Finding its Niche? Rethinking UNITAID's *Raison d'Être*

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Summary: UNITAID is a relatively new global-health agency with the mission of contributing to the scale-up of "access to treatment for HIV/AIDS, malaria and tuberculosis for the people in developing countries *by leveraging price reductions of quality drugs and diagnostics*." In this essay we examine the appropriateness and relevance of UNITAID's mandate. Is UNITAID's mandate still appropriate in light of recent global-health trends and priorities, including country ownership, health-systems strengthening, and sustainability? Or has UNITAID's approach of using "innovation [to] make markets work for the neediest" devolved into a hammer in search of an innovative, market-based nail? We recommend that UNITAID rethink its mission, and in particular examine whether the goal of scaling up access to treatment is necessarily achieved through price reduction of commodities. Moreover, UNITAID should choose arguments of fairness and justice rather than arguments of "the market" in deciding to pursue an intervention.

Introduction

Launched in 2006 by the governments of Brazil, Chile, France, Norway, and the United Kingdom,[1] UNITAID arrived fashionably late to the turn-of-the-millennium global-health boom. Perhaps in part due to its late entry, UNITAID is among the less well-known global-health agencies, living in the shadow of its older, more prominent siblings – UNAIDS (1996), the GAVI Alliance (2000), the Global Fund to Fight AIDS, Tuberculosis and Malaria (2002), the President's Emergency Plan for AIDS Relief (2003), and the President's Malaria Initiative (2005). As the youngest child in the family of global-health agencies – and particularly in the (relatively) crowded HIV/AIDS, tuberculosis, and malaria space – UNITAID has proactively worked to differentiate itself. Indeed, UNITAID is unlike any other global health agency. According to UNITAID, UNITAID is about market creation and manipulation; UNITAID is about products and commodities; but most of all UNITAID is about innovation.

In July 2011, UNITAID's Executive Board commissioned a five-year evaluation, requesting a "high quality, forward-looking report relevant to the future of UNITAID,"[2] with a final report expected in

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[1] Bermudez, Jorge (2008). "UNITAID: Innovative financing to scale up access to medicines." Global Forum Update on Research for Health; Vol. 5: pp. 182-185.

[2] UNITAID Executive Board (2012). Independent Steering Committee (ISC) of the 5-year evaluation. Resolution N. 11. 14th Executive Board Meeting. Geneva: 5-6 July 2011.

August 2012.[3] The evaluation will consider a broad range of core questions that may influence UNITAID's future directions. Among the most important: Where does UNITAID add value, and to what extent has UNITAID successfully complemented the roles of its older global health siblings? Can UNITAID's "catalytic funding approach" achieve long-term market and public health impacts? To what extent has UNITAID exerted a positive influence on health commodity markets, addressing market inefficiencies in line with its market-oriented core mandate?[4]

In the light of UNITAID's forthcoming evaluation report and its upcoming strategy for 2013 to 2015,[5] we examine UNITAID's role within the global-health financing architecture. Is UNITAID's mandate still appropriate or relevant? We do not examine the extent to which UNITAID has achieved success in its attempts to use "innovation" to game and manipulate global health commodity markets. Instead, we ask whether UNITAID's activities best support the movement to scale-up access to treatment for all three diseases through its constitutional focus on commodities and price reductions. Is UNITAID's mandate still appropriate in light of recent global-health trends and priorities, including country ownership, health-systems strengthening, and sustainability? Or has UNITAID's approach of using "innovation [to] make markets work for the neediest[6]" devolved into a hammer in search of an innovative, market-based nail?

What is UNITAID and where does it get money?

UNITAID's mission is:

> "to contribute to scale up access to treatment for HIV/AIDS, malaria and tuberculosis for the people in developing countries *by leveraging price reductions of quality drugs and diagnostics,* which currently are unaffordable for most developing countries, and to accelerate the pace at which they are made available."

