



WHAT HAPPENED TO THE MALARIA MARKET IN TANZANIA AFTER THE AMFM?

ASTMH, 65th Annual Meeting, Atlanta, Nov 2016

Daniel Michael¹, Nassor Kikumbi², ACTwatch Group*³

¹ PSI/Tanzania; ²Synomind Consulting Co. Ltd; ³ PSI



BACKGROUND

Key strategies have been implemented in Tanzania to ensure access to confirmatory testing and appropriate treatment for malaria cases. These include a private sector copayment mechanism (CPM), first implemented as the Affordable Medicines Facility-malaria (AMFm) pilot from 2010-2011 and subsequently the Global Fund's CPM. To extend quality case management services to the community level, a drug store accreditation program was recently taken to scale across much of the country. Accredited Drug Dispensing Outlets (ADDOs) are accredited drug stores, whereas non-accredited drug stores are known as *duka la dawa baridi* (DLDB).

METHODS

Nationally-representative malaria outlet surveys were conducted in 2010, 2011 and 2014. A census of public and private outlets with potential to distribute malaria testing and/or treatment was conducted among a representative sample of administrative units. An audit was completed for all antimalarials, malaria rapid diagnostic tests and microscopy.

RESULTS

What happened to QA ACT availability after the AMFm? By the end of the AMFm pilot period in 2011, quality-assured artemisinin combination therapy (QA ACT) was available in more than half of all antimalarial-stocking private sector outlets (66%) and 82% of public sector outlets. Availability increased in 2014 to 83% of private sector outlets and 98% of public sector outlets. In 2014, QA ACT availability was approximately 90% in private facilities (89%), pharmacies (91%) and ADDOs (87%) (Figure 1).

Has continuation of the private sector co-payment mechanism improved QA ACT market share? During the AMFm, QA ACT market share increased from 30% in 2010 to 42% in 2011. Subsequently, QA ACT market share was maintained and was 44% in 2014. The majority of QA ACTs distributed by the private sector in 2011 and 2014 had the green leaf logo indicating co-payment by the Global Fund. Despite these improvements, non-artemisinin therapies including sulphadoxine-pyrimethamine (SP) continued to dominate the market. In 2014, non-artemisinins accounted for more than half of all antimalarials distributed (56%). Although SP is indicated for intermittent preventive therapy for pregnant women (IPTp), very high market share for SP (51% in 2014) and product packaging and instructions indicating use for malaria case management in people of all ages, indicate that SP is being used for case management (Figure 2).

How much does QA ACT cost relative to other popular antimalarials? During the AMFm pilot, the private sector retail price of QA ACT declined such that in 2011, QA ACT and the most popular antimalarial, SP, were the same price. 2014 prices for QA ACT and SP were higher than respective prices in 2011, however the price of QA ACT increased to a greater extent than the price of SP. In 2014, QA ACT was 1.3 times more expensive than SP (Figure 3).

Where antimalarials are distributed, is confirmatory testing available? Availability of confirmatory testing, either by malaria rapid diagnostic test (RDT) or microscopy, has improved since 2010 in the public and private sectors. While 89% of public health facilities and 94% of private health facilities had testing available in 2014, overall private sector availability remained relative low (11%) (Figure 4).

CONCLUSION

The AMFm continuation under the private sector co-payment mechanism (CPM) has been successful in further improving access to QA ACT in the private sector, where the majority of antimalarials are distributed in Tanzania. In 2014, more than 80% of antimalarial-stocking private sector outlets had QA ACT available. However, QA ACT market share remained below 50%, and half of all antimalarials distributed in 2014 were the non-artemisinin therapy, SP. QA ACT private sector price was the same as the price of SP in 2011, however an increase in price in 2014 meant that QA ACT treatment was 1.3 times more expensive than SP. If a substantial gap in price for QA ACT and SP persists, price may serve as a barrier to QA ACT uptake. Furthermore, the very low availability of confirmatory testing in the private sector suggests that presumptive treatment remains common.

