PROGRAM REPORT

PROGRAM ENDED IN 2018

Project HOPE Centre - South Africa

Eli Lilly

Submitted as part of Access Accelerated

Access Observatory

PROGRAM ENDED IN 2018

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The information in this report has been submitted by the company concerned to the Access Observatory as part of its commitment to Access Accelerated. The information will be updated regularly. For more information about the Access Observatory go to www.accessobservatory.org

Program Description

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Program Overview

1 Program Name

Project HOPE Centre - South Africa

2 Diseases program aims to address

- Diabetes (type 2)
- Cardiovascular disease (hypertension)

3 Beneficiary population

- General population
- People with low income
- Marginalized/indigenous people

4 Countries

- South Africa

5 Program start date

November 12, 2012

6 Anticipated program completion date

August 31, 2018

7 Contact person

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8 Program summary

Since 1958, Project HOPE has worked in more than 120 countries to make quality and sustainable health care available for people around the globe. Our signature program in South Africa, The HOPE Centre, tackles the growing challenge of addressing non-communicable diseases (NCDs) in impoverished communities.

The Project HOPE South Africa is a branch of the Project HOPE, the People-to-People Health Foundation, Inc. The office has been operational since early 2012 and is registered as a Section 21 in South Africa (International Non-Profit with a South African operation) which launched the HOPE Centre, in Zandspruit, Region C of the City of Johannesburg, South Africa in September 2012. Since 2012, The HOPE Centre has served as a community-based model for effective and cost-efficient NCD prevention and care. Our model combines health promotion and screenings, delivery of quality primary health care, and support programs that promote patient self-care and prevention.

Today, The HOPE Centre operates as a center of excellence and informs our work as we expand our reach to address the burden of NCDs more broadly across South Africa. As such, we are currently supporting chronic disease management for NCDs at Fodisong Community Health Centre in the community of Itsoseng and training community health workers on NCDs to improve capacity for health promotion and screenings across our region.

The HOPE Centre is a one of kind health care centre, the first primary health care public establishment, strengthening health systems within Region C through managing patients living with Diabetes (DM) and Hypertension (HT) in the Zandspruit and surrounding areas. It strives in raising awareness of lifestyle behaviours causing DM and HT and its effects, in at risk population with unique circumstances through targeted screening and education. Community workers from the HOPE Centre screen high risk individuals in their homes and at focused awareness events and link them into care.

(continued on next page)

Program Overview

8 Program summary cont.

To date Project HOPE has screened just over 14 000 community residents for DM and HT in Zandspruit and the surrounding areas. The primary focus is on managing people living with DM and HT with the aim to delay or prevent complications through empowering and equipping people in vulnerable communities. The goal is to improve the quality of life for those affected by DM and HT. The HOPE Centre provides comprehensive treatment and care to the individuals with DM and HT.

Two flagship areas at the HOPE Centre are

1. Through an appointment system, waiting time is drastically reduced keeping an individual in the clinic under 2 hours,

2. Point of care testing enable skilled healthcare workers to make critical decisions that may have an impact on the clinical outcomes of the individuals with DM and HT.

Support programs forms an integral part of the model for service delivery through programs, such as the HOPE Centre garden called "KOPANO Gardens". It provides needed healthy vegetables and herbs for patients, as well as nutritional education and an economical opportunity to save the income from the sales of vegetables during clinic days. Exercise classes are provided to patients at no charge– providing a much-needed service for the community. Patients are also encouraged to register for the Village Savings and Loans programme a program on community saving and investing. The 5 STEPS to Self-Care Model is a patient support program that provides the patient with the necessary knowledge, skills and education to guide them through the process of better understanding their disease and how it effectively manages it. The Traditional Healers project is an additional project at the HOPE Centre trying to bring Western medicine practices and Traditional medicine practices together in the fight to stop Diabetes and Hypertension and its complications in its track. Traditional Healers are trained in identifying the symptoms of these conditions, the effects and dangers of mixing the medicine, recognising early signs of complications and early referrals and linkage to care. In addition to the ground-breaking work done at the HOPE Centre, Project HOPE also works closely with the National Department of Health to inform policy related to screening for NCD's and education of Community Health Workers on NCDs.

For more information about the program, please visit:

http://www.projecthope.org/news-blogs/multimedia/2013/hope-centre-in-south-africa.html

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Program Strategies & Activities

9 Strategies and activities

Strategy 1: Community Awareness and Linkage to Care

ACTIVITY	DESCRIPTION
Mobilization	1. Community screening and raising awareness for Diabetes and Hypertension. 2. Linking community members who are at high risk to medical care.

