



Access *Observatory* 2019 Report

Establishing the Foundation
for Shared Learning

AUTHORSHIP

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Access Observatory

The *Access Observatory* is a public reporting platform for programs that aim to improve access to disease prevention and treatment services in low and middle-income countries (LMICs). Programs in the *Access Observatory* focus on more than just medicines and include strategies to strengthen health systems and influence patient behaviors. The *Access Observatory* was created within the scope of Access Accelerated, a collaboration of more than 20 biopharmaceutical companies, working in partnership with the World Bank, the Union for International Cancer Control's City Cancer Challenge (C/Can 2025) initiative and others, that is committed to tackling the growing burden of non-communicable diseases (NCDs) in low and middle-income countries.

Program information available through the *Access Observatory* is authored by program teams and independently reviewed by the *Access Observatory* team to ensure completeness, clarity, and consistency. The *Access Observatory* is a reporting mechanism for Access Accelerated, though it is open to all access programs, including those designed and implemented by public and non-profit organizations. The *Access Observatory* in 2018 includes both Access Accelerated and non-Access Accelerated company programs. The *Access Observatory* has been designed and is managed by a team based in the Department of Global Health at the Boston University School of Public Health.

More information on the *Access Observatory* is available at accessobservatory.org.

Executive Summary

In 2017, over 20 biopharmaceutical companies launched Access Accelerated, an initiative that aims to improve access to prevention, care and treatment of NCDs in low and middle-income countries (LMICs), working in partnership with the World Bank, the Union for International Cancer Control's City Cancer Challenge (C/Can 2025) initiative and others. Members of Access Accelerated have committed to measuring their programs and reporting to the global health community. To facilitate these efforts, the *Access Observatory* team designed a new measurement framework based on public health priorities that serves as a common language for categorizing, understanding and comparing access programs. The *Access Observatory* (accessobservatory.org) is an online public repository of information on access programs, structured according to the measurement framework.

At the end of 2018, 73 active Access Accelerated programs operating in 112 countries were registered in the *Access Observatory*. Programs were geographically clustered in sub-Saharan Africa and Southeast Asia. Most programs used a few common strategies: community activities that aimed to increase awareness of disease symptoms and treatment options; health service strengthening activities, most notably health provider training courses; and direct health service delivery. Forty-six programs (63%) addressed cancer, while diabetes (18%) and cardiovascular disease (18%) were also of focus. Across the 73 programs, there were 267 partnerships between companies and other organizations; more than half of programs had at least one public sector partner. With respect to measurement, one-third of programs submitted data for at least one program indicator in 2018, nearly all of which were for an input or output indicator. Very few programs submitted documentation of a needs assessment conducted prior to program implementation. More information is needed for local stakeholders to understand whether programs are appropriately designed for the context in which they are implemented.

The first two years of the *Access Observatory* have been characterized by development and learning, which has created a strong foundation for future success. Looking forward, there is a need for continued engagement on the part of the pharmaceutical industry as well as global health stakeholders. Companies should strive to design more effective programs and ensure accountability through transparent measurement and reporting.

The *Access Observatory* is a first-of-its-kind global platform for measurement and reporting on access programs. Company CEOs and the Access Accelerated Secretariat have clearly communicated to the global health community that measurement and, most importantly, transparency in the measurement process are vital in order to ensure that companies receive credit for their efforts, that they are held accountable to their beneficiary populations and local stakeholders, and that program learnings can be shared.

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Letter to the Biopharmaceutical Companies' CEOs

Access Accelerated demonstrated important progress in 2018 and established a foundation for shared learning across companies and partners. Continuing to build on this foundation in the coming year will be key to realizing the full potential of Access Accelerated.

Sustained commitment to measurement and reporting is needed to realize the full potential of Access Accelerated.

We appreciate the CEOs' active response to the *Access Observatory* 2018 Report this past year. We were encouraged to learn that several CEOs communicated to company staff the importance of measurement and reporting following the report. We also value the CEOs' explicit, sustained commitment to measuring and reporting on their Access Accelerated programs. The value of this commitment has been recognized by other stakeholders, most notably the Access to Medicine Index, which gave credit to companies for reporting their programs in the *Access Observatory* in its 2018 report.

In 2018, we witnessed some companies start to reorganize towards more integration of access activities into traditional business operations, with respect to both management systems and reporting dashboards. This is a welcome development, and we encourage all companies to consider similar integration. Most companies that are moving toward a more integrated approach to access are increasing their investments in systems for measurement and reporting as an integral part of their strategy.

We strongly recommend that, going forward, needs assessments and situation analyses are conducted and published to inform the design of these new programs.

Though we saw little progress in the proportion of Access Accelerated programs that reported measurement indicators in the past year, we are happy to note that several companies are in the process of starting new programs. We strongly recommend that, going forward, needs assessments and situation analyses are conducted and published to inform the design of these new programs. This will ensure that programs are aligned to the needs of the targeted beneficiaries.

We also encourage companies to leverage their unique expertise in product development, manufacturing, licensing and pricing when designing new program strategies. Finally, we encourage companies to establish systems for measurement and reporting for all new programs from the very beginning. While there are costs involved in measurement, there is tremendous value in ensuring that the substantial investments made in access programs meet their desired objectives in a transparent manner. In this way companies can receive credit and recognition for their efforts.

We also encourage companies to leverage their unique expertise in product development, manufacturing, licensing and pricing when designing new program strategies.

Access Accelerated is focused on enhancing collaboration and reducing fragmentation of NCD programs through a collective approach. There are great opportunities for inter-company collaboration in testing innovative approaches to improve access and joint evaluation of company programs operating in the same disease or geographic area. There are also opportunities for joint implementation and evaluation of innovative pilot programs to create new knowledge as to which access strategies work best in different contexts. We recommend that companies explore opportunities for greater collaboration. We encourage you to review our Country Analysis of Kenya on page 50 in which we report on 25 programs from nine companies.

Finally, we ask that the CEOs extend our deep appreciation and gratitude to their staff who graciously responded to our numerous queries during the *Access Observatory* submission process. Their commitment has been instrumental to the progress made in the past year.

We look forward to working with the CEOs and their staff to improve measuring and reporting of access programs.

Richard Laing

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Preface



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Access Accelerated is an industry led multi-stakeholder collaboration focused on improving access to NCD prevention, treatment and care in low-income and middle-income countries. Pharmaceutical companies who are members of Access Accelerated have committed to measuring the impact of their access programs and publicly reporting results of such measurements to the global health community. *Access Observatory* is the independent platform for transparent public reporting of Access Accelerated's program activities and measured outcomes.

The spectrum of approaches used by companies to improve access is wide and rapidly evolving. While there is no one-size-fits-all approach, and fresh ideas are still emerging, the information captured by the *Access Observatory* can facilitate a constructive dialogue around access between pharmaceutical companies and other stakeholders in the global health community. The development of an evidence base of successful approaches for improving access — the role of industry, country governments, and global stakeholders — requires a strong understanding of which approaches have been tried, which have succeeded or failed, and why. Better data and comparability of existing and past initiatives can accelerate the feedback loop for program design and also highlight emerging best practices. Quicker refinements in the design of access programs can hasten pathways to more sustainable long-term access. Evidence about what works would help direct future investments toward more effective programs for improving access, not only by members of Access Accelerated but also by global health financiers. All of this crucially depends on objective measurement and systematic reporting to an independent platform — the role of the *Access Observatory*.

Admittedly, the process of identifying successes and failures in access programs (and the underlying reasons) is complex due to the inextricable linkages between the actions of government, industry, and other global stakeholders. Many aspects of this report highlight that the team at *Access Observatory* is very cognizant of that. They have tried to create a taxonomy of strategies that capture the commonly-used approaches and the underlying logic models for each strategy. This facilitates a more objective discussion about roles of different actors within the pathway through which an access program achieves its impact.

For example, an intriguing finding in this report is that a vast majority of Access Accelerated access programs focus on raising community awareness and strengthening health service delivery, while there are none in areas related to manufacturing and distribution.

It is important to keep in mind that while independent evaluation is valuable for fostering greater trust between the stakeholders involved in improving access, passive reporting of failures without an attempt to understand the factors outside the control of the main program, has the risk of hampering top management and investor support for access programs in a wholesale manner. The report shows that a large number of Access Accelerated programs did not report any indicator data into the *Observatory*. For measurement and reporting in access program to be sustainable, it is useful to think about where can we use the capabilities of transaction reporting systems (e.g., supply chain data visibility) to collect rigorous and reliable data rather than having to create completely new data collection methods.

This second Annual Report of *Access Observatory* has rich and valuable information about industry-led access-to-medicines initiatives. It shows what pharmaceutical companies are doing to improve access to medicines in low and middle-income countries, early indicators of what is working well, and what needs refinement, realignment and significant change. I hope you enjoy reading this report and learning from it as much as I did.

Background

It has been nearly four years since UN member states agreed on the Sustainable Development Goals (SDGs) outlining a roadmap for a more sustainable and prosperous future. The SDGs recognize the specific responsibility of the private sector in contributing to achieving these goals. Part of this responsibility involves documenting private sector contributions in a methodologically sound and transparent manner. The pharmaceutical industry has a special role to play in contributing to the SDGs because their products have a direct impact on the health and well-being of populations. As such, the industry has an increased responsibility to produce robust evidence of their contributions to global health goals.

Historically, very large flagship donation programs by pharmaceutical companies have targeted infectious diseases in low and middle-income countries (LMICs), in particular onchocerciasis (river blindness) and schistosomiasis (snail fever). However, changing population demographics and risk factor exposures have resulted in a growing global burden of NCDs in LMICs, which are exacerbated by challenges in accessing affordable prevention and treatment services. Due to this ongoing shift in disease burden, health systems must transform from addressing acute infectious diseases to providing life-long care for chronic conditions that become more common as individuals live longer. This transformation will require cooperation across sectors, public and private, social and medical and urban and rural. No single institution can do it alone in such a complex situation.

Within this shifting context, pharmaceutical companies are increasing their efforts to strengthen health systems, rather than depending on product donations, as part of their strategy to improve access. Recognizing the complexity of the challenge, they have developed new partnerships with a wide range of governmental and non-governmental organizations to address the many factors impacting the global burden of NCDs. Although the number of industry-led programs targeting NCDs in LMICs has increased substantially in recent years, there is a gap in robust publicly available information for most programs, making it difficult to assess whether program expansion will translate into stronger health systems, increased patient access, and improved population health.

In 2017, more than 20 biopharmaceutical companies, working in partnership with the World Bank, UICC*, and others, launched Access Accelerated, an initiative that aims to improve access to prevention, care and treatment for NCDs in LMICs.¹ As part of Access Accelerated, companies and partners committed to measuring and publicly reporting on their programs. The Access Accelerated Secretariat asked Boston University (BU) to independently develop a measurement framework for access programs and to support program reporting.

Boston University developed the *Access Observatory*, a reporting platform for private sector-led access programs.

Importance of Measurement and Reporting

- Generate critical evidence on program effectiveness
- Facilitate shared learning by individual programs and across the entire field
- Contribute to accountability of individual programs and the industry as a whole
- Enable collaboration in programmatic areas of common interest
- Inform efficient resource allocation
- Promote public understanding of private sector contributions

The agreement between the Access Accelerated Secretariat and Boston University is available for public view at accessobservatory.org/funding.

**Access Accelerated partner is now City Cancer Challenge (a newly established foundation) that emerged from UICC.*

Measurement Framework

The *Access Observatory* team designed and developed a new measurement framework that serves as a common language for categorizing, understanding and comparing access programs.

The framework includes three main components:

- A taxonomy of 11 strategies that describes common approaches used by access programs.
- A series of logic models—one for each strategy—detailing the pathways by which programs may achieve impact.
- A set of clearly defined indicators for reporting program activities and achievements.

Principles

Principles guiding development of the measurement framework and *Access Observatory*

Four core principles guided the development of the framework and *Access Observatory*, informing decisions on process and content.



Independence from Industry

- The measurement framework was designed with independence from the pharmaceutical industry.
- Analysis and interpretation of program information included in the *Access Observatory*, including that presented in this report, is done with total independence.



Transparency to the Public

- All information submitted to the *Access Observatory* is publicly available. No confidential information is accepted.
- Legal contracts, including clauses governing data transparency, are publicly available at accessobservatory.org/funding.



Methodological Rigor

- The measurement framework was constructed according to a standard “theory of change” approach with a series of logic models that outline pathways to potential program impact.
- The measurement framework includes a standard set of indicators selected from existing and validated public health instruments.



Prioritization of Public Health Goals

- The measurement framework is centered around the WHO’s goals of a health system: population health, financial risk protection, and responsiveness.²
- Logic models and accompanying indicators were designed to align with the UN SDGs and WHO recommendations.

²A “theory of change” is a method that explains how a given intervention, or set of interventions, is/are expected to lead to a specific development change, drawing on a causal analysis based on available evidence.³

Taxonomy of Strategies

As described in the *Access Observatory 2018 Report*⁴, a taxonomy was developed based on existing literature and extensive consultations. The taxonomy is organized into four broad strategy categories: community strategies; health system strategies; medicine production strategies; and medicine price strategies. Each of the 11 strategies fits within one of these four broader categories. Many pharmaceutical company-led programs do not exclusively focus on access to medicines but take a broader approach to address a variety of access barriers. The taxonomy of strategies helps to categorize programs and effectively demonstrates where efforts are being focused. Often, a single program may encompass one or more of these strategies.

Table 1: Taxonomy of Strategies: Categories and Strategies

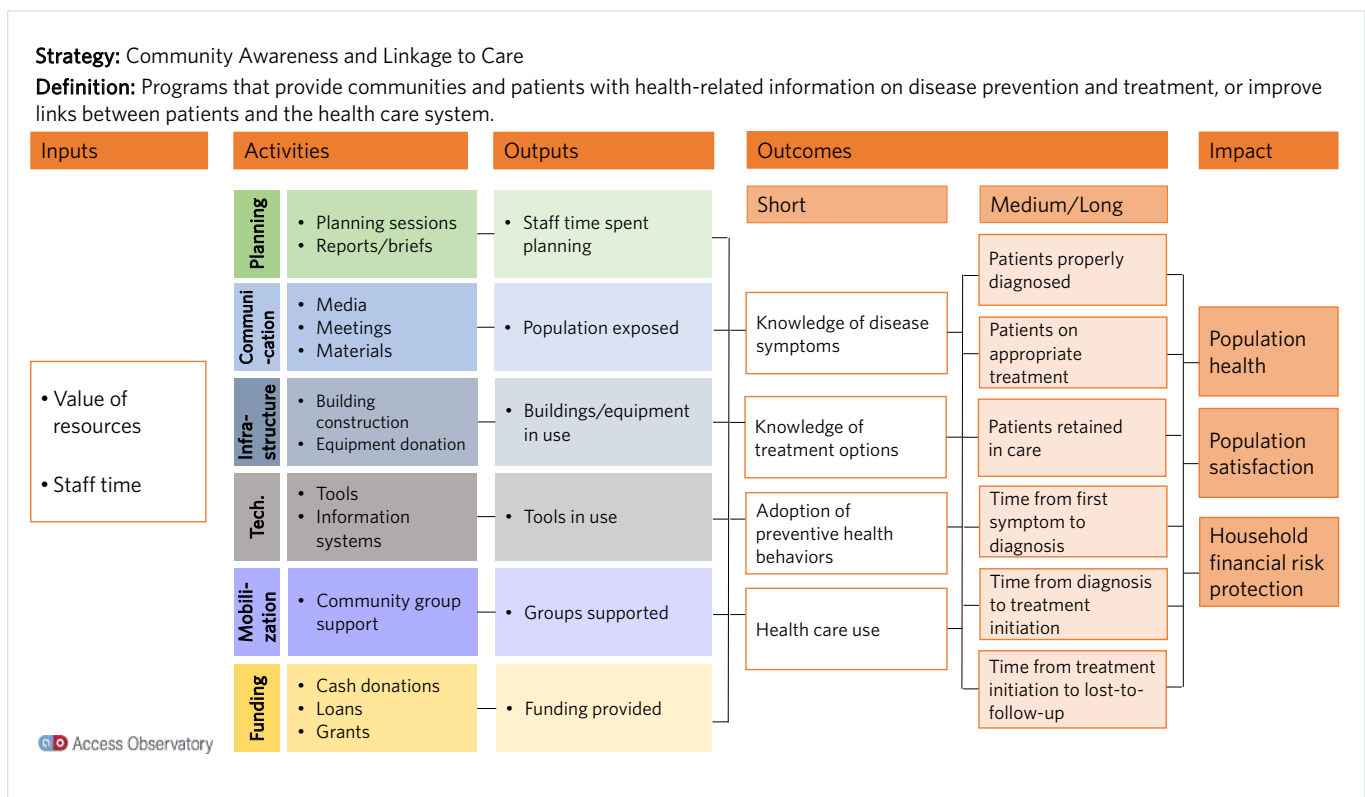
Strategy Category	Strategy
Community Strategies <i>Strategies with a primary focus on communities and community organizations, with a particular focus on patients.</i>	Community Awareness and Linkage to Care
Systems Strategies <i>Strategies with a primary focus on aspects of the health system that affect availability and access to medicines.</i>	Health Service Strengthening Financing Health Service Delivery Regulation and Legislation Supply Chain
Production Strategies <i>Strategies with a primary focus on increasing the production of medicines.</i>	Manufacturing Product Development Research Licensing Agreements
Price Strategies <i>Strategies with a primary focus on reducing the price of medicines.</i>	Price Scheme Medicine Donation

The complete definitions of each of the 11 strategies are available at accessobservatory.org.

