirely curable in a matter of several days, the disease is often fatal without swift diagnosis and effective treatment. Immediate intervention is particularly important for the most vulnerable groups, namely children under five years of age, pregnant women, and people with weak immune systems, such as those living with HIV/AIDS. Control of malaria today relies primarily on early diagnosis and treatment with effective medicines, and on preventing transmission, which is best accomplished through the use of long-lasting insecticide-treated bednets.

Widespread resistance in Africa and Asia to older malaria treatments, such as chloroquine, has exacerbated the problem and has contributed to the increase in mortality rates since the 1990s[19]. The only truly effective treatment in areas where resistance to other drugs is pervasive is artemisinin-based combination therapy, or ACT. However, ACTs are not reaching nearly enough people to reverse the deadly toll the disease takes.

The high cost of ACTs and long delays in bednet deliveries are two critical obstacles to controlling malaria effectively. In response, UNITAID, together with its partners UNICEF and the Global Fund to Fight AIDS, TB and Malaria, has therefore focused its efforts on:

Scaling up ACT treatment, with a target of treating 54.5 million cases of malaria by 2010-2011; and using its market model to influence the number of producers and products on the market, as well as reduce prices and help speed up quality assurance; and

Accelerating the scale-up of bednet coverage, by providing 20 million bednets in 2009 and 2010, and using its market model to ensure that delivery lead times and prices are reduced.

15 Cambodia, Ethiopia, Ghana, Indonesia, Madagascar, Mozambique, Sudan, and Zambia
16 Bangladesh, Cambodia, China, Côte d'Ivoire, Djibouti, Eritrea, Gambia, Guinea, Guinea Bissau, Mali, Mauritania, Namibia, and Somalia
17 World Health Organization, World Malaria Report 2008
18 Ibid.
19 World Health Organization/Roll Back Malaria, "Facts on ACTs" (January 2006 Update) http://www.rbm.who.int/cmc_upload/0/000/015/364/RBMInfosheet_9.htm.

Photo: © MHallahan/Sumitomo Chemical - Olyset® Net

Scaling up ACT Provision

Despite the existence of ACTs that cure malaria in just three days, nearly one million people continue to die annually, because of insufficient access to this effective treatment. The high cost of ACTs is a critical barrier, as is the low availability of paediatric ACT formulations. Without the prospect of sustainable funding that enables effective planning, countries remain reluctant to switch to ACTs from the far-cheaper chloroquine. Comparative prices range from five US cents for chloroquine to US$ 1 for Coartem, marketed by Novartis, and about 90 US cents for an ACT product manufactured by Cipla.

Several manufacturers produce ACTs, with nine products having received quality-assurance by the World Health Organization's (WHO) Prequalification Programme. But although children under five face the highest risk of dying from malaria, only one of the nine quality-assured ACTs is a child-friendly formulation. As is the case for other diseases, manufacturers' interest in paediatric medicines is alarmingly low.

UNITAID's approach is helping increase access to ACTs by:

Providing a sustainable financing model to mitigate countries' concerns about lack of long-term funding, which has been a barrier to countries' willingness to switch to ACTs;

Promoting greater competition in the ACT market by sending a signal of UNITAID's long-term commitment to, and sustainable funding for, ACTs – this should encourage the development of a greater variety of products at lower prices.

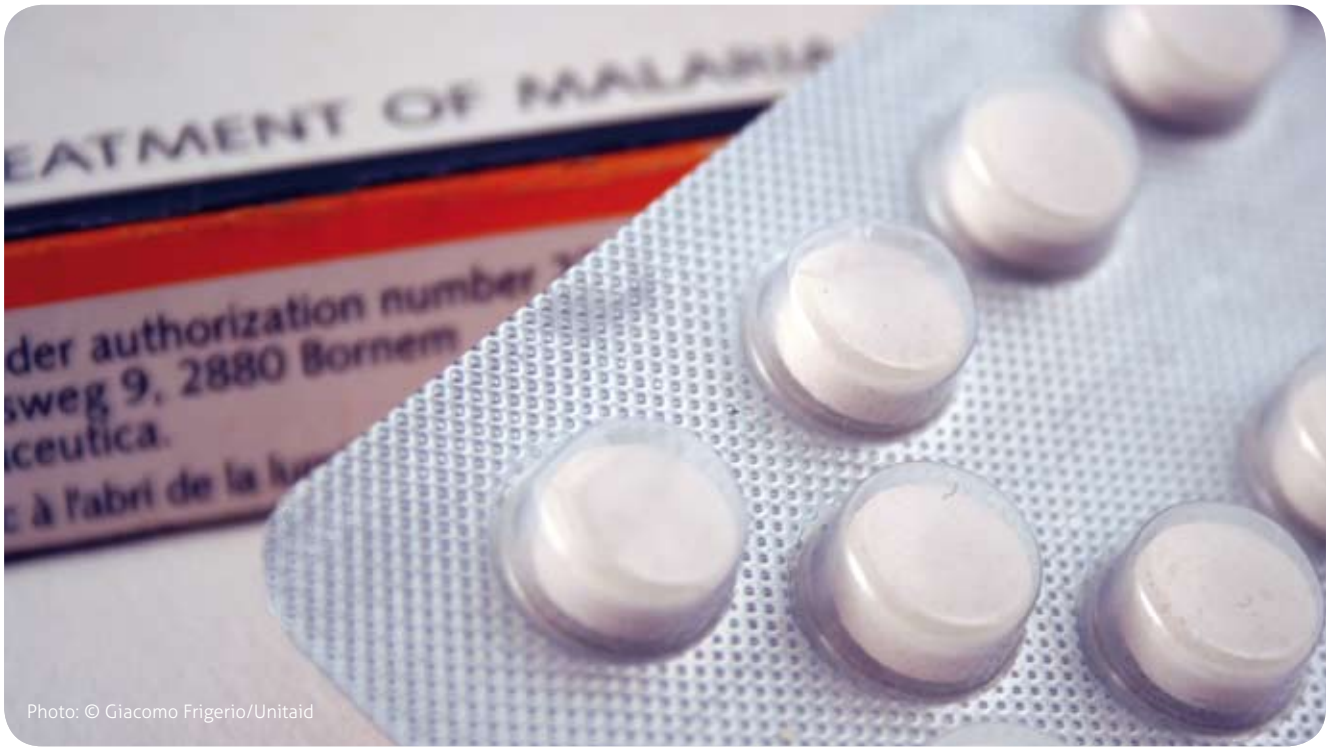


Photo: © Giacomo Frigerio/Unitaid

Getting Involved in Malaria Prevention:

Scaling up Bednet Provision

A highly-effective way to prevent malaria – especially among children younger than five years and pregnant women – is through the use of bednets that are treated with insecticides (Long-Lasting Insecticide-Treated Nets – LLINs). These repel, disable and/or kill mosquitoes coming into contact with the insecticide on the netting material.

However, the availability of bednets in low-income countries with high malaria prevalence has never been adequate: the purchase and distribution of bednets can take as long as two years because of delays in donor funding disbursement, lengthy in-country bidding processes for the nets, and the lead time required by companies to manufacture and deliver the products. According to the World Health Organization (WHO), the risk of a shortfall in the availability of bednets due to these delays could result in 200 000 additional deaths each year[20].

UNITAID is aiming to respond to this situation, marking its first investment in prevention products. UNITAID's Executive Board in 2008 approved funding of up US$ 109.2 million for a new project with UNICEF to provide 20 million LLINs for eight African countries in 2009 and 2010[21]. At the end of the project, the overall average increase in bednet coverage that will be achieved through UNITAID support is estimated at 20%. The partnership will also help countries achieve Roll Back Malaria targets of 80% insecticide-treated net use by the end of 2010.

The current market for delivering bednets is highly inefficient, largely due to delays in donor funding and lengthy country procurement processes. These delays negatively impact the achievement of a high level of bednet coverage by resulting in lower-than-expected orders, which in turn leads to stock build-up with manufacturers. In response, manufacturers scale down production, resulting in the fact that when funding does become available, manufacturers struggle to adequately meet the needs.

This project is applying UNITAID's model of impacting market dynamics. Ensuring long-term sustainable funding will allow for more predictable forecasting for orders. This, in turn, will send a signal to manufacturers to continue their production, resulting in a much more steady supply of bednets. The stability of UNITAID's funding is also expected to have an impact on prices.

Photo: © MHallahan/Sumitomo Chemical - Olyset® Net

20 Jeffrey Sachs, "Net Gains", April 2006 http://www.unmillenniumproject.org/documents/net_gains_jeffrey_sachs042906.pdf
21 Angola, Central African Republic, Congo, Democratic Republic of Congo, Guinea, Nigeria, Sudan (North & South), Zimbabwe

UNITAID's PATH FORWARD WITH MALARIA:

UNITAID is considering novel initiatives to support the fight against malaria in 2009 and beyond. These include:

Applying its market model to further support malaria prevention and treatment with rapid diagnostic tests, new ACTs and indoor insecticide sprays;

Approving up to US$ 130 million to the pilot phase of the Affordable Medicines Facility for Malaria (AMFm) – a global initiative that aims to make highly-effective ACTs more affordable and more widely available in areas with high malaria prevalence; and

Exploring mechanisms to ensure sustainable supplies of artemisinin for the production of ACTs through collaborative efforts with partners.