Strategy 2: Health Service Delivery

ACTIVITY	DESCRIPTION
Screening	Screening and raising awareness for Diabetes and Hypertension.
Diagnosis	Provide comprehensive Diabetes and Hypertension care services which includes diagnosis and treatment.
Treatment	Provide comprehensive Diabetes and Hypertension care services which includes diagnosis and treatment.

10 Strategy by country

STRATEGY	COUNTRY
Community Awareness and Linkage to Care	South Africa
Health Service Delivery	South Africa

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Companies, Partners & Stakeholders

11 Company roles

COMPANY	ROLE
Eli Lilly and Company	Funding company & partner

12 Funding and implementing partners

PARTNER	ROLE/URL	SECTOR
Project HOPE	Project HOPE is responsible for project implementation. They are supported by a grant from the Lilly NCD Partnership. In addition to the project-related work, Lilly staff have supported the project with in-kind skills-based contributions through our company's Connecting Hearts Abroad program. http://thehopecentresouthafrica.blogspot.co.uk/ & www.projecthope.org	Voluntary
University of Pretoria	Partner responsible for the measuring and evaluation of the impact of the program http://www.up.ac.za/	Public

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Companies, Partners & Stakeholders

13 Funding and implementing partners by country

PARTNER	COUNTRY
Project HOPE	South Africa
University of Pretoria	South Africa

14 Stakeholders

STAKEHOLDER	DESCRIPTION OF ENGAGEMENT
Government	Engagement with the Department of health through the City of Johannesburg during the planning phase was key to ensure buy-in and collaboration. A formal agreement between Project HOPE and City of Johannesburg was signed. During implementation phase, the City of Johannesburg has been come a collaborative partner and supports Project HOPE with medicines and medical supplies in the form of gift-in-kind including compliance oversight. Regular meetings are scheduled to maintain the partnership.
Local Universities	Engagement with University of Pretoria was key during the planning phase to support program design process. To ensure an ethical and measureable program was designed. During the implementation phase, the University of Pretoria provides continuous clinical, technical, M&E and research support. Regular meetings are scheduled to maintain the partnership.

Local Context, Equity & Sustainability

15 Local health needs addressed by program

In South Africa, an epidemiological transition is taking place with a shift in disease burden from infectious diseases such as HIV and TB to chronic diseases. With the change in eating patterns, and rural to urban migration, many of the new urban poor are now encountering a "double burden" of disease. Not only do they continue to be susceptible to infectious disease, but with the availability of nutrient poor but calorically dense food, combined with a sedentary lifestyle, they are at increased risk for obesity and developing chronic diseases.

In South Africa, chronic diseases accounted for 28% of all deaths in 2002. In 2005, a study showed 51% of men and 77% of women in South Africa were overweight, a major risk factor for chronic disease, predicted to increase over the next 10 years. Between 1997 and 2004, 195 people died per day because of some form of cardiovascular disease (CVD) in South Africa. Models suggest that by 2010 there will be over 600 deaths per day in South Africa due to chronic disease. Premature deaths caused by CVD in people of working age (35-64 years) are expected to increase by 41% between 2000 and 2030. Diabetes in South Africa is an emerging problem particularly when prevention messaging and early detection screenings are very limited. Many people present themselves at clinics when they are already suffering from a complication of the disease. Access to insulin and regular blood sugar monitoring is challenging in impoverished areas.

The Department of Health through the City of Johannesburg was consulted extensively to determine location and scope of this program.

a How needs were assessed

[No response provided]

b Formal needs assessment conducted

[No response provided]

16 Social inequity addressed

Yes, the program gives an equal opportunity to access health care services to all people living with diabetes and hypertension at no cost and address the socio-economical dynamics through healthy lifestyle behavior modifications. The program is implemented at primary care level targeting an underserved community of Zandspruit, west of Johannesburg.

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

The program was designed to contribute towards the South African National Department of Health priorities with alignment to National NCD care guidelines. The program was approved by University of Pretoria ethics committee and taking into consideration government regulations and requirements.

18 How program meets or exceeds local standards

1. Patient appointment system allows for total patient time to be less than 2 hours during a clinic visit.

2. Point of care equipment improve patient outcome by responding immediately to readily available results.

3. Technical expertise from specialist diabetes and hypertension health care providers.

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

[No response provided]

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Local Context, Equity & Sustainability

20 Health technologies are part of local standard treatment guidelines

N/A

21 Health technologies are covered by local health insurance schemes

Yes.

22 Program provides medicines listed on the National Essential Medicines List

N/A.