Logic Models

For each of the 11 strategies in the taxonomy, we developed a corresponding logic model as a simple tool to envision the pathways of potential program impact. The logic models provide a map for each strategy in terms of inputs, activities, outputs, outcomes, and impacts. Each logic model is not meant to be exhaustive, but rather is meant to communicate a basic level of those components which could then be compared or aggregated across programs. Programs which utilize more than one strategy should apply all relevant logic models.

Figure 1: Example of a Logic Model



The complete set of logic models is available at accessobservatory.org.

Indicators and Data Dictionary

For each concept in the logic models, at least one corresponding indicator was developed to allow programs to measure their progress along the logic model pathway. The full set of indicators is organized in a Data Dictionary, which provides a table of metadata for each indicator that includes the definition, explanation on how it should be measured, and recommended data sources.

Table 2: Example of Indicator MetaData from the Access Observatory Data Dictionary

Item	Description
Indicator Name	Number of People Trained
Indicator Type	Output
Strategies that Use Indicator	(1) Product development research; (2) Financing; (3) Health service strengthening; (4) Manufacturing; (5) Regulation & Legislation; (6) Supply chain
Definition	Number of trainees
Method of Measurement	Counting of people who completed all training requirements Calculation: Sum of the number of people trained
Recommended Disaggregation	By institution, sex, geographical region, by cadre
Frequency of Reporting	Annually unless otherwise stated
Recommended Data Source	Training organization records
Other Possible Source	Routine program data
Further Info	Adapted from: Indicator-Based Pharmacovigilance Assessment Tool Manual for Conducting Assessments in Developing Countries. Page 40 pdf.usaid.gov/pdf_docs/PNADS167.pdf

The full set of indicators is available at accessobservatory.org.

Access Observatory

The *Access Observatory* is an online public repository of information on access programs structured according to the measurement framework. With transparency as a core principle, all data reported into the *Access Observatory* are publicly available — confidential data are not accepted. The *Access Observatory* is the primary reporting mechanism for Access Accelerated programs, though it is open to all access programs, including those designed and implemented by public and non-profit organizations.

Overview of Submission and Review Process

Program managers, for example pharmaceutical company staff or implementing partner organizations, submit information to the *Access Observatory* via a three-part process. After each step, in accordance with our transparency principle, we complete a review of submitted materials to ensure that content is complete, clear, and consistent. Program teams are asked to revise their submissions based on feedback from the review team and then resubmit updated forms. All content posted on accessobservatory.org is authored by the program teams and not by the *Access Observatory* team.

Figure 2: Reporting and Review Process for the Access Observatory



Program registration includes information on program objectives and activities as well as alignment with local needs.

Program Registration

Programs first complete the Program Registration, which captures key descriptors including overall program goals, diseases addressed, target population, and the strategy or strategies employed (based on the Taxonomy of Strategies). The Program Registration also asks about program alignment with local regulations, health priorities, responsibilities of program partners and program sustainability. For example, sections of the form solicit information on the local health needs that the program aims to address, and whether medicines included in the program are part of national reimbursement lists. These elements are aligned with the WHO checklist recently developed for assessing industry-led access programs.⁵

Indicator Plan

After the Program Registration is complete, program teams complete and submit an Indicator Plan. The Indicator Plan captures the measurement indicators that will be reported by the program. For each indicator, programs provide a clear description of the data source and data collection and management procedures.

Indicator Values

After the Indicator Plan is finalized, programs complete and submit Indicator Values, where companies provide actual numbers for each indicator for a given year (e.g., number of people trained or number of patients on treatment). All values submitted to the *Access Observatory* are program-level aggregates; individual and patient level data are not accepted.

Table 3: Access Observatory Reporting Components

Program Registration	Program description	<ul style="list-style-type: none"> • Name • Goals, objectives, activities • Countries • Disease focus • Beneficiary population(s) 	<ul style="list-style-type: none"> • Start and end date • Funding partners • Implementation partners • Contact person
	Program strategies	<ul style="list-style-type: none"> • Strategies based on framework taxonomy 	
	Alignment with local laws and regulations	<ul style="list-style-type: none"> • Description of relevant local laws and regulation • Confirmation of program alignment 	
	Alignment with local health priorities	<ul style="list-style-type: none"> • Summary of local needs assessments • Description of consultation and collaboration with local partners 	<ul style="list-style-type: none"> • National essential medicines list • Reimbursement lists
	Sustainability plan	<ul style="list-style-type: none"> • Description for sustainability plan 	
Indicator Plan	Indicators to be reported	<ul style="list-style-type: none"> • Indicators based on framework set 	
	Data sources	<ul style="list-style-type: none"> • Program administrative records • Public information sources • Health records 	
	Data collection procedures	<ul style="list-style-type: none"> • Responsibilities of program implementing partners • Responsibilities of program funding partners 	
	Data management procedures	<ul style="list-style-type: none"> • Responsibilities of program implementing partners • Responsibilities of program funding partners 	
Indicator Value	Indicator values	<ul style="list-style-type: none"> • Value • Time period • Disaggregation (if applicable) 	

Public Access to Program Information

The *Access Observatory* website (accessobservatory.org) is an easy-to-use public interface through which all submitted information on programs can be accessed and downloaded. Summary reports for each program can be downloaded. The full set of raw information and indicator data can also be downloaded in a spreadsheet format.

The screenshot shows the homepage of the Access Observatory website. At the top left is the logo, which consists of a blue circle with a white 'a' and a red circle with a white 'o', followed by the text 'Access Observatory'. To the right of the logo are three navigation links: 'About', 'Program Reports', and 'Full Dataset'. Below the navigation is a large banner image of a lighthouse on a rocky island. Overlaid on the right side of the banner is the text 'Public reporting on efforts to improve access to medicines globally' and a 'Learn more' button. Below the banner, there are two columns of content. The left column is titled 'The Access Observatory is currently reporting on' and lists three statistics: '77 programs' (with a book icon), '112 countries' (with a globe icon), and '19 companies' (with a building icon). The right column is titled 'View the list of programs and download the full set of program information' and contains two buttons: 'Program Reports' and 'Full Dataset'. Below the 'Program Reports' button is a paragraph: 'Program Reports provide a description of each program, including country of operation, focus disease, access strategies and activities, and target populations.' Below the 'Full Dataset' button is another paragraph: 'The Full Dataset allows the download of information from all programs in a single spreadsheet for easier review.' At the bottom of the page, there is a footer with the logo and text 'Access Observatory' and '801 Massachusetts Avenue, Third Floor, Boston, MA 02118' on the left, and a 'Contact us' button on the right.

Results from Year Two

During 2018, 73 active Access Accelerated programs completed a program registration in the *Access Observatory*, compared to 62 programs in 2017. Two of the 62 programs registered last year ended prior to 2018, and 13 new programs were registered this past year. Of these, 43 finalized an indicator plan, and 25 submitted indicator values for 2018. Two non-Access Accelerated programs have completed a program registration in the *Access Observatory*. Fourteen programs reported anticipated end dates of 2018.

Figure 3: Number of Access Accelerated Programs in the Access Observatory



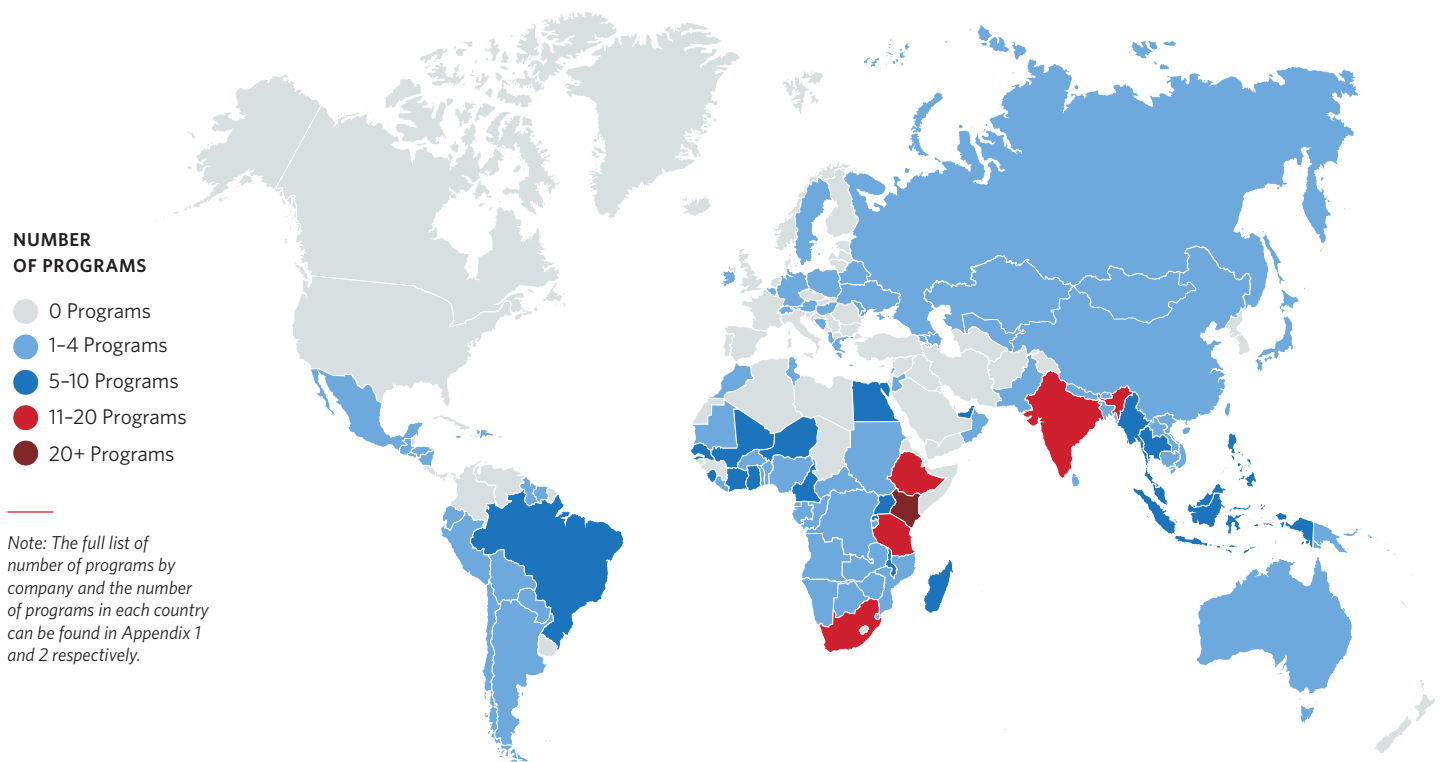
Programs are clustered in certain geographic regions, in particular Sub-Saharan Africa and Asia.

Some countries have a high number of programs, e.g., Kenya, India, and South Africa.

Program Geography

Seventy-three registered active programs were implemented in 112 countries. Most were single country initiatives, though 24 (32.9%) were implemented in multiple countries. Programs cluster in certain geographic regions, in particular Sub-Saharan Africa and Asia. As in 2017, there were countries with a very high number of programs, with five countries [Kenya (n=25), India (13), South Africa (12), Ethiopia (11) and Tanzania (11)] topping the list of countries where Access Accelerated programs were being implemented (see Appendix 2).

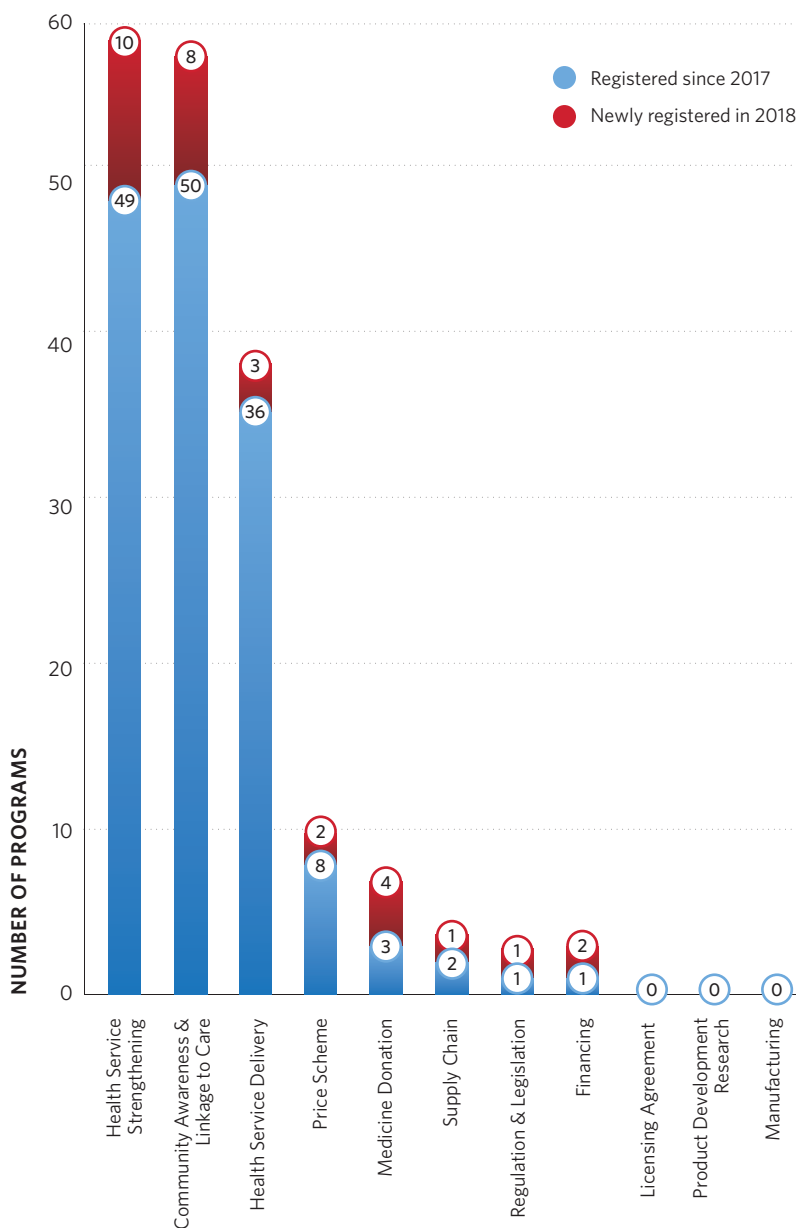
Figure 4: Geographic Distribution of Access Accelerated Programs



Program Strategies and Activities

In order to more easily describe and compare programs, each program self-identified which of the 11 strategies were used. Most programs selected between two and three strategies, and nearly all of the programs registered in 2017 and the 13 programs registered in 2018 are encompassed by just three strategies: Health Service Strengthening, Community Awareness and Linkage to Care, and Health Service Delivery.

Figure 5: Number of Programs by Strategy



Nearly all programs used one of the following strategies: Community Awareness and Linkage to Care; Health Service Strengthening; or Health Service Delivery.

Many of the programs included community meeting activities designed to increase awareness of disease and treatment options.