To fulfill this mission, UNITAID seeks innovative, reliable revenue sources which can generate a predictable demand for drugs and diagnostics, theoretically helping to reduce prices and increase availability of key commodities for these three diseases (and these three diseases alone).[7]

UNITAID is headquartered in Geneva, where it is hosted by the World Health Organization (WHO); however, UNITAID is not part of the WHO. Instead, the organization is governed by its 12-member Executive Board, which includes permanent representatives from each of the five founding countries (Brazil, Chile, France, Norway, and the United Kingdom), Spain, and the WHO (non-voting), plus six rotating members (two representing civil society networks, and one each representing African

[3] UNITAID Civil Society Delegation (2012). UNITAID Civil Society Delegation communique. 15th Executive Board Meeting. Paris: 12-13 December 2012. Accessed 6 September 2012 at http://unaidspcbngo.org/?p=16958
[4] 5-Year Evaluation of UNITAID (2012). Interview questions for Victoria Fan.
[5] UNITAID Civil Society Delegation (2012). UNITAID Civil Society Delegation communique. 15th Executive Board Meeting. Paris: 12-13 December 2012. Accessed 6 September 2012 at http://unaidspcbngo.org/?p=16958
[6] UNITAID (2011). Five years of innovation for better health. Annual Report 2011.
[7] UNITAID (2011). UNITAID Constitution.

countries, Asian countries, and foundations).[8] We note that the United States does not contribute to UNITAID, nor does the US participate in its governance.

A key feature of UNITAID is its use of novel funding sources. UNITAID is funded by voluntary contributions by 16 participating countries and the Bill and Melinda Gates Foundation (BMGF). While UNITAID's donors are free to raise and give funds in any form they wish, UNITAID emphasizes and encourages "innovative financing" sources that collect "solidarity contributions," i.e. small, "painless" taxes on the rich to "make globalization work better for the poor."[9] UNITAID's most successful form of innovative financing has been a small levy on airline tickets adopted by nine countries,[10] which now accounts for 60% of UNITAID's annual revenue.[11] UNITAID has also explored other innovative financing mechanisms, including a failed platform for voluntary micro-donations through travel-booking services[12] and a proposed (but not yet adopted) tax on financial transactions.[13]

UNITAID bills itself as a "multilateral" organization, often touting its broad support from the Gates Foundation and 29 country governments, a majority of which are low- or middle-income (LMICs). However, a closer look at revenue by donor shows a contrast between UNITAID's funding rhetoric and reality (Table 1). As only 16 of the 29 member countries have contributed funds to UNITAID, the prerequisites for UNITAID "membership" are not clearly defined. Further, France alone contributed 62% of UNITAID's cumulative revenue between 2006 and 2011, followed by the United Kingdom at 16%. Together, the high-income country donors and BMGF were responsible for over 95% of UNITAID's funding during that same period; LMICs, including founding members Brazil and Chile, have contributed less than 5% of the organization's total funding.

Table 1. Revenue by Donor (in thousands of US$)

Country/Donor	2011 Voluntary Contributions	Percent of Total, 2011	Cumulative Revenue, 2006-2011	Percent of Total, Cumulative
Bill and Melinda Gates Foundation	10,000	3.70%	50,000	3.13%
Brazil	-	0.00%	37,202	2.33%
Cameroon	1,018	0.38%	1,018	0.06%
Chile	2,282	0.84%	20,400	1.28%
Congo	1,090	0.40%	1,090	0.07%
Cyprus	488	0.18%	1,578	0.10%
France	144,251	53.38%	996,899	62.32%
Guinea	-	0.00%	49	0.00%
Luxembourg	611	0.23%	1,961	0.12%
Madagascar	12	0.00%	27	0.00%
Mali	526	0.19%	928	0.06%

[8] UNITAID. Executive Board and Members of the Executive Board. Accessed March 18, 2012 at http://www.unitaid.eu/en/governance-mainmenu-4/executive-board-mainmenu-33?task=view and http://www.unitaid.eu/en/governance-mainmenu-4/executive-board-mainmenu-33/164

[9] UNITAID (2011). Five years of innovation for better health. Annual Report 2011.

[10] Cameroon, Chile, Congo, France, Madagascar, Mali, Mauritius, Niger, and South Korea

[11] UNITAID (2011). Five years of innovation for better health. Annual Report 2011.

[12] Millennium Foundation (2011). "Who We Are: MASSIVEGOOD." Accessed March 18, 2012 at http://www.massivegood.org/en_US/news-feed/432-new-direction-for-massivegood

[13] UNITAID (2011). Five years of innovation for better health. Annual Report 2011.

