

REPORT TO THE BOARD ON THE AMFm

PURPOSE:

1. This report provides context for GF/B28/DPXX (“Integration of the Lessons from the Affordable Medicines Facility- malaria”) to integrate the lessons learned from the operations and financing of AMFm Phase 1 into Global Fund grant management and financial processes, including a transition period in 2013 for AMFm pilot countries.

This document is part of an internal deliberative process of the Global Fund and as such cannot be made public until after the Board meeting.

PART 1: INTRODUCTION

Information

1.1 The Strategy, Investment, and Impact Committee (SIIC) met in Geneva from 24 to 26 October 2012 for its 5th meeting. The Chair was Todd Summers (Private Foundations) and the Vice-Chair was Shaun Mellors (Communities).

1.2 This report is structured into four sections:

- Part 1: Introduction (Information)
- Part 2: Background on AMFm (Information)
- Part 3: Discussion of AMFm Phase 1 (Information)
- Part 4: Recommendation for the Future of AMFm beyond Phase 1 (Decision)

1.3 The SIIC established the AMFm Working Group of the MDAG (“Working Group”) in May 2012 (SIIC02/DP1) to recommend “options for future hosting or other support of the AMFm based on the results of the independent evaluation requested by the Board and other appropriate analyses of its risks, benefits, and impact.” In line with these terms of reference, the Working Group has developed recommendations to the SIIC based on the findings of the IE and other related studies. The Working Group met three times (June, August, and October 2012); the group established several different workstreams, which held regular teleconferences since the Working Group’s first meeting.

1.4 Due to the short time frame allowed for this work and the significant changes in the global health and malaria environment since 2008 that need to be taken into account, the Working Group has been working closely with the Roll Back Malaria Partnership’s AMFm Task Force (“Task Force”) to ensure full alignment of recommendations. The AMFm Task Force includes all AMFm Working Group members plus additional representatives from pilot countries, donors, and technical partners. The SIIC expresses its gratitude to the members of the AMFm Working Group and Task Force for their dedication and efforts to inform this recommendation to the Board.

1.5 The SIIC recognizes the contributions of implementing countries, technical partners, and donors and the potential role of the Working Group in 2013 to ensure an orderly transition to the recommended fully integrated model. With the completion of AMFm Phase 1, the SIIC has further noted its need to consider the existence and/or modified role of the Working Group.

1.6 Given the specific and technical nature of the issues surrounding AMFm, the SIIC has relied heavily upon the technical expertise, experience and input of the members of the Working Group, which form the basis for recommendations contained in this report.

PART 2: BACKGROUND ON AMFm

Information

2.1 The Affordable Medicines Facility–malaria (AMFm) has been hosted as a separate business line within the Global Fund since 2008 (GF/B18/DP07). It is a financing mechanism designed to expand access to effective antimalarial, quality assured artemisinin-based combination therapies (QAACs) by increasing availability and decreasing prices relative to less-effective antimalarials and artemisinin monotherapies. This is intended to reduce malaria-related deaths and delay the onset of widespread resistance to artemisinin.

2.2 The AMFm was built upon three pillars:

- negotiations with pharmaceutical manufacturers to reduce *ex-factory* prices of QAACTs for public and private sector buyers;
- further reductions of the price paid by first-line buyers (importers) through a subsidy (“co-payment”) paid on their behalf directly to manufacturers ; and
- supporting interventions (SI) at country-level to facilitate the safe and effective scale-up of access to QAACTs.

2.3 AMFm Phase 1 is funded from two sources. A co-payment fund of approximately US\$338 million, financed by UNITAID, the governments of the United Kingdom and Canada, and the Bill & Melinda Gates Foundation, covers subsidies for QAACTs. A further amount of up to US\$127 million comes from the extension of existing Global Fund malaria grants to finance supporting interventions at country level, which facilitate the safe and effective scale-up of access to ACTs.