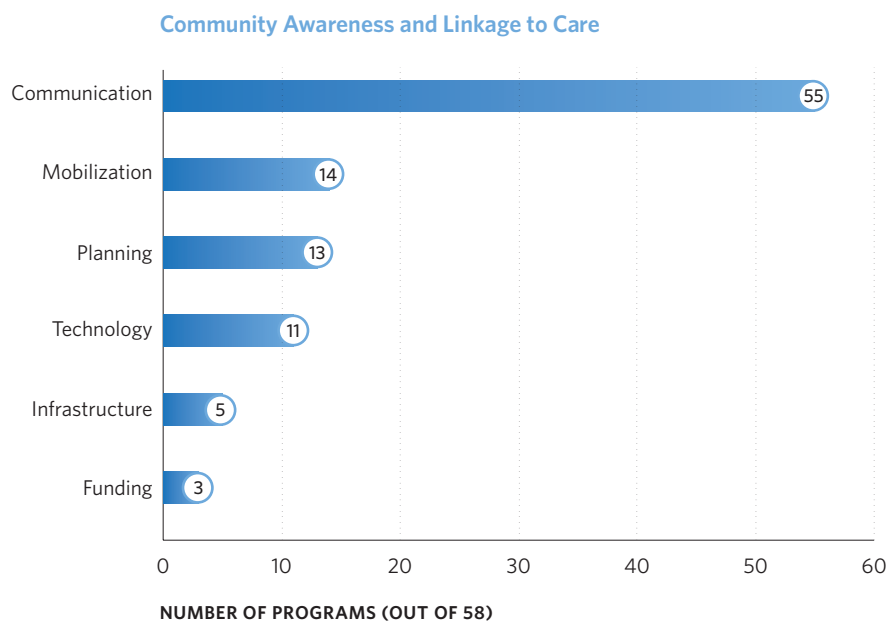
A large number of programs included health worker training activities.

The number of donation programs increased from 3 in 2017 to 7 in 2018.

Communication was the most common type of activity within the Community Awareness and Linkage to Care strategy.

Among programs that used the Community Awareness and Linkage to Care strategy, nearly all communities were informed about NCDs through mass media and community awareness meetings (95%). A smaller number supported community or patient groups (24%), or developed disease education software and websites (19%). Community meetings and outreach were the most frequently used method of communication (72%), followed by print media such as fliers and posters (33%), internet media such as twitter and websites (21%), and broadcast media such as radio and television (11%).

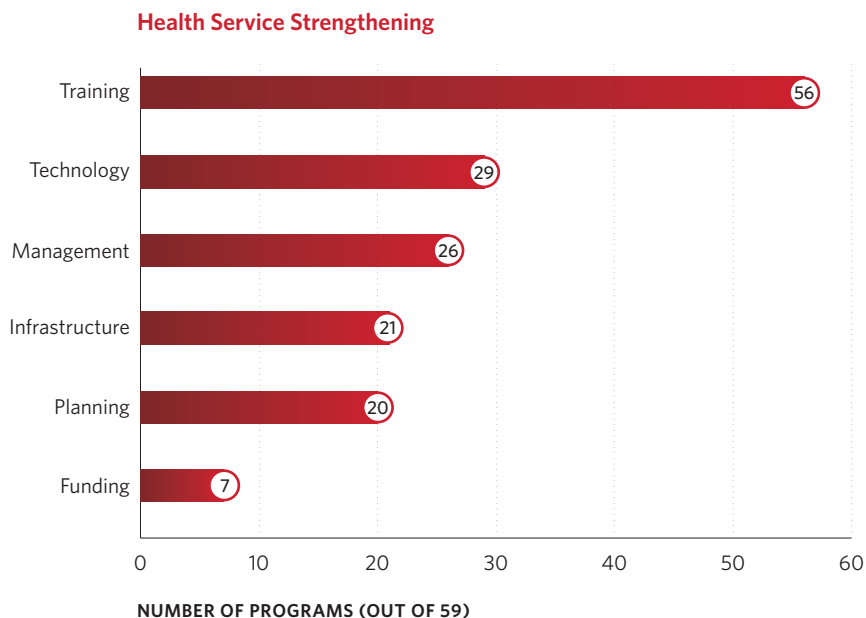
Figure 6: Activities for Programs that Used Community Awareness and Linkage to Care



A large number of programs conducted trainings as part of the Health Service Strengthening strategy.

Among programs that used the Health Service Strengthening strategy, nearly all trained health care providers (95%). A smaller number developed treatment and referral protocols (44%), provided technologies such as electronic medical records, screening and diagnostic decision apps (49%) or donated buildings and diagnostic equipment (36%). Most trainings were in-person (83%), few were online (6%), while others conducted both in-person and online training (11%). A majority of the trainings targeted health professionals including doctors, nurses, and pharmacists (75%), followed by community health workers (25%), and health care administrators (13%).

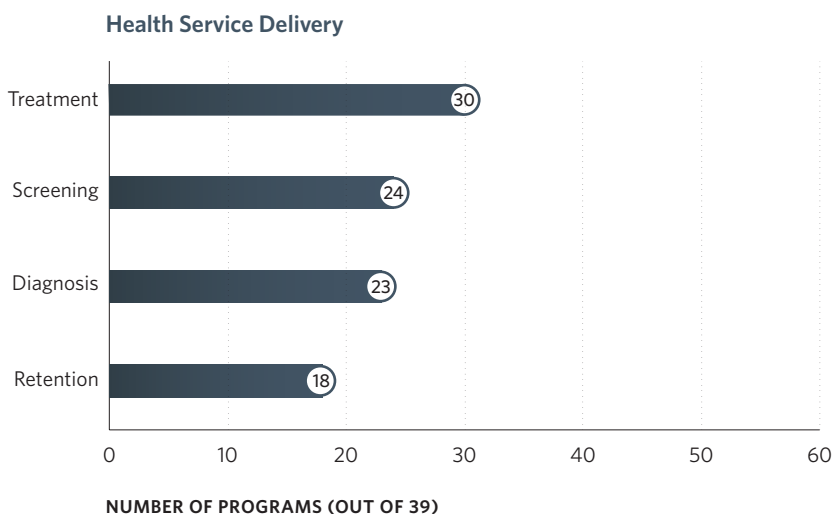
Figure 7: Activities for Programs that Used Health Service Strengthening



Among programs that used the Health Service Delivery strategy — programs designed to deliver health services directly to patients using program resources such as staff and infrastructure — a majority conducted screenings (62%), provided diagnosis (59%), or provided treatment of NCDs (77%). Several took steps to retain patients in care through phone calls and text message reminders (46%).

Providing treatment was the most common activity within the Health Service Delivery strategy.

Figure 8: Activities for Programs that Used Health Service Delivery



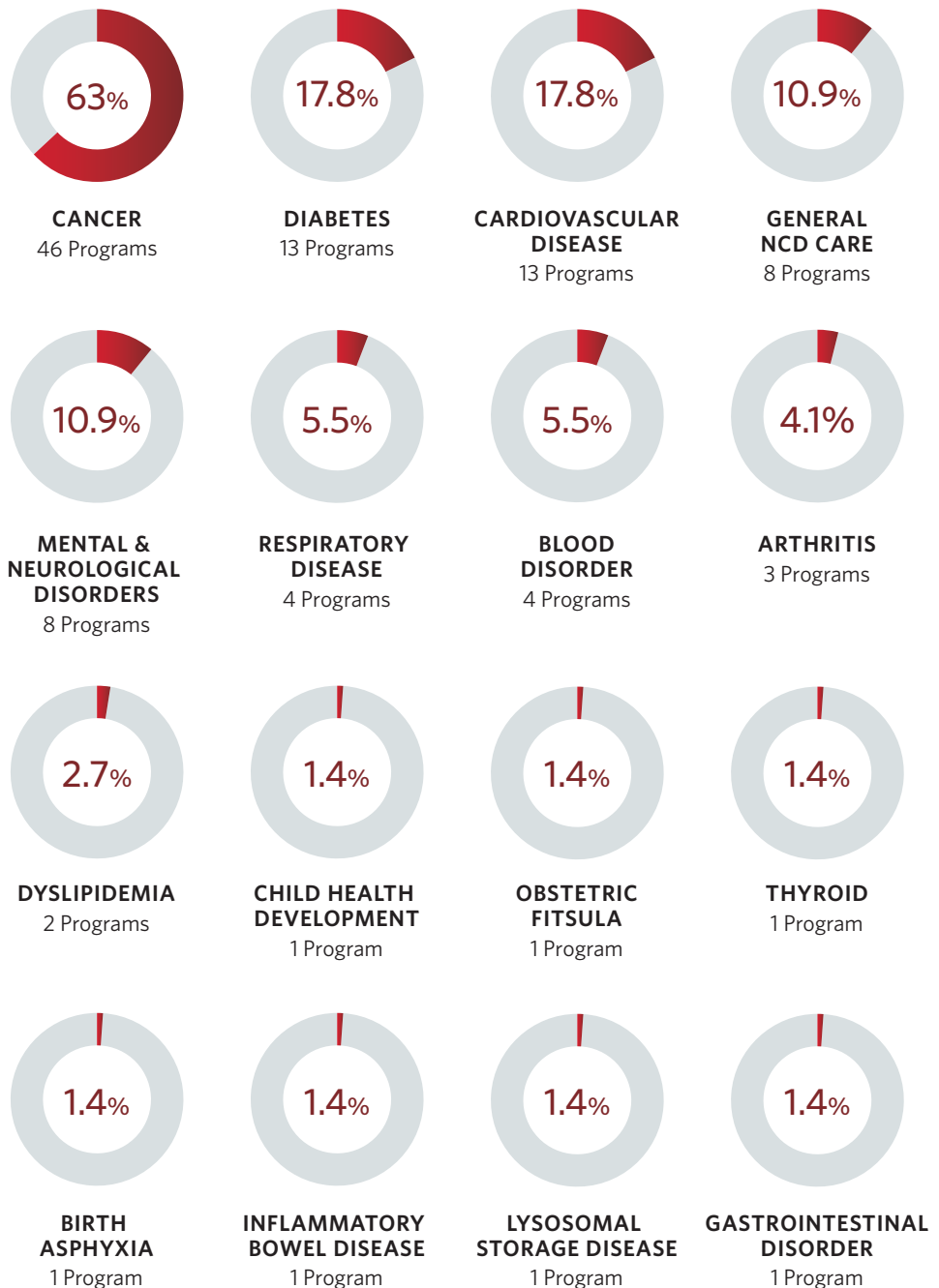
Most programs focused on cancer.

A large number aimed to address cervical cancer, breast cancer, or lung cancer.

Disease Scope

Programs were mainly focused on improving access to cancer care (especially breast, cervical, lung and childhood cancers) (63%), diabetes (18%), and cardiovascular disease (18%). This emphasis on cancer may change in the coming years.

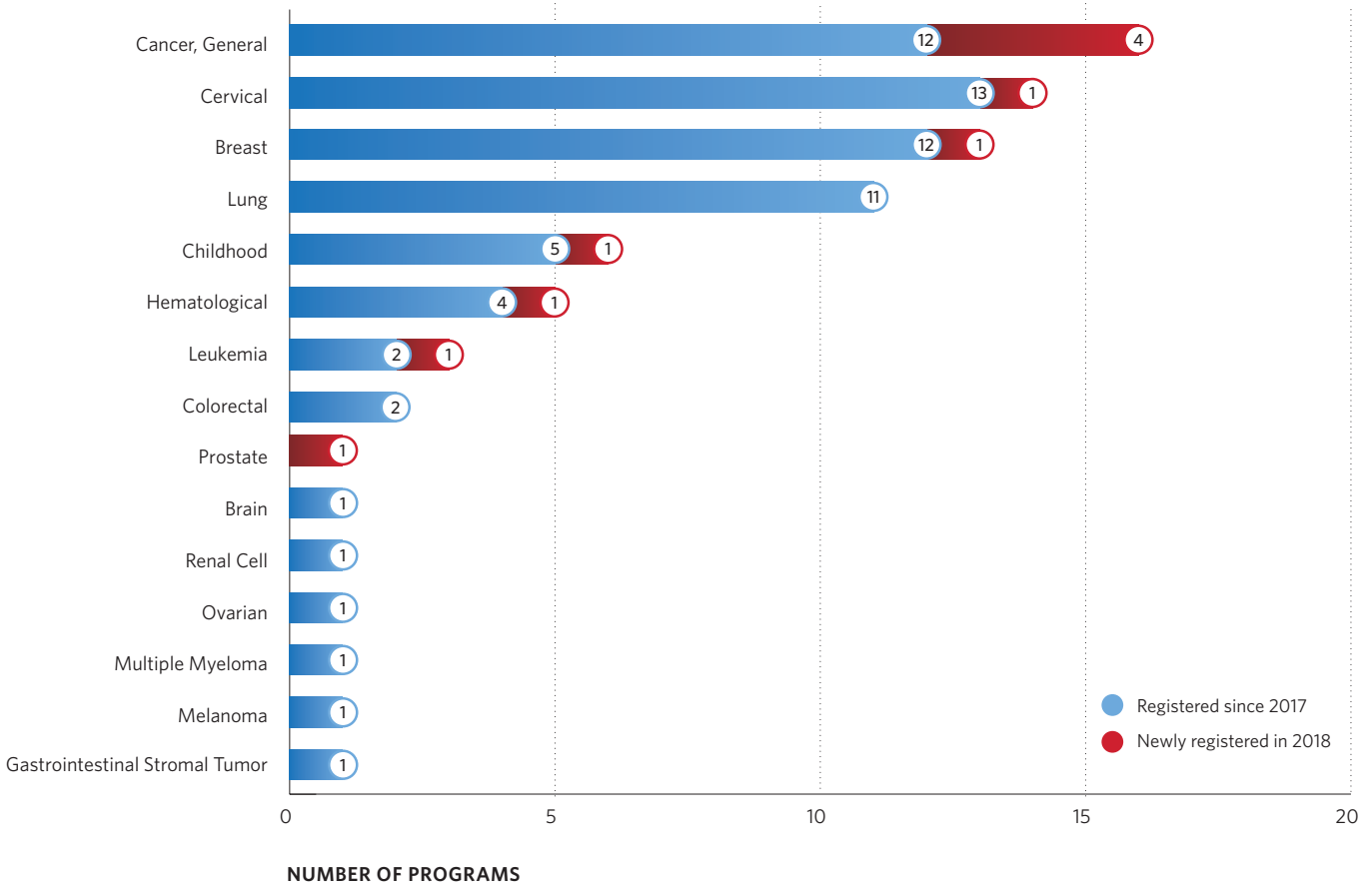
Figure 9: Number of Programs* by Disease



*Some programs target more than one disease.

Regarding the type of cancer, out of the 46 cancer programs, 30% focus on cervical cancer, 28% on breast cancer and 24% on lung cancer, followed by 13% childhood cancer and 11% on hematological cancer. The majority of the cancer programs registered in 2018 target cancer in general.

Figure 10: Number of Programs by Cancer Type



Around one-third of programs provided at least one health technology, including medicines, vaccines, and diagnostic equipment.

Most of the medicines are used to treat or prevent cancer, and were provided via a price scheme strategy.

Medicines and Technology

Twenty-seven of the 73 programs (37%) provided at least one health technology, and seven provided multiple health technologies. About 22% provided medicines, 16% medical devices including diagnostic equipment for cancer and prosthesis and 8% vaccines.

Table 6: Health Technology by Type and Name

Type of Health Technology	Name of Technology	Number of Programs
Medicine	Oncology Medicines	10
	Diabetes Medicines	4
	Hypertension Medicines	3
	Respiratory Disease Medicines	2
	Lysosomal Storage Disorder	1
Vaccine	HPV Vaccine	5
	Childhood Vaccines*	1
Medical Device	Cancer Diagnostic Equipment	4
	Diabetes Diagnostic Equipment	3
	Hypertension and Diabetes Diagnostic Equipment	2
	Ocular Prosthesis	1
	Android-based Clinical Decision Support System Platform	1
	Cryotherapy Equipment	1
	Fistula Treatment Equipment	1
	Ultrasound Machine	1

*Vaccine not specific for NCD but provided by a program that provides care for childhood asthma

Note: Some programs provide more than one health technology

A total of 16 programs included medicines, and 5 programs included vaccines. The majority of these medicines were delivered via a price scheme; only a minority of medicines were delivered as donations or through a service delivery strategy. Most of the medicines are used to treat or prevent cancer.