"AMFm is a truly innovative way of expanding access to malaria treatment, and we are grateful that UNITAID has made available substantial resources to try out this market mechanism over the coming years."

Dr. Michel Kazatchkine, Executive Director,
The Global Fund to Fight AIDS, Tuberculosis and Malaria

UNITAID's Commitment to the Affordable Medicines Facility for Malaria (AMFm)

Helping Make the Best Malaria Treatment the Most Affordable Malaria Treatment

Because of the high cost of artemisinin-based combination therapies (ACTs), people in high-prevalence areas are often forced to buy cheaper medicines that are not effective due to drug resistance, with results that are often fatal.

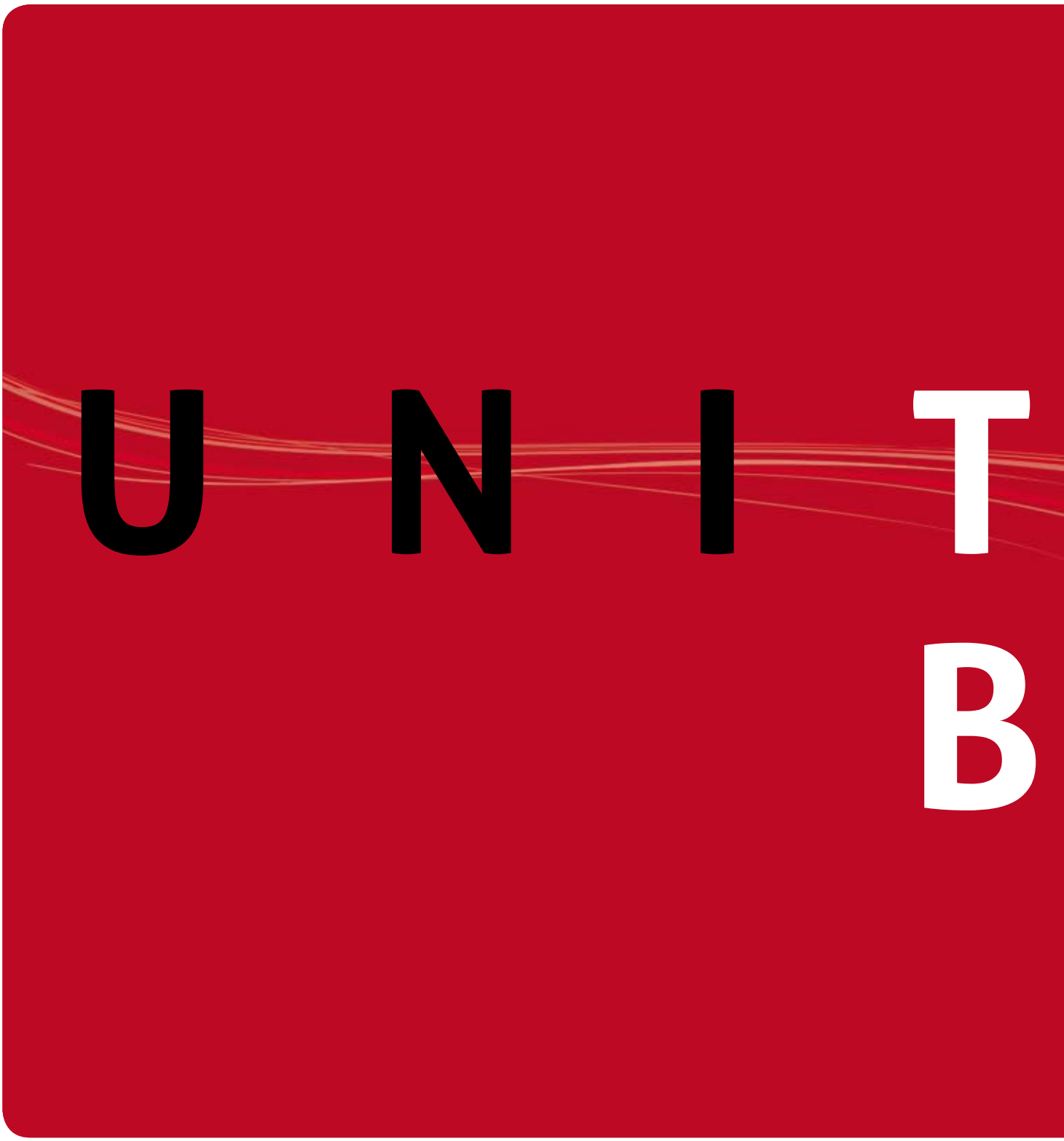
The Affordable Medicines Facility for Malaria (AMFm) is a new initiative that aims to provide affordable, effective and quality-assured ACTs for the public and private sectors in affected countries, with the ultimate goal of pushing substandard and no longer effective medicines out of the market. UNITAID is providing a crucial funding commitment to help test out the scheme, which is scheduled for launch in April 2009. Eleven countries have been identified as eligible for the pilot phase[22].

UNITAID will help increase people's access to effective treatment by playing a key role in price negotiations with manufacturers of ACTs. Together with its partners the Roll Back Malaria Partnership and the Global Fund to Fight AIDS, TB and Malaria, UNITAID will also lead global demand and supply forecasting for ACTs for the first two years of the project. This includes an assessment of global artemisinin production from the artemisia annua plant, which currently is grown primarily in China, Vietnam, Tanzania and Kenya.

The Global Fund and the United Kingdom are also contributing to the AMFm. Estimates project that the initiative will need up to US$ 340 million to implement and monitor the project over a period of two years.

Photo: © Giacomo Frigerio/Unitaid

22 Benin, Cambodia, Ghana, Kenya, Madagascar, Niger, Nigeria, Rwanda, Senegal, Tanzania and Uganda


U N I T
B

A I D

Helping fight the Curable Disease *that Continues to Kill*

Helping Fight the Curable Disease that Continues to Kill

A Rising Tide of Drug-resistant TB Poses Massive Challenges

Tuberculosis (TB) is a curable infectious disease that continues to take a deadly toll globally, particularly in developing countries – the World Health Organization (WHO) estimates that more than 1.7 million people died of TB in 2006, while more than nine million became infected, including nearly one million children[23].

The global HIV/AIDS pandemic poses greater treatment challenges, with HIV-positive people – who are particularly susceptible to infection because of weak immune systems – accounting for nearly 8% of new infections and 15% of TB deaths in 2006[24].

Further, there is an increasing emergence of drug-resistant strains of the disease, which no longer respond to the standard and most potent TB medicines. According to World Health Organization 2006 figures, half a million people are infected with multi-drug resistant TB worldwide. Drug resistance occurs primarily because of improper treatment of standard (drug-sensitive) TB, but resistant strains are also being spread from person to person.

Drug-resistant TB is both difficult to diagnose and treat, and is extremely costly – factors which lead to a major treatment access gap. The discovery of extensively drug-resistant TB (XDR-TB) over the last few years – for which there are virtually no treatment options left due to broad resistance – has added a further sense of urgency to find better ways to diagnose and treat the disease.

TB is a difficult disease to tackle, primarily because adequate diagnostic and treatment tools are severely lacking. Because TB is generally considered a part of history in most industrialised countries, investment into research and development for better tools to fight the disease remains woefully inadequate.

UNITAID, together with its partners the Global Drug Facility of the Stop TB Partnership, which supplies countries with TB medicines and diagnostics, the Green Light Committee, which focuses on providing countries with drugs to treat drug-resistant TB, and the Global Fund to Fight AIDS, TB and Malaria, is working to improve the global response to TB by:

- Helping improve the availability of quality-assured MDR-TB treatment, increase treatment access and pushing for price reductions by encouraging the entry of more manufacturers into the market;
- Promoting the scale-up of MDR-TB diagnosis using new rapid diagnostic tests which reduce the period required to diagnose MDR-TB from as many as three months to two days;
- Addressing the specific needs of children with TB by ensuring access to child-strength TB medicines, and promoting the development of new paediatric formulations for children under four years of age; and
- Helping curb the emergence of resistant TB strains by ensuring that first-line TB treatment is readily accessible and available in countries; supporting stockpiles of first-line drugs to prevent the need for expensive emergency orders, and pushing for price reduction and stabilization.