2.4 AMFm Phase 1 is currently being implemented through the public, private for-profit, and private not-for-profit sectors in nine pilots in eight countries: Cambodia, Ghana, Kenya, Madagascar, Niger, Nigeria, Tanzania (mainland and Zanzibar) and Uganda. Implementation of Phase 1 started in mid-2010 with the signing of grant agreements with the Global Fund and the ordering of co-paid QAACTs by in-country buyers, and will end on 31 December 2012. The pilots started at different times for local operational reasons, including the grant negotiation process and availability of an eligible QAACT.

2.5 The Board (GF/B20/DP24) established that AMFm would be evaluated against four stated objectives: (1) increased ACT availability, (2) increased ACT affordability, (3) increased ACT use, especially among vulnerable groups, (4) “crowding out” of oral artemisinin monotherapies and older, less-effective antimalarials. In the 2010 Technical Evaluation Reference Group (TERG) “Position Paper to the Policy and Strategy Committee on the AMFm Independent Evaluation,” the TERG recommended that, given the short implementation period, the AMFm evaluation should concentrate on the “upstream” parameters (QAACT availability, price, and market share) relevant to the business model of the AMFm as a financing mechanism, rather than the “downstream” parameters (access to and use of ACTs) which are expected to follow from the “upstream” part and are neither new or unique to the AMFm. An AMFm Independent Evaluation (IE) was set up to monitor if the pilots achieved these objectives against preset targets (“success benchmarks”). This consisted of a series of country case studies to reflect properly in its findings the local contextual factors that affected the achievement of the success parameters. The *ex-ante* establishment of success benchmarks and the in-depth country case study approach (versus inter-country comparisons) adopted by the IE follow from direct recommendations from the 2010 TERG position paper. The evaluation period ran between mid-2010 and December 2011. The IE published a preliminary report dated 18 July 2012 and a final report dated 28 September 2012.

Findings of the Independent Evaluation and Related Studies

3.1 The IE published a preliminary report dated 18 July 2012 and a final report dated 28 September 2012; the quantitative data and IE's main conclusions were the same in both versions, but these were complemented by findings from the remote areas studies (summarized in Para 3.5 below) and some additional information in the final report. The preliminary findings of the IE have already been reported to the Board (GF/B27/06). It was not possible to include Cambodia in the IE due to significant delays in sourcing appropriate QAACTs for that country. In some countries there was a significant gap between the availability of co-paid QAACTs and the launch of the SIs. Full implementation of all the pillars of the AMFm model varied between 0 and 11 months at the time of endline data collection. Availability of co-paid QAACTs varied between 9 and 17 months.

3.2 It has not been possible, due to design and resourcing constraints, for the IE to provide any information on the achievement of the "downstream" parameters related to use of ACTs.

3.3 Of the 8 pilot programmes evaluated, the "upstream" success benchmarks were clearly met in 5 pilots for availability, 5 for affordability, and 4 for market share¹. It was possible that these benchmarks were also achieved in one additional pilot for availability and price and in 3 for market share, but the results did not meet statistical significance. The success benchmarks for crowding out artemisinin monotherapies were met in two pilots where the amount of artemisinin monotherapies in the market made these benchmarks relevant.

3.4 AMFm was described by the IE as a "game changer" for the private for-profit sector in 6 out of the 8 pilots, noting that it is an important source of antimalarial treatment for many people, including the most vulnerable and remote from public sector healthcare facilities. According to the IE, approximately 70% of all co-paid QAACTs were delivered to the private for-profit sector, 26% for the public sector, and 4% for the private non-profit sector. The IE has shown that QAACTs have been rapidly and widely distributed through pre-existing private sector distribution channels. AMFm led to few fundamental changes to public sector antimalarial supply, where QAACT supply was hindered by procurement and grant disbursement problems. Among other factors facilitating AMFm, the IE noted that a strong local governance structure with involvement of the private sector was important.