Table 7: Medicines Included in Programs by Therapeutic Group

Main Therapeutic Group (Number of Programs)	International Non-Proprietary Name	Number of Programs
Oncology (10)	Alectinib	1
	Anastrozole	1
	Bentruximab vedotin	1
	Bevacizumab*	2
	Erlotinib	1
	Capacitabine	1
	Imatinib*	1
	Letrozole	1
	Obinutuzumab	1
	Pertuzumab	2
	Ponatinib	1
	Rituximab*	2
	Tamoxifen*	1
	Trastuzumab*	3
	Vedoluzimab	1
Human Papilloma virus vaccine*	5	
Cardiovascular Medicines (3)	Amlodipine*	2
	Amlodipine + Irbesartan	1
	Bisoprolol*	1
	Furosemide*	1
	Hydrochlorothiazide*	1
	Irbesartan	1
	Irbesartan + Hydrochlorothiazide	1
	Ramipril	1
	Simvastatin*	1
Valsartan	1	
Diabetes (4)	Glibenclamide	1
	Glimeperide	2
	Glimepiride + Metformin	1
	Insulin*	2
	Metformin*	1
	Vildagliptin	1
Asthma (2)	Salbutamol	1
Lysosomal Storage Disorder (1)	Agalsidase alfa	1
	Idursalfase	1
	Velaglucerase alfa	1

Thirteen of the 36 medicines and medicine combinations are included in the WHO Model List of Essential Medicines.

Note: Five company programs did not specify the medicines that the programs provide.

*Medicine is included in the World Health Organization Model List of Essential Medicines of 2017.⁶

Companies were mainly involved in funding, planning and supporting program implementation, while the implementing partners were mainly involved in program planning and direct program implementation.

Nearly every program reported working with a funding or an implementing partner.

Partners represented a wide spectrum of the public sector, private sector and voluntary sector.

Role of Pharmaceutical Companies

Companies were mainly involved in funding, planning and supporting program implementation, while the implementing partners were mainly involved in program planning and direct program implementation. Eighty-five percent of programs were solely funded by the pharmaceutical companies, while 15% were co-funded by other partners including governments. In 53% of programs, the companies' sole role was providing funding. In the remaining 47% of programs, companies supported various planning and implementation activities. According to our program typology, 66% programs partnered directly or indirectly with multiple implementing organizations which delivered the program directly to beneficiaries.

Partnerships and Stakeholders

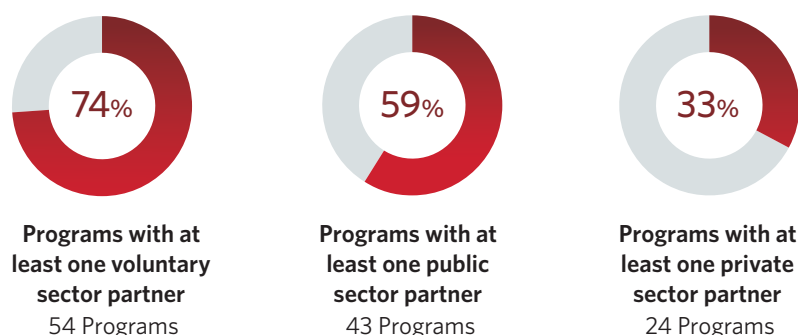
Two-hundred and ten unique implementing partners were identified across all 73 active Access Accelerated programs. Twenty-six implementing partners were involved in multiple programs. Seventy-four percent of the programs work with at least one civil society or voluntary sector partner and 59% with at least one public sector partner, including 33% of programs working directly with the national Ministry of Health. About 30% of programs work directly with hospitals and only 23% with academic partners. The voluntary and public sector partners including hospitals and universities are involved in raising awareness about NCDs, strengthening health service delivery through training of health care professionals, providing infrastructure and technology, and delivering direct health services including screening, diagnosis and treatment of NCDs.

Figure 11: Number of Programs by Funding and Implementing Partner's Sector

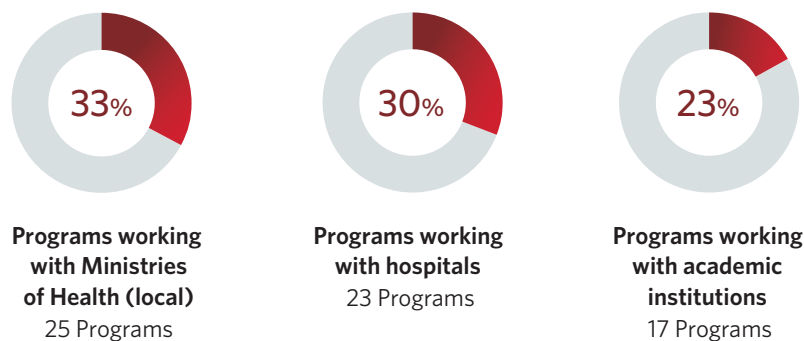


*Some programs had more than one funding or implementing partner. The average number of partners per program was based on 267 partners identified across all programs, irrespective of whether the partners implemented multiple programs.

Programs By Sector



Programs By Institutions



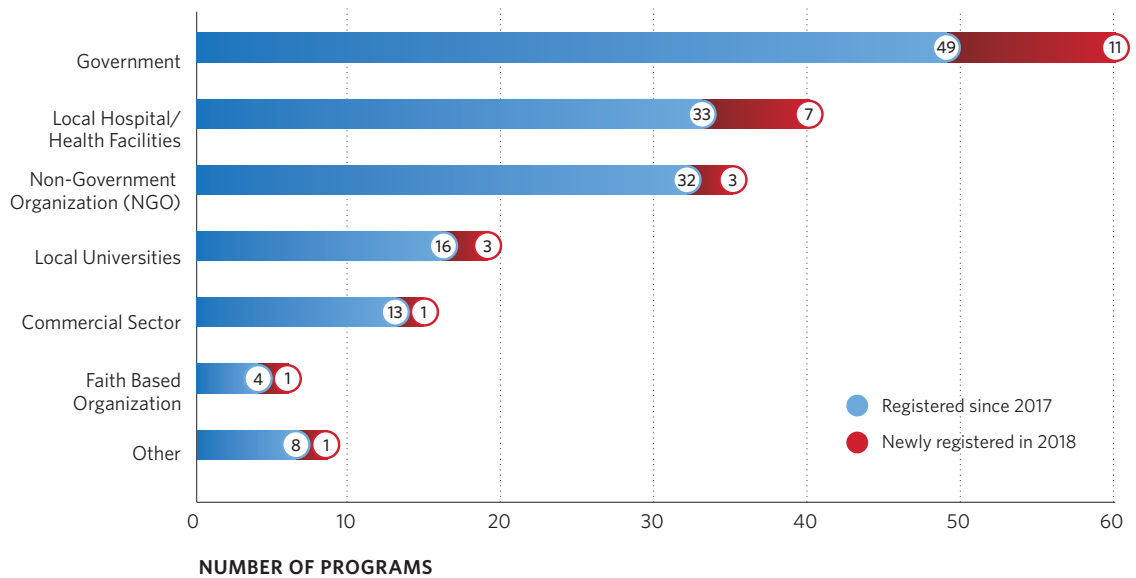
A public sector partner is a governmental organization that implements or funds the program, which includes intergovernmental agencies such as the World Health Organization (WHO). A private sector partner is a business unit established, owned, and operated by private individuals or organizations for profit that implements or funds the program, while a voluntary sector partner is a private organization or private individual whose purpose is to benefit and enrich society, often without profit as a motive and with little or no government intervention that is involved in implementing or funding the program.

Government was the most frequently mentioned local stakeholder that programs worked with.

Three multi-company programs were registered and active in 2018. The programs were independently supported by different pharmaceutical companies without any formal collaboration among the companies.

Apart from the implementing and funding partners that companies directly work with, most of the programs also reported different types and levels of engagement with local stakeholders. Most of the programs engaged with the government (82%), about 55% engaged with local hospitals and 48% with local non-governmental organizations. The pattern of engagement of local stakeholders is similar in programs that registered in both 2017 and 2018.

Figure 12: Number of Programs by Local Stakeholders



Some programs engaged with more than one stakeholder.

Note: The full list of funding and implementing partners reported by programs can be found in Appendix 3.

Program Alignment with Local Priorities

While it may be a common assumption that access programs would be in-line with local priorities, policies, and laws, public information with clear statements and examples of how this occurred on the ground is limited. A number of questions in the *Access Observatory* aim to more fully describe companies' specific intentions and efforts to align with local priorities. In addition, questions assess sustainability and how implemented programs will continue or be absorbed by local partners.

Table 8: Program Response to Local Priorities

Local Priority Issue Questions	Number of programs that responded with explanation	Number of programs that responded "none or not applicable"	Number of programs that did not respond
How have local policies, practices, and laws (e.g., infrastructure development regulations, education requirements, etc.) been taken into consideration when designing the program?	70	0	3
Please describe how your program is responsive to local health needs and challenges.	70	1	2
Please describe how you have engaged with any of these local stakeholders in the planning and/or implementation of this program.	68	0	5
If applicable, please describe how you have planned for sustainability of the implementation of your program.	60	4	9
Does your program aim to address social inequity in any way (if yes, please explain).	65	5	3

The most common sustainability strategies reported by programs include:

- Training of providers who will train other providers or continue to provide care after the program has ended
- Studying effectiveness of interventions to determine future implementation and/or generate evidence to advocate for more government allocation of funds on a long term basis
- Cost sharing (patients or participants share cost of medicines or trainings)
- Developing disease control strategies, clinical guidelines, and patient tracking and referral systems which will continue to be used after the program has ended
- Incorporating program training curriculum into the national training curriculum

Common strategies for sustainability included building local capacity by training future trainers of health workers and using cost-sharing arrangements to ensure financial sustainability.

Few programs provided a needs assessment report.

Needs Assessments and Program Duration

Seventeen programs (23%) indicated that they conducted a needs assessment, of which seven programs (9.6%) uploaded the report.

Thirty-four programs (47%) did not have a specified program closing date, which may mean there is a long-term commitment of the companies to continue to implement the programs. For those program providing start and anticipated end dates, the mean duration of the program was 42 months.

Addressing Social Inequity

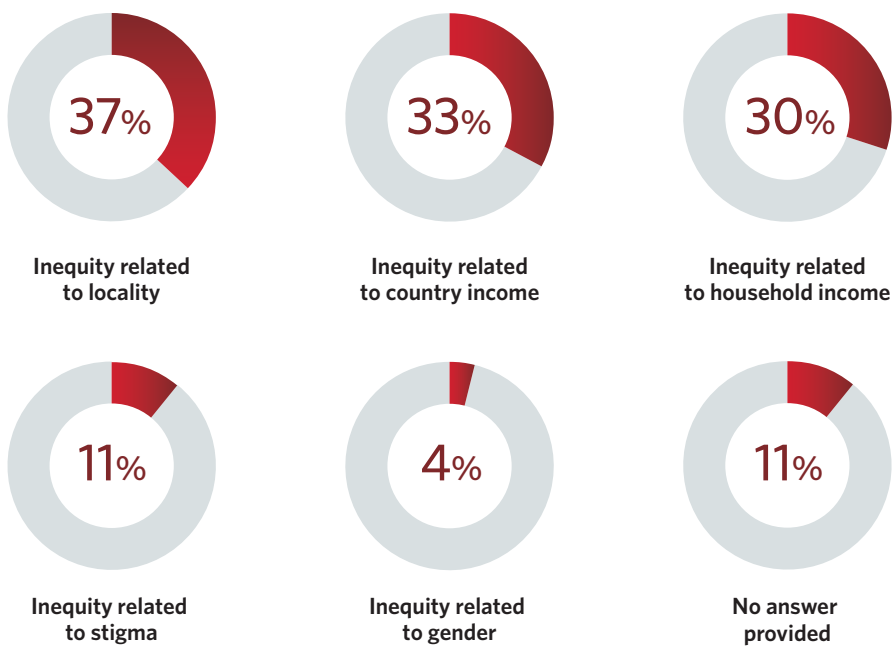
In its commitment letter, Access Accelerated very clearly states its goal of addressing a key aspect of social inequity — lack of “access to appropriate, quality and affordable prevention, treatments and care.” One question in the *Access Observatory* Program Registration specifically inquires about how the program is addressing social inequity.

The social inequities that companies’ programs address fall into five main categories: inequities between high and low and middle-income countries, between affluent and less affluent households, between rural and urban (locality), gender and stigma. Most frequently, programs report addressing inequities related to locality.

The majority of programs aimed to address income-related inequity and inequity related to where people lived within countries.

More information is needed for local stakeholders to understand how programs are adequately designed for the context in which they are implemented.

Figure 13: Number of Programs by Type of Social Inequity Addressed



Note: Categories coded based on open text responses. Some programs address more than one type of inequity

One-third of programs submitted at least one 2018 Indicator Value.

Nearly all 2018 Indicator Values submitted were for input or output indicators, with very few submitting for an outcome indicator and none for an impact indicator.

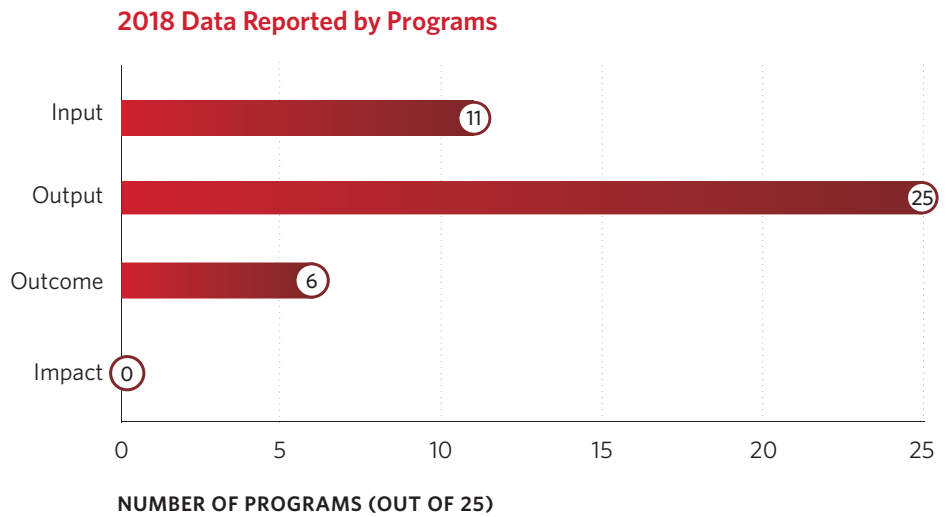
Program Indicators

In total, 25 programs submitted at least one 2018 Indicator Value. Of these, 11 (44%) submitted input indicators and 25 (100%) submitted output indicators. Only six programs (24%) submitted outcome indicators and none submitted impact indicators.

Figure 14: Access Observatory Program Indicators



Figure 15: Number of Programs by Type of 2018 Indicator Value Submitted



The most common input indicators reported in both 2017 and 2018 were “Value of resources” and “Staff time” spent on the project while the most common output indicators were “Number of people trained,” “Population exposed to community communication activities,” “Number of people on treatment” and “Number of people diagnosed.” Similarly, the most common outcome indicator reported was “Health provider knowledge” and “Health provider knowledge change.” There were no impact indicators reported for both 2017 and 2018.

Table 9: Commonly-Submitted Indicator Values

Indicator	Type of Indicator	Number of Programs 2017 (n=21)	Number of Programs 2018 (n=25)
Number of people trained ¹	Output	13 (62%)	18 (72%)
Population exposed to community communication activities ²	Output	11 (52%)	14 (56%)
Value of resources	Input	6 (29%)	10 (40%)
Number of patients diagnosed ³	Output	5 (24%)	9 (36%)
Number of patients on treatment ⁴	Output	6 (29%)	7 (28%)
Staff time	Input	5 (24%)	7 (28%)
Communication materials in use	Outcome	3 (14%)	5 (20%)
Population screened ⁵	Output	3 (14%)	4 (16%)
Tools in use	Output	2 (10%)	4 (16%)
Building/Equipment in use ⁶	Output	3 (14%)	3 (12%)
Percentage of professionals trained out of total number targeted	Output	2 (10%)	3 (12%)
Health provider knowledge	Outcome	3 (14%)	2 (8%)
Health provider knowledge change	Outcome	1 (5%)	2 (8%)
Number of patients diagnosed early ⁷	Output	1 (5%)	2 (8%)
Patients retained in care	Outcome	1 (5%)	2 (8%)
Patients with complete cancer remission	Outcome	1 (5%)	2 (8%)
Sites in use	Output	2 (10%)	2 (8%)

There were 28 other unique indicators such as "Time between first symptoms and diagnosis" and "Availability of medicines at outlets" that were reported by only one program in 2018.

¹This indicator is an aggregate of the following indicators: Number of people trained and Number of participants in trainings.

²This indicator is an aggregate of the following indicators: Population exposed to community communication activities and Population exposed to oral communication activities.