Mauritius	1,937	0.72%	7,032	0.44%
Niger	-	0.00%	281	0.02%
Norway	18,761	6.94%	109,550	6.85%
Republic of Korea	7,000	2.59%	28,000	1.75%
Spain	-2,813	-1.04%	81,603	5.10%
United Kingdom	85,072	31.48%	262,088	16.38%
Total Revenue	270,235	1.00	1,599,706	1.00

Source: UNITAID (2011). UNITAID Annual Report 2011.

UNITAID is a funding agency; its projects are implemented by partners which are already active in country. However, while UNITAID does not directly handle procurement or project implementation, UNITAID funds are exclusively earmarked for the purchase and supply of commodities for the three diseases, including shipping and procurement management. Implementing partners must find "extra funding sourced separately from other donors" to cover implementation and management, including operating and administrative expenses.[14] UNITAID does not receive proposals directly from developing country governments or local non-governmental organizations (NGOs),[15] instead preferring to work through a limited number of "programmatic partners," which are primarily multilaterals and large foundations.

What interventions does UNITAID provide?

UNITAID believes that it can manipulate the market for health commodities and achieve lasting market impact through short-term, strategic investments. UNITAID describes its "market-based" approach as serving three primary functions:

- **Market catalyst:** identifying and facilitating adoption and uptake of new and superior health commodities;
- **Market creator:** providing incentives for manufacturers to produce otherwise unattractive products with low market demand but substantial public health benefits; and
- **Market 'fixer':** addressing market inefficiencies, contributing to access of quality assured medicines, diagnostics, and preventative items. [16]

In practice, UNITAID's market-based toolbox primarily consists of large-scale procurement of selected health commodities, though it has also experimented with other approaches (chiefly a Medicines Patent Pool and the Affordable Medicines Facility for Malaria). Because its funding is considered to be predictable and immune from annual political fluctuations, UNITAID is able to make multi-year funding commitments, helping to achieve price reductions through bulk purchasing. By purchasing such large quantities of medicines and diagnostics, UNITAID also attempts to stimulate production and drive economies of scale for drug manufacturers, a strategy which UNITAID believes will lower prices for all buyers.[17]

[14] UNITAID (2009). Strategy 2010-2012: Improving global markets to address HIV/AIDS, tuberculosis, and malaria.
[15] UNITAID (2011). UNITAID Constitution.
[16] UNITAID (2012). How UNITAID Works in Markets. Accessed March 18, 2012 at http://www.unitaid.eu/en/about/market-approach
[17] UNITAID (2012). UNITAID: Mission. Accessed March 18, 2012 at http://www.unitaid.eu/en/about/mission-mainmenu-89

UNITAID's niche focus areas for bulk, long-term purchasing have included pediatric and second-line AIDS treatment, artemisinin-combination therapies (ACTs) to treat malaria, long-lasting insecticide nets (LLINs) to prevent malaria transmission, and treatment for pediatric and multi drug-resistant tuberculosis (MDR-TB) – see Table 2. UNITAID divides its funds between HIV/AIDS (52% of funding), malaria (25%), and tuberculosis (16%), plus a small selection of cross-cutting projects (7%).[18] Most UNITAID projects target underserved "niches" that are either expensive or otherwise unattractive to other donors, such as pediatric drugs and second-line treatment.

Table 2. Major UNITAID Interventions

UNITAID Intervention	Implementing Partner	Amount Committed (2006-2011)
Market Catalyst		
Second-line ART HIV/AIDS Project	Clinton Health Access Initiative	$305,058,000
Long Lasting Insecticide Treated Nets (Project Completed December 2010)	UNICEF	$109,250,000
MDR-TB Scale-Up Initiative	The Global Fund	$55,667,000
Market Creator		
Pediatric HIV/AIDS Project	Clinton Health Access Initiative	$380,058,000
Affordable Medicines Facility for Malaria (AMFm)	The Global Fund	$180,000,000
ExpandX TB (MDR-TB Diagnostics)	Foundation for Innovative New Diagnostics	$89,663,000
Pediatric TB Project	Stop TB Partnership Global Drug Facility	$37,691,000
Market Fixer		
Support for Quality Assurance of Medicines (HIV/AIDS, malaria, TB)	World Health Organization	$53,110,000
MDR-TB Strategic Rotating Stockpile	Stop TB Partnership Global Drug Facility	$37,691,000
First-Line Anti-TB Drugs Initiative	Stop TB Partnership Global Drug Facility	$27,646,000
ESTHERAID (Supply chain management)	ESTHER	$15,950,000
Unclear Category		
PMTCT	UNICEF	$104,466,000
ACT Scale-Up	The Global Fund	$78,888,000
Support for Global Fund Round 6	The Global Fund	$52,500,000

