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GLOBAL FUND BOARD APPROVES MODIFICATION OF AMFM

The Global Fund Board has decided that the Affordable Medicines Facility-malaria (AMFm) programme will not continue as a stand-alone programme, but elements will be retained and integrated into the core funding system. The decision was made at the 28th Global Fund Board meeting held in Geneva on 14th and 15th of November.

The AMFm is an artemisinin combination therapy (ACT) subsidy programme with three main elements: price negotiations, a co-payment system to further reduce the price to first line buyers, and interventions to ensure effective scale up of ACT distribution. The programme is currently being implemented in eight pilots in seven countries. The pilot phase was to end in 2012, but was extended for a year (to end of 2013) to allow for a smooth transition and continuity of access to the affordable medicines.

The Strategy, Investment and Impact Committee (SIIC), in its report to the Board (link), said that although the pilot had shown remarkable success in over half the countries, certain elements must be changed and the programme should be integrated within the Global Fund system to ensure sustainability.

An external evaluation had shown that AMFm had significant impact in the private for profit sector in six out of eight pilots, but less impact in the public sectors of many of the pilots. It also appears that the longer the pilot was in place, the greater the effect of the programme.

The AMFm has operated since mid-2010 as an independent funding line, with financing from UNITAID, the Bill and Melinda Gates Foundation, and the Canadian and UK Governments.

Under the proposed modified model, the Global Fund will still engage manufacturers in price negotiations and process co-payment on behalf of countries. However, countries will now be expected to mobilise resources for the co-payment, and place their proposals for controlling and treating malaria in their

concept notes for funding through the new funding model.

The Board further asked countries to align the private sector co-payment with their national plans. That way, ACTs can be provided in conjunction with other interventions such as mass communication campaigns. Following the decision, an orderly transition is expected in the pilot countries, with other interested countries gradually taking up the co-payment element.

The Board further recommended that given the changing malaria epidemiology in many countries, diagnostic testing should be scaled up in both private and public health sectors to ensure that over-treatment or treatment for non-malarial fevers with ACTs does not occur.

This recommendation is consistent with guidance from the technical partners such as the World Health Organisation (WHO) and Roll Back Malaria (RBM). Increased diagnostic testing accompanying the ACT roll-out will also help minimise the spread of artimisinen-resistant malaria parasites.

The importance of linking the use of ACT to malaria diagnosis was also highlighted in the Board decision. The Board asked for assessment of the feasibility of introducing a malaria rapid diagnostic test (RDT) co-payment system. Should such a system be adopted, countries will be expected to mobilise co-payment funds for both the ACTs and the RDTs. The decision on how to allocate resources between RDTs and ACTs will be left to individual countries.

Individual countries will be told the maximum amount of money that can be used for private sector co-payment. However, the SIIC report was not clear on how the amounts would be decided. Countries will be required to justify the co-payment amount requested for the private sector.

Having ceiling amounts per country is meant to ration the supply of ACTs. A recent analysis by the Clinton Health Access Initiative (CHAI) said that over 400 million antimalarials were used by individuals, buying those medicines through private sector outlets, who did not have malaria (CHAI Report).

“The need to link treatment with diagnostic confirmation is vital, but the human resources to do this are scarce. We will need to work hard at solving this piece of the puzzle of malaria control,” said an implementer country delegate to the Board.

The SIIC estimates that between $114 and $154 million will be needed for co-payment for the pilot countries over the one-year transition period. In addition, an estimated $26 million will be required for supporting interventions. However, the Board expects existing grants to cover the costs for supporting interventions.

During the Board deliberations, the representative of the British/Australian delegation, who is from the UK Department for International Development (DFID), said that DFID was prepared to donate to the Global Fund an additional GBP36,000,000 (US$57,000,000) to help finance the transition year for these co-payments.

A few details remain unclear following the Board decision. While the AMFm unit will continue to exist during the upcoming year, it is not clear exactly how the system for collecting and processing co-payment funds will be implemented. In the past, some funders, most notably the US government, refused to fund the co-payment under the AMFm.

The Board was satisfied with the public-private cooperation that had developed as a result of the AMFm. To strengthen these further, countries were asked to develop policies that enable the use of grants to work with the private sector through co-payment mechanisms.

The decision to retain elements of the AMFm can be viewed as a compromise between two options that

were being discussed: continuation (as is) and termination.

The text of the Board decision on the AMFm can be found in point 6 in the Board Decision Points document available at www.theglobalfund.org/en/board/meetings/twentyeighth. The paper submitted by the SIIC to the Board (Document GF/B28/04) should be posted shortly at the same site.

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