3.5 The IE also carried out a study of the availability of QAACTs in "remote" areas of Kenya and Ghana during the 1st quarter of 2012. Remoteness was defined in terms of geographical access to major service centers. It found that QAACTs were widely available in these remote areas, particularly in public health facilities that had any antimalarials (95-96%). Availability was also high in private for-profit outlets (Ghana – 68%, Kenya – 46%). Almost all of these were AMFm-supported QAACTs (97-98%). There was a substantial increase in availability of QAACTs compared to the baseline measures (Ghana – 26%, Kenya – 27%). QAACT market share, dominated by AMFm-supported QAACTs, was also substantial (Ghana – 59%, Kenya 48%). Prices were also low and in line with the recommended retail prices in both countries.

¹ Market share was the measure used for "crowding out" less-effective antimalarials and oral artemisinin monotherapies

3.6 The findings of the IE for remote areas are supported by a recently published study from Tanzania carried out during the AMFm pilot period. This showed that availability of low priced ACTs did not vary significantly based on remoteness.

3.7 The conclusions from the IE summarized in this report reflect the positions of the Working Group and the TERG.

3.8 The Working Group noted that it was impressed by the level of co-operation and collaboration between the private for-profit sector (manufacturers and first-line buyers) and the public sector during AMFm Phase 1 at both global and country levels. It feels that the positive contribution of the private sector in the piloting of AMFm should be recognized.

SIIC Recommendation: Expand, Accelerate, Modify, or Terminate/Suspend?

3.9 Based on the findings of the IE and of the other related studies analyzed by the Working Group, the SIIC concurs with the Working Group's recommendation for continuing with some form of co-payment system to increase availability and affordability (and therefore access) of QAACTs in the private for-profit sector. The IE has shown that the greatest benefit from AMFm has come from its impact on access to QAACTs through the private for-profit sector.

3.10 The Working Group proposed the following analysis for each of the four recommendation options found in GF/B20/DP24 for the AMFm business line:

- *Expand:* Given changes in the malaria environment since the current AMFm model was designed, as malaria is no longer the predominant cause of fever in many settings, and reliable malaria rapid diagnostic tests are available, the current model should not be expanded in an unchanged form. A transition to a model that incorporates efforts to improve access to malaria diagnostic testing as well as a modified design in line with the principles identified for the new Global Fund financing model is needed for long-term viability. **Expansion is not recommended.**
- *Accelerate:* For the same reasons as stated for "Expand," accelerating the current AMFm model is not recommended. **Acceleration is not recommended.**
- *Modify:* The IE has not been able to give a clear and unambiguous answer as to whether AMFm has had a clear and indisputable impact on malaria mortality and morbidity. Mortality and morbidity benefits of any package of malaria control interventions are difficult to assess, and separating out the relative contribution of several concomitant malaria control interventions may not be technically feasible even if more time were available for the assessment of impact. However there is sufficient evidence from the Phase 1 pilot programmes and other related studies that a manufacturer-level subsidy can increase access to effective antimalarial treatments (in this case QAACTs). In order to improve targeting of malaria treatment, efforts to improve access to affordable and quality assured malaria diagnostic testing should be an integral part of initiatives aiming at improving access to QAACTs in both the public and private sectors. **Modification is recommended.**
- *Terminate or Suspend:* Termination of the AMFm model completely would lose all the benefits and learnings from Phase 1 pilots. Given that the IE has shown the success benchmarks have been achieved in the majority of countries, it would be difficult to

justify an abrupt and complete termination with no alternative to replace it. **Termination or Suspension is not recommended.**

On the basis of the analysis and recommendations presented by the Working Group, the SIIC is recommending modification.

