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Chronic Care Program in sub-Saharan Africa

Takeda

Submitted as part of Access Accelerated

Access Observatory

Contents

Program Description

Program Overview

1 Program Name

Chronic Care Program in sub-Saharan Africa

2 Diseases program aims to address

- Diabetes: Type 1, Type2
- Cardiovascular Disease: Hypertension
- Other NCD: Gastro Intestinal

3 Beneficiary population

- Age Group: All ages
- Gender: All genders
- Special Populations: Low income, rural

4 Countries

- Kenya

5 Program start date

July 1, 2016

6 Anticipated program completion date

Completion date not specified.

7 Contact person

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8 Program summary

Takeda has been working with Amref Heath Africa to deliver a comprehensive diabetes and hypertension program in Kenya that is addressing prevention, early screening, diagnosis, care, and treatment for these conditions in the community and primary health care system in Kenya. The program is intended to be eventually expanded throughout the sub-Saharan region, where chronic non-communicable diseases (NCDs) are the leading cause of death in some age groups.

This program targets chronic NCDs specifically diabetes and hypertension. The core objective of the program is to ensure that patients receive improved care. It is being delivered in a number of counties in Kenya with the cooperation of the Ministries of Health in those counties. Through this program, trained community health workers raise awareness among their populations on risk factors such as poor diet, physical inactivity, alcohol abuse, tobacco smoking and exposure to tobacco smoke. Regular check-ups and screenings are also promoted through this program. People presenting symptoms of these conditions in the community are referred to local primary care workers that are trained and educated through this program to deploy chronic disease protocols.

The program delivers the training in a blended approach - both face-to-face and virtual training - in a way that is accessible and sustainable, significantly addressing the issue of training health workers in rural areas.

Virtual training is through Amref Health Africa's LEAP mHealth platform. LEAP delivers training through SMS and audio files using basic phone technology, as well as rich content such as animations and illustrations to smartphones.

In addition, the program provides county-owned and private facilities with basic technologies for screening, diagnosis, treatment, and monitoring of diabetes and hypertension using an innovative solution for improving collection, analysis, and dissemination of community health data, named the Mobile-Jamii Afya Link (MJALI). MJALI incorporates a mobile application for capturing data and transmitting it to an online database and analytics visualization platform at no cost to the patient or the facility. MJALI is used by community health workers and clinicians to monitor key health indicators during household or clinic visits, make referrals, and assist in making decisions on patient management.

The program is currently active in three counties in Kenya - Nairobi, Makueni and Kajiado. Notably, this program alongside other Takeda programs, namely Integrated Cancer Curriculum Program and Palliative Care Program that strengthen the healthcare system for NCDs across the whole patient journey have been absorbed into a multi-stakeholder driven and owned program - the Blueprint for Innovative Access to Healthcare program that is currently being piloted in Meru county.

Program Strategies & Activities

9 Strategies and activities

Strategy 1: Community Awareness and Linkage to Care

ACTIVITY	DESCRIPTION
Communication	Raising awareness among target populations about risk factors for diabetes and hypertension and GI related conditions, and the importance of regular check-ups.
Training	Training community health workers on raising awareness of NCD risk factors and encouraging regular check-ups.
Mobilization	Public awareness campaigns

Strategy 2: Health Service Strengthening

ACTIVITY	DESCRIPTION
Training	Training clinical officers on deployment of chronic disease protocols.
Technology	Providing LEAP mHealth platform and MJALI community data health system for training and for patient management.
Management	Delivering treatment protocols and evidence-based clinical pathways for the relevant conditions.
Infrastructure	Basic technologies for screening, diagnosis, treatment, and monitoring of diabetes and hypertension using an innovative solution for improving collection, analysis, and dissemination of community health data, named the Mobile-Jamii Afya Link (MJALI).

Strategy 3: Health Service Delivery

ACTIVITY	DESCRIPTION
Screening	Screening for diabetes and hypertension in selected counties in Kenya.
Diagnosis	Diagnosing the relevant conditions.
Treatment	Delivery of treatment against the chronic disease protocols.
Retention	The community healthcare workers are trained to educate patients on their conditions and the importance of adhering to treatment.