23 WHO Report 2008 Global Tuberculosis Control Surveillance, Planning, Financing
24 WHO Report 2008 Global Tuberculosis Control Surveillance, Planning, Financing

UNITAID became a major stakeholder in a number of global efforts to address TB in 2008. The agency worked with the Stop TB Partnership's Global Drug Facility to increase access to quality-assured paediatric, first-line and second-line TB medicines, and with the Foundation for Innovative and New Diagnostics (FIND) to accelerate detection of MDR-TB. TB projects supported by UNITAID benefited people in 72 countries across Eastern Europe, the Middle East, Africa, Asia, Latin America and the Caribbean.

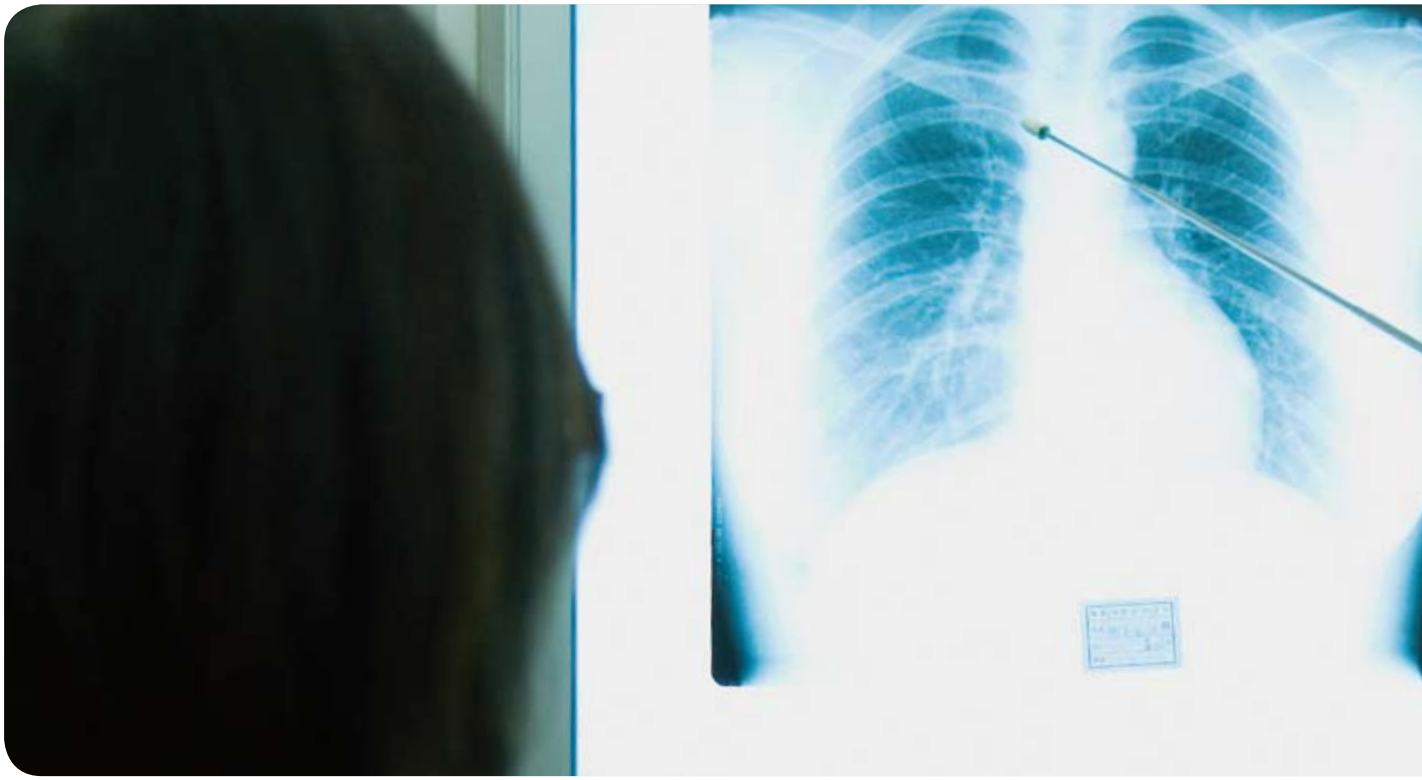
Photo: © Philippe Levy

PUSHING FOR SCALE-UP OF MDR-TB DIAGNOSIS AND TREATMENT

UNITAID GOALS:

- Increase access to MDR-TB diagnosis and treatment;
- Increase the number of quality manufacturers and products;
- Decrease drug delivery lead times and prevent treatment interruptions; and
- Work on reducing the price of quality-assured MDR-TB drugs by increasing demand and using a pooled procurement model.

Because of difficulties to diagnose MDR-TB and the lengthy and extremely expensive treatment it requires, countries have a limited capacity to address the disease effectively. UNITAID in 2008 disbursed approximately US$ 4.9 million to the Global Drug Facility to purchase 1 598 MDR-TB treatment courses for Global Fund grantees and countries participating in Stop TB Partnership programmes, reaching people in 17 countries across Africa, the Middle East, Asia and Europe[25].



25 Azerbaijan, Dominican Republic, Lesotho, Republic of Moldova, Timor-Leste, Burkina Faso, Cambodia, Democratic Republic of Congo, Guinea, Haiti, Kenya, Kyrgyzstan, Malawi, Mozambique, Myanmar, Nepal, Uzbekistan

MDR-TB: Tough Treatment, Difficult Diagnosis

Treating MDR-TB is a lengthy and often unsuccessful process, due primarily to inadequate treatment and diagnostic tools. It requires patients to submit to treatment for up to two years, whereby they need to take a large number of pills per day and receive painful daily injections. Many of the medicines on the market are sub-standard. Even the quality-assured treatments have significant side effects and are expensive. A treatment course of 24 months for one patient with MDR-TB can cost between US$ 1 500 and US$ 9 100 as there are few manufacturers in the market that produce quality-assured medicines. So far, only two medicines by one manufacturer have received prequalification status by the World Health Organization.

Diagnosing MDR-TB has also been a major difficulty, especially in resource-poor settings, where access to laboratories with sophisticated equipment can be limited. Identifying MDR-TB, and precisely determining the individual drugs to which a patient is resistant, can require growing specimens for up to three months in a laboratory – delays that can be life-threatening to very ill patients. Lack of diagnostic capacity in countries, in turn, hinders effective MDR-TB treatment scale-up.

Difficulty treating and diagnosing MDR-TB has led to the fact that, according to Stop TB Partnership 2006 figures, fewer than 2.5% of the approximately 500 000 people who have developed MDR-TB receive the appropriate treatment. This is largely because without access to simple diagnostics, fewer than 5% of cases are identified[26].

MDR-TB is an incredibly difficult disease for countries to manage effectively. In the long term, there is an urgent need for shorter and more potent treatment, but in the short term, there is an urgent need to scale up MDR-TB diagnosis and treatment with existing tools.

Photo: © Jack Wild/GettyI mages

26 WHO Report 2008, Global tuberculosis control http://www.who.int/tb/publications/global_report/2008/chapter_2/en/index3.html

RESPONDING TO THE URGENCY OF MDR-TB

By March 2008, countries with pending orders were able to receive medicines from the UNITAID-financed Strategic Rotating Stockpile (SRS), which supplied 800 patient treatments. The success of the SRS resulted in UNITAID approving an additional US$ 9.6 million to the Stockpile which will now have the capacity to service a total of 5 800 patient treatments. All Green Light Committee (GLC) approved country programmes, including Global Fund grantees will have access to this facility.

Expanding MDR-TB Treatment and Ensuring Emergency Stock

UNITAID, together with its partners the Global Drug Facility of the Stop TB Partnership, the Green Light Committee and the Global Fund to Fight AIDS, TB and Malaria, are working to increase the number of patients that have access to MDR-TB treatment (see box above). A special emphasis is being placed on accelerating treatment scale-up by decreasing drug delivery lead times.

Further, UNITAID is ensuring that treatment interruptions are avoided by fully funding the Strategic Rotating Stockpile – a storehouse of medicines to treat MDR-TB, located in Amsterdam. The stockpile enables people with MDR-TB to receive treatment within three weeks of the medicines being ordered, as opposed to the customary three to six months. As countries place emergency orders, the medicines are continually restocked. Stockpiles also help keep costs down, as the project's goal is to achieve price reductions of up to 25% by 2011.

Acting as a Catalyst to Break the Vicious Circle of MDR-TB Treatment

The difficulty in addressing MDR-TB is compounded by the lack of quality medicines to treat it. While there is a surplus of MDR-TB medicines on the market, only two have received quality assurance through the World Health Organization's Prequalification Programme. Part of the effort therefore needs to be to encourage more quality-assured manufacturers to enter the market, and to discourage use of non-quality-assured medicines, which may have dubious therapeutic value and could provoke further drug resistance.

MDR-TB medicines have a short shelf life – 18 months, against the 18 to 24 months needed for treatment. This means that the medicines need to be manufactured on demand, which poses enormous logistical challenges as the production of MDR-TB drugs can take up to six months. Companies serious about providing quality products have little incentive to embark on massive production unless they can be assured of a predictable market.

