Affordable Medicines Facility - malaria Uganda’s Perspective

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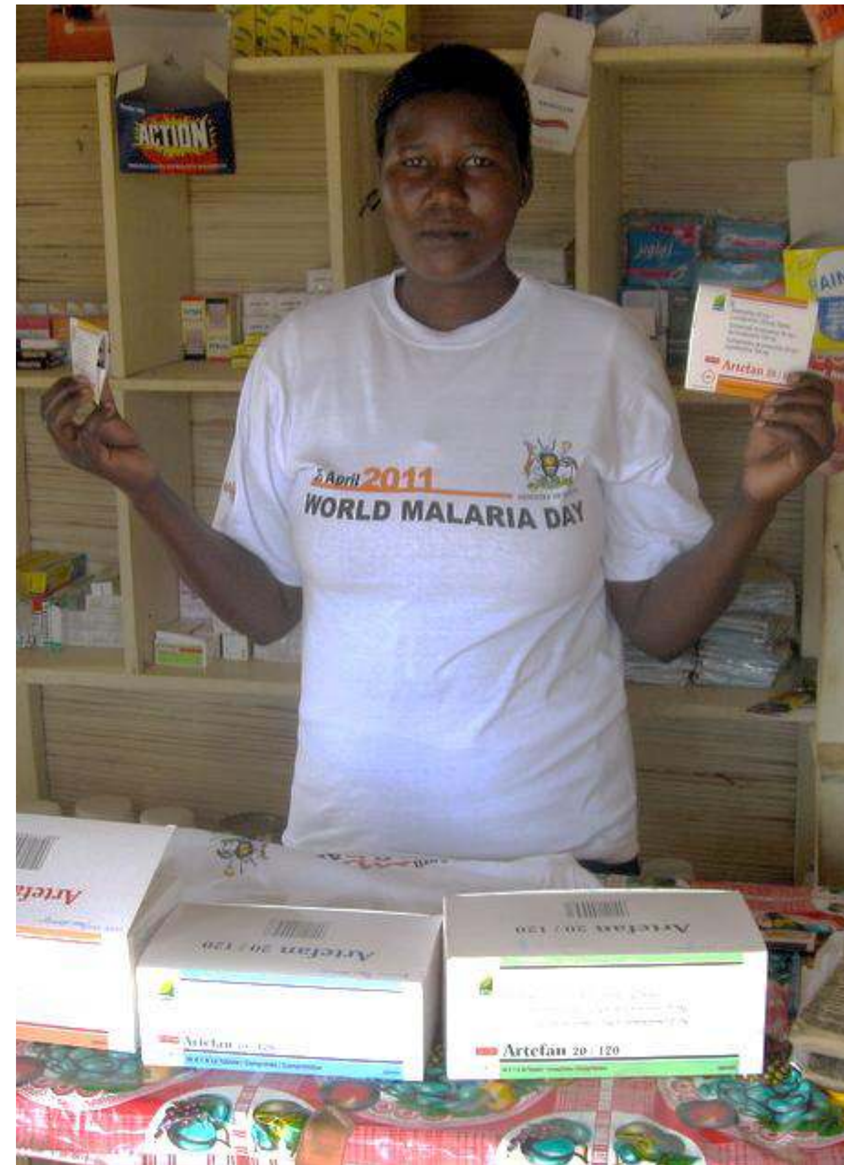
Agenda

- AMFm accomplishments and challenges
- Reaction to country-specific findings from the AMFm IE
- Requirements for AMFm transition period and the future

Uganda's AMFm experience



AMFm Background:

•Uganda has a high malaria burden, with about 40% of patients seeking care in the public sector (60% in private sector)

•Uganda launched the AMFm on World Malaria Day (April 25 2011)

•Key Supporting Interventions (BCC, public and private sector HCW training, price & availability monitoring) were included to strengthen Uganda's AMFm strategy

•MOH established AMFm Task Force, held regular implementation committee meetings and guided coordination of Government, NGO partners, private sector

Results:

•Over the past 16 months, Uganda received over 35m AMFm ACTs (40m ACTs were ordered)

AMFm Accomplishments

Achievement	Impact
(**Policy**) OTC approval for ACTs	• Drive increase in ACTs available through private drug stores
(**Regulatory**) Direct distribution of ACTs by approved by importers	• Shorten private sector supply chain; reduce mark-ups; pass cost savings to patients
(**Price**) Successful recommended retail price (RRP) negotiations	• Agreed upon RRP: 300 to 1,200 UGX ($0.12 to $0.50 USD)
(**PPP**) Good example public-private partnership in health	• AMFm partnership catalyzed PPP strategy on diarrhea treatment (broader febrile illness management)

AMFm Results:[1]

- AMFm pilot significantly increased (46%) availability of quality assured ACTs, with most substantial increase (54%) in the private sector
- AMFm provided patients with choice, and results show stronger preference for accessing malaria treatment in the private sector (17% increase in market share over public sector)
- AMFm was able to significantly increase (33%) QAACT market share in the privates sector

