



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

ASTMH, 65th Annual Meeting, Atlanta, Nov 2016

Chinazo Ujuju¹, Jennifer Anyanti¹, Wole Fajemisin¹, Godwin Ntadom², ACTwatch Group^{*3}

¹ Society for Family Health, Nigeria; ² Nigeria National Malaria Elimination Program; ³ PSI

BACKGROUND

Key strategies have been implemented in Nigeria 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, which ran through to 2016.

METHODS

Nationally-representative malaria outlet surveys were conducted in 2009, 2011, 2013 and 2015. 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 about half of all antimalarial-stocking private sector outlets (53%) and 61% of public sector outlets. Availability increased in subsequent survey rounds and in 2015, was over 80% in both the public (86%) and private sector sectors (84%). In 2015, QA ACT availability was notably high in pharmacies (98%) and drug stores (86%) (Figure 1).

Has continuation of the private sector co-payment mechanism improved QA ACT market share? The private sector was responsible for the majority of antimalarial distribution (<80%) at each survey round. During the AMFm, QA ACT market share increased from 2% in 2009 to 20% in 2011. Subsequently, QA ACT market share increased further to 31% in 2013 and 39% in 2015. The majority of QA ACTs distributed 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 2015, non-artemisinins accounted for nearly half of all antimalarials distributed. Although SP is indicated for intermittent preventive therapy for pregnant women (IPTp), very high market share for SP (29% in 2015) 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. Oral artemisinin monotherapies (oral AMT) are banned in Nigeria due to the threat they pose for artemisinin drug resistance. However, oral AMT is commonly available in the private sector, and accounted for 3% of the total market share in 2015 (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 dramatically. Price has remained similar since 2011 and is trending downward. However, in 2015 QA ACT remained 3.4 times more expensive than the most popular non-artemisinin therapy, SP. QA ACT was nearly 7 times more expensive than chloroquine in 2015 (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 2009 in the public and private sectors. While more than 85% of public health facilities had testing available in 2015, private sector availability remained relative low (12%) (Figure 4).

CONCLUSION

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 Nigeria. In 2015, private sector QA ACT availability was high (84%) and similar to public sector availability (86%), indicating that private sector readiness for appropriate malaria treatment parallels public sector readiness. QA ACT market share increased under the CPM but remained low at 39% in 2015, and approximately half of all antimalarials distributed in 2015 were non-artemisinin therapies. High QA ACT price relative to non-artemisinin therapies including SP and chloroquine is likely still a barrier to 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