23 Sustainability plan

The sustainability of the program – centred around the HOPE Centre and its' services – lies in two main areas:

- First, the transfer of capacity to public health clinics in patient treatment and support, and
- Secondly, in capacitating a wide range of services providers (public and NGO) in effective community screening for T2DM and HTN by community health workers (CHWs).

Additional Program Information

24 Additional program information

[No response provided]

a Potential conflict of interest discussed with government entity

[No response provided]

25 Access Accelerated Initiative participant

Yes.

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

Yes.

Program Indicators

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PROGRAM NAME

Project HOPE Centre - South Africa

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

	INDICATOR	TYPE	STRATEGY	2012-2018	2017	2018
1	Value of resources	Input	All Program Strategies	---	---	---
2	Patients retained in care	Outcome	Health Service Delivery		---	46 percent
3	Population exposed by community awareness campaign out of total target population	Output	Community Awareness and Linkage to Care	884:5375 people	---	---
4	Staff time	Input	All Program Strategies	---	---	---
5	Number of patients on treatment	Outcome	Community Awareness and Linkage to Care	---	---	891 people
6	Number of patients diagnosed	Outcome	Community Awareness and Linkage to Care	294 people	---	---

INDICATOR **Value of resources**

STRATEGY ALL PROGRAM STRATEGIES

1

	ITEM	DESCRIPTION
	Definition	Total expenditure by company to operate program, including all expenditures that can reasonably be defined as necessary to operate the program
	Method of measurement	Program administrative records or accounting or tax records provide details in the expenditures on the program in a defined period of time CALCULATION Sum of expenditures (e.g., staff, materials) on program in US$
28	Data source	Routine program data.
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Finance manager is responsible for data collection	The expenses made on this project are recorded by the finance and accounting department. This includes the monthly gift in kind the project receives from the government (City of Johannesburg). We document the monetary value of the gifts based on their current market price.	Data collected on a monthly basis, but submitted annually
31	Data processing	Project HOPE local and global finance team	On a quarterly basis, the finance manager sums the total expenditure to operate the program in the past quarter. We report it on a yearly basis.	Once per year
32	Data validation		We have internal audits.	

33 Challenges in data collection and steps to address challenges

No challenges.

INDICATOR	2017	2018
1 Value of resources	---	---

Comments: N/A

INDICATOR **Patients retained in care**

STRATEGY HEALTH SERVICE DELIVERY

2

	ITEM	DESCRIPTION
	Definition	Percentage of registered patients who had a facility visit out of total number of registered patients expected to receive treatment for a specific condition within that time period (e.g. month)
	Method of measurement	The health facility patient registry should provide information on the number of patient registered with the health facility CALCULATION Number of registered patients attending the point of care / Number of registered patients expected to attend within that time period x 100
28	Data source	Routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Nurses & community healthcare workers (CHW)	Information from routine visits of patients receiving treatment through this program are recorded in the REDCap database used in the project for patient management.	Monthly for internal use; reported on a quarterly basis
31	Data processing	Hope Center data clerk	Once a month, the program coordinator calculates the proportion of patients that were retained in care by dividing the patients who had a facility visit by the total number of patients expected to receive treatment for a specific condition within that time period.We have SOPs (Standard Operating Procedures) to check the data once a month.	Monthly for internal use; reported on a quarterly basis
32	Data validation		No additional validation process of internal financial processes.	

33 Challenges in data collection and steps to address challenges

No challenges.

INDICATOR	2017	2018
2 Patients retained in care	---	45.5%

Comments: This data will not increase and will be zero by the 31st of August 2018 as the program is ending. There will be no increase in this data and this is the last reporting on this indicator.

INDICATOR

Population exposed by community awareness campaign out of total target population

3

STRATEGY COMMUNITY AWARENESS AND LINKAGE TO CARE

	ITEM	DESCRIPTION
	Definition	Percentage of population reached through a community awareness campaign out of total population targeted
	Method of measurement	Counting of participants that attend campaign meetings or reached by media messaged disseminated and number of people in the target population CALCULATION Sum of people/participants in the target audience segment participated/attended the community awareness campaign recorded divided by the number of people targeted by the campaign
	Data source	Routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Community health workers (CHW)	The program coordinator keeps a record of the number of people reached through the communication activities of the program.	Now we are not doing any campaign but before we were doing it once a quarter.
31	Data processing	HOPE Center Program coordinator & data clerk	On a quarterly basis, the program coordinator calculates the proportion of the target population reached through the communication activities.	Every three months
32	Data validation		Validation of the quality of the data set is done following our internal SOPs (Standard Operating Procedures). We are using the sampling techniques of the monthly collected data.	

33 Challenges in data collection and steps to address challenges

No challenges.