Considerations for Modification of the AMFm Business Line

3.11 **Guiding Principles:** The SIIC was presented with the following guiding principles for modifying the AMFm model by the Working Group:

- **Scope:** As there are adequate systems for ensuring access to effective treatments through the public sector, any modification of the AMFm model would be specifically targeted at increasing access through the private for-profit sector.
- **Country-driven:** Many, but not all, malaria endemic countries may want and need to subsidize effective antimalarial treatment through the private for-profit sector in order to achieve their malaria case management targets. Any modification must put country-ownership and alignment with country needs and plans at the center of its design. By integrating with country malaria plans, it will ensure that supporting interventions at country level are included, aligned, and implemented.
- **Evidence-based:** The model must be evidence-based with continuous learning built in. It must be able to demonstrate use by malaria patients, including the most vulnerable groups.
- **Comprehensive:** Under the new model, efforts to improve access to effective treatment must be coupled with efforts to improve access to diagnostic testing.
- **Financing:** Financing must be sustainable over the long-term and aligned with the Global Fund core financing model, providing predictability and supporting systematic planning.
- **Accountability:** It is important with major initiatives that there is accountability to monitor the changes and ensure accountability both to the Board and to major stakeholders.
- **Public-private Co-operation:** The learnings of the value of close co-ordination between the public and private sectors at a country level should be retained.
- **Global Level Co-operation:** The success of the collaboration between QAACT manufacturers and the Global Fund in designing and implementing Phase 1 should be recognized and the mechanisms to ensure this is continued should not be lost.
- **Transition:** It is crucial that the Global Fund ensures responsible and orderly transition for the AMFm Phase 1 countries into the new modified model.

3.12 The SIIC agrees that there is a need to integrate the lessons learned from the operations and resourcing of Phase 1 of the AMFm into the core Global Fund grant management and financial processes to better ensure sustainability. Under the SIIC recommendation, the decision of whether and how much funding to allocate to QAACT and RDT co-payments would be left to the countries themselves as part of normal Global Fund funding processes. This should not, however, preclude countries also financing these payments with other forms of aid finance (in agreement with the donors) and/or domestic funding streams.

3.13 It will be important for the Board and countries to understand that this new model will mean that, following responsible transition, there will no longer be a separate funding mechanism within the Global Fund for QAACT co-payments. Countries will be responsible for

mobilizing the necessary resources for co-payments and/or other private sector interventions, including from the Global Fund core funding mechanism.

3.14 As the co-payment mechanism was responsible for the impact achieved during the AMFm pilot, the SIIC recommends that it should remain in place for use by interested countries. This mechanism consisted of (a) centrally negotiating *ex-manufacturer* prices with the QAACT manufacturers, (b) providing direct payments from the Secretariat to manufacturers to co-pay QAACT orders and (c) enabling private sector buyers in relevant countries to purchase directly co-paid QAACTs from manufacturers. In principle this mechanism could also be extended to RDTs. However the number of manufacturers and the products they supply is much greater than for QAACTs. The SIIC acknowledges the need for an assessment by technical partners of the feasibility of including diagnostic testing into the co-payment system.

3.15 The SIIC leadership requested that the TERG and the MDAG look into broader AMFm learnings regarding the role of the private sector and markets, and how they affect broader Global Fund investments.

Considerations for Transition to the Integrated Model

3.16 The overarching objectives for a transition period are to ensure: (i) access to QAACTs in AMFm pilot countries is not disrupted; (ii) global ACT and active pharmaceutical ingredient markets are not destabilized; and (iii) countries are well supported to transition to the new model. In practice, the number of variables means **the length of an orderly and responsible transition is still to be defined**. These variables include:

- how quickly the Global Fund’s new funding model can be rolled out;
- the need for detailed country consultations with the existing pilot countries on next opportunities for grant renewals or reprogramming;
- the time required by the Secretariat to develop and put in place systems to integrate lessons learned from the AMFm model into Global Fund core grant processes.

3.17 The demand for co-paid QAACTs in 2011 was such that the initial contributions to the co-payment fund were committed sooner than expected. To counter this problem, “demand levers” were introduced to ration supply of co-paid QAACTs. This has caused concerns from the Phase 1 countries around the perceived lack of transparency on their introduction and their application. In planning for transition in 2013, the SIIC concluded that each country should be informed of the amount of funding available to support private sector co-payments and should determine the parameters, such as whether demand levers are used, under which funding is utilized in each such country.