Source: Compiled by authors from UNITAID Annual Report 2011. See appendix for detailed descriptions

Should UNITAID rethink its mission?

From a simple description of its project implementation model – give money to a contractor, have the contractor distribute lifesaving medicines, save lives – UNITAID might sound quite traditional. A key feature distinguishing UNITAID from other global-health agencies isn't *what* it does, but rather *why* it does it.

[18] UNITAID (2011). Five years of innovation for better health. Annual Report 2011.

Global-health agencies such as the Global Fund and PEPFAR typically define success in terms of health impacts, i.e. lives saved or infections averted. For example, the Global Fund aspires to save 10 million lives and prevent 140-180 million infections from HIV/AIDS, tuberculosis, and malaria;[19] similarly, PEPFAR aims to prevent 12 million new HIV infections[20] and support 6 million people on ARV treatment.[21]

In contrast, UNITAID is quite different from other agencies in that it does not chiefly define its goals in terms of health impacts. Instead, UNITAID "measures its success based on its impact on the markets for medicines, diagnostics and related products,"[22] which can be considered an intermediary goal – or worse, *a conflation of strategy with mission*. UNITAID believes that a critical mass of public health problems is caused market shortcomings, which lead to low access to adequate treatment or diagnostics. UNITAID thus takes a market-based approach, where its projects are targeted as "market interventions" which aim to lower prices, improve quality, and incentivize manufacturer innovation and competition. In other words, UNITAID is based on three assumptions: (1) that "market shortcomings…result in the loss of life for the most vulnerable"; (2) that "time-limited projects" can "yield both short-term market impact (lower prices, better quality, improved formulations) and long-term sustainable impact, where manufacturers invest, innovate and compete"; and (3) that "the end result is an increased number of healthier people with access to quality products".[23]

Typical VFM frameworks involve components of allocative and technical efficiency, with allocative efficiency focused on selecting the most cost-effective intervention or of maximizing disability-adjusted life years (DALYs) per dollar spent. In contrast, UNITAID aims to achieve value for money through technical efficiency by lowering prices or improving quality throughout the commodity market: "interventions are high value for money because UNITAID's market impact extends to all countries, not just those receiving direct UNITAID support."[24] For example, by investing heavily in pediatric ARVs through pooled procurement and achieving a very high market share (>80%),[25] UNITAID believes that it helped to create healthier market conditions – more generic manufacturers, lower prices, and better adapted formulations – with benefits accruing to all global health funders and HIV-positive children worldwide.[26]

However, because of its focus mainly on technical efficiency rather than allocative efficiency, UNITAID has been criticized for pouring additional funds into what many perceive as an overfunded disease (i.e. HIV), particularly since it was founded after the Global Fund and PEPFAR. Van Gelder and Stevens (2010) note that "despite only causing around four percent of mortality in developing countries,

[19] The Global Fund (2011). Our strategy. Accessed 6 September 2012 at http://www.theglobalfund.org/en/about/strategy/
[20] PEPFAR (2009). Executive summary of PEPFAR's strategy. Accessed 6 September 2012 at http://www.pepfar.gov/strategy/document/133244.htm
[21] PEPFAR (2012). AIDS 2012: Latest PEPFAR results. Accessed 6 September 2012 at http://www.pepfar.gov/documents/organization/195771.pdf
[22] UNITAID (2011). Key performance indicators.
[23] UNITAID (2011). Five years of innovation for better health. Annual Report 2011.
[24] UNITAID (2012). Why UNITAID adopts a market-based approach. Accessed 6 September 2012 at http://www.unitaid.eu/about/market-approach
[25] UNITAID (2012). HIV, tuberculosis and malaria medicines landscape: Progress report on emerging issues and potential opportunities to improve access.
[26] UNITAID (2011). Five years of innovation for better health. Annual Report 2011.