INDICATOR	2012-2018	2017	2018
3 Population exposed by community awareness campaign out of total target population	884:5375 people	---	---

Comments:

2012 - 2018: No year-specific data available. Please note there will be no updates as patients are being transferred out of the clinic and by the end of August 2018 there will be zero patients on treatment. Funding for this project ends on the 31st of August 2018. No new activities for screening are taking place from January 2018.

INDICATOR **Staff time**

STRATEGY ALL PROGRAM STRATEGIES

4

	ITEM	DESCRIPTION
	Definition	The ratio of the total number of paid hours during a year by the number of working hours in that period. This indicator excludes the time of volunteers or staff time for external partners.
	Method of measurement	The ratio is also called Full Time Equivalent (FTE) CALCULATION Sum of the number of paid hours per year Total number of working hours per year
28	Data source	Routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	HOPE Center Volunteer Coordinator Nurses and Human Resources Department	The staff working on this program track the number of hours spent on the program.	Every month
31	Data processing	Project HOPE Center Human Resources & Finance	Self complete monthly time sheets are filled in by all program staff, gathered by Volunteer Nurses & HR, and processed by HR & Finance.Once a year, the Finance & HR managers calculate the Full Time Equivalent (FTE) by dividing the total number of paid hours during the year by the number of working hours in that period.	Once per year
32	Data validation		We do it through Payroll Accounting Software.	

33 Challenges in data collection and steps to address challenges

No challenges.

INDICATOR	2017	2018
4 Staff time	---	---

Comments: N/A

INDICATOR

Number of patients on treatment

5

STRATEGY COMMUNITY AWARENESS AND LINKAGE TO CARE

	ITEM	DESCRIPTION
	Definition	Number of patients on appropriate treatment (according to standard treatment guidelines related to NCDs)
	Method of measurement	This information may be obtained from facilities, prescriptions data and medical records and then compared to national Standard Treatment Guidelines. National Standard Treatment Guidelines (STG) may be defined as 'systematically developed statements to help practitioners or prescribers make decisions about appropriate treatments for specific clinical conditions'. At a minimum, they should contain information on clinical features, diagnostic criteria, non-medicine and medicine treatments (first-, second-, third-line), and referral criteria. If national STG are not available international guidelines can provide parameters, however, a justification should be added CALCULATION Counting the number of patients treated according to standard treatment guidelines related to NCDs visiting the facility
28	Data source	Routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Nurses	Patient data is collected in patient files at the HOPE Centre and then recorded on the project database.	With current resources, we are collecting data once a year because the project is coming to an end in August 2018.
31	Data processing	Monitoring and evaluation manager at HOPE center	Once a year, the program coordinator sums the number of patients who received treatment for different diseases at the HOPE Centre.	Once per year
32	Data validation		The monitoring and evaluation manager (M&E Manager) goes through the data to identify duplicates, errors and missing data, and take appropriate steps to correct them on a monthly basis.	

33 Challenges in data collection and steps to address challenges

No challenges.

INDICATOR		2017	2018
5	Number of patients on treatment	---	891 people

Comments: Please note there will be no updates as patients are being transferred out of the clinic and by the end of August 2018 there will be zero patients on treatment. Funding for this project ends on the 31st of August 2018.

INDICATOR **Number of patients diagnosed**

STRATEGY COMMUNITY AWARENESS AND LINKAGE TO CARE

6

	ITEM	DESCRIPTION
	Definition	Number of individuals correctly diagnosed with the disease through the program
	Method of measurement	CALCULATION Sum the number of individuals correctly diagnosed with the disease
28	Data source	Routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Nurses	HOPE Centre keeps a record of patients who are diagnosed with hypertension and diabetes during the community screening and education exercise.	Due to the status of the project, we are not collecting data of any new patients. Before it was done annually and according to our guideline.
31	Data processing	Hope Center nurses and data clerk	We sum the number of patients with diabetes & hypertension in a monthly basis, but we report it in a quarterly basis.	Every three months
32	Data validation		Data is validated by the Measurement & Evaluation Manager (M&E Manager). The monitoring and evaluation manager goes through the data to identify duplicates, errors and missing data, and take appropriate steps to correct them.	

33 Challenges in data collection and steps to address challenges

No challenges.

INDICATOR	2012-2018	2017	2018
6 Number of patients diagnosed	294 people	---	---

Comments:

2012 - 2018 data: No year-specific data available. 294 were diagnosed by HOPE Centre and the rest of the 1957 patients at HOPE Centre were referred from other Health Care Providers. Please note there will be no updates as patients are being transferred out of the clinic and by the end of August 2018 there will be zero patients on treatment. Funding for this project ends on the 31st of August 2018.

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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 is 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.