UNITAID is applying its unique market model to break this vicious circle. Through predictable, sustainable funding, long-term demand should increase and more quality-assured producers will see an incentive to enter the market. This, in turn, should help improve drug quality, shorten lead times and ultimately eliminate the need for buffer stocks.

Further, the larger purchase volumes associated with increased demand should help drive production costs down through economies of scale, while increased competition among multiple manufacturers should also lead to price reductions. The Green Light Committee expects MDR-TB drug prices to fall by up to 25% by 2011.

Rolling Out a Revolutionary Rapid Diagnostic

A new diagnostic test is now available which cuts the time it takes to diagnose MDR-TB from up to three months down to only two days. This 'line probe assay', which has been recommended by the World Health Organization (WHO), represents a revolution in MDR-TB diagnosis, and will facilitate treatment of patients, as well as contribute to the ability to forecast demand for MDR-TB medicines. This, in turn, should also have an impact on price, availability and quality of treatment; UNITAID's strategic value here is the dual approach of supporting faster diagnosis and quality-assured treatment.

UNITAID announced in June 2008 that it would commit US$ 26 million to fund these tests over a three year period until 2011, with the aim of facilitating the response to 15% of the global MDR-TB burden, representing a three-fold increase over the current 5% being diagnosed. In 2008, UNITAID allocated approximately US$ 9 million to the Stop TB Partnership's Global Drug Facility and to the Foundation for Innovative New Diagnostics (FIND) to begin rollout of tests to 16 countries across Africa, Asia and Europe[27].

The Global Drug Facility is working with WHO's Global Laboratory Initiative and FIND to help countries prepare for the installation and use of the diagnostic tests. By the end of 2008, Ethiopia and Lesotho were ready to start rolling out the tests. The project aims to enable reliable diagnosis for 74 000 people with MDR-TB by the end of 2011.

Photo: © Giacomo Frigerio/Unitaid

27 Azerbaijan, Bangladesh, Côte d'Ivoire, the Democratic Republic of Congo, Ethiopia, Georgia, Indonesia, Kazakhstan, Kyrgyzstan, Lesotho, Republic of Moldova, Myanmar, Tajikistan, Ukraine, Uzbekistan, Vietnam

EXPANDING ACCESS TO TUBERCULOSIS TREATMENT FOR CHILDREN

UNITAID's GOALS:

Provide child-friendly TB medicines to children under 15 years of age, reaching a total of over 750 000 treatments by 2011; and

Ensure the development and supply of new child-friendly TB formulations for infants under four in at least 58 countries by 2011.

Despite the fact that children make up as much as 20% of new cases of active tuberculosis in high-burden settings[28], paediatric TB remains largely neglected. And as is also the case for many other diseases, the development of appropriate and adapted paediatric TB drug formulations consistently lags behind that of adults.

UNITAID in 2008 worked to increase access to child-friendly TB treatments with its partner the Stop TB Partnership's Global Drug Facility, which purchased more than 117 361 TB treatments adapted for children for use in 36 countries across Africa, Asia and the Middle East[29]. By helping increase the number of manufacturers, the partnership also achieved price reductions for paediatric TB medicines of up to 18%. In addition, UNITAID's funding support to WHO has facilitated the prequalification of the first ever paediatric TB medicine[30].

Ma Kay's Story

Ten-year old Ma Kay Zin Aung is from a small village in Ayeyarwaddy Division in Myanmar. She receives child-friendly TB treatment through UNITAID's support of the Global Drug Facility. Ma Kay began her six-month treatment in November 2008, after testing positive for TB. Before being put on treatment, she suffered from coughing, loss of appetite, weight loss, night sweats and fever. A volunteer health worker, who lives near her family's house, brought her to a nearby health clinic for a chest x-ray. After testing positive, Ma Kay was immediately put on paediatric TB medicines provided through UNITAID. Ma Kay says she is feeling much better and is hopeful she will be cured after getting the six-month treatment.

28 Science Daily, Lack Of Tuberculosis Trials In Children Unacceptable, August 2008 http://www.sciencedaily.com/releases/2008/08/080818220559.htm
29 Afghanistan, Bangladesh, Benin, Burundi, Cambodia, Cameroon, Cape Verde, Congo, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Gambia, Guinea, Guinea Bissau, Indonesia, Iraq, Jordan, Kazakhstan, Kenya, Kyrgyzstan, Lebanon, Lesotho, Macedonia, Madagascar, Malawi, Mali, Mauritania, Niger, Nepal, Pakistan, Rwanda, Somalia, Tajikistan, Yemen, Zambia
30 INH 100 mg

A FIRST-LINE OF DEFENCE AGAINST EMERGING RESISTANCE: IMPROVING FIRST-LINE TB TREATMENT

UNITAID's GOALS:

Provide ready access to affordable first-line medicines and minimize the risk of stock-outs by supporting diagnosis and treatment of 866 373 patients by 2011; and

Achieve first-line TB drug price stabilization and reduction.

Through UNITAID's funding support, the Stop TB Partnership's Global Drug Facility was able to increase provision of first-line TB treatments at short notice to reach 451 000 people in 15 countries across Africa, Asia, the Middle East and Europe[31].

Standard first-line TB treatment requires a patient to take antibiotics daily for a minimum of six months. An unfinished treatment course can lead to treatment failure and the emergence of drug resistance, requiring patients to submit to even longer treatment – lasting up to two years – with expensive and more invasive drugs that carry significant side effects. The first line of defence against the development of drug-resistant TB, therefore, is broad access to first-line TB treatment with appropriate patient treatment follow-up.

The price of first-line TB medicines has gradually increased in recent years. Further, interruptions in supply – called 'stock outs' – can contribute to the danger of creating resistance through treatment interruption.

In response, UNITAID, through its partner the Global Drug Facility (GDF) of the Stop TB Partnership, is ensuring there is steady availability of first-line drugs in countries by supporting the creation and implementation of a strategic rotating stockpile of first-line TB drugs. UNITAID is also working to stabilize and further reduce prices for first-line drugs by strengthening the purchasing power of GDF through the predictable, long-term funding it provides.

"We need scientific and technologic innovation, such as new medicines and vaccines, but we also need innovative ways to ensure that scientific progress benefits those who need it. That's where UNITAID makes the difference."

Bill Gates, Le Figaro, 25 February 2008

31 Bangladesh, Bosnia and Herzegovina, Cameroon, Guinea, Iraq, Kenya, Madagascar, Mali, Mozambique, Myanmar, Niger, Nigeria, Tajikistan, Togo and Uganda

UNITAID's PATH FORWARD WITH TUBERCULOSIS:

UNITAID is considering novel initiatives to support the fight against tuberculosis in 2009 and beyond. These include:

Supporting the manufacture of selected Active Pharmaceutical Ingredients to increase the number of producers and to stabilize prices;

Increasing financing for quality-assured second-line TB drugs and creating incentives for new manufacturers to enter the market; and

Supporting new technologies to improve the quality of diagnosis.

Photo: © Kazuyoshi-Nomachi/Corbis

INVESTING IN QUALITY

Photo: © Giacomo Frigerio/Unitaid

INVESTING IN QUALITY

UNITAID continued to support the WHO Prequalification Programme to increase the availability of quality medicines for procurement in developing countries. Through UNITAID support, 21 medicinal products were quality assured in 2007, and 40 in 2008, two thirds of which are priority medicines for UNITAID. This doubled the number of UNITAID's quality-assured priority medicines.

The WHO Prequalification Programme

The World Health Organization (WHO) established its Prequalification Programme in 2001. The purpose of the Programme is to increase access to medicines that meet unified standards of acceptable quality, safety and efficacy for HIV/AIDS, malaria and tuberculosis. From the outset, the Programmme was supported by UNAIDS, UNICEF, UNFPA and the World Bank as a concrete contribution to the United Nations priority goal of addressing widespread diseases in countries with limited access to quality medicines.

Manufacturers wishing their products to be included in the WHO list must present extensive information and open their manufacturing sites to an inspection team that assesses working procedures for compliance with WHO Good Manufacturing Practices (GMP). The assessment teams evaluating the products and manufacturers include experts from some of the national regulatory authorities.

The Prequalification Programme does not intend to replace national regulatory authorities or national authorization systems for the importation of medicines. Prequalification draws on the expertise of some of the best national regulatory authorities to provide a list of prequalified products that comply with unified international standards.

The list of prequalified medicinal products produced by the Programme is used principally by United Nations agencies – including UNAIDS and UNICEF – NGOs and governments to guide their procurement decisions. The list has, however, become a vital tool for any organization involved in the bulk purchase of medicines, both at national and international levels.

