The Global Fund
To Fight AIDS, Tuberculosis and Malaria

ACTm

Update on the Affordable Medicines Facility – malaria (AMFm)

Artemisinin Conference-Nairobi

15-16 January 2013

Phase 1 was a "Test of Concept"

AMFm comprises three elements:

1) **Negotiations with ACT manufacturers**
   - Same reduced price to public and private sector first-line buyers
2) **Buyer subsidy (co-payments) at top of global supply chain**
   - Further reduce price of ACTs to first line buyers
3) **"Supporting interventions"** to ensure effective ACT scale-up

Uses pre-existing supply chains in all sectors:

public, private non-profit, private for-profit

Operational in nine pilots in eight countries:

Cambodia (limited), Ghana, Kenya, Madagascar, Niger, Nigeria, Tanzania (mainland and Zanzibar), Uganda

ACTs Approved and Delivered by Sector

[As of 31 December 2012]

At global level:

Sector	Treatments Approved for co-payments (millions)	Treatments Delivered (millions)
Public	76	70
Private for-profit	12	10
Private not-for-profit	251	192
Total	**339**	**272**

AMFm Phase 1 Independent Evaluation

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- Commissioned by the Secretariat, per **Board Decision**
- **Pre/post study design**:
  - National-level **outlet surveys**, urban and rural areas
  - **Country case studies**: context and implementation process
  - Secondary analysis of **available household survey** data
  - **"Remote areas" study** in two "fast moving" countries
- **Benchmarks** established ex-ante for key indicators (availability, affordability, market share and use): "success" after **12 months** of implementation
- In practice, every pilot had less than 12 months of implementation of the full model

Achievement of success benchmarks

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For the three "upstream" objectives :

– Increased availability and affordability: **5/8** pilots achieved
– Increased market share: **4/8** pilots achieved or surpassed

in both urban and rural areas; AND "remote areas"

For the one "downstream" objective:

- Increasing use (including by vulnerable populations)
  - Data not available for inclusion in Independent Evaluation Report; supplementary report released later
  - CHAI review of national-scale surveys from 3 pilots indicates increased use of ACTs among children receiving antimalarials, including among the poorest groups

For the artemisinin monotherapy objectives:

– Met in all pilots with sufficient AMTs in the market to make the benchmarks relevant

Summary Results

Achivement of Benchmarks for Public & Private Sectors Combined

	Ghana	Kenya	Mada-gascar	Niger	Nigeria	Tanzania (mainland)	Uganda	Zanzibar
Availability								
Price vs. a/malarials								
Price vs. oAMTs								
Mkt share QAACTs								
Mkt share oAMTs								
Use in febrile <5 yrs.	No data	No data		No data				

AMFm had significant impact in the **private for profit** sector in 6 out of 8 pilots

Key findings: Role of the private sector

In 6 of 8 pilots, private sector 1st line buyers responded rapidly, moving ACTs quickly and efficiently, with limited evidence of profiteering

- Not overloaded by annual forecast/tender requirements
- Both urban and rural areas reached
- Considerable penetration in “remote” areas where this was studied (Ghana, Kenya and Tanzania)
- “Reasonable” mark-ups, except in Uganda and Zanzibar

Duration of implementation

Longer duration of implementation of all three elements of the AMFm model

1. Manufacturer negotiations
2. Co-payments and
3. Key supporting interventions at scale

appears correlated with improved performance

- No large-scale sustained IEC/BCC by end of 2011 in Madagascar, Niger, Uganda, where less change from baseline was observed on some key indicators
- Large improvement in Zanzibar despite short implementation, reflecting favourable implementation context and strong SIs

Supporting interventions

Several supporting interventions appear to be critical:

- Strong AMFm governance structure (Task Force in country), involving the private sector
- Strong, large scale mass media campaign
- Use and promotion of recommended retail prices
- Training of providers
- Regulatory changes and measures (over the counter status, tax waivers, enforcement of oral AMT bans, …)

Diagnostic testing gaps

- Given the intensification of transmission control efforts, scaling-up access to diagnostic testing is increasingly important
- Availability of malaria diagnostic testing can be improved
  - Progress remains to be made in the private sector, and in the public sector in several pilots

Outlets stocking any diagnostic test for malaria among public and private for-profit outlets with antimalarials in stock