3.18 The SIIC was presented with models developed by the Working Group (in collaboration with external consultants) and the Secretariat showing the resource needs for 2013 to ensure that there is no interruption of co-paid QAACT supplying the pilot countries. The details of this analysis are shown in Annex 1. The estimates of the financing needs for co-payments are:

- Estimate 1 (bottom up demand forecast): US\$ 154 million
- Estimate 2 (historic rates of co-payment approvals): US\$ 114 million

3.19 In addition to the funding needs for co-payments, the Working Group and the Secretariat estimate that up to US\$26 million will be needed to fund critical supporting interventions (mass

communication programmes, retail price monitoring, training, etc.). This is an upper level estimate based upon a review of budgets submitted in country applications to the Global Fund and US President's Malaria Initiative (PMI) Malaria Operational Plans. It also assumes that there will be a need to maintain supporting interventions through a transitional period. The supporting interventions would continue to come from countries' core global grant resources and not from additional dedicated donor funding.

PART 4: RECOMMENDATION FOR THE FUTURE OF AMFm BEYOND PHASE 1 Decision

4.1 The SIIC is recommending that the AMFm model be modified in line with these recommendations:

Integration:

4.2 In order to ensure that countries can continue to access the co-payment mechanism, the Global Fund should retain the capability for central negotiation of *ex-manufacturer* prices and for the processing of co-payments for orders placed by private sector buyers in relevant countries. There is a need for an assessment by technical partners of the feasibility of including rapid diagnostic testing into the co-payment system.

4.3 Noting learnings from the AMFm Phase 1 about the importance of the private for-profit sector in many countries, the SIIC recommends that the Global Fund should, where necessary, put in place policies and procedures to ensure that countries can utilize core Global Fund grants to work with the private for-profit sector through a co-payment mechanism for malaria interventions, if this is in line with their needs and plans and remains consistent with current normative guidance.

4.4 As part of the routine monitoring and evaluation of Global Fund grants, countries using the co-payment mechanism for the private for-profit sector should ensure that there is a monitoring and evaluation component to their plans. This is to ensure that there is good evidence to show that co-payments and the involvement of the private for-profit sector is increasing access to effective diagnostic testing and treatment.

Transition:

4.5 The Global Fund should plan for the requirements for the SIIC-recommended Transition for the co-payment fund in 2013 based on the estimates presented by the Working Group and the Secretariat and detailed in Annex 1. These estimates set the total funding requirements for all Phase 1 countries between US\$114-154 million (depending on assumptions). These transition costs will only be financed through voluntary donor contributions into the existing AMFm fund, as it is currently unclear how soon integration under the modified model can be operationalized. As is the Secretariat estimates that there will be no more funding available for co-payment approvals after 31 December 2012, it is strongly recommended that an urgent resource mobilization exercise is undertaken. This should emphasize to potential donors that this is in order to ensure an orderly and responsible transition to the modified co-payment system. If the Board adopts the SIIC recommended decision point, the Secretariat is requested to report to the FOPC and SIIC prior to the end of 2012 on the outcome of resource mobilization efforts undertaken to finance the co-payments for the Transition.

4.6 Following consultation, the countries should be able to express preferences on how the demand shaping levers are applied in their particular country circumstances. As the two forecasts of resource needs indicate different country needs, the Secretariat must carry out further analysis and consultation to confirm resource needs and gaps. This analysis will then inform the actual funding amounts to be applied from the start of 2013. Further, as resource availability is confirmed over the end of 2012, country financing will need to be scaled up/down to reflect resource availability.

4.7 In addition, the Global Fund should plan for another US\$26 million, as estimated by the Working Group and the Secretariat, for critical supporting interventions to ensure a smooth and orderly transition to the new co-payment mechanism. During the 2013 transition, the funding for the critical supporting interventions should come from existing Global Fund grants, in line with the current process. The SIIC recommends that the Board authorize the Secretariat to deploy remaining resources from malaria grants in Phase 1 for supporting interventions.