HELPING EXPAND THE NUMBER OF QUALITY MEDICINES TO FIGHT HIV/AIDS, MALARIA AND TB

There is high demand for affordable medicines to treat HIV/AIDS, malaria and TB in developing countries, and ensuring these medicines are quality-assured is critical to achieving effective treatment. UNITAID provides funding for HIV/AIDS, malaria and tuberculosis (TB) treatment only to projects that use medicines that are quality-assured by the World Health Organization (WHO), or by another stringent regulatory agency. Therefore, UNITAID's support of WHO's Prequalification Programme has a direct positive impact on UNITAID's efforts to tackle the three diseases, with the number of quality-assured medicines that address UNITAID priority areas having doubled.

UNITAID's support to WHO's Prequalification Programme in 2008 helped make available a number of products, including:

- Five medicines to treat HIV/AIDS, including two new triple fixed-dose combinations;
- Four medicines to treat TB, including two new fixed-dose combinations and one new paediatric formulation; and
- Six ACT medicines to treat malaria, including four fixed-dose combinations and two paediatric formulations.

By providing long-term, sustainable funding to the Prequalification Programme, UNITAID is supporting WHO quality assurance as a free-of-charge public service for manufacturers. Further, by helping facilitate and accelerate the process for manufacturers to gain quality assurance, UNITAID is encouraging generic manufacturers to enter the market. This, in turn, helps foster the market competition that brings prices down, resulting in lower prices for HIV/AIDS, malaria and TB drugs.

Support of the Prequalification Programme additionally aims to increase in-country capacity for production of priority medicines and their quality control, as well as for national regulation, in order to hasten regulatory uptake of medicines in recipient countries. UNITAID is also supporting the development and updating of global norms and quality standards, which help further ensure the production and regulation of quality assured medicines.

Further activities have included increasing the number of prequalified laboratories used for quality control from three to eight by the end of 2008; implementing four comprehensive sampling and testing programmes; doubling the number of training workshops for capacity building in resource-limited countries; and tripling the technical assistance missions to pharmaceutical manufacturers, in order to help support their capacity to improve the quality of their products.

UNITAID's Path Ahead with Medicines Quality:

By the end of 2009, UNITAID, through its support of the WHO Prequalification Programme, is aiming for:

- Assessment, inspection and prequalification of approximately 50 additional UNITAID priority products;
- Re-assessment and maintenance of the list of UNITAID-supplied products already prequalified; and
- Prequalification of selected Active Pharmaceutical Ingredients (APIs) for UNITAID-supplied products.

PROJECTS AT A GLANCE

PROJECT FUNDING APPROVED BY UNITAID'S EXECUTIVE BOARD

New Projects in 2008	Amount in US$
MDR-TB Acceleration of Access	33 690 000
MDR-TB Diagnostics--Expanding and Accelerating Access to Diagnostics for Patients at risk of MDR-TB	26 129 897
Accelerating Scale-up of Long-Lasting Insecticide-treated Nets (LLINS)	109 250 000
Project aiming to Ease and Safeguard the Availability of ARV treatment and its good management for people living with HIV/AIDS	15 950 000
Prequalification of UNITAID Priority Diagnostics	7 500 000
TOTAL	**192 519 897**

Continuing Projects	Amount in US$
Extension of PMTCT-RUTF	4 764 228
Prequalification of UNITAID priority medicines	40 000 000
PMTCT	50 009 221
Extension to paediatric TB	5 938 952
Additional support to MDR-TB Scale-up Initiative	16 842 000
Extension to the UNITAID-CHAI paediatric HIV/AIDS project	63 736 788
Extension to the UNITAID-CHAI second line HIV/AIDS project	75 989 000
TOTAL	**257 280 189**

TOTAL 2008	449 800 086

Note: the above table represents ceiling amounts approved by the UNITAID Executive Board, which are subject to further negotiation prior to signing legal agreements.

PARTNERS: WORKING TOWARDS THE COMMON GOAL OF EXPANDING ACCESS TO HEALTH

UNITAID works with partners active in the fight against HIV/AIDS, malaria and tuberculosis. In assessing partners' requests for funds UNITAID, through the Executive Board, selects projects that are committed to influencing UNITAID's niches for medicines, diagnostics and related commodities and have an expected positive impact on the market. All UNITAID funding requests are reviewed by an advisory group of external experts.

Once a project has been approved and the money committed, the implementing partner and UNITAID enter into negotiations with quality-assured manufacturers to achieve two main goals: ensuring that the needed products are available in a timely manner and reducing their price through bulk-purchasing and pool procurement. Having secured these objectives, the partners purchase the products and supply them to countries through national partners which may include governments, NGOs and procurement agents. UNITAID is in regular communication with partners and systematically monitors projects' progress and results.

In order to refine its process for assessing project proposals, UNITAID set up an Interim Expert Advisory Group in 2008 to screen and evaluate project submissions against UNITAID's strategic objective of achieving health outcomes through market impact. In 2009, the organization will establish a formal, independent, impartial technical review group, the Proposals Review Committee, made up of external experts in public health, market dynamics, health economics, supply chain management and intellectual property.

As of the end of 2008, UNITAID's partners included:

WHO, UNICEF, UNAIDS,
THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA,
ROLL BACK MALARIA PARTNERSHIP,
STOP TB PARTNERSHIP, FOUNDATION FOR INNOVATIVE NEW DIAGNOSTICS,
THE WILLIAM J. CLINTON FOUNDATION, HIV/AIDS INITIATIVE
AND THE GLOBAL DRUG FACILITY.

UNITAID AND WHO

In line with the Memorandum of Understanding signed at its inaugural ceremony at the United Nations on 19 September 2006, WHO serves as UNITAID's trustee and also hosts its Secretariat. WHO was a natural choice for UNITAID, given its role as the coordinating authority on international health. WHO offers UNITAID a strategic platform from which to operate and provides important legal, financial, administrative and technical support. Although UNITAID's Secretariat does not constitute a separate legal entity within WHO, it enjoys a large degree of autonomy and is free to take a flexible approach to fulfilling its mission objectives.

Use of WHO's legal, financial and administrative services provides an added assurance to the proper use of UNITAID's resources. UNITAID derives significant benefits from its proximity to WHO programmes in HIV/AIDS, malaria, tuberculosis, and health systems as well as from the global network of WHO regional and country offices. These include WHO advice on norms and standards as well as technical and policy support to its member states.

UNITAID collaborates closely with WHO technical units, and relies on WHO guidelines for managing the control of diseases. The organization is also a major supporter of the WHO Prequalification Programme

Photo: © WHO

MEASURING OUR PERFORMANCE

For UNITAID, monitoring and evaluation involve working with partners to define a legal and operational framework for their project plans. The framework allows planners and others to see clearly how the project contributes to the overall goals of UNITAID; i.e. to have a long-term, sustainable impact on the market for key medicines, diagnostics and related commodities. Key components of UNITAID's strategic focus that need to be measured over the course of the project are:

ACCESS	Reaching target patient populations with treatments;
AVAILABILITY	Increasing availability of new drug formulations and medical products in the market and increasing the number of manufacturers of these products;
QUALITY	Ensuring the quality of new formulations/products and new manufacturers in the market through support to and partner interaction with the WHO Prequalification Programme;
PRICE	Price reduction (or price containment, depending on products and niche) of the product(s) over the course of the project; and
DELIVERY	Ensuring timely delivery of products from manufacturers to countries to meet programme needs for treatment.

From this framework comes a set of indicators for reporting on project performance. It is important to remember that these indicators are not static, but evolve over the course of the project, particularly if the project focus changes as specific objectives are achieved.

Since UNITAID's overall objective is to serve the needs of the poorest countries and most vulnerable populations, it dedicates at least 85% of its funds to providing health commodities to low-income countries. UNITAID uses less than 10% of its funds to purchase products for lower middle-income countries and less than 5% for upper middle-income countries. These eligibility criteria are a key consideration in the monitoring and evaluation framework of our partners' projects.

DONORS

"Finding new flows of development finance is crucial if the world is to meet its ambitious series of anti-poverty goals by the target date of 2015."

UN Secretary-General Ban Ki-moon

Brazil, Chile, France, Norway and the United Kingdom launched UNITAID in September 2006 to respond to the need for additional, innovative sources of funding for global health and development. By the end of 2008, UNITAID's membership grew from five in 2006 to 29 countries and one foundation. The majority of UNITAID's member countries are African. In 2008 three new countries announced contributions to UNITAID - Cyprus, Jordan and Luxembourg .

UNITAID receives its funds through airline ticket taxes or regular budget contributions. Countries implementing the airline tax as of the end of 2008 include Chile, Côte d'Ivoire, Democratic Republic of Congo, France, Madagascar, Mauritius, Niger and the Republic of Korea. Norway allocates part of its tax on carbon dioxide emissions from air travel to UNITAID. Jordan joined UNITAID in late 2008 and declared its intention of introducing the air tax. In addition, two African countries – Kenya and Burkina-Faso – pledged their intention of introducing the air tax in the near future to support UNITAID.