Figure 1: Availability of quality-assured ACT Among outlets with at least one antimalarial in stock

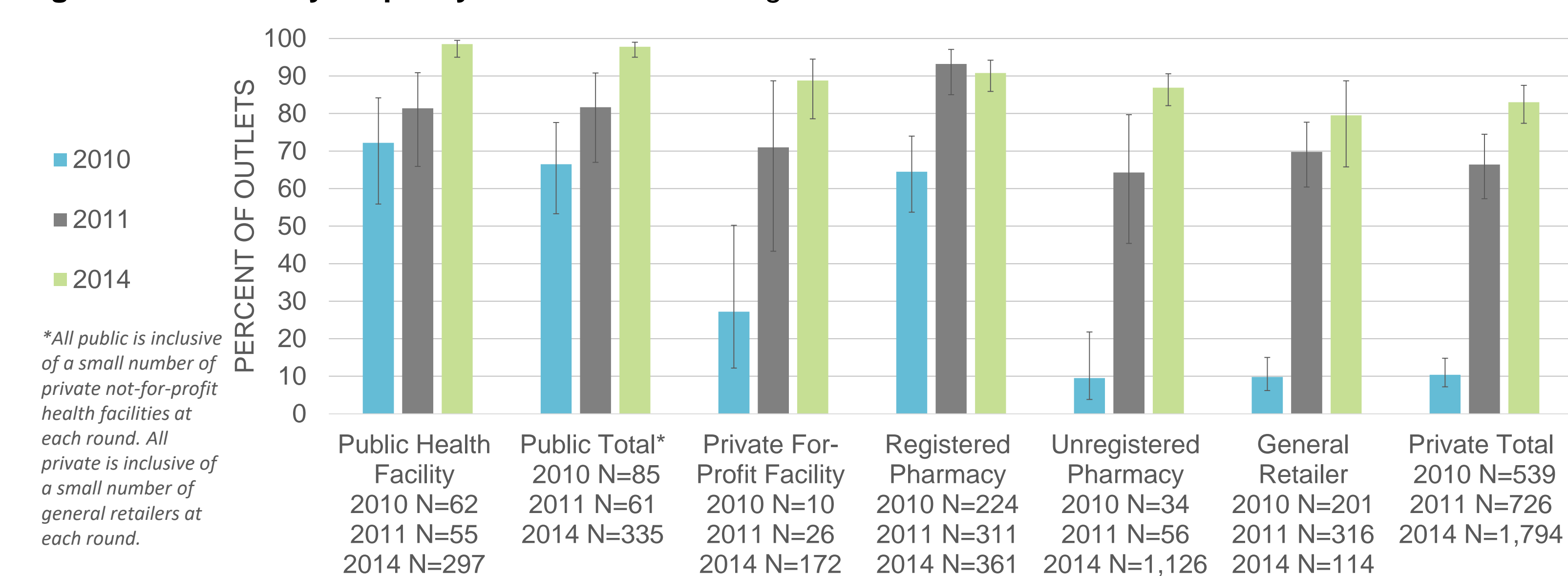


Figure 2: Antimalarial market share Relative market volume (sale/distribution) of antimalarials