Decision Point 1: Integration of the Lessons from the Affordable Medicines Facility- malaria

The Board refers to its decision (GF/B20/DP24) to review the findings of the Independent Evaluation of the Affordable Medicines Facility – malaria (AMFm) Phase 1 and make a recommendation on whether to “expand, accelerate, modify, terminate or suspend the AMFm business line” in pilot countries.

The Board:

- 1. notes the findings of the Independent Evaluation (“IE”), as detailed in the Strategy, Investment and Impact Committee (“SIIC”) Report to the Board (GF/B28/XX), on the effectiveness of the AMFm in the eight pilot programs and, in particular, notes the results regarding the “upstream” success parameters recommended in 2010 by the Technical Evaluation Reference Group (“TERG”).***
- 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 and the TERG’s interpretation of those findings 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.***
- 4. recognizes the importance of ensuring access to affordable diagnostic testing and treatment for malaria and the role of the private sector in delivering this access.***
- 5. notes the role of the Global Fund in helping to ensure sustainable affordable pricing for health commodities through innovative strategies and***

initiatives, including through engagement of the private sector.

- 6. thanks countries, partners, donors and manufacturers for their participation and support in AMFm.*

The Board decides to modify the existing AMFm business line by integrating the lessons learned from the operations and resourcing of Phase 1 of the AMFm into Global Fund grant management and financial processes by:

- a. requesting the Secretariat to establish and operationalize a co-payment system through which the Global Fund will make direct payments to manufacturers on behalf of in-country buyers and at negotiated prices for countries which request the use of approved grant funds for a private sector subsidy to achieve their malaria case management targets and utilize supporting interventions; and*
- b. Acknowledging the need for an assessment by technical partners of the feasibility to include diagnostic testing into the co-payment system, which would inform the operationalization of the co-payment system.*

2013 Transition by AMFm Pilot Countries to Full Integration:

The Board:

- 1. notes that the integration of a co-payment system into Global Fund grant management and financial processes will mean that, following a responsible Transition, co-payments for anti-malarial drugs will no longer be available through a separate funding mechanism hosted by the Global Fund.*
- 2. decides that, during the Transition in 2013 to operationalizing the integration of a co-payment system, the pilot countries will have a defined funding allocation to support private sector co-payments, subject to availability of dedicated resources for such payments, and that each country will determine the parameters, such as the use of demand levers, under which that funding is utilized.*
- 3. requests the Secretariat to report to the FOPC and SIIC prior to the end of 2012 on the outcome of resource mobilization efforts undertaken to finance the co-payments for the Transition.*
- 4. authorizes the Secretariat to deploy remaining resources from malaria grants in Phase 1 for supporting interventions, which is separate from co-payment funds.*

This document is part of an internal deliberative process of the Global Fund and as such cannot be made public until after the Board meeting.

Transition to New Integrated Model for Existing AMFm Countries

This Annex gives details of the estimates that the Working Group and the Secretariat have developed for the resource needs in 2013 to ensure the responsible and orderly transition of the AMFm Phase 1 countries.

Given the urgency for resourcing in 2013, two estimates for transition in 2013 have been developed.

The two estimates for 2013 both cover needs for the private for-profit and private not-for-profit sectors only. Public sector ACT requirements by Global Fund principal recipients in 2013 have been budgeted already at full price (*i.e.* without a co-payment through AMFm) in existing Global Fund grants². Approximately US\$36 million is currently budgeted for public sector ACT procurement in AMFm pilot countries in 2013.

Estimate 1: Bottom-up Modeling of Future Demand:

The first estimate of US\$154 million reflects modeling of projected potential private sector demand³ based on bottom up analysis of demand. This estimate is based on projections of antimalarial demand in the private sector in all pilot countries from analysis of household surveys, coupled with estimates from Center for Disease Dynamics, Economics, and Policy (CDDEP) of the share of this market that would be captured by co-paid QAACTs. Price assumptions used in this model reflect some degree of rationing as they incorporate the weighted average price under the AMFm to date, however they also reflect a growing market share for co-paid QAACTs.