HIV/AIDS currently consumes around 25 percent of all development aid for health," and "40 percent of all global health funding for R&D."[27] But UNITAID argues that it addresses "underserved niches" within the HIV/AIDS sector, including pediatric and second-line drugs, which would otherwise be neglected. If effective, UNITAID's strategy to decrease drug prices would also spark cost savings across other donors' HIV/AIDS programs, creating greater value for money *because* such large amounts are currently spent on HIV/AIDS treatment.

More generally, with regard to its choice of supported interventions, UNITAID turns conventional VFM wisdom on its head. Other donors select interventions based on an evaluation of their cost-effectiveness, i.e. which interventions can save the most people for the least amount of money. In contrast, because of its ultimate goal to achieve VFM by lowering sector-wide prices, UNITAID looks for the most *overpriced* interventions; high cost is seen not a bug, but rather a feature when looking to maximize price reductions.

In our view the critical question that UNITAID should address in its next board meeting is: Is UNITAID's focus, particularly on small, niche markets, the right priority, particularly if its mission is to scale-up treatment access? Should marginally lowering the prices for second-line TB drugs take precedence over meeting the need for first-line treatments today? Is it ethical or smart to provide a single patient with second-line TB drugs instead of treating up to *120* patients with first-line drugs, all for the same cost?[28] Even if there are still many people around the world who lack access to first-line TB treatment?

We question whether UNITAID's de facto approach to emphasize expensive drug classes is the best strategy to achieve its main mission to "scale up access to treatment for HIV/AIDS, malaria and tuberculosis by leveraging price reductions…" Further, does UNITAID's mission imply that UNITAID will *not* support scale up of access to treatment if it does *not* achieve price reductions or other market impact because of its activities?

We examined current global back-of-the-envelope figures of number of people in need of treatment for HIV, tuberculosis, and malaria, and what percentage of such people received treatment. Table 3 shows that a large percentage of people still do not receive treatment for first-line HIV and tuberculosis drugs, let alone second-line drugs. Moreover, there are 10 times as many adults in need of first-line HIV treatment than children, and 67 times as many adults in need of first-line HIV treatment than second-line HIV treatment. Hence, UNITAID should examine its role in scaling-up access to treatment for those individuals requiring first-line HIV treatment relative to those requiring second-line HIV treatment. A similar argument can be made for first-line and second-line tuberculosis treatment.

Table 3. Intervention Need and Coverage in Low- and Middle-Income Countries

Intervention	Estimated Need (Number of people, 2010)	Global coverage, 2010 (%)	UNITAID contribution of global coverage	Estimated Price
First-line HIV (Adult)	30,150,000¶	25%¶	n.a.	$62-$242†

[27] Van Gelder, Alec and Philip Stevens (2010). "What purpose UNITAID's Patent Pool?" International Policy Press. International Policy Network.

[28] UNITAID (2012). HIV, tuberculosis and malaria medicines landscape: Progress report on emerging issues and potential opportunities to improve access.

HIV (Pediatric)	3,400,000¶	13%¶	80%¶	$46-$410†
2nd line HIV (Adult)	450,000*	47%*	34%¶	$509-$837†
First-line TB	8,360,000¶	69%‡	n.a.	$20-$40*
2nd line TB	440,000*	10%*	18%*	$2,400*
ACTs	225,000,000*	128%*	24%*	$0.24-$1.40**

Notes: All HIV estimates based on WHO (2011).[29] Other sources: *UNITAID Estimates; ¶Calculated from UNITAID and WHO estimates; †Global Price Reporting Mechanism; **Global Fund PQR; ‡The Global Plan to Stop TB