Program Strategies & Activities

10   Strategy by country

STRATEGY	COUNTRY
Community Awareness and Linkage to Care	Kenya
Health Service Strengthening	Kenya
Health Service Delivery	Kenya

Companies, Partners & Stakeholders

11 Company roles

COMPANY	ROLE
Takeda	Planning, monitoring, and evaluating the program in partnership with AMREF Health Africa and Pan African Heart Foundation (PANAHF), and funding the program.

12 Funding and implementing partners

PARTNER	ROLE/URL	SECTOR
AMREF Health Africa	Training of community health workers using the LEAP platform and providing the Mobile Jamii Afya Link (M-JALi) platform community health data system. Implementation partner - strong relationships / partnerships with Ministry of Health, local governments, and network of community health workers (CHW) - ability to capture data at a community level, through M-JALi. http://amref.org/	Voluntary

13 Funding and implementing partners by country

PARTNER	COUNTRY
AMREF Health Africa	Kenya

Companies, Partners & Stakeholders

14 Stakeholders

STAKEHOLDER	DESCRIPTION OF ENGAGEMENT	REQUESTED OR RECEIVED FROM STAKEHOLDER
Government	Our partners actively collaborate with and support the national and local county governments.	Infrastructure: No Human Resources: Yes Funding: No Monitoring or Oversight: Yes Other resource: Yes
Non-govern-mental organization (NGO)	We work closely with our partners who deliver this program to ensure we are offering a comprehensive chronic care program to improve awareness, screening, diagnosis, treatment as well as patient adherence to their treatment protocols.	Infrastructure: No Human Resources: Yes Funding: Yes Monitoring or Oversight: Yes Other resource: Yes
Local Hospitals/Health Facilities	We educate health practitioners at the local health clinics on the conditions and how to treat them.	Infrastructure: No Human Resources: Yes Funding: No Monitoring or Oversight: Yes Other resource: Yes

Local Context, Equity & Sustainability

15 Local health needs addressed by program

Description of initiative:

Unmet need
- All Takeda AtM initiatives are based on addressing significant local unmet medical needs and gaps in healthcare capacity. We work together with our Non Governmental Organisation (NGO) partners and local clinicians, researchers, healthcare workers and Ministries of Health to identify these gaps and the unmet need. This ensures that resources are focused on public health priorities.
- The combination of great distances to healthcare facilities from rural areas, lack of training of healthcare practitioners and Community Healthcare Workers, and lack of necessary equipment and medicines all contribute to poor results in the treatment of Non Communicable Diseases (NCDs) in Kenya. NCDs account for 27% of total deaths and over 50% of total hospital admissions in Kenya.[1]

There are three significant gaps that this program address:
1. The poor adherence to medication is one of the most significant barriers to tackling NCDs such as diabetes and hypertension in Kenya – a lack of understanding leads to patients regularly skipping a dose or, in extreme cases, failing to take their medication at all. This regularly happens in the first 6 months following diagnosis – arguably the most critical time, when we have a real chance to change the outcome. There are two significant factors that support this:
    i. Lack of understanding as to the long-term effects. Medication can make patients feel better and reduce their symptoms in a short period of time – patients therefore often stop taking medication at this point, failing to comprehend the importance of completing the prescribed course.
    ii. The high cost of medications. The distribution of medication to treat NCDs is not consistent or reliable, meaning that most patients have to fund courses of treatment from private facilities. A lack of proper regulation means that in many cases facilities charge prohibitively high prices.
2. Limited and inconsistent access to treatment. Different counties in Kenya have different approaches to the supply of medicines – with both Makueni and Kajiado Counties for example, they are distributed for free to diagnosed patients at certain levels of clinics. However:
    i. Budgets to purchase chronic medications are very small. Priority is given to infectious diseases that are still prevalent in the rural areas.
    ii. Purchase prices for chronic medications are high for these low-income areas; it is also difficult for the counties to sustain purchasing since they do not sell for a profit.
    iii. The supply of the medications is not always constant.
3. Lack of adequately trained staff who are able to effectively diagnose and treat NCDs, which results in:
    i. Patients not always receiving the appropriate level of care.
    ii. Patients, especially in rural areas, failing follow up with consultations.