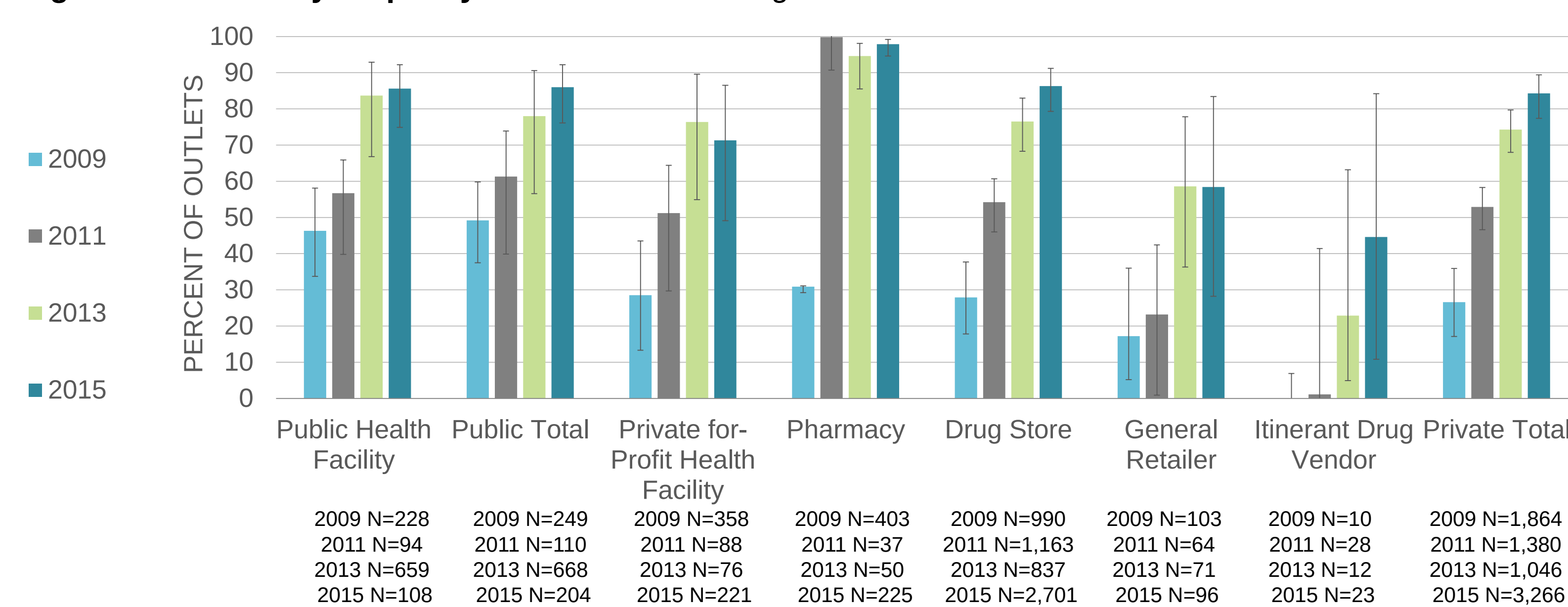


Figure 2: Antimalarial market share Relative market volume (sale/distribution) of antimalarials