³This indicator is an aggregate of the following indicators: New Patients Diagnosed, Number of children impacted by second opinion diagnosis, Number of diagnosed cases and Number of patients diagnosed.

⁴This indicator is an aggregate of the following indicators: Number of patients initiating treatment, Number of patients on appropriate treatment per study protocol, Number of patients on treatment, Number of patients treated, and Patients on active treatment.

⁵This indicator is an aggregate of the following indicators: Population screened and Number of women screened/receiving clinical breast exam.

⁶This indicator is an aggregate of the following indicators: Buildings/equipment in use and Equipment in use.

⁷This indicator is an aggregate of the following indicators: Number of diagnosed cases at early stages and Patients early diagnosed.

Highlights of Programs that Submitted 2018 Indicator Data

Twenty-five programs submitted 2018 indicator data. Six programs submitted outcome indicator data:

- Eli Lilly Project HOPE Centre — South Africa
- Novartis Access
- Sanofi FAST — Fight Against STigma — Armenia
- Sanofi FAST — Fight Against STigma — Mali
- Sanofi My Child Matters — Paraguay
- Sanofi My Child Matters — Retinoblastoma

Seven of the 25 programs that submitted 2018 indicator data were focused on improving access to mental health care.

Mental Health Programs that Submitted 2018 Indicator Data

Seven of the 25 programs that submitted 2018 indicator data were focused on improving access to mental health care. They include:

- Sanofi's Fight Against Stigma (FAST) initiatives, focused on improving access to treatment for depression and schizophrenia, as well as reducing stigma and discrimination
- Eisai's "Remember I Love You" program, focused on improving awareness and early diagnosis of Alzheimer disease and dementia

Strategies

The strategies used by these programs include Community Awareness and Linkage to Care, Health Service Strengthening and Health Service Delivery.

Summary of Activities

Community Awareness and Linkage to Care

Most of the programs create awareness about mental health through developing and disseminating mental health behavior change communication materials, radio and TV broadcasts, information workshops in schools and communities, and training teachers, educators and social workers on mental health issues and related communication skills. The aim of the awareness activities is to reduce stigma and discrimination associated with mental health conditions in communities. One of the programs created a social media platform for dissemination of information about dementia (Eisai Remember I Love You).

Health Service Strengthening

The programs conduct continuous training of general practitioners and on the diagnosis and management of mental health illnesses (Sanofi FAST Armenia; Sanofi FAST Guatemala; Sanofi FAST Madagascar;

Sanofi FAST Mali; Sanofi FAST Morocco; Sanofi FAST Myanmar). The trained general practitioners are provided electronic tablets, equipped with an interactive version of the World Health Organization Mental Health Gap Action Program (WHO mhGAP) intervention guide, and e-medical records, to aid in patient management (Sanofi FAST Myanmar).

Health Service Delivery

One of the programs provide free consultations, treatment, and support to underprivileged families (Sanofi FAST Guatemala) while another program (Sanofi FAST Myanmar) screens for mental health disorders in the population using trained community health workers (CHWs) who are provided with smartphones equipped with interactive screening questionnaires to identify and refer people with mental health disorders to general practitioners.

Indicators Reported

The programs reported the following indicators:

Input	Staff time; value of resources
Output	Population exposed to community communication activities; Population exposed by community awareness campaign out of total target population; Communication materials in use; Number of radio or TV programs; Number of people supported via self-help groups; Number of free consultations; Number of patients diagnosed; Number of patients on treatment; Number of people trained; Percentage of professionals trained out of total number targeted
Outcome	Health provider knowledge; Health Provider Knowledge Change

Next Steps

Data on outcome indicators (e.g., change in the knowledge, attitude and behaviours related to mental health) collected within the context of a study design that would allow for causal attribution are needed to assess whether these programs reduced stigma.

To demonstrate whether the programs were able to provide treatment, the number of people with a diagnosis of a mental disorder receiving treatment out of those with a diagnosis but without treatment would need to be recorded over time and compared to communities without the program.

Data on outcome indicators collected within the context of a study design that would allow for causal attribution are needed to assess whether these programs reduced stigma.

Diabetes and Hypertension Programs that Submitted 2018 Indicator Data

Five of the 25 programs that submitted 2018 data were focused on improving access to diabetes and/or hypertension care. They include:

- Daiichi Sankyo Mobile Healthcare Field Clinic Services
- Eli Lilly Project Hope Center
- Novartis Access
- Pfizer Foundation Abundant Health
- Sanofi Kids and Diabetes in Schools

Strategies

The strategies used include Community Awareness and Linkage to Care, Health Service Strengthening, Health Service Delivery, and Price Scheme.

Summary of Activities

Community Awareness and Linkage to Care

The programs create awareness about diabetes and/or hypertension through community engagement activities (Pfizer Foundation Abundant Health, Daiichi Sankyo Mobile Healthcare Field Clinic Services; Novartis Access), informational website (Pfizer Foundation Abundant Health), diabetes education to teachers, school nurses and staff, students and parents, including parents of children with diabetes (Sanofi Kids and Diabetes in Schools), and community screening of diabetes and/or hypertension (Pfizer Foundation Abundant Health; Novartis Access; Eli Lilly Project Hope Center).

Health Service Strengthening

The programs train community health workers and health care providers on guidelines for treatment and management of hypertension and diabetes (Pfizer Foundation Abundant Health; Novartis Access; Eli Lilly Project Hope Center).

In addition, one of the programs trains traditional healers to identify the symptoms and complications of diabetes and hypertension, the dangers of mixing traditional and conventional medicines, and the need for early referral of patients with these conditions (Eli Lilly Project Hope Center).

Health Service Delivery

The programs conduct community screening for diabetes and hypertension (Pfizer Foundation Abundant Health; Eli Lilly Project Hope Center) and provide free or subsidized treatment for diabetes and hypertension in health facilities (Eli Lilly Project Hope; Novartis Access) or mobile clinics (Daiichi Sankyo Mobile Healthcare Field Clinic Services).

Five of the 25 programs (20%) that submitted 2018 data were focused on improving access to diabetes and/or hypertension care.

Price Scheme

In one of the programs (Novartis Access) reduced price medicines are distributed through public and non-profit health facilities.

Other Activities

One of the programs involves planting gardens that provide healthy vegetables and nutritional education to patients. The program also provides free exercise classes to patients and encourage patients to register for a village savings and loan program (Eli Lilly Project Hope Center).

Indicators Reported

The programs reported the following indicators:

Output	Number of mobile healthcare field clinics; Number of patients on treatment; Number of patients diagnosed; Population screened; Population exposed to community communication activities; Number of people trained; Tools in use; Volume of medicines sold
Outcome	Patients retained in care; Number of patients diagnosed after community awareness and linkages to care program; Availability of medicines at outlets

Next Steps

To assess whether programs aiming to increase the proportion of people aware of risk factors or proportion of patient screened or receiving treatment for diabetes or hypertension indeed achieved their objectives, programs need to measure outcomes in the context of a study design that will allow causal attribution. Examples of relevant outcomes:

- Proportion of people aware of risk factors due to the program
- Proportion of patients receiving treatment according to standard treatment guidelines of patients treated under the program
- Proportion of patients achieving clinical outcomes in terms of blood pressure or blood glucose

In addition, the economic consequences for households accessing treatment is important. This can be measured through patient out-of-pocket expenditure on health services and medicines in relation to other expenses.

To assess whether programs achieved their objectives, programs need to measure outcomes in the context of a study design that will allow causal attribution.

Four programs working on childhood cancers submitted 2018 indicator data to the Access Observatory. All four programs are part of Sanofi's My Child Matters (MCM) Initiative, which is focused on improving early diagnosis and treatment of childhood cancers.

Childhood Cancer Programs that Submitted 2018 Indicator Data

Four programs working on improving early diagnosis and treatment of childhood cancers submitted 2018 indicator data to the *Access Observatory*:

- Sanofi My Child Matters (MCM) Thailand
- Sanofi MCM Paraguay
- Sanofi MCM Retinoblastoma
- Sanofi MCM Telepathology for Childhood Cancer Diagnosis

Strategies

The programs use the Community Awareness and Linkage to Care, Health Service Strengthening, and Health Service Delivery strategies.

Summary of Activities

Community Awareness and Linkage to Care

The programs use community campaigns and social, mass, and print media to educate parents and the general population on childhood cancers signs and treatment options, good hygiene, and good feeding habits (Sanofi MCM Thailand, Sanofi MCM Paraguay and Sanofi MCM Retinoblastoma). One of the programs provide funds to families to support transport of their children the hospital to receive chemotherapy (Sanofi MCM Thailand).

Health Service Strengthening

The programs train healthcare providers in the early diagnosis and management of childhood cancers. The programs also provide childhood cancer diagnostic and treatment equipment to health facilities. Some of the programs provide temporary lodging for families of children with cancer to stay during the course of treatment (Sanofi MCM Paraguay; Sanofi MCM Thailand).

Health Service Delivery

The programs screen children for cancer and bring treatment closer to the patients through decentralized satellite clinics (Sanofi MCM Thailand; Sanofi MCM Paraguay). One of the programs pays part of the cost of treatment for the poorest families (Sanofi MCM Retinoblastoma).

Indicators Reported

The programs reported the following indicators:

Input	Value of resources
Output	Population exposed to community communication activities; Communication materials in use; Community groups supported Number of diagnosed cases; Number of diagnosed cases at early stages; Number of children impacted by second opinion diagnosis, Number of patients on treatment; Number of ocular prosthesis; Number of training session; Number of people trained; Tools in use; Buildings/ equipment in use; Sites in use; Number of research communications (publication); Number of research communications (presentation)
Outcome	Time between first symptoms and diagnosis; Patients retained in care; Patients with complete cancer remission

Next Steps

To evaluate whether programs achieved their aims of improving cancer survival of children, they need to include outcome and impact measures that capture disease remission or survival in the context of a study design that will allow causal attribution. Some of the programs already capture these measures, while others do not. Economic consequences for households accessing treatment is important. This can be measured through patient out-of-pocket expenditure on health services and medicines in relation to other expenses.

To evaluate whether programs improved cancer survival of children, they need to include outcome and impact measures that capture disease remission or survival in the context of a study design that will allow causal attribution.

Three programs working on breast cancer and one program working on cancers in general submitted 2018 data to the Access Observatory.

Breast Cancer and General Cancer Programs that Submitted 2018 Indicator Data

Three programs working on breast cancer and one program working on cancers in general submitted 2018 data to the *Access Observatory*. The programs working on improving access to breast cancer awareness, early diagnosis and treatment are:

- Novartis Access
- Pfizer Foundation Integrated Approach to Improving Oncology Care
- Pfizer Foundation Improving Oncology Care: Scaling Up Breast Cancer Services in La Libertad Region, Peru

One program is focused on improving access to palliative care for cancers in general:

- Takeda Palliative Care Training in sub-Saharan Africa

Strategies

The programs use the Community Awareness and Linkage to Care, Health Service Strengthening, Health Service Delivery, and Price Scheme strategies.

Summary of Activities

Community Awareness and Linkage to Care

One of the programs creates awareness through community health workers (volunteers) who educate women on the symptoms of breast cancer and the need to go to their local health clinics for annual clinical breast exam (Pfizer Foundation Improving Oncology Care: Scaling Up Breast Cancer Services in La Libertad Region, Peru). Another program supports local cancer survivors organizations in promoting cancer awareness by providing cancer educational resources for them to share with group members (Pfizer Foundation Integrated Approach to Improving Oncology Care).

Health Service Strengthening

Programs train healthcare providers on the early diagnosis and management of cancers. One program uses a mobile health (m-health) platform for continuous training, peer collaboration, and real time evaluation reports (Takeda Palliative care training in SSA), while another donates biopsy needles to local hospitals (Pfizer Foundation Integrated Approach to Improving Oncology Care).

Health Service Delivery

One of the programs involves screening women for breast cancer through clinical breast exam and fine needle aspiration biopsy with ultrasound triage (Pfizer Foundation Improving Oncology Care: Scaling Up Breast Cancer Services in La Libertad Region, Peru).

Price Scheme

For one of the programs (Novartis Access), reduced price breast cancer medicines are distributed through public and non-profit health facilities.

Indicators Reported

The programs reported the following indicators:

Input	Staff time, Value of resources
Output	Number of people trained; Number of women screened/receiving clinical breast exam; Population exposed to oral communication activities; Volume of medicines sold
Outcome	Availability of medicines at outlets

Next Steps

To assess whether programs improve breast cancer survival, they need to feature outcomes that capture disease remission or survival in the context of a study design that will allow causal attribution. For programs that aim to strengthen diagnostic capacities, one relevant outcome to measure would be the proportion of patients diagnosed at certain stages of breast cancer. Finally, economic consequences for households accessing treatment is important. This can be measured through patient out-of-pocket expenditure on health services and medicines in relation to other expenses.

To assess whether programs improved breast cancer survival, they need to feature outcomes that capture disease remission or survival in the context of a study design that will allow causal attribution.

Six out of 25 programs that do not fit into the previous program classifications reported 2018 program data.

Other Programs that Submitted 2018 Indicator Data

Six additional programs that do not fit into the previous program classifications reported 2018 program data. They include:

- **Astellas Action on Fistula**, which is focused on diagnosis and treatment of obstetric fistula
- **Daiichi Sankyo Cultivating Healthcare Workers in China**, which trains healthcare workers to manage asthma and other common childhood diseases
- **Takeda HERhealth**, which is focused on building health knowledge and capacity of females in work places
- **Merck KGaA, Darmstadt, Germany Integrated Thyroid NCD Care in Philippines**, which is focused on diagnosis and treatment of thyroid disorders
- **Merck KGaA, Darmstadt, Germany STEM Program for Women and Youth**, which aims to empower women and youth in the fields of STEM
- **Sumitomo Dainippon Promoting Sound Child Growth Pilot Project**, which trains community health workers to organize home visits for mothers and babies

Strategies

These programs use the Community Awareness and Linkage to Care, Health Service Strengthening, and Health Service Delivery strategies.

Summary of Activities

Community Awareness and Linkage to Care

The programs create awareness through awareness meetings and campaigns in communities (Daiichi Sankyo Cultivating Healthcare Workers, Astellas Action on Fistula), radio broadcasts (Astellas Action on Fistula; Merck KGaA, Darmstadt, Germany, Integrated Thyroid NCD Care in Philippines), and online and print media (Merck KGaA, Darmstadt, Germany, Integrated Thyroid NCD Care in Philippines).

Health Service Strengthening

The programs train healthcare workers to diagnose and manage specific diseases (Astellas Action on Fistula; Daiichi Sankyo Cultivating Healthcare Workers; Merck KGaA, Darmstadt, Germany, Integrated Thyroid NCD Care in Philippines), train community health workers to organize home visits for mothers and babies (Sumitomo Promoting Sound Child Growth Pilot Project) and build workplace managers capacity to better understand workers health needs and their responsibility to manage health in the workplace (Takeda HERhealth).

Health Service Delivery

One of the programs (Astellas Action on Fistula) provides fistula repair surgery for women.

Indicators Reported

The programs reported the following indicators:

Output

Communication materials in use; Population exposed to oral communication activities; Population exposed to media communication activities; Tools in use; Number of users receiving tools; Management procedures in use; Staff time spent planning; Number of people trained; Number of patients on treatment.

Next Steps

To assess whether programs aiming to increase the number of people treated, the knowledge of healthcare providers, and the health knowledge of women in workplaces indeed achieved their objectives, programs need to measure outcomes in the context of a study design that will allow causal attribution. Examples of relevant outcomes:

- Change in the knowledge of healthcare providers trained under the program
- Change in the knowledge of women in the workplace and women in STEM
- Change in the health seeking behavior of women in the workplace
- Proportion of patients receiving treatment according to standard treatment guidelines of patients treated under the program
- Proportion of patients achieving clinical outcomes after receiving treatment through the program

In addition, the economic consequences for households accessing treatment is important. This can be measured through patient out-of-pocket expenditure on health services and medicines in relation to other expenses.

To assess whether programs indeed achieved their objectives, programs need to measure outcomes in the context of a study design that will allow causal attribution.

Results from C/Can 2025

C/Can 2025 City Cancer Challenge is a multi-sectoral initiative that seeks to engage all city stakeholders including government (local, regional, national), civil society, academia, healthcare facilities and professionals, and the private sector in the design, planning and implementation of cancer care solutions.

C/Can 2025 supports cities to undertake comprehensive city-wide assessments to identify current gaps, needs and priorities in cancer care and to prioritize objectives, develop costed activity plans, identify partners and financing solutions to support implementation of plans, and develop monitoring and evaluation frameworks.