Countries that made regular budget contributions to UNITAID in 2008 include Brazil, Cyprus, Luxembourg, Spain, the United Kingdom. The Bill & Melinda Gates Foundation also provided funding support.

Countries that have signed an agreement to support UNITAID in the future include Benin, Burkina Faso, Cameroon, Central African Republic, Congo, Gabon, Guinea, Liberia, Mali, Morocco, Namibia, Senegal, São Tomé and Principe, South Africa and Togo.

Since UNITAID funds come from innovative additional sources that are sustainable and predictable, the organization impacts on the market in a way that expands access to more and better patient-adapted products. The viable business model based on long-term forecasting enables UNITAID to guarantee high volume purchases and pool procurement which in turn encourages manufacturers to invest in the development of new medicines and high volume production. As a result, prices come down and UNITAID and its partners can supply more medicines and diagnostics to patients.

For example, the price reduction obtained by CHAI for paediatric antiretroviral medicines since November 2006 has enabled three times more children living with HIV to be treated for the same amount of money. UNITAID funding has also enabled the development of new medicines that are better adapted to patients' needs, for example, one-pill treatments rather than several tablets a day.

"UNITAID is a brilliant and innovative approach for collecting funds for health commodities which will be sustained as long as people keep flying. As such these funds are less vulnerable to political decisions and developmental budgets and their flexibility means they can be tapped immediately if necessary to save lives and safeguard services."

Professor Awa Marie Coll-Seck, Executive Director, Roll Back Malaria Partnership

"Four years ago, along with several world leaders, I launched here in New York the International Action against Hunger and Poverty. Our proposal, then and now, has been to adopt innovative funding mechanisms.

The UNITAID Drug Purchase Facility is one early result of that initiative, helping to fight AIDS, tuberculosis and malaria in several African countries."

President Luiz Inacio Lula da Silva of Brazil, 63rd
United Nations General Assembly, September 2008

Photo: © Eric Le Feuvre

HOW THE AIR TAX WORKS

One extra dollar makes little difference to a passenger – to a child with malaria, it can mean the difference between life and death.

The solidarity contribution on airline tickets represented 72% of UNITAID's financial base by end 2008 and was complemented by multi-year budgetary contributions from a number of member countries. As of November 2008, seven of UNITAID's 29 member countries were implementing the airline tax.

The tax on airline tickets is applied to all airlines departing from countries that impose it and is paid by passengers when purchasing their tickets, normally as an addition to existing airport taxes. Airlines are responsible for declaring and collecting the levy. Passengers in transit are exempt, thus avoiding any further administrative burden for airports in participating countries. The solidarity levy respects countries' tax sovereignty.

For passengers, the cost of the tax is very low compared to the total cost of a ticket; it can range from US $ 1 for economy tickets to US $ 40 for business and first class. Different rates can be set according to countries' level of development and there is an extra option to vary the charge according to the distance travelled. For example, some countries in Africa have chosen to impose the levy only on international flights or business and first class tickets.

At the end of 2008, the ticket levy was implemented in the following countries: Chile, Côte d'Ivoire, France, Republic of Korea, Madagascar, Mauritius and Niger. Norway allocates part of its tax on carbon dioxide emissions from fuel to UNITAID.
Additional countries aiming to introduce an airline ticket levy include: Benin, Burkina Faso, Cameroon, Central African Republic, Gabon, Guinea, Kenya, Liberia, Mali, Morocco, Namibia, Senegal, São Tomé and Principe, and Togo.

In simple terms, a US$ 2 contribution on an airline ticket purchase in Chile is equivalent to two paediatric treatments for malaria. A business class ticket bought in Niger for international travel generates US$ 24 tax, which is sufficient to cure an adult of first-line TB. And the EURO 40 tax on a business class ticket bought in France can treat a child with HIV for one year.

Photo: © Kevin Fleming/Corbis

GOVERNANCE

Executive Board

The Executive Board makes all decisions relating to UNITAID strategy and policy (except for those delegated to the Secretariat). For example, the Executive Board determines UNITAID's objectives, scope and work plan and approves all partnership arrangements with other organizations and institutions. It also monitors UNITAID's progress, approves UNITAID budgets and financial commitments and participates in the performance review of the Executive Secretary. The Board generally takes its decisions by consensus.

The Executive Board consists of 11 members:

- One representative nominated by each of the five founding countries (Brazil, Chile, France, Norway and the United Kingdom);
- One representative of African countries designated by the African Union;
- One representative of Asian countries;
- Two representatives of relevant civil society networks (non-governmental organizations and communities living with HIV/AIDS, malaria and tuberculosis);
- One representative of the constituency of foundations; and
- One representative of the World Health Organization.

"UNITAID is a shining example of an innovative source of funding that can help us reach the MDGs'."

Kofi Annan, 19 September 2006

Members of the UNITAID Executive Board

Chair of the Board	***Philippe Douste-Blazy*** Special Adviser on Innovative Financing for Development - UN Under-Secretary-General
Brazil	***Antonio Carlos do Nascimento Pedro*** Minister - Ministry of External Relations - Brasilia, Brazil
Chile	***Fernando Muñoz*** Attaché - Permanent Mission of Chile to the United Nations and other International Organizations - Geneva, Switzerland
France	***Louis-Charles Viossat*** HIV/AIDS Ambassador - Ministry of Foreign Affaires - Paris, France
Norway	***Sissel Hodne Steen*** Counsellor - Permanent Mission of Norway to the United Nations and other International Organizations - Geneva, Switzerland
United Kingdom	***Gavin McGillivray*** Head - International Financial Institutions Department, DFID - London, United Kingdom
African countries	***Damase Bodzongo*** Director General of Health - Ministry of Health - Brazzaville, Congo
Asian countries	***Park Kang-ho*** Director General - Development Cooperation Bureau Ministry of Foreign Affairs and Trade of the Republic of Korea - Seoul, Republic of Korea
Non-governmental organizations	***Khalil Elouardighi*** Plaidoyer - PLUS Coalition International Sida - Paris, France
Communities living with the diseases	***Carol Nawina Nyirenda*** Treatment Advocacy & Literacy Campaign, TALC - Lusaka, Zambia
Constituency of foundations	***Joe Cerrell*** Director of Global Health Policy & Advocacy The Bill & Melinda Gates Foundation - Seattle, United States
WHO	***Namita Pradhan*** Representative of the Director-General for Partnerships and UN Reform World Health Organization - Geneva, Switzerland

UNITAID was officially launched on 19 September 2006 in New York at the opening session of the United Nations General Assembly by France's President Jacques Chirac, Brazil's President Luiz Inacio Lula da Silva, Norway's Prime Minister Jens Stoltenberg, Chile's Minister of Foreign Affairs Alejandro Foxley Rioseco, the United Kingdom's Parliamentary Under-Secretary of International Development Gareth Thomas, United Nations Secretary-General Kofi Annan, the Republic of the Congo's President Denis Sassou-Nguesso and former United States President Bill Clinton.

Photo: © Unitaid

Consultative Forum

The annual Consultative Forum serves as a platform for debate, advocacy, fund raising and inclusion of new partners. It provides feedback, recommendations and advice for consideration by UNITAID's Executive Board.

UNITAID hosted its Second Consultative Forum on 6 December 2008 in Dakar, Senegal. The all-day meeting attracted over 100 participants including Ministers of Health from Burkina Faso, Kenya, Senegal and Zambia. International and national non-governmental organizations, community-based organizations, communities living with HIV/AIDS, malaria and tuberculosis, partner agencies were also present and members of UNITAID's Executive Board and Secretariat were also present.

The Forum was an opportunity for UNITAID to present its achievements over the last two years and to obtain partners' views and suggestions on the way forward. The Forum's recommendations will feed into future discussions and considerations by UNITAID's Executive Board and Secretariat.

Secretariat

UNITAID's Secretariat is responsible for carrying out and managing day-to-day operations and for coordinating implementation of UNITAID's work plan. It prepares proposed work plans and budgets for approval by the Board and reports on the results of the actions undertaken and the use of resources. The Secretariat manages relationships with partners to ensure project and financial monitoring. It also provides support to the Consultative Forum, a platform for debate, advocacy, fundraising and the inclusion of new partners.

The Secretariat is hosted by WHO in Geneva, Switzerland. Its operations, including recruitment, procurement, finance and management of the UNITAID Trust Fund, are administered in accordance with World Health Organization rules and regulations. The relationship with WHO is governed by a hosting agreement, which allows adaptations or exceptions to WHO administrative procedures and practices to allow UNITAID to fulfill its mandate.

Expenses related to the Secretariat of UNITAID have been kept low in line with UNITAID's goal of operating in a manner that minimizes overhead costs. The Secretariat, headed by Dr. Jorge Bermudez, Executive Secretary, currently consists of 30 people representing 22 nationalities. The working languages are English and French.