UNITAID takes an instrumental argument in its intervention choice – i.e. UNITAID chooses interventions because of the potential to drive price reductions or other market impact in selected commodities. This argument is analogous to purchasing something on sale because it is on sale (or purchasing something expensive because it is expensive). We do not necessarily dispute the potential importance of these small niche markets, but UNITAID's "market-based," jargon-filled justifications obscure more reasonable arguments for its intervention choices. There may well be good reasons for UNITAID's focus on selected expensive drugs, i.e. basic arguments of fairness and justice to reach populations that would otherwise be unable to receive second-line treatment, or because children should not be born condemned to a preventable death sentence, or because of concerns to stem potentially drug-resistant epidemics. It is even possible that these intervention choices are demand-based, if UNITAID primarily makes funding decisions based on requests and gap analysis from its implementing partners (although those demands from countries and donors might be very different if UNITAID offered financing to a broader range of interventions, i.e. first-line ARVs and TB treatment drug regimens). However, these rationales receive little or no attention in UNITAID's documents. We suggest that UNITAID be more thoughtful in its arguments for justifying an intervention. Given its focus on relatively small populations with expensive drugs, UNITAID should draw on arguments of justice and fairness, e.g. Daniels (2008)[30], and use fair processes[31] and priority-setting institutions at international, regional, or national levels[32] to decide what kind of patient it serves or what kind of interventions it prioritizes.

Unfortunately, UNITAID's mission statement perpetuates a kind of hammer-before-nail reasoning by defining ex ante the strategy, i.e. "by leveraging price reduction" in order to reach a goal, i.e. "scale up access to treatment." Instead, UNITAID should seriously consider identifying the problem and working backwards to identify a range of solutions and strategies to address that. Is the problem to scaling up treatment and access necessarily because of the constraint and bottleneck of high prices of commodities? Or are the problems of scaling up treatment ones of service delivery, implementation, and governance?

Worse, does UNITAID's model potentially undermine other global health priorities, including country ownership, health-systems strengthening, and sustainability? As described above, UNITAID is a funding agency; its funds can only finance commodity procurement (not service delivery), and its

[29] WHO (2011). Global HIV/AIDS response: Epidemic update and health sector progress towards universal access. Progress report 2011.
[30] Daniels, Norman (2008). Just health: meeting health needs fairly. New York: Cambridge University Press.
[31] Daniels, Norman (2005). Fair process in patient selection for antiretroviral treatment in WHO's goal of 3 by 5. Lancet 366 (9480):169-71.
[32] Glassman, Amanda and Kalipso Chalikdou (2012). Priority-setting in health: building institutions for smarter public spending. Washington, DC: Center for Global Development. Accessed at http://www.cgdev.org/content/publications/detail/1426240/

projects are implemented by partners which are already active in country. Further, UNITAID is constitutionally prohibited from giving grants to national governments or local NGOS, instead preferring to work through ten "programmatic partners," which are primarily multilaterals and large foundations. CHAI is by far the largest recipient of UNITAID support, accounting for about 44% of UNITAID's cumulative commitments between 2006 and 2011.[33]

This strategy runs contrary to current trends in global health, which emphasize country ownership and health systems strengthening as key components. It is hard to imagine how UNITAID's model of bulk-purchased, INGO-managed commodity delivery could contribute to the development of sustainable, national procurement and supply chain systems. Without the involvement of national governments in the procurement process, it is unlikely that UNITAID's on-the-ground impact can be sustained past the close of its projects, or gradually transitioned toward country control.

Likewise, UNITAID takes no interest in the service delivery systems which are ultimately necessary for commodities to improve health. Implicit in UNITAID's model is the belief that increasing commodity supply should increase commodity access. However, for drugs to reach their intended beneficiaries and achieve the desired health impact, several steps must occur. First, the drugs must be purchased from manufacturers and transported to the recipient country; UNITAID supports this step, but its involvement ends here. After UNITAID bows out, the drugs must be distributed throughout the country to health centers, hospitals, clinics, and pharmacies. Health facilities must guard the drug supply from theft or loss, making the commodities available to doctors and nurses. Health workers must meet with patients, properly diagnose their conditions, and prescribe the appropriate medications. Finally, patients themselves must adhere to the prescribed course of treatment, sometimes for six months (e.g. TB) or the rest of a patient's life (e.g. HIV). Loss or inefficiencies can occur at point along this delivery chain (i.e. stock-outs, diversion, health worker absenteeism, misdiagnosis, or poor patient adherence), all of which can prevent a greater supply of health commodities from generating greater health. While we do not advocate for UNITAID's direct involvement in service delivery, we are skeptical of its implicit assumption that commodity provision is the primary bottleneck to better health for the poor and vulnerable.