Objectives, including societal impact
Our program specifically responds to issues around hypertension, diabetes and gastro-intestinal diseases.

We aim to:
- ensure that patients receive improved care.
- provide both face-to-face and virtual training for HCPs and CHWs to deliver training in a way that is accessible and sustainable – and significantly addresses the issue of training health workers in rural areas.
- effectively utilize mobile technology not just for training, but to improve the standard of care through the remote monitoring of key health indicators, making referrals and supporting all elements of patient management –including ensuring that patients follow their prescribed courses of treatment.

Local Context, Equity & Sustainability

15 Local health needs addressed by program, cont.

Stakeholder engagement (government / NGOs / commercial sector / health providers / universities)
• Critical to this initiative is working together with and supporting the national and county governments.
• We actively collaborate with national and local government to further screening, diagnosis and treatment of hypertension and diabetes.
• Program partners are engaging the Ministry of Health to find solutions for providing hypertension and diabetes medicines at affordable prices.

Proprietary medicines or technology used in the program
• AMREF Health Africa's LEAP mHealth platform
• Mobile-Jamii Afya Link (M-JALiMJALI) - for more information please see http://mjali.amref.org/mjali#

a How needs were assessed

Through the pilot program, we found the following:

Hypertension:
• 56% of Kenyans have never been screened for raised blood pressure.
• Raised blood pressure (defined as SBP =140 mmHg and/or DBP =90 mmHg) was found in 23.8 percent of the respondents
    - 8% have severe hypertension (defined as SBP =160 mmHg and/or DBP =100 mmHg).
    - 7% were not currently taking medication.
• Of those diagnosed with hypertension, only 22.3 percent had been prescribed medication.

Diabetes:
• 87.8% of Kenyans had never been screened for raised blood sugar and among those previously diagnosed with elevated blood sugar, less than half were currently taking medication.
• 3.1% and 1.9% of Kenyans have impaired fasting glycaemia and raised blood glucose respectively.
• Raised blood glucose defined as plasma venous value = 7.0 mmol/L Identified.

b Formal needs assessment conducted

Yes.

16 Social inequity addressed

This program aims to address social inequity by improving access to NCD care for under-served populations in rural areas of Kenya through raising awareness of these conditions in the community, training healthcare practitioners in the diagnosis and treatment of these conditions, and by providing data on prevalence of NCDs in these areas to the Ministries of Health in an effort to ensure more equitable access in the future.

Local Context, Equity & Sustainability

17 Local policies, practices, and laws considered during program design

POLICY, PRACTICE, LAW	APPLICABLE TO PROGRAM	DESCRIPTION OF HOW IT WAS TAKEN INTO CONSIDERATION
National regulations	Yes	In SSA, prior to the start of any activity, our partners are required to align with both the National Ministry of Health and local county governments.
Procurement procedures	[No response provided]	[No response provided]
Standard treatment guidelines	Yes	The diabetes and hypertension management guidelines being used as part of this initiative are based on UK's National Institute of Health and Care Excellence (NICE) and are consistent with Kenya's guidelines for the management of these conditions.
Quality and safety requirements	[No response provided]	[No response provided]
Remuneration scales and hiring practices	[No response provided]	[No response provided]
Other, please specify	Yes	Governance is a key component in all of our initiatives, and Takeda is committed to ensuring clear accountability in all of the activities that we are involved in. As a result, clear governance structures have been put in place, and, along with our partners, we are committed to ensuring good governance.

18 How diversion of resources from other public health priorities are avoided

Addressing the growing burden of non-communicable diseases is a public health priority. Through this program we are equipping local health practitioners with the knowledge and skills to diagnose, treat and support the patients suffering with chronic NCDs.

19 Program provides health technologies (medical devices, medicines, and vaccines)

No.

20 Health technology(ies) are part of local standard treatment guidelines

N/A.

21 Health technologies are covered by local health insurance schemes

N/A.

Local Context, Equity & Sustainability

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22   Program provides medicines listed on the National Essential Medicines List

No. These are mobile application training technologies.