Staff

Jorge Bermudez, Executive Secretary
Philippe Duneton, Deputy Executive Secretary

Ganzorig Arslaanbatar, Budget and Finance Officer
Daniela Bagozzi, Senior Communication Adviser
Marie Boroli, Assistant
Pascale Daou, Technical Officer, Donor Tracking
Imelda De Leon, Portfolio Manager, Malaria
Nicoletta De Lissandri, Assistant to Executive Secretary
Kvetka Dzackova, Budget Finance Officer
Ivan Ginet, Assistant
Elizabeth Hoff, Chief, Operations
Louise Kleberg, Technical Officer, Proposals
Frédéric Martel, Programme Officer
Joele Renée Ndjesse-Atouga, Secretary
Paola Martinez-Sotelo, Assistant
Sarah Mascheroni, Technical Officer, Events
Joyce Matovu, Assistant
Gelise McCullough, Technical Officer
Paulo Meireles, Portfolio Manager, HIV/AIDS
Kothi Veer Narasimhan, Technical Officer, Human Resources
Iqbal Nandra, Campaign Manager
Lisa Regis, Portfolio Manager, Tuberculosis
Meera Sobarun, Finance Officer
Dirk Steller, Finance Officer
Kate Strong, Monitoring & Evaluation Officer
Helga Theil, Assistant
Ellen 't Hoen, Senior Adviser, Intellectual Property
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UNITAID Financial Highlights 2008

Introduction

It is a pleasure to present the UNITAID financial highlights for the year ended 2008. They complement the Financial Report 2008 which has been prepared under the United Nations System Accounting Standards and generally follow many of the requirements of International Public Sector Accounting Standards (IPSAS). The Report, which was submitted to the Executive Board under separate cover, is available on the website (http://www.unitaid.eu).

The Financial Report aims to provide transparency and accessibility to financial information disclosed by UNITAID. It is an important element in the overall framework of accountability and financial integrity of the Organization, enabling partners and collaborators to see how their funds have been used.

Financial highlights

UNITAID was created on 18 September 2006 and the following Statement of Financial Performance (or revenue and expense account), which compares the first 15.5 months of its existence with the 12 months of 2008, shows that it has consolidated its position through increased expenditure on projects (Direct Financial Cooperation) which has increased by 60 per cent compared to the previous period as well as comprising an increased share of total operating expenditure (up by 2 per cent from 95.7 to 97.7 percent):

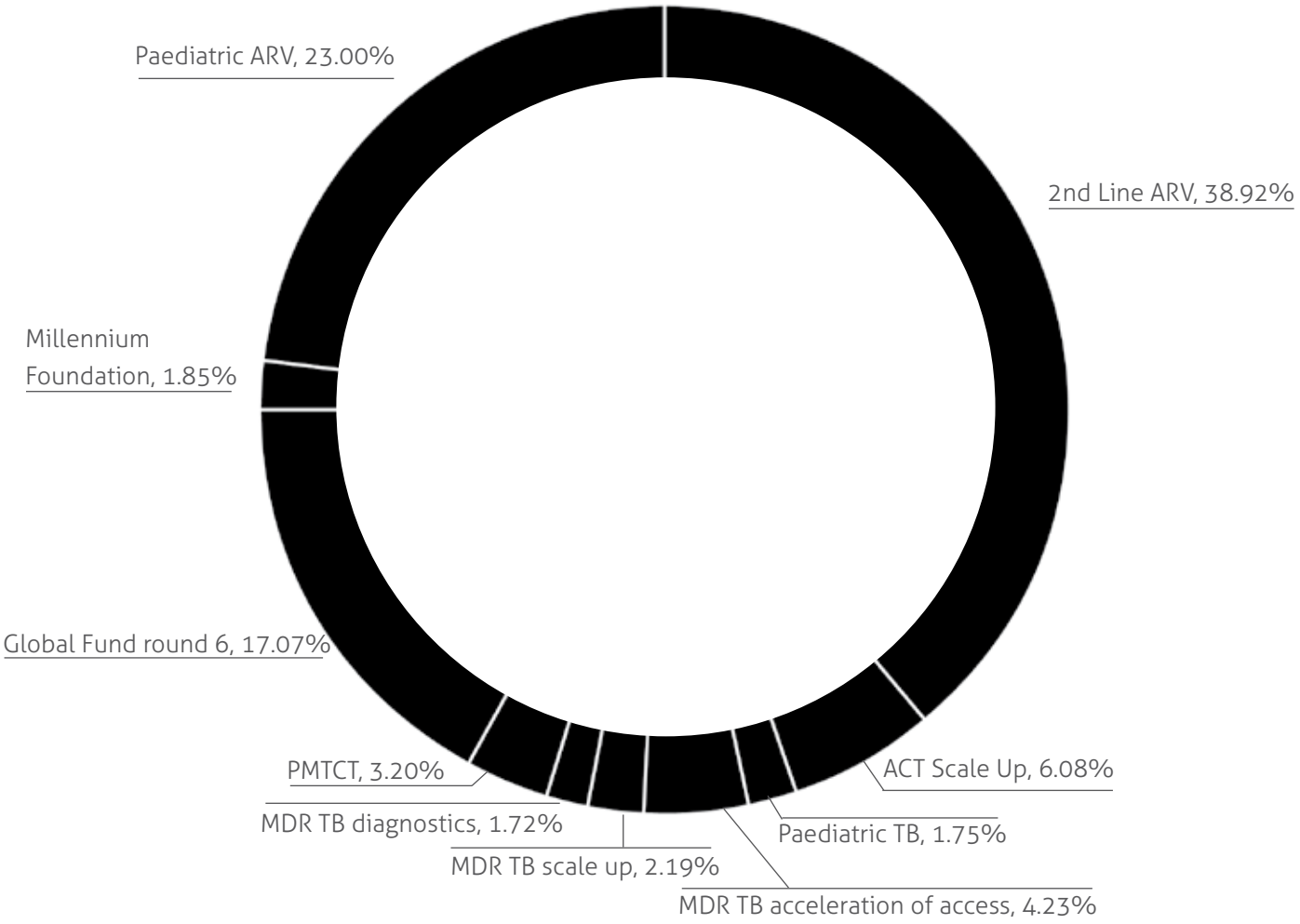
Statement of Financial Performance

	2008	*2006-2007*
	US$'000s	
OPERATING REVENUE		
Voluntary contributions	349 059	368 889
TOTAL OPERATING REVENUE	349 059	368 889
OPERATING EXPENSES		
Staff costs	3 419	1 732
Direct financial cooperation (DFC)	226 696	141 807
Consulting, research services	228	0
Contractual Services	752	463
Non-expendable equipment	5	123
Training	1	43
Travel	824	224
General operating costs	82	555
Telecommunications	40	26
WHO hosting fees	0	3 229
TOTAL OPERATING EXPENSES	232 047	148 202
SURPLUS FROM OPERATIONS	117 012	220 687
Financial revenue and expense - net	8 919	1 409
TOTAL SURPLUS FOR THE PERIOD	125 931	222 096

Chart 1 below shows the breakup among projects on Direct Financial Cooperation (DFC), which is the most important element of UNITAID's expenses.

Chart 1 – Analysis of DFC

2008 Direct Financial Cooperation



Consequent to the increase in DFC, other expenses have reduced proportionately by 2 per cent as compared to 2006-2007. It is analysed graphically in Chart 2, which shows that staff costs comprise over 60 per cent; excluding any administrative fees to WHO which will be paid for the biennium in 2009.

The UNITAID budget for these fees amounts to US$7 million for the biennium 2008-2009. In line with UNITAID maintaining a lean secretariat, its non DFC costs were below 5% of total operating expenses and in line with the performance targets set by the Executive Board.