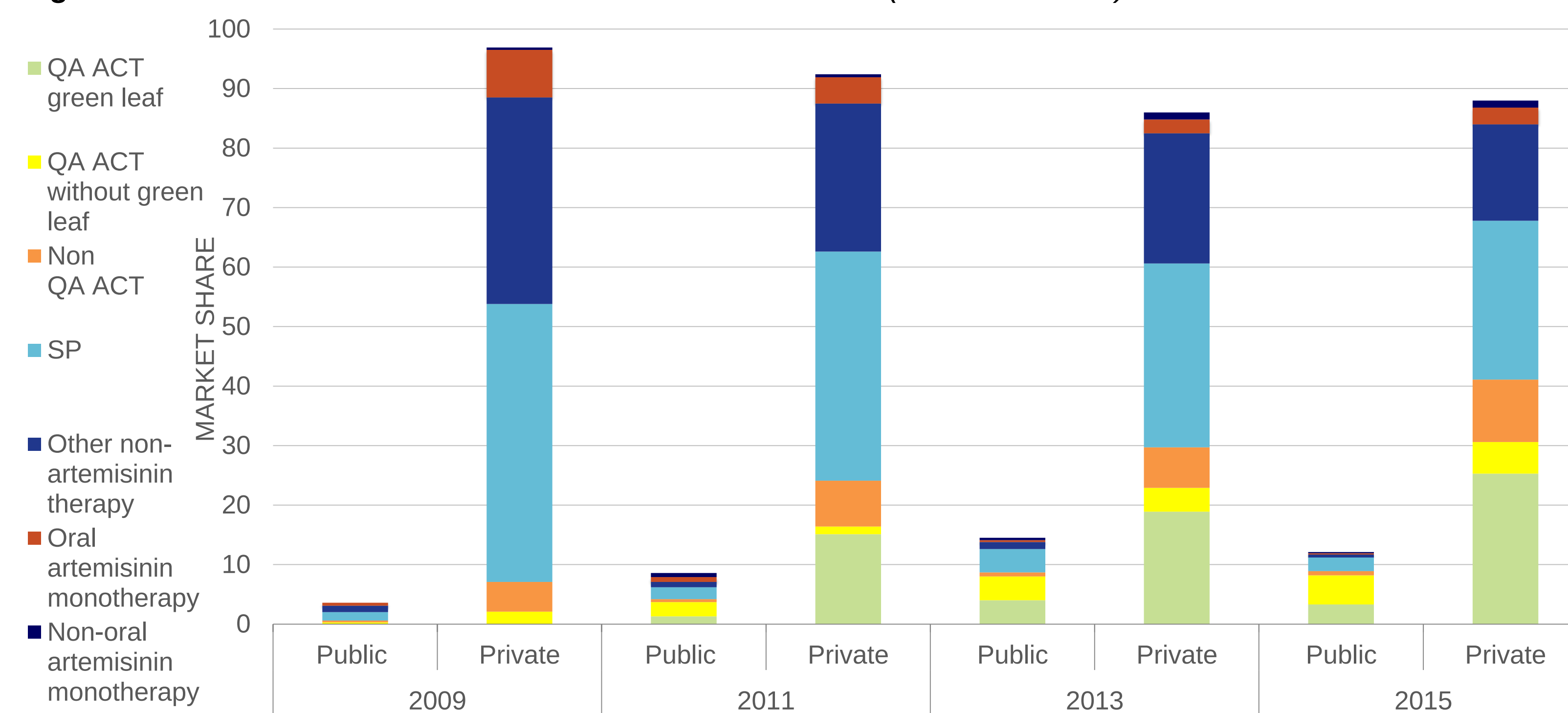


Figure 3: Median private sector price of QA ACT and popular non-artemisinin therapies, SP and chloroquine. Retail price for one adult equivalent treatment dose (tablet formulation) deflated to 2009 US Dollars

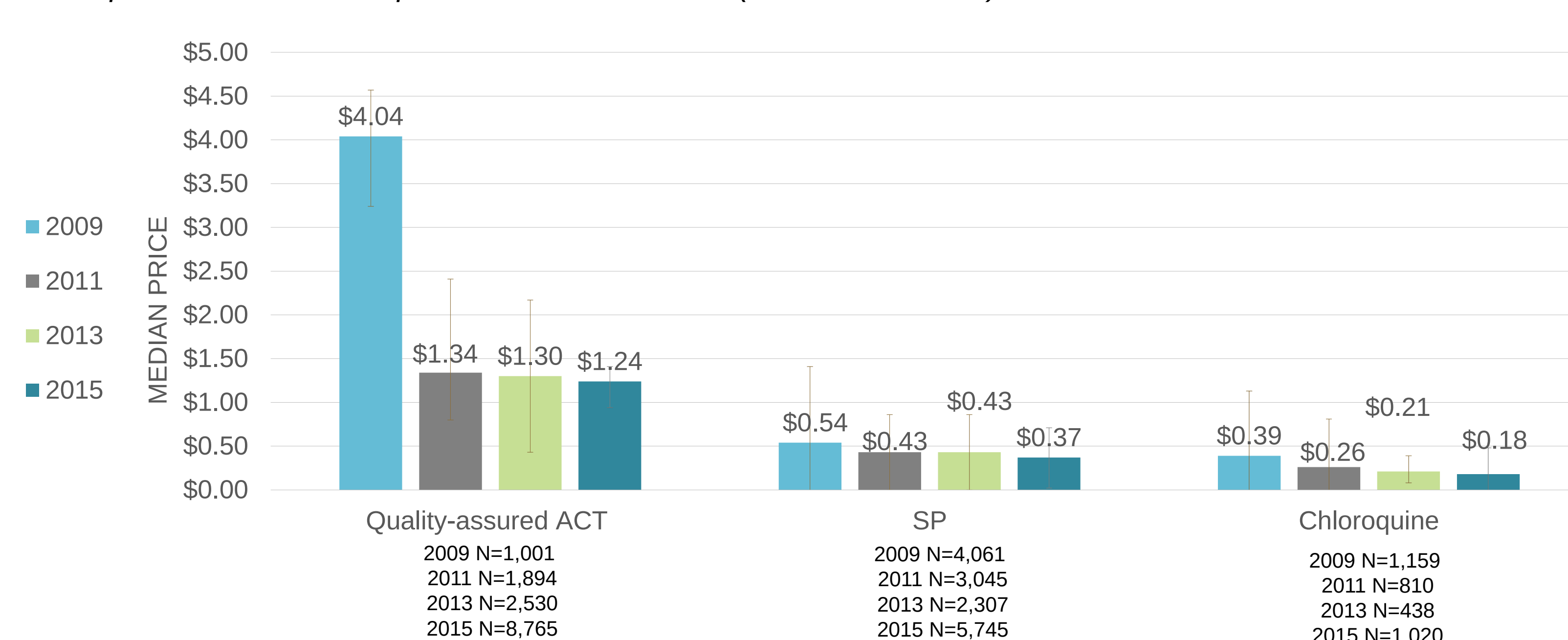


Figure 4: Availability of malaria blood testing Among outlets stocking antimalarials on the day of the survey or in the past 3 months