23   Sustainability plan

Sustainability of the initiative:

Sustainable Financing
-       Amref is a National Health Insurance Fund (NHIF) agent, and it uses the M-JALi platform to enroll patients into the NHIF through the CHWs and facilities, allowing patients to access NHIF services / benefits. NHIF will also help bridge the resource gap by providing secured funding towards NCD management.

Further, the training activities adopt a train-the-trainer model, through which those who receive the educational opportunity pass their learnings on to others, professionally and personally. This promotes sustainable capacity building.

Additional Program Information

24 Additional program information

[No response provided]

a Potential conflict of interest discussed with government entity

Yes.
In Sub-Saharan Africa, prior to the start of any activity, our partners are required to align with both the National Ministry of Health and local county governments. In order to avoid conflict of interest, Takeda does not play an active part in the delivery of the programs.

25 Access Accelerated Initiative participant

Yes.

26 International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) membership

Yes.

Resources

1 The STEPwise Survey 2015.

Program Indicators

Chronic Care Program in sub-Saharan Africa

27 List of indicator data to be reported into Access Observatory database

INDICATOR	TYPE	STRATEGY	2017	2018	2017-2020
1 Number of people trained	Output	Health Service Strengthening	155 people	---	---
2 Population screened	Output	Health Service Delivery	---	200,309 people	---
3 Tools in use	Output	Health Service Strengthening	---	---	2 tools
4 Population exposed to media communication activities	Output	Health Service Strengthening	---	28,000 people	---
5 Health provider knowledge change	Outcome	Health Service Strengthening			
Diabetes			---	98%	---
Hypertension			---	33%	---

Number of people trained

STRATEGY   HEALTH SERVICE STRENGTHENING

	ITEM	DESCRIPTION
	Definition	Number of trainees
	Method of measurement	Counting of people who completed all training requirements CALCULATION Sum of the number of people trained
28	Data source	Routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Company, Implementing partner: Pan African Heart Foundation (PANAHF)	Staff who are responsible for the program maintain an attendance sheet for all training sessions and submit the data to the Access to Medicines office periodically.	Ongoing
31	Data processing	Implementing partner: Pan African Heart Foundation (PANAHF)	Staff who are responsible for the program review the number of attendees per training session and sum up the total number of people who attended each type of training over the past one year.	Once per year
32	Data validation		We do not conduct any further validation of this indicator data.	

33   Challenges in data collection and steps to address challenges

[No response provided]

INDICATOR	2017	2018
1 Number of people trained	155 people	---

Comments:

2017: This data is collected by Amref and represents the number of Community Health Workers (CHVs) trained (140) as well as their supervisors/mentors known Community Health Extension Workers (CHEWs) (15) who are healthworkers that are attached to health facilities. Out of the 140 trained CHWs, this may be further disaggregated by: SEX Male - 41 Female - 99 LEVEL OF EDUCATION No Education - 5 Primary Education - 54 Secondary Education - 72 Tertiary Education - 9 NUMBER OF YEARS OF EXPERIENCE AS A CHW 1 to 2 years - 1 2 to 5 years - 3 More than 5 years - 136.

ITEM	DESCRIPTION
Definition	Number of individuals screened for disease as a result of the screening test or procedure being provided by the program
Method of measurement	Counting of people who were screened for disease in the program CALCULATION Sum of the number of people screened
28 Data source	Routine program data
29 Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Implementing partner: Pan African Heart Foundation (PANAHF)	Pan African Heart Foundation (PANAHF) keeps a record of people screened for hypertensions and diabetes. Staff who are responsible for the program collect and submit the data to the Access to Medicines office periodically.	Ongoing
31	Data processing	Implementing partner: Pan African Heart Foundation (PANAHF)	Staff who are responsible for the program sum up the number of people screened and submit the data to the Access to Medicines office periodically.	Ongoing
32	Data validation		Staff who are responsible for the program review and validate the data received by the implementation partner periodically.	

