Questions and Answers
on the Affordable Medicines Facility – Malaria (AMFm)

26 October, 2012

1. What is the Affordable Medicines Facility – Malaria (AMFm)?

The AMFm is a financing mechanism whose aim has been supply quality-assured artemisinin-based combination therapies (ACTs) at highly subsidized prices in the public, private not-for-profit, and private for-profit sectors. Beginning in 2010, phase 1 of AMFm included nine pilots in eight countries: Cambodia, Ghana, Kenya, Madagascar, Niger, Nigeria, Tanzania (mainland and Zanzibar), and Uganda. The AMFm’s stated objectives have been to: a) increase ACT affordability; b) increase ACT availability; c) increase ACT use, including among vulnerable groups; and d) increase the market share of ACTs relative to oral artemisinin-based monotherapies and other less effective antimalarial medicines.

The AMFm is hosted and managed by the Global Fund to Fight AIDS, Tuberculosis and Malaria, with financial support provided by UNITAID and other donors. At the end of 2011, an independent evaluation was conducted of the pilot, and the final assessment report was published in September 2012. At its next board meeting in November 2012, the Global Fund will decide whether to continue, modify, expand, suspend or terminate the AMFm. In September 2012, the Global Fund board extended Phase 1 until 31 December 2013 to ensure an orderly transition to the chosen future arrangement. WHO has been participating in the AMFm Working Group of the Global Fund’s Market Dynamics Advisory Group, and has contributed to the broad-based consultation on the future of AMFm.

2. What are WHO’s views on expanding access to ACTs in endemic countries?

WHO strongly supports efforts to increase the availability, affordability and rational use of quality-assured ACTs – the recommended first-line treatment for uncomplicated Plasmodium falciparum malaria, in both the public and private sectors. WHO recommends diagnostic testing for all suspected malaria cases in all epidemiological settings, for all age groups, in order to ensure rational use of ACTs, to promote correct identification and management of non-malaria fevers, and to prevent the emergence of artemisinin resistance. Priority for access to subsidized medicines and diagnostics should be given to children under five years of age – the group most vulnerable to malaria and other preventable and treatable illnesses such as pneumonia and diarrhea. Treatment based on clinical suspicion should only be considered for patients with suspected severe malaria and other high-risk groups, in the absence or expected delay of parasitological diagnosis.

3. How has the AMFm affected the rational use of ACTs?

Improving the rational use of ACTs was not a specific strategic objective of AMFm. As a result, the co-payment of quality-assured ACTs was not coupled with that of rapid diagnostic tests (RDTs), and the initiative did not promote the expansion of malaria diagnostic testing. During the
AMFm pilot phase, approximately 70% of all subsidized ACTs were delivered to the private for-profit sector, 26% for the public sector and 4% for the private non-profit sector. Despite the fact that malaria mortality rates are highest among children, nearly 50% of these ACTs were adult packs, and a significant fraction of ACTs were delivered to the private sector in urban areas, where malaria endemicity is low, and most fevers are not due to malaria. Evidence from ongoing studies shows that even in rural endemic areas, the majority of ACTs provided through the AMFm did not reach true malaria patients.

At present, there is limited information about what percentage of children under five years of age with malaria had access to subsidized ACTs. At the same time, no information has been made available on the use of these medicines by the poorest communities, so it is difficult to measure whether the reduced prices have benefited whole populations. In addition, the independent evaluation of AMFm did not document an impact on reducing the market share of oral artemisinin-based monotherapies, except in Nigeria and Zanzibar.

4. What is the view of the Malaria Policy Advisory Committee?

The Malaria Policy Advisory Committee (MPAC) is an independent committee advising WHO on policy-setting for malaria prevention, control and elimination. The Committee was established in late 2011 and has held two consultations thus far. During its most recent meeting in September 2012, WHO sought the MPAC’s advice on the future of malaria case management in the private sector. After a review of available evidence on the results of Phase 1 of AMFm, the MPAC reiterated the importance of including diagnostic testing in all initiatives aiming to improve access to ACTs in the public and private sectors. It also recommended that new global initiatives on malaria case management in the private sector apply a holistic approach to improving the management of all febrile illnesses. The MPAC underlined that all future initiatives that include subsidies for ACTs and RDTs should be designed to ensure sustainability.

5. What needs to be done in endemic countries?

In 2011, the AMFm subsidized approximately 60% of global orders of quality-assured ACTs. The initiative has resulted in increased availability, decreased prices and increased market share of quality-assured ACTs in several AMFm countries. These changes have been very rapid but the benefits seem to have been limited to the private sector only. ACT shortages have continued to occur in public health facilities in both AMFm countries and in countries not participating in the pilot. There is an urgent need to improve endemic country preparedness to prevent future stock-outs, and to elaborate comprehensive plans to ensure that malaria treatment needs are met in all countries in the short and medium term. At its upcoming board meeting in November 2012, the Global Fund will take decisions on its future hosting and management of AMFm, and on how to continue – during the coming year – to support countries which participated in the pilot.

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