Program Geography

C/Can 2025 started in 2017 with four key learning cities: Asunción in Paraguay, Cali in Colombia, Kumasi in Ghana, and Yangon in Myanmar. The initiative is scaling-up support to a wide network of ‘Challenge Cities’ with a population greater than 1 million in every region.

Figure 16: Geographic Distribution of C/Can 2025 Cities



Program Strategies and Activities

The program strategies and activities include:

Program Strategy	Activity
Health Service Strengthening	Planning Work with cities to conduct a comprehensive needs assessment, prioritize objectives, and develop activity plans.
	Training Work with American Society for Clinical Pathology (ASCP) to improve quality of pathology diagnosis through training of health professionals.
Financing	Planning C/Can 2025 is developing the City Health Financing Lab to support cities to access financing for their cancer priorities.
Regulation and Legislation	Advocacy C/Can 2025 is enhancing advocacy efforts in cities.

Partnerships and Stakeholders

C/Can 2025 works with 18 global partners, including five private sector, six public sector and seven voluntary sector partners.*

The private sector partners are involved in:

- Program funding
- Implementation

The public sector partners are involved in:

- Program implementation
- Technical implementation support
- Capacity building

The voluntary sector partners are involved in:

- Program implementation
- Technical implementation support
- Capacity building
- In-kind and financial support during all phases of the initiative's design, development and implementation at global, regional and city levels

C/Can 2025 also works with several national, regional, and city level stakeholders including heads of states and governors, ministries of health, finance and commerce, national cancer societies, national cancer institutes, local hospitals, and local universities, among others.

Program Indicators

C/Can 2025 submitted data for 16 indicators (Table 10) which showed an increase in program activities and output from 2017 to 2018.

Next Steps

There is much that can be learned from the experience of cities in improving access to cancer care and treatment. Detailed output and outcome indicator data from each city will be valuable to this end.

*C/Can 2025 partners are: Access Accelerated, AdvaMed (representing Varian, Elekta, and Accuray), the World Bank, the World Economic Forum, the University of Pittsburgh Medical Center (UPMC), Amgen, American Society of Clinical Oncology (ASCO), American Society of Clinical Pathology (ASCP), Direct Relief, Dalberg, Icon Group, National Cancer Institute-US, European Society for Radiotherapy and Oncology (ESTRO), International Atomic Energy Agency (IAEA), World Child Cancer, Sanofi Espoir Foundation (SEF), University de Valle, and WHO/PAHO.

C/Can 2025 submitted data for 16 indicators, which showed an increase in program activities and outputs from 2017 to 2018.

Table 10: C/Can 2025 Indicator Values 2017 and 2018

Indicator	Unit	2017	2018
Total population served	People	38.11 million	38.11 million
Development and strengthening of cancer policies, protocols and processes	Policies, protocols, guidelines, processes	0	15
Healthcare professionals supported with technical assistance	People	14	378
Technical experts providing technical assistance in cancer treatment and care	People	2	44
Development of tools, guidance and protocols for cancer treatment and care	Tools, guidance, protocols	0	3
City stakeholders actively engaged	Percentage	0	73
Cities collaborating to improve cancer treatment and care	Percentage	0	100
Cities engaged in the City Cancer Challenge	Cities	4	4
Participation of health facilities in identifying needs in cancer treatment and care	Percentage	0	86
Participation of healthcare professionals in identifying needs in cancer treatment and care	People	560	817
Participation of patients in identifying needs in cancer treatment and care	People	599	652
Needs assessment completed in cities	Needs assessment	3	4
Technical assistance in cancer treatment and care provided	Technical assistance activity	3	12
City development of project implementation plans	Cities	0	2
Technical support provided to facilitate sustainable financing of cancer treatment and care	Cities	2	4
Technical experts contributing to technical support on sustainable financing for cancer treatment and care	People	10	30

Country Analysis: Kenya

In 2018, Kenya was home to 25 Access Accelerated programs being implemented by nine different companies. Of these, 13 were implemented only in Kenya, while the rest were implemented in Kenya and other countries. Overall, 10 programs (40%) submitted an indicator plan, and five submitted indicator data values for 2018.

Program Strategy and Activities

Similar to Access Accelerated programs overall, the majority of programs in Kenya used Health Service Strengthening and Community Awareness and Linkage to Care strategies. However, programs in Kenya more often used the Price Scheme strategy and less often used the Health Service Delivery strategy.

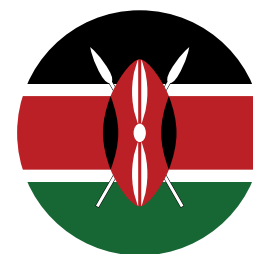
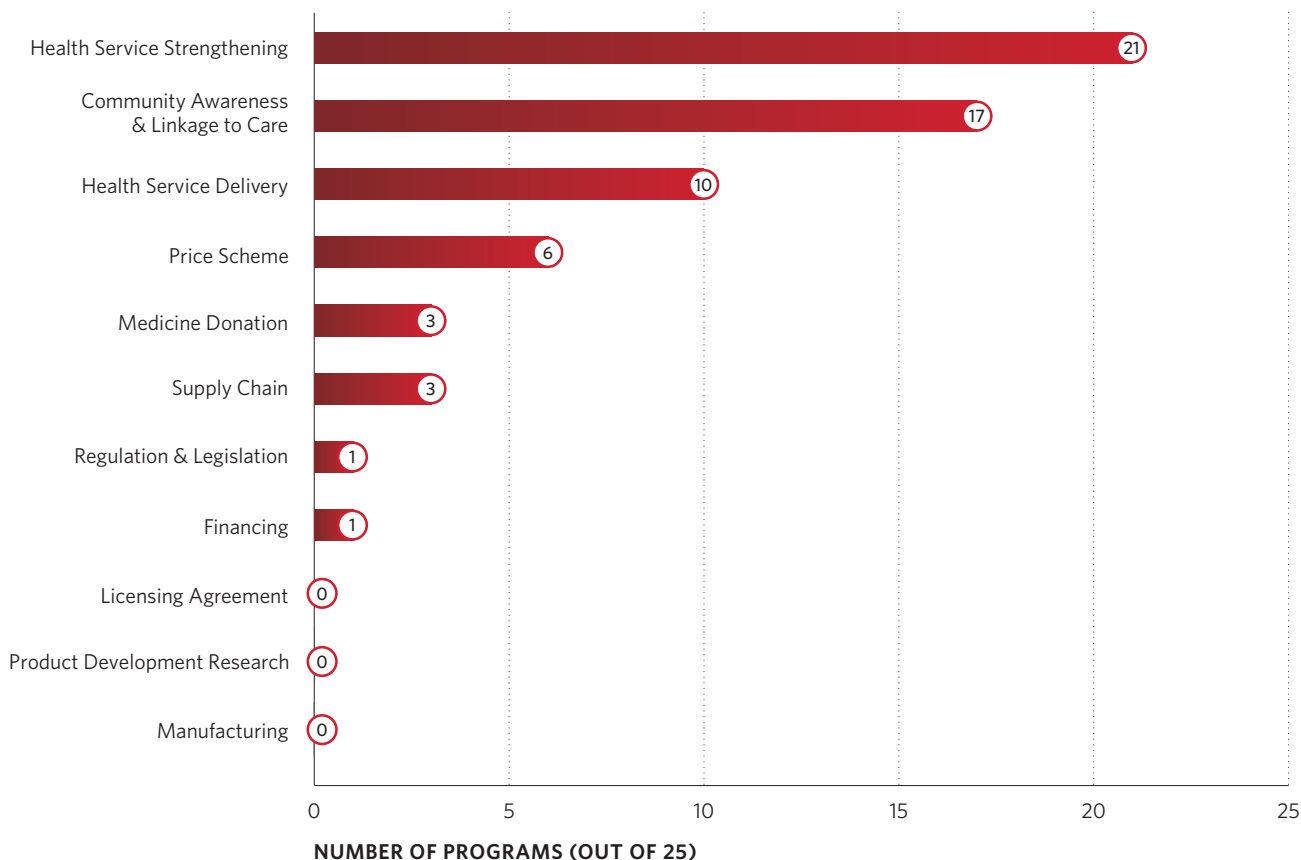


Figure 17: Number of Programs in Kenya by Strategy



Training of health care professionals was the most common Health Service Strengthening activity, while communicating NCD information to communities through mass media and community awareness meetings was the most common Community Awareness and Linkage to Care activity in Kenya.

Disease Scope

Programs in Kenya were mainly focused on improving access to cancer care (especially breast, cervical, and hematological cancers) (80%), diabetes (24%), and cardiovascular disease (20%). Four programs from four different companies focused on breast cancer, and all four of these programs used the Community Awareness and Linkage to Care, Health Service Strengthening

(training of providers) and Health Service Delivery strategies. Four other programs focused on cervical cancer, all of which used Community Awareness and Linkage to Care and Health Service Strengthening strategies. No information was provided on any coordination or cooperation between the companies operating related cancer programs.

With all of the different but complementary NCD access programs currently running in Kenya, there are ample opportunities for companies to coordinate, cooperate, and share investment in monitoring and evaluation in the coming years.

Partnerships and Stakeholders

The majority of programs (96%) in Kenya had at least one local partner. Similar to Access Accelerated programs overall, 72% of programs in Kenya worked with at least one civil society or voluntary sector partner, 52% with at least one public sector partner and 20% with academic partners. Few programs in Kenya reported working directly with Ministry of Health or hospitals. Despite the lack of explicit cooperation across companies, some implementing partners managed multiple programs. For example, one partner (AMPATH) is implementing two cervical cancer programs with two different companies (Celgene and Takeda).

Program Indicators

Five programs reported 2018 indicators. All five programs reported output indicators, one program reported input indicators and one reported outcome indicators. None of the programs reported impact indicators. "Number of people trained" and "Population exposed to community communication activities" were the common output indicators reported by programs in Kenya.

Other Company Programs

Novo-Nordisk, though not a member of Access Accelerated, has been active with a diabetes program entitled "Reaching the Base of the Pyramid in Kenya." This program has also been subject to evaluation.^{7,8}

Astra-Zeneca, though not a member of Access Accelerated and not reported in the *Access Observatory*, has been active in the area of cardiovascular disease in Kenya and has been the subject of an evaluation of the impact of an intervention on knowledge and treatment of hypertension.⁹

Recommendations for Promoting Coordination

With all of the different but complementary NCD access programs currently running in Kenya, there are ample opportunities for companies to coordinate, cooperate, and share investment in monitoring and evaluation in the coming years. The Ministry of Health of Kenya has an important role to play in these efforts.

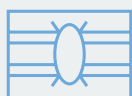
Summary of Year Two Findings



Overall, 73 programs registered in the Access Observatory operated in 2018. This includes 13 new programs registered this past year.



Two-thirds of programs did not report any indicator data. More complete data is needed to fully capture Access Accelerated's achievements and demonstrate progress in fulfilling commitments.



Programs continue to be concentrated in a small set of countries, most notably Kenya, which now has 25 Access Accelerated programs. This level of geographic focus provides opportunities for cross-company collaborations that could yield greater efficiency and impact.



The majority of programs use three strategies: Community Awareness and Linkage to Care; Health Service Strengthening; and Health Service Delivery. No programs use manufacturing or licensing agreement strategies, which might be considered core strengths of the industry. There are opportunities for companies to innovate in these areas where they have competitive advantages compared to other actors in global health.



One-third of programs included medicines and medical devices as part of their strategy. 13 out of 36 medicines or medicine combinations are on the WHO Model List of Essential Medicines.⁶ Most of the medicines included in programs are for the treatment of cancer, many of which require well-functioning secondary and tertiary health care infrastructure to deliver.



One-quarter of programs indicated that they conducted a needs assessment prior to the start of implementation. Needs assessments are a critical input into program design and help to ensure that programs respond to local needs and are fit to the local context.



Most programs indicated a priority in addressing social equity. More and better data are needed to assess whether programs are achieving pro-equity goals.



New reporting by C/Can 2025 is an important expansion of the Access Accelerated portfolio. There is much that can be learned from the experience of cities in improving access to cancer care and treatment. Detailed output and outcome indicator data from each city will be valuable to this end.

Looking Forward

Year Two of the *Access Observatory* saw the establishment of a strong foundation for shared learning. Looking forward, there is a need to further engage implementing partners who are fundamental to project implementation and data collection efforts. Companies are increasing investment in building their internal systems, but the success of partnership requires active participation in transparent data collection and reporting.

In 2018, we saw a small increase in programs reporting both output data, allowing for the assessment of program implementation, and outcome data, allowing for the assessment of social outcomes. Methods of measurement may vary depending on the ultimate purpose of the information being produced, and measurement activities undertaken by companies should be fit-for-purpose. Program evaluation requires resources, and investments in measuring impact should not outweigh the benefits of the evidence produced. Effective coordination between biopharmaceutical companies and other stakeholders in program evaluation remains an untapped opportunity to increase efficiencies in program evaluation. *Access Observatory* data serve as a basis for identifying opportunities for innovation and coordination.

Transparency of program outcomes allows companies to receive credit for their efforts and increases efficiency while also creating trust and accountability.

Importance of Implementing Partners

We found an increasing number of unique partners (210) involved in program implementation. Nearly all programs (99%) had at least one partner and on average programs had 3.7 implementing partners. While 74% of the programs had at least one voluntary sector partner, 58% had at least one public sector partner. The strong reliance on implementing partners is consistent with established practice for medical donation programs, an area where companies and partners have combined to create the Partnership for Quality Medical Donations.¹⁰

Anecdotal evidence suggests that companies often experience difficulty in reporting data for output and outcome indicators when implementation is managed by partner organizations. This appears to be due in part to the nature of the agreements signed between companies and implementing partners, which usually do not stipulate at the outset of the program data reporting requirements. Companies that ask for data mid-program or even upon completion of their program have found that their partners are unable to retro-fit monitoring and evaluation systems to align with the standardized framework used by the *Access Observatory*.

Retro-fitting monitoring and evaluation systems for ongoing and completed programs may not be possible. However, the opportunity exists for companies and partners to adopt the *Access Observatory* framework for all future programs and to stipulate as part of their agreement the input, output, and outcome indicators that will be collected and reported. This is particularly important in multi-country programs, and in cases where multiple companies use the same implementing partner, to ensure harmonization and efficiency.

Many implementing partners have considerable experience working with multiple companies and diseases, and their contributions to shared learning should be encouraged. There may be efficiency gains by having them participate and contribute to regional or national coordination activities.

The opportunity exists for companies and partners to adopt the Access Observatory framework for all future programs and stipulate as part of their agreement the input, output, and outcome indicators that will be collected and reported.

Company Progress in Developing Internal Systems for Integrated Reporting

We found a limited increase in the number of programs that reported indicator values this past year as compared to the previous year.

We found a limited increase in the number of programs that reported indicator values this past year as compared to the previous year. However, this masks in important ways progress that we have observed by several companies in developing internal systems for integrated reporting on their access activities. By systems for integrated reporting, we mean the processes and information technologies that companies use for tracking, managing, and reporting on their access programs, which are increasingly being integrated into systems originally designed solely for commercial activities. Many companies were too early in the process of developing their new systems to provide indicator values for 2018, but several have made important investments that we expect to yield valuable data in the near future.

Program Monitoring Versus Evaluation

Program measurement information can serve multiple purposes, including facilitating internal and external learning and demonstrating effectiveness and accountability to beneficiaries. Methods of measurement may vary depending on the ultimate purpose of the information being produced, and measurement activities undertaken by companies should be fit-for-purpose.

Methods of measurement may vary depending on the ultimate purpose of the information being produced, and measurement activities undertaken by companies should be fit-for-purpose.

Assessing whether a program has been implemented as planned requires monitoring. Program monitoring is the systematic and routine collection of data on the program activities (what is done) and outputs (what has been delivered as the result of the activities).

Assessing the impact of a program and whether it improved social outcomes requires a counterfactual approach. Program evaluation refers to the analysis of program impact and relies on data for outcomes and, if possible, impact. In order to attribute improvements in outcomes to the program, data must be collected within a study design setup (experimental or quasi-experimental) that allows for causal inference.

While program monitoring is usually done by the program implementer, program evaluation often requires partnership with an independent third party with methodological expertise. Table 11 compares program monitoring and evaluation.