33 Challenges in data collection and steps to address challenges

[No response provided]

INDICATOR	2017	2018
2 Population screened	---	200,309 people

Comments: 2018: This data is reported by Amref. 200,309 represents the number of people screened by CHWs and CHEWs for diabetes and hypertension in 3 counties Of the 200,309 people screened, this may be disaggregated by: COUNTY: Kajiado - 62,091 Nairobi - 66,773 Makueni - 71,445 AGE of people screened for diabetes and hypertension 55+ years - 52,236 45-54 years - 30,544 35-44 years - 39,552 25-34 years - 52,895 18-24 years - 25,082 HYPERTENSION Of the 200,309 people screened, 5,446 people were referred to a health facility, diagnosis confirmed (more than 140/90 mmHg), and treatment commenced. This may be disaggregated by county as follows: COUNTY Number of people screened that were referred for High BP , diagnosis confirmed and treated - Kajiado- 1,137 Number of people screened that were referred for High BP, diagnosis confirmed and treated - Nairobi - 1,827 Number of people screened that were referred for High BP, diagnosis confirmed and treated - Makueni - 2,482.

ITEM	DESCRIPTION
Definition	Number of tools (e.g., mHealth, EMR, etc.) introduced and in use by the program (please distinguish from "Management Procedures in Use" indicator)
Method of measurement	Counting the number of tools created and in use by the program CALCULATION Sum of number of tools created by the program
28 Data source	Non-routine program data
29 Frequency of reporting	Once per year

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Implementing partner: AMREF Health Africa	Amref is responsible for deployment of tools and provide training and technical support to healthworkers that use the tools.	Every three months
31 Data processing	Implementing partner: AMREF Health Africa	Amref is responsible for deployment of tools and provide training and technical support to healthworkers that use the tools	Every three months
32 Data validation		Takeda conducts ad-hoc site visits and is unable to validate the data. However, Takeda interrogates the submitted data in project management meetings.	

33 Challenges in data collection and steps to address challenges

[No response provided]

INDICATOR	2017	2018	2019	2017-2020
3 Tools in use	---	---	---	2 tools

Comments:

Data not available by year. This data is reported by Amref and represents the number of tools customised for and used in this program: 1) LEAP is a mobile based learning platform used to train CHWs using their mobile devices, enabling the health workers to learn at their own pace and with their own mobile devices while in the community. This is in addition to face-to-face learning, thus providing a blended approach. 2) Mobile Jamii Afya Link (M-Jali) is a data collection tool for household/community level data on NCDs at the community level through community health workers. The M-Jali platform is customizable to specific requirements.

Population exposed to media communication activities

4

	ITEM	DESCRIPTION
	Definition	Number of population reached through media awareness campaign
	Method of measurement	Counting of participants reached by media message disseminated CALCULATION Number of people in the target audience reached by disseminated media message in a given period of time
28	Data source	Non-routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Implementing partner: AMREF Health Africa	Amref keeps a digital log of SMS broadcast messages that are sent out to community members in order to raise awareness and educate communities on Hypertension and Diabetes.	Every 6 months
31	Data processing	Implementing partner: AMREF Health Africa	Every 6 months Amref sums the total number of SMS messages sent and provides the total aggregated number to Takeda.	Every 6 months
32	Data validation		Amref has access to the logs of broadcast messages - Takeda is not in a position to validate the data.	

33 Challenges in data collection and steps to address challenges

[No response provided]

INDICATOR	2017	2018
4 Population exposed to media communication activities	---	28,000 people

Comments:

2018: This is data reported by Amref - SMSs were sent to the 140 CHWs that were trained. The CHWs cascaded the information through door-to-door activities and community gatherings - churches, community social halls, etc.

Health provider knowledge change

5

ITEM	DESCRIPTION
Definition	The percentage change in providers' knowledge after training. The assessment should be designed to assess the possession of the skills and knowledge to be able to comply with predefined standards
Method of measurement	The assessment of provider skills and knowledge occurs through a written, oral, or observational assessment that providers have to undergo before and after the training. The percentage change in score after the training is calculated CALCULATION $\frac{\text{Post-training score} - \text{Pre-training score}}{\text{Pre-training score}} \times 100$
28 Data source	Non-routine program data
29 Frequency of reporting	Once per year

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Implementing partner: AMREF Health Africa	Each health provider attending the training completes a pre- and post-test knowledge questionnaire. Amref marks the questionnaire based on the correct answers provided by the specialists and records the scores.	Ongoing
31 Data processing	Implementing partner: AMREF Health Africa	Takeda may conduct ad-hoc site visits; however, we do not conduct any further validation of this data.	[No response provided]
32 Data validation		Takeda may conduct ad-hoc site visits; however, we do not conduct any further validation of this data.	