Source: 1. AMFm Independent Evaluation Results, ICF Macro/PSI/LSHTM, 2012

AMFm Challenges

Challenge	Impact
(**GF Process**) Delayed first disbursement of AMFm grant (Feb – Nov 2011)	• Lack of supporting interventions (e.g. BCC, provider training; lack of public and provider awareness of AMFm pilot and prices
(**MOH Process**) Delayed contracting of AMFm SI to SSRs (Nov 2011 – Oct 2012)	• Further lack of supporting interventions
(**ACT availability**) Delays/reduced AMFm order approvals	• ACT demand outpaced supply; volatility with ACT stock and pipeline
(**Communication**) Delayed direct communication/feedback on key implementation issues	• Delayed *direct* communication from AMFm Unit and RBM to MOH limits in-country planning and escalation of key issues to senior decision makers

AMFm Results:[1]

- AMFm did not reduce average QAACT price to under 300% the price of SP (QAACT price was 330% SP price)
- Private sector provider knowledge of AMFm program and RRP remained low (25% and 1% respectively)

Source: 1. AMFm Independent Evaluation Results, ICF Macro/PSI/LSHTM, 2012

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Lesson Learned from the AMFm: Reactions to country-specific findings from the independent evaluation

In-country RBM partners reaction to AMFm IE:
AMFm IE was conducted prematurely. Uganda only received 7 month of subsidy (May 2011 to Nov 2011), and no supporting intervention (e.g BCC, public and private sector training) at the time of the endline data collection.

How can Uganda improve on the AMFm IE Results?

1. Consumer awareness is necessary to better regulate retail prices
2. High availability of subsidized ACTs is necessary to meet patient demand and create competitive pricing
3. Price transparency along the private sector supply chain is critical to ensure cost savings are passed on to the patient

Recommendations from in-country RBM partners

1. BCC should be always be coordinated with ACT supply
2. BCC must be used to inform patients on retail price of subsidized ACTs
3. Subsidy must ensure consistent and high level of ACT stock and pipeline
4. Uganda must strengthen regulatory enforcement, limiting local production of SP and stopping sale of oral monotherapies to further improve ACT availability

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AMFm Transition Period: Uganda's Requirements

Uganda' s *Transition Period* requirements are similar under i) current existing funding scenario or ii) reduced funding scenario

Strategic Requirements

1. GF/RBM need to communicate to Uganda the amount of resources available during transition period
2. Allow Uganda to allocate resources to both the subsidy and supporting interventions
3. Allow Uganda to extend the existing AMFm supporting interventions (BCC, private sector training, public sector training) into 2013 with modification to include diagnosis focus

Operational Requirements

1. Mechanism for order approval and allocation need to become more transparent
2. Transition period and total subsidy amount should be provided to Uganda, allowing Uganda to determine how to prioritize funds.
3. Yes. This makes sense because a larger majority of consumers access ACTs in the private sector, and there are assured stocks within GF Round 10, so shift subsidies into the private sector in this transition period

Future AMFm modification: Uganda's Requirements

Strategic Requirements

1. Rational use of ACTs is most important for Uganda.
    - According to WHO guidelines and national policy, Uganda is moving towards universal diagnosis. It makes sense to have mechanism for the private sector to access lower priced RDTs.
2. Age based targeting may not be as important as rational use, since HCW and patients will likely combine (multiple child packs) treatment packs from previous experience.
    - Focus on quantifying ACT requirements according to consumption data and use of definitive parasitological diagnosis & good clinical practices is more effective than age based targeting
3. Geographical target may not make sense in Uganda as 95% of the country is endemic and transmission is high throughout the year
4. Partial subsidy can be considered as long as supporting interventions (BCC and trainings) are supported.

Operational Requirements

1. RDTs should always be priced lower than ACTs in order for rational use under any subsidization model
2. Supporting Interventions need to be strengthened and deployed alongside subsidization model

Thank You

Annex

1. AMFm TF & RBM stakeholder feedback on AMFm Transition Plan

2. AMFm TF & RBM stakeholder feedback on AMFm Future Scenario

Annex 1: AMFm TF and RBM Stakeholder feedback on AMFm transition period options (Sept 14, 2012)

Scenario	Strategic Considerations	Operational Considerations
Same amount of current funding	• Current AMFm supporting interventions (training of HCWs and BCC) needs to continue into 2013 in addition to the subsidies • Uganda is shifting toward diagnosis, which needs to be included in the above component • supporting interventions need to run alongside distribution • If possible, RDT subsidy should be introduced	• Mechanism for order approval and allocation should become more transparent • Shift ACCT subsidy into the private sector during transition period since larger majority of consumers access ACTs in the private sector, and ACTs are assured within GF round 10 • Must strengthen supporting interventions • RRP of RDTs must be lower than ACTs
50% of Current Funding	• Same as above	• Same as above

Annex 2: AMFm TF and RBM Stakeholder feedback on AMFm future scenarios options (Sept 14, 2012)

Scenario	Strategic Considerations	Operational Considerations
Diagnosis focus	• Subsidy for diagnosis in the private sector is the ideal scenario • Must make sure that RDT is well subsidize to ensure rational use of ACTs	• RBM partners will also want to see if GF can re-distribute some of the 16M RDTs under AMFm to the private sector • Must strengthen supporting interventions to ensure success of diagnosis
Age targeting	• Once diagnostics are in place, rational use will follow • Epidemiology and diagnostics is better targeting rather than by age	• HCW will likely combine packs
Partial subsidy	• Partial subsidy can be considered as long as supporting interventions (BCC and trainings) are supported	• Retail price for ACT must be higher than RDT. • Reprofile some of the partial subsidy funding towards subsidizing RDTs.
Geographic targeting	• Does not apply for Uganda	• Does not apply for Uganda