UNITAID's emphasis on second-line treatment regimens does not incentivize reductions in the incidence of diseases requiring second-line treatment – nor does it help to reduce the causes which promote drug resistance in the first place. Except for its efforts in PMTCT and bed nets, UNITAID's de facto incentives are not aligned to prevention.

Innovation versus institutional inertia

Thus far, UNITAID has defined itself by its innovation, particularly in financing. But true innovation requires creative thinking, and sometimes even creative destruction. We hope that the imminent evaluation provides the impetus for UNITAID to turn inward and do something truly innovative: buck institutional inertia, change course as necessary, and reinvent itself as the solution to 2012's biggest global health challenges. Moving forward, we urge UNITAID to examine its mission to scale-up access to treatment for these three diseases.

[33] UNITAID (2011). Five years of innovation for better health. Annual Report 2011.

Appendix. Descriptions of Major UNITAID Interventions[34]

	Project Description	Implementing Partner	Amount Committed (2006-2011)
Market Catalyst			
Second-line HIV/AIDS Project	Catalyze the market for second-line anti-retrovirals through supplier selection techniques that increase the number of quality-assured second-line products and reduce their prices	Clinton Health Access Initiative	$305,058,000
Long Lasting Insecticide Treated Nets (Project Completed December 2010)	Create healthy market conditions – increased access, better quality and shorter production lead times – for LLINs. Over 20 million nets were provided to eight countries. UNITAID intervened to stop critical supply shortages and incentivize manufacturers to increase capacity.	UNICEF	$109,250,000
MDR-TB Scale-Up Initiative	Improve the price, number and quality of second-line TB medicines in order to increase the number of patients on treatment. Stabilize the market by increasing the number of manufacturers.	The Global Fund	$55,667,000
Market Creator			
Pediatric HIV/AIDS Project	Create market for pediatric anti-retrovirals, early infant diagnostics and other components	Clinton Health Access Initiative	$380,058,000
Affordable Medicines Facility for Malaria (AMFm)	Create a consumer market for ACTs by reducing the price paid by end-users through a subsidy mechanism to the private sector. The pilot phase of the AMFm is currently implemented through nine programs in eight countries.	The Global Fund	$180,000,000
ExpandX TB (MDR-TB Diagnostics)	Introduce new rapid technologies and laboratory service for MDR-TB diagnosis. The goal is to identify an estimated 119,000 MDR-TB patients in 27 countries and enable appropriate treatment.	Foundation for Innovative New Diagnostics	$89,663,000
Pediatric TB Project	Create a market for child-friendly TB medicines for children under-5 through increasing the number of manufacturers and stimulating competition.	Stop TB Partnership Global Drug Facility	$37,691,000
Market Fixer			
Support for Quality Assurance of Medicines	Increase the number of prequalified UNITAID medicines for HIV/AIDS, malaria and tuberculosis.	World Health Organization	$53,110,000
MDR-TB Strategic Rotating Stockpile	Fix the market for MDR-TB by facilitating faster lead times to quickly get patients on treatments in emergency situations.	Stop TB Partnership Global Drug Facility	$37,691,000

[34] UNITAID (2011). Five years of innovation for better health. Annual Report 2011.

First Line Anti-TB Drugs Initiative	Purchase first-line tuberculosis drugs to minimize the risk of stock-outs through the Stop TB Partnership Global Drug Facility.	Stop TB Partnership Global Drug Facility	$27,646,000
ESTHERAID	Improve supply chain management from national medical stories to treatment centers in five West African countries. Support the efforts of medical centers and treatment sites by making sure that UNITAID-supplied tests and treatments are received and used.	ESTHER	$15,950,000
Unclear Category			
PMTCT	UNITAID has supported three PMTCT projects since 2007 to test, treat and support HIV-positive women and their infants.	UNICEF	$104,466,000
ACT Scale-Up	Raise ACT treatment targets and provide market stability for these quality treatments	The Global Fund	$78,888,000
Support for Global Fund Round 6	Scale up access to treatment and reduce prices of medicines for HIV/AIDS, MDR-TB and malaria through Global Fund grants in Round 6, Phase 1.	The Global Fund	$52,500,000