33 Challenges in data collection and steps to address challenges

[No response provided]

INDICATOR	2017	2018
5 Health provider knowledge change		
Diabetes	---	98%
Hypertension	---	33%

Comments: 2018: This data is reported by Amref and represents the average Health provider knowledge change for 2 topics: Diabetes and Hypertension. 38% represents the average Health provider knowledge change for 2 topics: Diabetes and Hypertension Health provider knowledge change for DIABETES Diabetes (83-42) * 100/42 = 98% Health provider knowledge change for HYPERTENSION Hypertension (76-57) * 100/57 =33%.

Appendix

This program report is based on the information gathered from the Access Observatory questionnaire below.

Program Description

PROGRAM OVERVIEW

1 Program Name

2 Diseases program aims to address:

Please identify the disease(s) that your program aims to address (select all that apply).

3 Beneficiary population

Please identify the beneficiary population of this program (select all that apply).

4 Countries

Please select all countries that this program is being implemented in (select all that apply).

5 Program Start Date

6 Anticipated Program Completion Date

7 Contact person

On the public profile for this program, if you would like to display a contact person for this program, please list the name and email address here (i.e. someone from the public could email with questions about this program profile and data).

8 Program summary

Please provide a brief summary of your program including program objectives (e.g., the intended purposes and expected results of the program; if a pilot program, please note this). Please provide a URL, if available. Please limit replies to 750 words.

PROGRAM STRATEGIES & ACTIVITIES

9 Strategies and activities

Based on the BUSPH Taxonomy of Strategies, which strategy or strategies apply to your program (please select all that apply)?

10 Strategy by country

If you have registered one program for multiple countries, this question allows you to provide a bit more specificity about each country (e.g. some countries have different strategies, diseases, partners, etc.). Please complete these tables as applicable. For each portion you have you selected from above (program strategies), please identify which country/countries these apply.

COMPANIES, PARTNERS AND STAKEHOLDERS

11 Company roles

Please identify all pharmaceutical companies, including yours, who are collaborating on this program:

What role does each company play in the implementation of your program?

12 Funding and implementing partners

Please identify all funding and implementing partners who are supporting the implementation of this program (Implementing partners is defined as either an associate government or non-government entity or agency that supplements the works of a larger organization or agency by helping to carry out institutional arrangements in line with the larger organization's goals and objectives.)

a. What role does each partner play in the implementation of your program? Please give background on the organization and describe the nature of the relationship between the organization and your company. Describe the local team's responsibilities for the program, with reference to the program strategies and activities. (response required for each partner selected).

b. For each partner, please categorize them as either a Public Sector, Private Sector, or Voluntary Sector partner. (Public Sector is defined as government; Private Sector is defined as A business unit established, owned, and operated by private individuals for profit, instead of by or for any government or its agencies. Generation and return of profit to its owners or shareholders is emphasized; Voluntary Sector is defined as Organizations whose purpose is to benefit and enrich society, often without profit as a motive and with little or no government intervention. Unlike the private sector where the generation and return of profit to its owners is emphasized, money raised or earned by an organization in the voluntary sector is usually invested back into the community or the organization itself (ex. Charities, foundations, advocacy groups etc.))

c. Please provide the URL to the partner organizations' webpages

13 Funding and implementing partners by country

If you have registered one program for multiple countries, this question allows you to provide a bit more specificity about each country (e.g., some countries have different strategies, diseases, partners, etc.). Please complete these tables as applicable. For each portion you have you selected from above (funding and implementing partners), please identify which country/countries these apply.

14 Stakeholders

Please describe how you have engaged with any of these local stakeholders in the planning and/or implementation of this program. (Stakeholders defined as individuals or entities who are involved in or affected by the execution or outcome of a project and may have influence and authority to dictate whether a project is a success or not (ex. Ministry of Health, NGO, Faith-based organization, etc.). Select all that apply.