Table 11: Comparison of program monitoring and evaluation

	Monitoring	Evaluation
Goal	Measure program implementation	Measure program effects compared to the absence of the program
Type of data	Program activities Program outputs	Program outcomes Program impacts
Responsible for data collection and analysis	Implementing partners	External party

In 2018, 25 out of 73 programs (34%) reported output data, which allow companies to assess program implementation. As companies develop their internal systems to monitor program implementation, it is expected that the number of programs reporting on activities and outputs should grow to 100% by 2022. Access Accelerated would then be able to collectively report on the scope of program implementation.

In 2018, 6 out of 73 programs (8%) reported outcome data. Health provider knowledge or knowledge change, availability of medicines at outlets, number of patients retained in care, number of patients with complete cancer remission, and time between first symptoms and diagnosis were some of the outcome indicators reported. Reporting on outcomes, such as the number of patients receiving adequate treatment, can be a meaningful way of assessing whether programs are addressing gaps in access to treatment. By 2022 we expect many of the programs to be reporting short-term outcomes to the *Access Observatory*. In particular, we would expect a program evaluation for new programs.

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Reporting on outcomes, such as the number of patients receiving adequate treatment, can be a meaningful way of assessing whether programs are addressing gaps in access to treatment.

When to Measure Impact

Not every program needs to be rigorously evaluated. If there is already good evidence that the strategies that the program uses are effective in a given setting, it may not be necessary to invest the resources required to re-demonstrate effectiveness. For instance, if vaccinating children against rotavirus has been demonstrated to be effective and efficient in one context, doing an evaluation of a rotavirus vaccination program in a similar setting is often unnecessary. In this case reporting on the number of children receiving the full course of vaccines as a program output should be sufficient. However, even in this example, evaluation may be needed to demonstrate that aspects of the program delivery platform are functioning properly.

Rigorous evaluation of the outcome and impact of new strategies is often needed. For example, evaluation of a new pricing scheme linking patients with money lending organizations to obtain loans to pay for their cancer treatment should be evaluated because the program effects are unknown. Such a program could improve access to treatment but could also harm patients by impoverishing them and their families. Program beneficiaries, communities, and local governments are key audiences for the evidence produced by a rigorous program evaluation.

There is an untapped opportunity to increase efficiencies in program evaluation through effective coordination between biopharmaceutical companies and other stakeholders.

Program evaluation requires resources, and investments in measuring outcome and impact indicators should not outweigh the benefits of the evidence produced. For instance, evaluating a rotavirus vaccination program seems to be of limited benefit in relation to the resources needed because existing evidence can be used to determine likely program effectiveness. However, evaluating an innovative pricing scheme that links patients with lenders for cancer treatment could be a good investment, particularly if the evaluation is done during a small pilot phase of the program which would reduce overall cost. The evidence generated by rigorous program evaluation is valuable to many stakeholders, including governments and philanthropic organizations, and in that sense is a public good. Publication of such evaluations in peer-reviewed journals has many benefits. Such publications share learnings but also set standards for what is expected in evaluation. A recent publication evaluating an intervention to improve healthcare providers' knowledge and treatment of hypertension in Kenya is such a publication.⁹ This supports a model of shared investment in evaluations of these programs. There is an untapped opportunity to increase efficiencies in program evaluation through effective coordination between biopharmaceutical companies and other stakeholders.

A significant number of biopharmaceutical companies that are part of Access Accelerated have already committed to best practices in program measuring and reporting which are aligned with the *Access Observatory*.¹¹ Since these principles predate the Access Accelerated programs, many partners are already investing in measurement and reporting, which will accelerate progress in program reporting in the *Access Observatory*.

Innovative Pricing Schemes

The majority of programs reviewed this year used the same few strategies: Community Awareness and Linkage to Care; Health System Strengthening; and Health Service Delivery. However, a few programs adopted relatively innovative pricing schemes that could constitute an area in which the industry has a unique role and responsibility. Pricing scheme approaches used include: cost sharing of medicines with government for patients purchasing from the public sector; bundling of medicines (e.g. buy two and get one free); and use of vouchers for reduced pricing of laboratory tests and medicines in the private sector. One additional program used a personalized pricing approach where pricing of medicines depends on ability to pay. We encourage more companies to consider innovative approaches to pricing their medicines, a strategy that they are uniquely positioned to implement. Evaluation of the effects of these programs on health and financial protection is critical to ensure that programs that harm patients or their families or that waste health system resources are discontinued and not repeated elsewhere.

The majority of programs reviewed this year used the same few strategies: Community Awareness and Linkage to Care; Health System Strengthening; and Health Service Delivery.

Transparency in Reporting

Access Accelerated companies and C/Can 2025 have made a commitment to transparency in reporting. Transparency creates trust and allows for accountability.

Transparency can also increase efficiency: if the *Access Observatory* is the reference for pharmaceutical industry-led access programs, companies are able to refer to it and do not need to report to each individual entity separately. This would require consensus building within the global health community on the measurement framework, indicators and standards for reporting.

In Conclusion

The consolidated efforts of Access Accelerated partners, including companies, the World Bank, and C/Can 2025 can play an important role in achieving the Sustainable Development Goals by 2030. The commitment of CEOs of leading biopharmaceutical companies to rigorous measurement and transparent reporting of access programs sets an important precedent for other partners. The results reported to the *Access Observatory* establish a strong foundation for shared learning. A sustained effort is needed in the coming years to realize the full potential of Access Accelerated.

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- ⁸ Evaluating Novo Nordisk's Base of the Pyramid project in Kenya: Summary of Findings <https://www.dropbox.com/s/r7zjzky11e25d1a/Final%20Report-%20BoP%20Kenya%20010517.pdf?dl=1>
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Appendix 1

List of Programs Reported into the Access Observatory

	Primary Pharmaceutical Company	Name of Initiative	Country or Countries of Implementation
1	Astellas	Action on Fistula	Kenya
2	Bristol-Myers Squibb Foundation	Global Hope (Africa)	Botswana, Malawi, Uganda
3	Bristol-Myers Squibb Foundation	Pink Ribbon, Red Ribbon (Africa)	Ethiopia, Tanzania
4	Bristol-Myers Squibb Foundation	Project ECHO for Cancer Care (South Africa)	South Africa
5	Bristol-Myers Squibb Foundation	Secure The Future — Senegal	Senegal
6	Bristol-Myers Squibb Foundation	Secure the Future Kimberly Hospital Complex — South Africa	South Africa
7	Bristol-Myers Squibb Foundation	Secure The Future — Tanzania	Tanzania
8	Bristol-Myers Squibb Foundation	Secure The Future — UThukela District, KwaZulu-Natal, South Africa	South Africa
9	Bristol-Myers Squibb Foundation	Secure The Future Lung Cancer in Kenya	Kenya
10	Bristol-Myers Squibb Foundation	Secure The Future — Lung Cancer in Swaziland	Swaziland
11	Bristol-Myers Squibb Foundation	Secure The Future — Gauteng Province South Africa	South Africa
12	Bristol-Myers Squibb Foundation	Children And Mothers Partnerships (CHAMPS) Initiative — Kenya	Kenya
13	Bristol-Myers Squibb Foundation	Secure The Future — KwaZulu Natal South Africa	South Africa
14	Bristol-Myers Squibb Foundation	Secure The Future — Multinational Lung Cancer Control Program (MLCCP)	Kenya, South Africa, Swaziland, Tanzania
15	Celgene	Celgene AMPATH Oncology Partnership	Kenya
16	Chugai	Helping safer childbirth	Myanmar
17	Chugai	Health Camp against NCDs	Myanmar
18	Daiichi-Sankyo	Cultivating Healthcare Workers in China	China
19	Daiichi-Sankyo	Mobile Healthcare Field Clinic Services	Tanzania
20	Eisai	Remember I Love You	China
21	Eli Lilly and Company	Project HOPE Centre — South Africa	South Africa
22	Eli Lilly and Company	Tshwane Insulin Project (TIP)	South Africa
23	GlaxoSmithKline	MSI-GSK Cervical Cancer Prevention Project	Bangladesh, Madagascar, Sierra Leone
24	GlaxoSmithKline	PRRR-GSK Cervical Cancer Prevention Project	Ethiopia
25	Merck & Co., Inc.	SPARSH HEALTHLINE	India
26	Merck & Co., Inc.	SPARTA	Australia, Austria, Belgium, Brazil, Germany, Greece, India, Indonesia, Ireland, Malaysia, Mexico, Oman, Philippines, Russia, Singapore, Sweden, Switzerland, Taiwan, Thailand, United Arab Emirates, Vietnam

Primary Pharmaceutical Company	Name of Initiative	Country or Countries of Implementation
27 Merck & Co., Inc.	GARDASIL — Gavi	Armenia, Bangladesh, Benin, Bolivia, Burkina Faso, Burundi, Cambodia, Cote d'Ivoire, Ethiopia, Ghana, Guyana, Honduras, Indonesia, Kenya, Lao PDR, Liberia, Madagascar, Malawi, Mali, Niger, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Solomon Islands, Sri Lanka, Tanzania, The Gambia, Togo, Uganda, Uzbekistan, Zimbabwe
28 Merck & Co., Inc.	GARDASIL — Haiti, Zanmi Lasante	Haiti
29 Merck & Co., Inc.	GARDASIL — Peru, CerviCusco	Peru
30 Merck KGaA, Darmstadt, Germany	Merck Cancer Access Program	Botswana, Egypt, Ethiopia, Ghana, India, Kenya, Liberia, Namibia, Sierra Leone, South Africa, Tanzania, Uganda, Zambia
31 Merck KGaA, Darmstadt, Germany	Merck Capacity Advancement Program	Angola, Bangladesh, Cambodia, Cameroon, Central African Republic, Congo, Cote d'Ivoire, Equatorial Guinea, Ethiopia, Ghana, India, Indonesia, Kenya, Liberia, Malawi, Mali, Mozambique, Myanmar, Nepal, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Sri Lanka, Tanzania, Uganda, United Arab Emirates, Zambia, Zimbabwe
32 Merck KGaA, Darmstadt, Germany	Merck Community Awareness Program	Angola, Ethiopia, Ghana, India, Indonesia, Kenya, Mozambique, South Africa, Tanzania, Uganda
33 Merck KGaA, Darmstadt, Germany	Merck STEM Program for Women and Youth	Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Congo, Egypt, Ethiopia, Gabon, Ghana, Kenya, Liberia, Malawi, Morocco, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Tanzania, Uganda, Zambia, Zimbabwe
34 Merck KGaA, Darmstadt, Germany	Integrated Thyroid NCD Care in the Philippines	Philippines
35 Novartis	Glivec International Patient Assistance Program (GIPAP)	Argentina, Armenia, Azerbaijan, Bahamas, Bangladesh, Belarus, Benin, Bhutan, Burkina Faso, Cambodia, Cameroon, Central African Republic, Chile, China, Congo, Cote d'Ivoire, Democratic Republic of the Congo, Dominican Republic, Ecuador, El Salvador, Ethiopia, Fiji, Gabon, Georgia, Ghana, Haiti, Honduras, India, Indonesia, Jamaica, Kazakhstan, Kenya, Kyrgyzstan, Madagascar, Malawi, Malaysia, Mali, Mauritania, Mauritius, Mexico, Moldova, Mongolia, Morocco, Mozambique, Nepal, Nicaragua, Niger, Pakistan, Papua New Guinea, Paraguay, Peru, Philippines, Rwanda, Senegal, Seychelles, Sierra Leone, Solomon Islands, South Sudan, Sudan, Suriname, Tajikistan, Thailand, Timor-Leste, Togo, Uganda, Vietnam, Zambia, Zimbabwe
36 Novartis	Novartis Access	Cameroon, Ethiopia, Kenya, Lebanon
37 Novo Nordisk*	Changing Diabetes in Children	Bangladesh, Cambodia, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Guinea, India, Kenya, Myanmar, Senegal, Sudan, Tanzania, Uganda
38 Pfizer, Inc.	Healthy Communities	Myanmar, Vietnam
39 Pfizer Foundation	Improving Oncology Care: Scaling Up Breast Cancer Services in La Libertad Region, Peru	Peru
40 Pfizer Foundation	SMARThealth Extend	India, Indonesia
41 Pfizer Foundation	Abundant Health	Vietnam

Primary Pharmaceutical Company		Name of Initiative	Country or Countries of Implementation
42	Pfizer Foundation	Integrated Approach to Improving Oncology Care	Brazil
43	Roche	UNMOL (Urdu for Precious): Access to Cancer Medicines in Pakistan	Pakistan
44	Roche	Breast Cancer National Access Programme, Kenya	Kenya
45	Roche	The Blue Tree, India	India
46	Roche	Perjeta Patient Support Programme	Egypt
47	Sanofi	KiDS and Diabetes in School	Brazil, Egypt, Hungary, India, Japan, Pakistan, Poland, United Arab Emirates
48	Sanofi	Sanofi Mental Health Program (FAST — Fight Against STigma) — Armenia	Armenia
49	Sanofi	Sanofi Mental Health Program (FAST — Fight Against STigma) — Myanmar	Myanmar
50	Sanofi	My Child Matters — Paraguay	Paraguay
51	Sanofi	My Child Matters — Retinoblastoma	Cote d'Ivoire, Democratic Republic of the Congo, Madagascar, Mali, Senegal
52	Sanofi	My Child Matters — Thailand	Thailand
53	Sanofi	Sanofi Mental Health Program (FAST - Fight Against STigma) — Madagascar	Madagascar
54	Sanofi	Sanofi Mental Health Program (FAST — Fight Against STigma) — Morocco	Morocco
55	Sanofi	Ngao Ya Afya	Kenya
56	Sanofi	My Child Matters — Telepathology for Childhood Cancer Diagnosis	Benin, Burkina Faso, Cameroon, Cote d'Ivoire, Democratic Republic of the Congo, Mali, Niger, Senegal
57	Sanofi	Sanofi Mental Health Program (FAST — Fight Against STigma) — Mali	Mali
58	Sanofi	Sanofi Mental Health Program (FAST — Fight Against STigma) — Guatemala	Guatemala
59	Shionogi	Mother to Mother Project**	Kenya
60	Shire	Hemophilia Home Care in India	India
61	Sumitomo Dainippon	Promoting Sound Child Growth Pilot Project	Cambodia
62	Takeda	Beyond Medicines in Ukraine	Ukraine
63	Takeda	Cancer Education for Primary Healthcare Professionals in Kenya	Kenya
64	Takeda	Chronic Care Program in sub-Saharan Africa	Kenya
65	Takeda	Oncology Fellowship in sub-Saharan Africa	Kenya
66	Takeda	Palliative Care Training in sub-Saharan Africa	Kenya
67	Takeda	HERhealth	China, Ethiopia, India, Kenya

Primary Pharmaceutical Company		Name of Initiative	Country or Countries of Implementation
68	Takeda	Patient Assistance Program for Adcetris®	Egypt, Hong-Kong, Indonesia, Kenya, Lebanon, Malaysia, Mexico, Peru, Philippines, Singapore, Thailand, Ukraine, United Arab Emirates
69	Takeda	Cancer Alliance for sub-Saharan Africa	Kenya
70	Takeda	AMPATH Oncology Preceptorships & Telemedicine Program	Kenya, Rwanda, Tanzania, Uganda
71	Takeda	Patient Assistance Program (PAP) — Entyvio®	Brazil, Lebanon, Malaysia, Philippines, Thailand, Ukraine, United Arab Emirates
72	Takeda	Integrated Cancer Curriculum	Kenya
73	Takeda	BluePrint for Success — Meru County	Kenya
74	Takeda	Lysosomal Storage Disorder Charitable Access Program (LSD CAP)	Albania, Belarus, Bosnia and Herzegovina, Egypt, India, Jordan, Morocco, Pakistan, Paraguay, Sudan, Tanzania, Tunisia
75	Takeda	Takeda Max Access Solution (MAS)	Brazil, Ethiopia, Ghana, India, Kazakhstan, Kenya, Malaysia, Nepal, Niger, Paraguay, Philippines, Senegal, Seychelles, Thailand, Tunisia