Chart 2 – Analysis of Expenditure without DFC

2008 Breakup of Expenses, excluding DFC

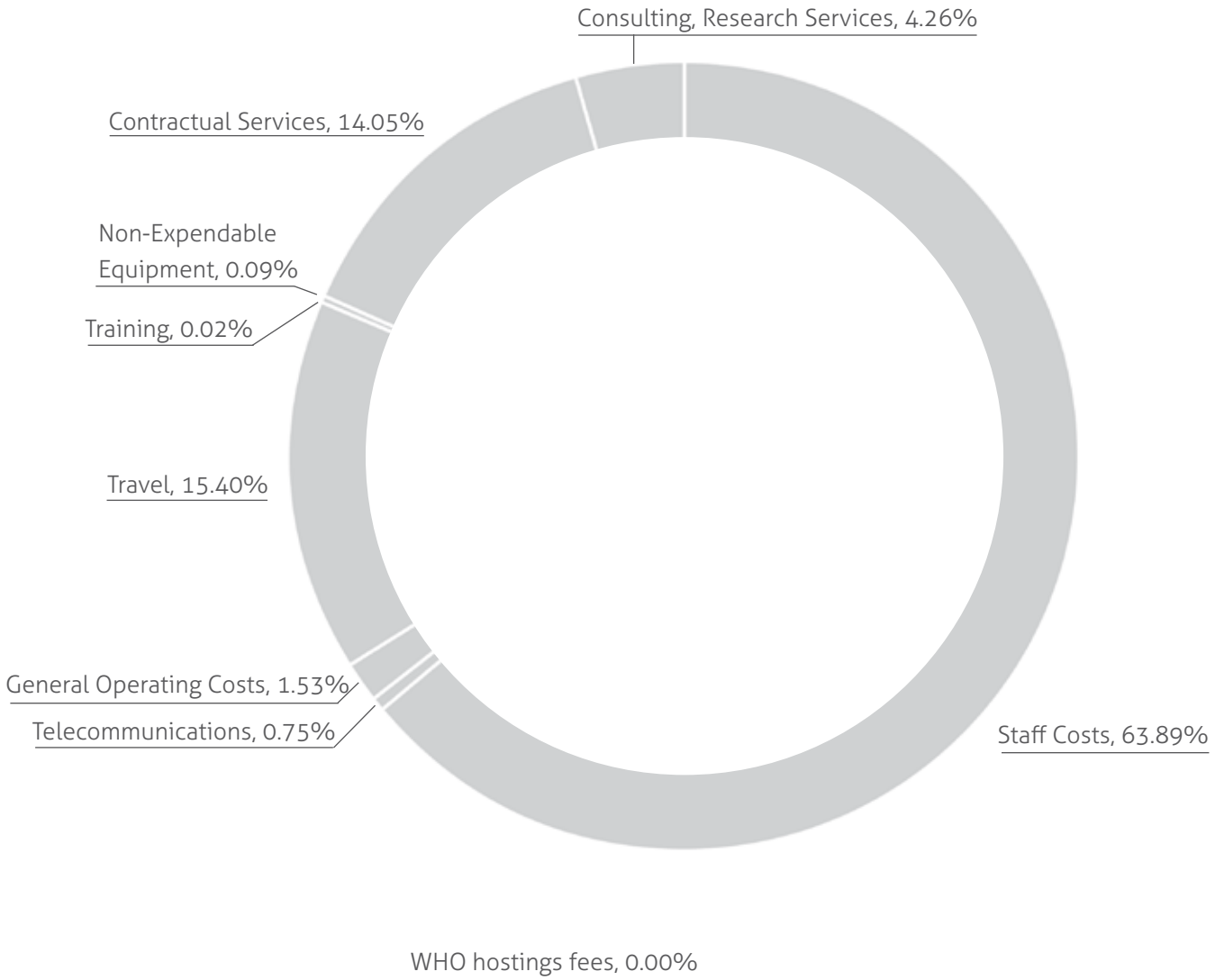
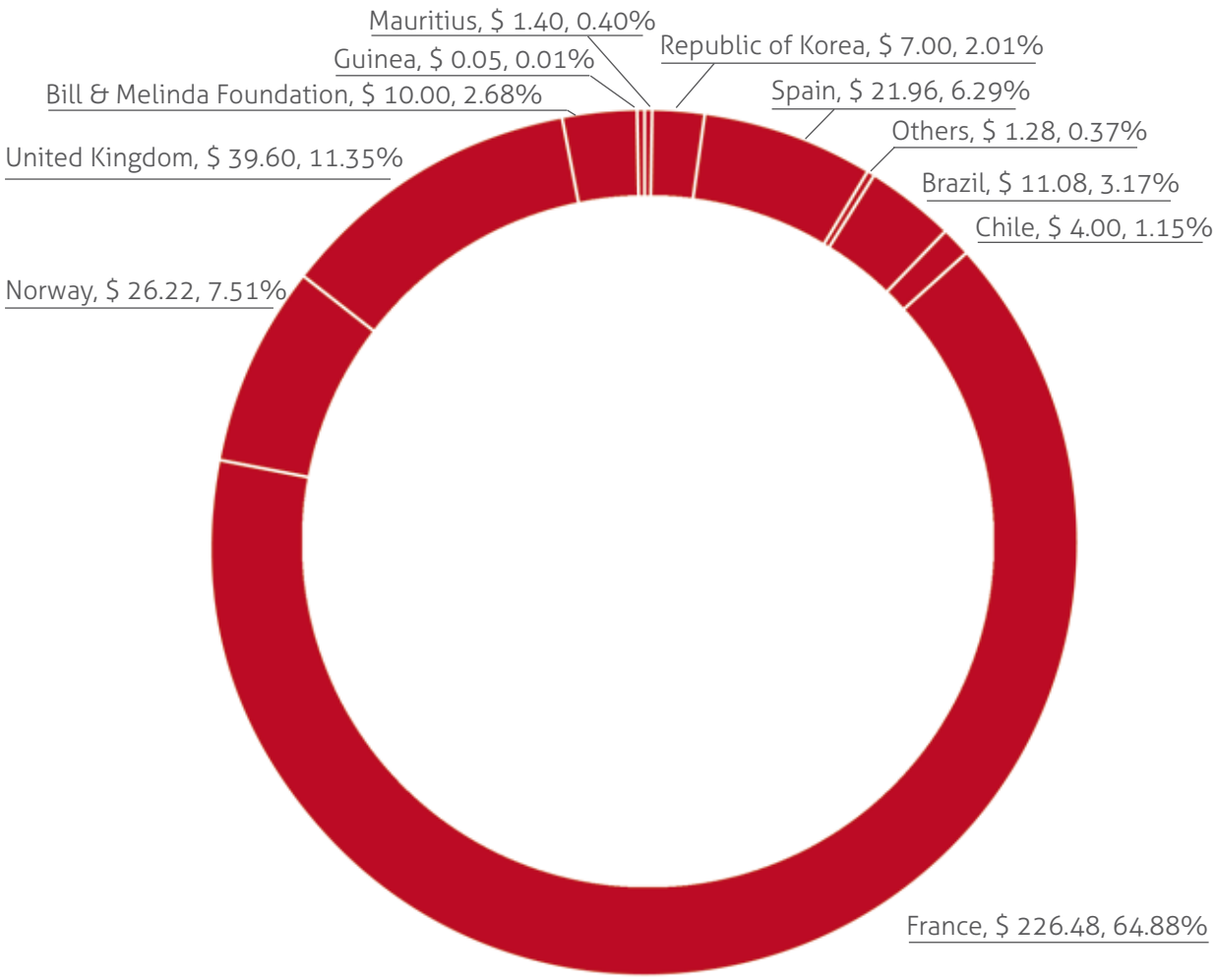


Chart 3 - Analysis of 2008 Voluntary Contributions by Donor

2008 Confirmed contributions in US$m, total US$ 349.06m



Financing UNITAID

As an innovative funding mechanism, the International Drug Purchase Facility (UNITAID) is dependent on voluntary contributions from its donors. The majority of UNITAID's revenue comes from a tax levied on air tickets so as to ensure a regular income to UNITAID, regardless of government budget constraints or donors' source of revenue. UNITAID is therefore based on long term predictable funding.

Financial situation

The financial stability of UNITAID depends not only on the timely receipt of income but also on the effective management of liquidity and on the appropriate investment and foreign exchange policies. The Statement of Financial Position (or Balance Sheet) shows the situation as at 31 December 2008 with a healthy cash balance, which is pooled with all such amounts by WHO and invested in accordance with its policies and practices.

Statement of Financial Position

	2008	*2006-2007*
	US$'000s	
ASSETS		
Current assets		
Cash and cash equivalents	312 292	196 154
Accounts receivable (non-exchange transactions)	54 135	34 174
Staff receivables	57	0
Total current assets	366 484	230 328
Non-current assets		
Accounts receivable (non-exchange transactions)	0	40 000
Total non-current assets	0	40 000
TOTAL ASSETS	366 484	270 328
LIABILITIES		
Current liabilities		
Accounts payable (non-exchange transactions)	22 110	8 232
Employee benefits	207	0
Deferred revenue	0	40 000
Total current liabilities	22 317	48 232
Non-current liabilities		
Employee benefits	60	0
Total non-current liabilities	60	0
TOTAL LIABILITIES	22 377	48 232
NET ASSETS/EQUITY		
Unrealised gains/(losses) on revaluation	(3 920)	
Accumulated surpluses - fund balance	348 027	222 096
TOTAL NET ASSETS/EQUITY	344 107	222 096
TOTAL LIABILITIES AND NET ASSETS/EQUITY	366 484	270 328

Conclusion

In common with WHO, UNITAID is using the new Global Management System (GSM), which has been developed to take into account the modern financial management policies and practices on the basis of best practice followed by the public and private sectors. Together with the planned adoption of IPSAS and the strengthening of the audit process, this modern computerized system will further improve the overall quality of UNITAID financial reporting.

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UNITAID is hosted and
administered by the
World Health Organization