• Government, please explain
• Non-Government Organization (NGO), please explain
• Faith-based organization, please explain
• Commercial sector, please explain
• Local hospitals/health facilities, please explain
• Local universities, please explain
• Other, please explain

LOCAL CONTEXT, EQUITY & SUSTAINABILITY

15 Local health needs addressed by program

Please describe how your program is responsive to local health needs and challenges (e.g., how you decided and worked together with local partners to determine that this program was appropriate for this context)?

a How were needs assessed

b Was a formal need assessment conducted

(Yes/No) If yes, please upload file or provide URL.

16 Social inequity addressed

Does your program aim to address social inequity in any way (if yes, please explain). (Inequity is defined as lack of fairness or justice. Sometime 'social disparities,' 'structural barriers' and 'oppression and discrimination' are used to describe the same phenomenon. In social sciences and public health social inequities refer to the systematic lack of fairness or justice related to gender, ethnicity, geographical location and religion. These unequal social relations and structures of power operate to produce experiences of inequitable health outcomes, treatment and access to care. Health and social programs are often designed with the aim to address the lack of fairness and adjust for these systematic failures of systems or policies.*)

*Reference: The definition was adapted from Ingram R et al. Social Inequities and Mental Health: A Scoping Review. Vancouver: Study for Gender Inequities and Mental Health, 2013.

17 Local policies, practices, and laws considered during program design

How have local policies, practices, and laws (e.g., infrastructure development regulations, education requirements, etc.) been taken into consideration when designing the program?

18 How diversion of resources from other public health priorities are avoided

Please explain how the program avoids diverting resources away from other public health priorities? (e.g. local human resources involved in program implementation diverted from other programs or activities).

19 Program provides health technologies

Does your program include health technologies (health technologies include medical devices, medicines, and vaccines developed to solve a health problem and improve quality of lives)? (Yes/No)

20 Health technology(ies) are part of local standard treatment guidelines

Are the health technology(ies) which are part of your program part of local standard treatment guidelines? (Yes/No) If not, what was the local need for these technologies?

21 Health technologies are covered by local health insurance schemes

Does your program include health technologies that are covered by local health insurance schemes? (Yes/No) If not, what are the local needs for these technologies?

22 Program provides medicines listed on the National Essential Medicines List

Does your program include medicines that are listed on the National Essential Medicines List? (Yes/No) If not, what was the local need for these technologies?

23 Sustainability plan

If applicable, please describe how you have planned for sustainability of the implementation of your program (ex. Creating a transition plan from your company to the local government during the development of the program).

ADDITIONAL PROGRAM INFORMATION

24 Additional program information

Is there any additional information that you would like to add about your program that has not been collected in other sections of the form?

a Potential conflict of interest discussed with government entity

Have you discussed with governmental entity potential conflicts of interest between the social aims of your program and your business activities? (Yes/No) If yes, please provide more details and the name of the government entity.

25 Access Accelerated Initiative participant

Is this program part of the Access Accelerated Initiative? (Yes/No)

26 International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) membership

Is your company a member of the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA)? (Yes/No)

Program Indicators

INDICATOR DESCRIPTION

27 List of indicator data to be reported into Access Observatory database

For this program, activities, please select all inputs and impacts for which you plan to collect and report data into this database.

28 Data source

For this indicator, please select the data source(s) you will rely on.

29 Frequency of reporting

Indicate the frequency with which data for this indicator can be submitted to the Observatory.

30 Data collection

a. Responsible party: For this indicator, please indicate the party/parties responsible for data collection.

b. Data collection — Description: Please briefly describe the data source and collection procedure in detail.

c. Data collection — Frequency: For this indicator, please indicate the frequency of data collection.

31 Data processing

a. Responsible party: Please indicate all parties that conduct any processing of this data.

b. Data processing— Description: Please briefly describe all processing procedures the data go through. Be explicit in describing the procedures, who enacts them, and the frequency of processing.

c. Data processing — Frequency: What is the frequency with which this data is processed?

32 Data validation

Description: Describe the process (if any) your company uses to validate the quality of the data sent from the local team.

33 Challenges in data collection and steps to address challenges

Please indicate any challenges that you have in collecting data for this indicator and what you are doing to address those challenges.