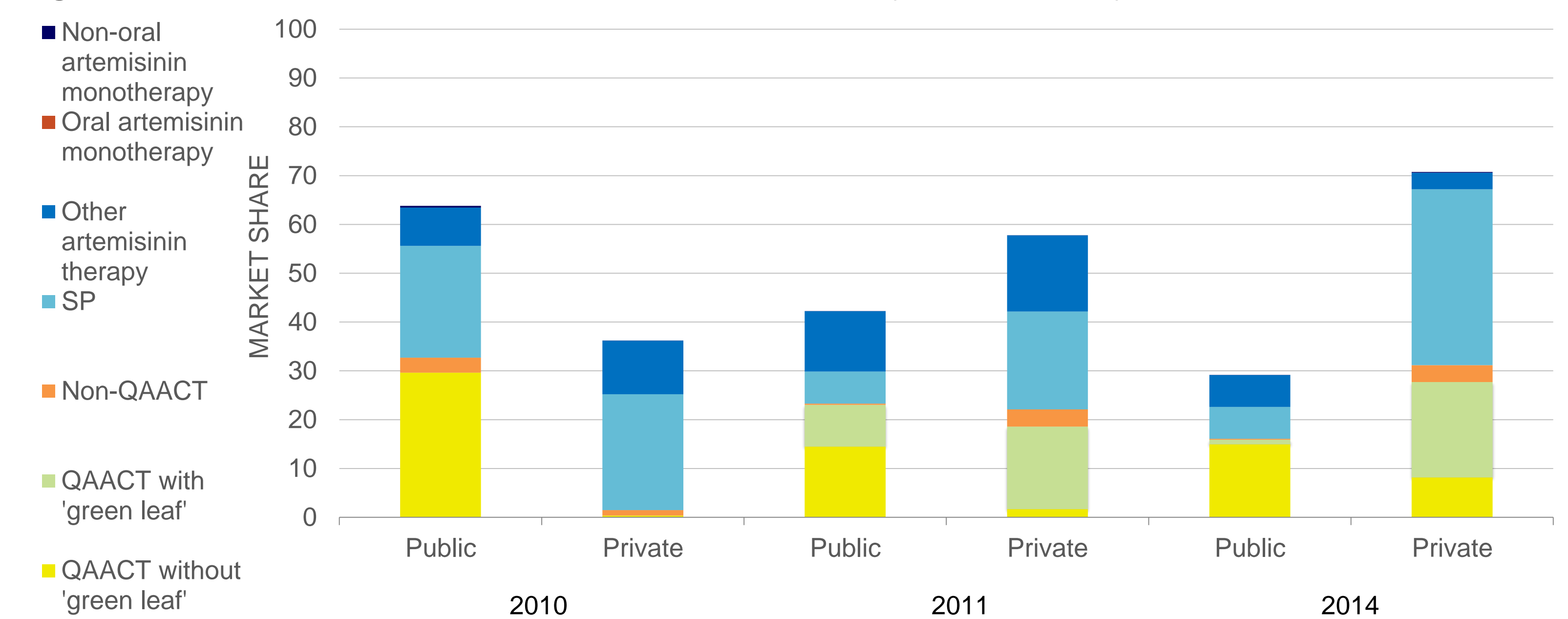


Figure 3: Median private sector price of QA ACT and the most popular non-artemisinin therapy, SP Retail price for one adult equivalent treatment dose (tablet formulation) deflated to 2010 US Dollars

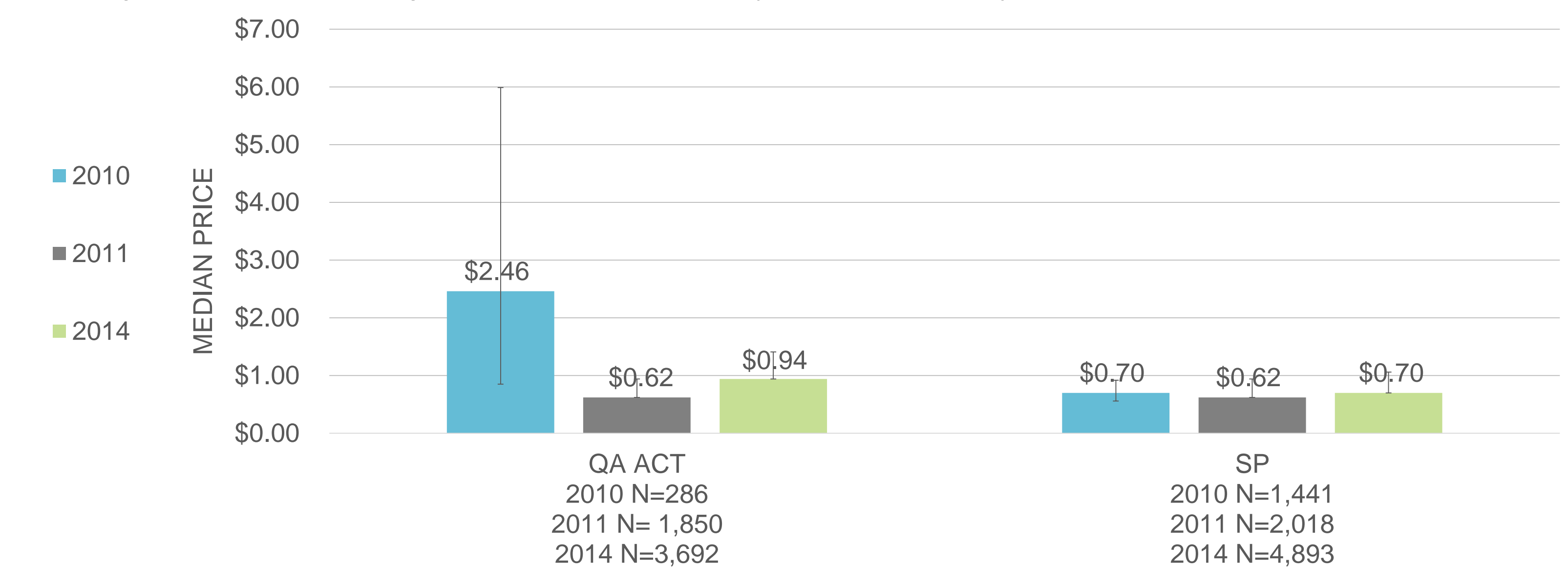


Figure 4: Availability of malaria blood testing Among outlets stocking antimalarials on the day of the survey or in the past 3 months