Percentage of outlets with any diagnostic test for malaria

	Public health facilities (Baseline)	Public health facilities (Endline)	Private for-profit facilities (Basline)	Private for-profit facilities (Endline)
Ghana	72	41	4	4
Kenya	45	56	13	14
Madagascar	89	94	0	1
Niger	60	66	0	1
Nigeria	29	29	2	4
Tanzania – mainland	37	48	2	6
Uganda	35	75	16	21
Zanzibar	94	98	36	32

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Board consideration

1. Notes the findings of the Independent Evaluation (IE) on the effectiveness of the AMFm in the eight pilot programs and, in particular, notes the results regarding the "upstream" success parameters
2. Recognizes that the successes of the AMFm are due to the co-payment system, consisting of price negotiations with manufacturers and direct co-payments from the Global Fund to manufacturers on behalf of approved first-line buyers, and the use of supporting interventions.
3. Notes that the results of the IE indicate there is sufficient evidence to approve a modified approach to support countries in achieving the Roll Back Malaria targets of universal coverage of malaria treatment if coupled with efforts to improve access to diagnostic testing.

Board Recommendation

Modify the existing AMFm business line by **integrating** lessons learned from Phase 1 into Global Fund grant management and financial processes

- Maintain global-level price negotiations and co-payment system
- Financing to support private sector strategy come from Global Fund grants only
- Request partners to conduct a feasibility study on inclusion of RDTs into co-payment system

Orderly & responsible transition for AMFm pilots in 2013

- Secure resources for private sector co-payment
- Consult with AMFm pilot countries on transition arrangements and plan for the integrated model

2013 Transition

Objectives:

1. Access to quality-assured ACTs in AMFm Phase 1 countries is not disrupted;

2. ACT and API markets are not destabilized; and

3. Countries are supported to transition to the integrated model taking into consideration countries preferences.

2013 Transition

Parameters

- Channels:
  - Public sector to be funded through the traditional grant system (full prices)
  - Private sector to be funded through the co-payment fund

- Scale: Country-driven depending on lessons learned from Phase 1

- Scope: ACT co-payments for private sector only and supporting interventions

- Note: RDT assessment and feasibility for co-payment mechanism for the private sector to be carried out by technical partner

2013 Transition

Co-payment system

As per Global Fund Board decision, countries will:

- Have a defined funding allocation for co-payment
- Determine parameters for the use of this funding allocation

- Example of rationing levers used by the Secretariat during Phase 1:
  - Adult/paediatric packs, first-line buyer pipeline, treatment price, manufacturer performance, mode of transport, delivery date
- AMFm countries are currently working on the desired changes to demand levers applied by Secretariat during Phase 1 within funding allocation
  - Secretariat to apply those levers in accordance with country guidance (start date still need to be defined)

2013 Transition

Supporting interventions

- The estimate for SI in 2013 for all AMFm pilot countries is US$26 million (based on US$0.07/capita)
- The IE report showed that certain supporting interventions appeared more strongly correlated with the desired outcomes:
  - IEC/BCC campaigns at scale
  - Development and promotion of a recommended retail price
  - Provider training
- AMFm countries are currently working on budget for SI (enabling to continue key activities in 2013)

2013 Transition

Ressources mobilisation

- Request for funding: **US$114** (historical approval) **to US$154 million**
  - DFID: 57 USD
  - UNITAID: proposal waiting approval (before end January 2013)
  - Gates Foundation and CIDA: under discussion
- Only for co-payment in private sector
- Funding for supporting interventions still with GF grants

Beyond 2013: Integration

- ACT co-payments will no longer be available through a separate funding mechanism as it was during Phase 1
- All eligible countries that wish to expand access to ACTs and (potentially) RDT will be able to allocate funding from their core Global Fund grants to a private sector subsidy (current AMFm countries plus additional)
- The Global Fund Secretariat will continue to centrally negotiate prices and make direct payments to manufacturers on behalf of buyers in those countries
- AMFM Countries are currently working on reprogramming grants, phase 2, or will have to wait for the New Funding Model

AMFm Phase 1	Integrated model
Separate co-payment fund with contributions from external donors	Countries allocate resources for co-payment from Global Fund grants
Co-payments for ACTs only	Co-payments for ACTs and (potentially) RDTs
Open to limited set of pilots	Open to all eligible countries that choose to allocate funds from GF grants for private sector ACT subsidies
Co-payments for public & private sector FLBs	Co-payments for private sector FLBs only
“Demand shaping levers” developed by Secretariat	“Demand shaping levers” set by country against pre-determined ‘envelope’
Supporting interventions funded through core Global Fund grant	

Thank you !