Human Development Network

Observations on the AMFM evaluation and opportunities for the future
World Bank Perspectives

Maryse B. Pierre-Louis, MD, MPH, MS/HSA
Lead Health Specialist, Public Health Cluster Leader
Human Development Network
The World Bank
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Introduction

- Full disclosure : The Bank has played a lead role in the design of the AMFm from the publication of the report by Prof. Kenneth Arrow and others in 2004 to the decision of the Board of GFATM to host and manage the AMFm through: intellectual leadership; senior leadership commitment; convening power, management and technical leadership and proactive engagement with partner agencies.
- The Bank has also been involved in the various subsequent technical and strategic discussions on AMFm throughout its implementation, both at the RBM Board and through work of various RBM working groups.
- The Bank has been supportive of the AMFm evaluation as a basis for moving towards Phase II.

Background (1): snapshot of objectives of AMFm

- The four main objectives of AMFm are to:
  - (i) to increase ACT affordability;
  - (ii) to increase ACT availability;
  - (iii) to increase ACT use, including among vulnerable groups;
  - (iv) to "crowd out" oral artemisinin monotherapy, chloroquine and sulfadoxine-Pyrimethamine (SP) by gaining market share.
- Success of AMFm to be measured by how well these primary objectives were met.

Background (2): Main results of the independent evaluation (summary based on report published on the GFATM website in July 2012)

- Of the 8 pilot countries:
  - success benchmarks were clearly met in 5 countries for availability;
  - 5 countries for QAACT price relative to the most popular anti malarial that is not a QAACT ;
  - 4 countries for QAACT market share;
  - The success benchmarks related to oral AMT price and market share were met in all pilots with sufficient AMTs in the market to make these benchmarks relevant.
  - AMFm "game changer" in the private for profit sector, except in 2 countries (increase in QAACT availability, market share; decrease in QAACT prices)
- Overall, Phase I achieved considerable success, increasing availability, gaining market share and reducing prices.

Overall Conclusions

- The evaluation suggests that the innovative financial architecture of the AMFm and the use of the private sector, in addition to the public sector, have been effective in expanding access to life-saving treatments in Africa.

- The initiation of implementation and progress towards results varied across countries requiring country specific consideration for appropriate conclusions.

- Going forward, this is an opportunity to improve the AMFm model on the basis of lessons learned from phase I (examples: criteria for the inclusion of countries? Inclusion of RDTs? Accompanying interventions. Levels of subsidies or co-payments?)

Way forward: A few thoughts (1)

- RDT technical guidelines issued by WHO during AMFM phase I implementation:
  - Challenges in implementing those guidelines remain at country level:
    - Country support for RDT roll out, financing gaps, private sector involvement, quality assurance and control and other PSM challenges.
- AMFM Phase II- Immediate and burning questions: RDTs or not RDTs? Continuation or expansion?
  - Can the same financing architecture used for malaria medicines be applied to mRDTs?
  - If yes, in which countries to start up : same pilot countries?
  - Continuation in the same countries or expansion?
  - Which level of subsidies?
  - Cost implications of the scenario selected ?
  - Market dynamics (ACT demand, manufacturing capacity)
- Balancing interim actions with longer term perspectives

Way forward: A few thoughts (2)

- It is critical that the selection of an option be submitted to the same analytical rigor used in the design of AMFm: the availability of robust evidence is indeed essential to build consensus and will therefore be a pre requisite for the Bank to endorse whatever option is proposed subsequently (Bank internal review process).

- The conclusions of this independent evaluation as well as the lessons/experiences learned from phase I should play a pivotal role in the design and implementation modalities of the subsequent phase. In this context, the local capacity which was built during phase I should be further strengthened and exploited to ensure the continuity and sustainability of follow up actions.