*Non-Access Accelerated Company

**Non-Access Accelerated Program

Appendix 2

Number of Programs by Country

Country	World Bank Region (2018)	Income Group (2018)	Program Count
1 Albania	Europe & Central Asia	Upper middle income	1
2 Angola	Sub-Saharan Africa	Lower middle income	3
3 Argentina	Latin America & Caribbean	High income	1
4 Armenia	Europe & Central Asia	Upper middle income	3
5 Australia	East Asia & Pacific	High income	1
6 Austria	Europe & Central Asia	High income	1
7 Azerbaijan	Europe & Central Asia	Upper middle income	1
8 Bahamas	Latin America & Caribbean	High income	1
9 Bangladesh	South Asia	Lower middle income	4
10 Belarus	Europe & Central Asia	Upper middle income	2
11 Belgium	Europe & Central Asia	High income	1
12 Benin	Sub-Saharan Africa	Low income	4
13 Bhutan	South Asia	Lower middle income	1
14 Bolivia	Latin America & Caribbean	Lower middle income	1
15 Bosnia and Herzegovina	Europe & Central Asia	Upper middle income	1
16 Botswana	Sub-Saharan Africa	Upper middle income	3
17 Brazil	Latin America & Caribbean	Upper middle income	5
18 Burkina Faso	Sub-Saharan Africa	Low income	4
19 Burundi	Sub-Saharan Africa	Low income	2
20 Cambodia	East Asia & Africa	Lower middle income	4
21 Cameroon	Sub-Saharan Africa	Lower middle income	5
22 Central African Republic	Sub-Saharan Africa	Low income	2
23 Chile	Latin America & Caribbean	High Income	1
24 China	East Asia & Pacific	Upper middle income	4
25 Congo, Democratic Republic	Sub-Saharan Africa	Low income	3
26 Congo, Republic	Sub-Saharan Africa	Lower middle income	3
27 Cote d'Ivoire	Sub-Saharan Africa	Lower middle income	5
28 Dominican Republic	Latin America & Caribbean	Upper middle income	1
29 Ecuador	Latin America & Caribbean	Upper middle income	1
30 Egypt	Middle East & North Africa	Lower middle income	6
31 El Salvador	Latin America & Caribbean	Lower middle income	1
32 Equatorial Guinea	Sub-Saharan Africa	Upper middle income	1
33 Ethiopia	Sub-Saharan Africa	Low income	11
34 Fiji	East Asia & Pacific	Upper middle income	1
35 Gabon	Sub-Saharan Africa	Upper middle income	2
36 Gambia, The	Sub-Saharan Africa	Low income	1
37 Georgia	Europe & Central Asia	Lower middle income	1
38 Germany	Europe & Central Asia	High income	1
39 Ghana	Sub-Saharan Africa	Lower middle income	7
40 Greece	Europe & Central Asia	High income	1

Country	World Bank Region (2018)	Income Group (2018)	Program Count	
41	Guatemala	Latin America & Caribbean	Upper middle income	1
42	Guyana	Latin America & Caribbean	Upper middle income	1
43	Haiti	Latin America & Caribbean	Low income	2
44	Honduras	Latin America & Caribbean	Lower middle income	2
45	Hong-Kong	East Asia & Pacific	High income	1
46	Hungary	Europe & Central Asia	High income	1
47	India	South Asia	Lower middle income	13
48	Indonesia	East Asia & Pacific	Lower middle income	7
49	Ireland	Europe & Central Asia	High income	1
50	Jamaica	Latin America & Caribbean	Upper middle income	1
51	Japan	East Asia & Pacific	High income	1
52	Jordan	Middle East & North Africa	Upper middle income	1
53	Kazakhstan	Europe & Central Asia	Upper middle income	2
54	Kenya	Sub-Saharan Africa	Lower middle income	25
55	Kyrgyzstan	Europe & Central Asia	Lower middle income	1
56	Lao LDR	East Asia & Pacific	Lower middle income	1
57	Lebanon	Middle East & North Africa	Upper middle income	3
58	Liberia	Sub-Saharan Africa	Low income	4
59	Madagascar	Sub-Saharan Africa	Low income	5
60	Malawi	Sub-Saharan Africa	Low income	5
61	Malaysia	East Asia & Pacific	Upper middle income	5
62	Mali	Sub-Saharan Africa	Low income	6
63	Mauritania	Sub-Saharan Africa	Lower middle income	1
64	Mauritius	Sub-Saharan Africa	Upper middle income	1
65	Mexico	Latin America & Caribbean	Upper middle income	3
66	Moldova	Europe & Central Asia	Lower middle income	1
67	Mongolia	East Asia & Pacific	Lower middle income	1
68	Morocco	Middle East & North Africa	Lower middle income	4
69	Mozambique	Sub-Saharan Africa	Low income	4
70	Myanmar	East Asia & Pacific	Lower middle income	5
71	Namibia	Sub-Saharan Africa	Upper middle income	2
72	Nepal	South Asia	Low income	3
73	Nicaragua	Latin America & Caribbean	Lower middle income	1
74	Niger	Sub-Saharan Africa	Low income	5
75	Nigeria	Sub-Saharan Africa	Lower middle income	2
76	Oman	Middle East & North Africa	High income	1
77	Pakistan	South Asia	Lower middle income	4
78	Papua New Guinea	East Asia & Pacific	Lower middle income	1
79	Paraguay	Latin America & Caribbean	Upper middle income	4
80	Peru	Latin America & Caribbean	Upper middle income	4
81	Philippines	East Asia & Pacific	Lower middle income	6
82	Poland	Europe & Central Asia	High income	1
83	Russia	Europe & Central Asia	Upper middle income	1
84	Rwanda	Sub-Saharan Africa	Low income	5

Country	World Bank Region (2018)	Income Group (2018)	Program Count
85 Sao Tome and Principe	Sub-Saharan Africa	Lower middle income	1
86 Senegal	Sub-Saharan Africa	Low income	8
87 Seychelles	Sub-Saharan Africa	High income	2
88 Sierra Leone	Sub-Saharan Africa	Low income	6
89 Singapore	East Asia & Pacific	High income	2
90 Solomon Islands	East Asia & Pacific	Lower middle income	2
91 South Africa	Sub-Saharan Africa	Upper middle income	12
92 South Sudan	Sub-Saharan Africa	Low income	1
93 Sri Lanka	South Asia	Lower middle income	2
94 Sudan	Sub-Saharan Africa	Lower middle income	2
95 Suriname	Latin America & Caribbean	Upper middle income	1
96 Swaziland	Sub-Saharan Africa	Lower middle income	2
97 Sweden	Europe & Central Asia	High income	1
98 Switzerland	Europe & Central Asia	High income	1
99 Taiwan	East Asia & Pacific	High income	1
100 Tajikistan	Europe & Central Asia	Low income	1
101 Tanzania	Sub-Saharan Africa	Low income	11
102 Thailand	East Asia & Pacific	Upper middle income	6
103 Timor-Leste	East Asia & Pacific	Lower middle income	1
104 Togo	Sub-Saharan Africa	Low income	2
105 Tunisia	Middle East & North Africa	Lower middle income	2
106 Uganda	Sub-Saharan Africa	Low income	8
107 Ukraine	Europe & Central Asia	Lower middle income	3
108 United Arab Emirates	Middle East & North Africa	High income	5
109 Uzbekistan	Europe & Central Asia	Lower middle income	1
110 Vietnam	East Asia & Pacific	Lower middle income	4
111 Zambia	Sub-Saharan Africa	Lower middle income	4
112 Zimbabwe	Sub-Saharan Africa	Low income	4

Source: World Bank. World Bank country and lending groups. Accessed May 23, 2019 from <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups>

Appendix 3

List of Funding and Implementing Partners

Partner	Program Count
Academic Model Providing Access to Healthcare (AMPATH)	3
Addington Hospital	1
African Cancer Registry Network (AFCRN)	4
ALAS, Guatemala	1
Alexandria University in Egypt	1
Alzheimer's Disease Chinese	1
AMCC (Alliance Mondiale Contre le Cancer)	2
AMDA-MINDS	2
American Cancer Society (ACS)	1
American Society for Clinical Pathology	1
AMREF Health Africa (African Medical and Research Foundation)	6
Armenia Ministry of Health	1
Associação de Diabetes Juvenil of Brazil (ADJ)	1
Axios International	3
Baylor International Pediatric Aids Initiative (BIPAI)	1
Bhekuzulu Self Sustaining Project (BSSP)	1
Bill and Melinda Gates Foundation	1
Boston University	1
Botswana Ministry of Health	1
Brawijaya University, Malang, Indonesia	1
Bugando Medical Centre in Mwanza, Tanzania	2
Business for Social Responsibility (BSR)	1
Cairo Scan Lab	1
Cameroon Baptist Convention Health Services	1
Can Survive Egypt	1
CarePay	1
Catholic University of Allied and Health Services	3
Centro de Estudos e Pesquisa do Hospital Perola Byington	1
Cerebrus Consulting	1
CerviCusco	1
Charlotte Maxeke Johannesburg Academic Hospital	1
Cheikh Anta Diop University	1
Cherkasky Onco Dispenser Patient Association	1
China Charity Federation	1
China Population Welfare Foundation	1
Chris Hani Baragwanath Academic Hospital (CHBAH)	1
Christian Health Association of Kenya	1
Commune Health Stations (CHS) of Tan Phu District, Ho Chi Minh City, Vietnam	1
CORDAID (Catholic Organization for Relief and Development Aid)	1
CSD Healthcare Clinic	1

Partner	Program Count
CUAMM Tanzania	1
Curie Institute (Paris, France)	1
Diabetes Association of Pakistan	1
Diagnostic Center of Feofaniva	1
Direct Relief	1
District Health Administration, Jhajjar District, Haryana, India	1
District Health Agency, Malang, Indonesia	1
Doctors with Africa (CUAAM)	1
Egyptian Association for Comprehensive Development	1
Egyptian Society of Pediatric Endocrinology and Diabetes	1
Elewa Foundation	2
Emmaus Hospital	1
Estcourt Hospital	1
FHI360	1
First Lady Beyond Zero Campaign	1
Fistula Foundation	1
French Ministry of Health	1
GAVI Alliance	1
George Institute for Global Health	1
GERESA (Peru Ministry of Health's Regional Health Administration) including Turjillo Health Network Administration	1
GFAOP (Groupe Franco-Africain d'Onco-Pédiatrie)	2
Ghana Ministry of Health	1
Greys Hospital	1
Grounds for Health (GfH) Mathiwo Wondu, Ethiopia Cancer Society	1
Guangnan County Health Bureau	1
Guangnan County Women's Federation	1
HCL	1
HCMC Department of Health (DOH) Vietnam	1
Helen Joesph Hospital Pulmonology Department	1
Hospital de Cancer de Barretos	1
Hungarian Diabetes Association	1
ICICI Bank	1
Indiana University, USA	2
Inkosi Albert Luthuli Central Hospital	1
Innovative Cancer Care Foundation (ICCF)	1
Instituto Oncoguia	1
International Diabetes Federation (IDF)	1
International Society for Pediatric and Adolescent Diabetes (ISPAD)	1
IREN-Norte (The Northern Region Cancer Institute)	1
Japan Association for Diabetes Education and Care (JADEC)	1
John Taolo Getsewe Provincial Department of Health	1
Kenya Cancer Association (KENCO)	1
Kenya Conference of Catholic Bishops	1

Partner	Program Count
Kenya Hospice and Palliative Care Association (KEHPCA)	3
Kenya Medical Research Institute	1
Kenya Ministry of Health	4
Kenya Ministry of Health through Counties-Level	1
Kenya Red Cross	1
Kenyan Network of Cancer Organizations (KENCASA)	2
Kenyatta National Hospital	1
Kimberly Hospital Complex (KHC)	1
Kimberly District Hospital, Northern Cape, South Africa	1
KwaZulu Natal Non-Communicable Diseases Directorate	1
KwaZulu-Natal Department of Health	2
Ladysmith Hospital	1
Lahore Grammar School	1
Le Dantec University Hospital	1
Local associations or foundations (in Abidjan, in Lubumbashi)	1
Local governments in Tanzania	1
Local hospitals & health centers in India	1
Local Universities in countries where program is implemented*	1
M.P. Shah Hospital	1
Malawi Ministry of Health	1
Marie Stopes International	1
Mathiwos Wondu Ye cancer Sociary (Tanzania)	1
Mathiwos Wondu Ye-Ethiopia Cancer Society (MWECS)	1
Max Foundation	2
MD Anderson Cancer Center	1
Medical Data Management (MDM)	1
Medical/pharmaceutical associations (multiple countries)*	1
Medybiz Pharma Pvt. Ltd.	1
Ministries of Health (multiple countries)*	1
Ministry of Health of Senegal	1
Ministry of Public Health and Social Welfare Paraguay	1
Ministry of Public Health of Madagascar	1
Moi Teaching and Referral Hospital	4
Moi University School of Medicine	1
Moroccan Association of Social Psychiatry	1
Moroccan League Against Epilepsy	1
Moroccan Ministry of Health	1
Mpilonhle Sanctuary Organization (MSO)	1
Multiple hospitals (Private Hospitals) in India	1
Multiple hospitals (Public Hospitals) in India	1
Myanmar Medical Association (MMA)	1
Myanmar Mental Health Society	1
Nairobi Hospital	1
National Cancer Institute of Ukraine — Hematology Department	1

Partner	Program Count
National Health Laboratory Services (NHLS) South Africa	1
National Health Security Office (Thailand)	1
National Institute for Occupational Diseases (NIOH) South Africa	1
Oncquest Laboratories	1
Pakistan Bait-ul-Maal	1
Pan African Heart Foundation (PANAHF)	1
Paris 6 University (DIUOP)	1
PATH (Program for Appropriate Technology in Health)	1
Pathfinder International	1
Patient groups in India	1
Pediatric Hematology and Oncology Department — National University of Asuncion	1
PharmAccess Foundation	1
Philippines Thyroid Association	1
PH Japan (People's Hope Japan)	1
Pink Ribbon Red Ribbon	1
Plan International	2
Population Services International (PSI)	1
Portea Medical	1
PriceWaterhouseCoopers	1
Project ECHO	1
Project HOPE	2
Prothelem	1
Provincial Government of South Africa	1
PSI/Myanmar	1
PSI/Vietnam	1
Pt. BD Sharma University of Health Sciences and PGIMS Rohtak, Haryana, India	1
Public Health Foundation of India	1
Public Hospitals in Cote d'Ivoire, Democratic Republic of the Congo, Madagascar, Mali, Senegal	1
Rabat University (Morocco)	1
Raya Call Center	1
ReNACI Foundation	1
Retinostop association	1
Right To Care	1
S.K. Distributors	1
Saint Chads Community Health Center	1
Saint Kizito Hospital	1
Sante Sud	1
School of Excellence for the Prevention of Breast Cancer — INEN (The National Cancer Institute in Lima)	1
Senegal Ministry of Education	1
Sociedad Brasileira de Diabetes (SBD)	1
Songklanagarind hospital foundation	1
South Africa Ministry of Health	1
Susan G. Komen	1

Partner	Program Count
Swaziland Ministry of Health	2
Swaziland National Cancer Registry	1
Tan Phu Medicine Center	1
Tanzania Ministry of Health	2
Tata Memorial Hospital	1
Tech Mahindra Limited	1
Texas Childrens Cancer and Hematology Centers	1
Thai Pediatric Oncology Group	1
The Cancer Alliance	1
The Kenya Medical Research Institute	1
The Medical Women Association of Tanzania (MEWATA)	1
The National Cancer Care Program Kenya	1
The National Cancer Institute of Kenya	1
The National Referral Hospital Swaziland	1
The Nursing Council of Kenya	
The Phillipines Department of Health	1
Third Party (Dimension Research)	1
UAE Ministry of Education	1
UAE Ministry of Health & Prevention	1
Uganda Ministry of Health	1
UNESCO (United Nations Educational, Scientific and Cultural Organization)	1
UNICEF (United Nations Children's Fund)	1
Unique Courier	1
Université Numérique Francophone Mondiale (UNFM — World Digital Francophone University)	1
University of Nairobi	2
University of New Mexico Health Sciences Centers ECHO Institute	1
University of Pretoria	2
University of Rzeszow	1
University Research Co., LLC	1
U.S. Agency for International Development (USAID)	1
U.S. National Institutes of Health (NIH)	1
Uthukela District Health Office	1
Wishing Well Foundation	1
Wits Health Consortium	1
WITS/Gauteng Palliative Care Center at CHBAH (Bara PC)	1
World Association for Social Psychiatry	4
World Health Organization (WHO)	7
World Heart Federation	1
Zanmi Lasante	1
Zindagi Trust	1

*Program implemented in the following countries: Angola, Bangladesh, Cambodia, Cameroon, Central African Republic, Congo, Cote d'Ivoire, Equatorial Guinea, Ethiopia, Ghana, India, Indonesia, Kenya, Liberia, Malawi, Mali, Mozambique, Myanmar, Nepal, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Sri Lanka, Tanzania, Uganda, United Arab Emirates, Zambia, Zimbabwe

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