AMFm Pilot Country	Estimated co-payment required for 2013 Private Sector ACT Needs (US\$ '000)
Cambodia	471
Ghana	10,426
Kenya	11,577
Madagascar	3,726
Niger	4,784
Nigeria	85,118
Tanzania (incl. Zanzibar)	11,352
Uganda	27,352
Total	154,810

It is important to note that this forecast was designed to be relatively robust at global- and regional/multi-country levels, but much less so at the country level. Therefore, there is a risk of basing serious country-specific decisions on uncertain projections.

² There are potential gaps in Kenya and Tanzania Global Fund public sector procurement in 2013. The Secretariat is exploring options to cover these needs through reprogramming and other grant flexibilities.

³ Modelling methodology used is available on request.

Estimate 2: Modeled on Historic Rates of Co-payment Approvals:

The second estimate of US\$114 million reflects historical rates of co-payment approvals under the AMFm Phase 1. As such this estimate can be considered a potential floor for private for-profit sector coverage in 2013 if the existing aggregate AMFm market is to be maintained at a minimum. The estimate is based on data of approved orders from the private sector in the pilot countries over the last 12 months, when rationing measures, in the form of “demand-shaping levers” have been in effect⁴. The average co-payment price per course of treatment over this period is the same as used to cost the above US\$154 million estimate of private sector demand.

AMFm Pilot Country	Total Co-payment for private sector, October 2011-September 2012 (US\$'000)
Cambodia	304
Ghana	20,313
Kenya	15,712
Madagascar	913
Niger	1,951
Nigeria	45,843
Tanzania	16,122
Uganda	12,949
Zanzibar	nil
Total	114,111

During the transition phase, the Working Group is recommending two modifications to the current AMFm model. These will be introduced in 2013 to reflect the move towards an integrated model. Firstly, countries will be informed of indicative ‘country envelopes’ for the year, and secondly, following the opportunity for country consultation, countries will be able to indicate preferences on how ‘demand shaping levers’ are applied for their private sectors. The implementation of these envelopes will retain the current model of co-payment and actual approval of orders through the Global Fund Secretariat. As the two models indicate different country envelopes, further analysis and consultation to confirm resource needs and gaps, will inform the actual envelopes to be applied from the start of 2013. Further, as resource availability is confirmed over the end of 2012, country indicative envelopes will need to be scaled up/down to reflect resource availability.

In addition to the funding requirement for co-payments, the working group estimates that up to US\$26 million will be needed in 2013 in the pilot countries for critical supporting interventions. This is an upper level estimate based on a review of budgets for key supporting interventions for behavior change communication and training activities submitted in country applications to the Global Fund for the AMFm as well as PMI Malaria Operational Plans; it is calculated at US\$0.07 per capita. During the 2013 Transition, supporting interventions will be resourced in the first instance through existing Global Fund malaria grants. Funds will be found by utilizing all available flexibilities in existing grants, including re-programming.

⁴ These levers were put in place in August 2011 to ensure co-payments could continue to be approved through the end of the AMFm pilot. Based on available resources, this US\$114 million approved only represents 40% of the requests received on behalf of private sector first-line buyers over the past 12 months.

Resource Documents:

1	Independent Evaluation of Phase 1 of the Affordable Medicines Facility - malaria (AMFm): Multicountry Independent Evaluation Report (Final Report)	http://www.theglobalfund.org/documents/amfm/AMFm_2012IEPhase1FullFinal_Report_en/
2	Report to the Board on the AMFm (GF/B27/06)	http://www.theglobalfund.org/documents/board/27/BM27_06BoardOnAMFm_Report_en/
3	Expert Advisory Group on the Affordable Medicines Facility-malaria (AMFm): Review of the AMFm Phase 1 Independent Evaluation Preliminary Report (Friday 22 June 2012, Geneva)	http://www.theglobalfund.org/documents/amfm/wave1/AMFm_ExpertAdvisoryGroupMeeting_Report_EN