APRIL 2020

Sanofi Mental Health Program (FAST – Fight Against STigma) – Armenia

Sanofi

Submitted as part of Access Accelerated

Access Observatory

Contents

Program Description

Program Overview

1 Program Name

Sanofi mental health program (FAST – Fight Against STigma) – Armenia

2 Diseases program aims to address

• Mental & neurological disorders (Depression; Schizophrenia)

3 Beneficiary population

• General Population

4 Countries

• Armenia

5 Program start date

January 01, 2017

6 Anticipated program completion date

December 31, 2019

7 Contact person

Pierre-Emile Bruand (pierre.bruand@sanofi.com)

8 Program summary

FAST Armenia is a three-year public-private partnership involving the Ministry of Health-care of the Republic of Armenia, the World Association of Social Psychiatry (WASP) and Sanofi. It aims to improve access to care for people with schizophrenia and/or depression in Armenia, and, therefore, help reduce the impact of some of the most burdensome and costly illnesses. [1,2] This is a national program taking place in six regions (Armavir, Tavush, Lori, Syunik, Shirak, Yerevan).

The objectives of the program are to:

- Train 600 General Practitioners (GPs) and 200 nurses on the diagnosis and management of schizophrenia and major depressive disorder (MDD).
- Train 180 non-mental health specialists on MDD, since depression is highly prevalent in people with cancer, cardiovascular disease, diabetes as well as in post-partum women.
- Provide continuing medical education on MDD and related topics to 120 mental health professionals (five one-day symposia).
- Raise awareness among the general population in order to tackle the stigma and exclusion which people with mental disorders have to face.[3]

Training materials have been developed with the World Association of Social Psychiatry, and have been adapted by local psychiatrists. The training will be delivered in each of the six regions through face-to-face training workshops by local psychiatrists. Relevant awareness and Behaviour Change Communication materials are being developed with local mental health professionals and associations. The number of patients diagnosed and managed will be monitored through the current national referral system.

Program Strategies & Activities

9 Strategies and activities

Strategy 1: Community Awareness and Linkage to Care

ACTIVITY	DESCRIPTION
Communication	Developing and disseminating health-related information on diseaseb and behaviour change communication materials.

Strategy 2: Health Service Strengthening

ACTIVITY	DESCRIPTION
Training	Developing training materials for GPs/nurses (schizophrenia and depression) and for non-mental health specialists (depression). Organising /implementing training sessions in 6 regional centres.
Technology	Developing paper-based monitoring system leveraging existing national referral system.

10 Strategy by country

STRATEGY	COUNTRY
Community Awareness and Linkage to Care	Armenia
Health Service Strengthening	Armenia

Companies, Partners & Stakeholders

11 Company roles

COMPANY	ROLE
Sanofi	• Develop, plan, monitor and evaluate the program in collaboration with other partners. • Provide training materials (slide kits and training documents) that will be adapted and used to train healthcare professionals on schizophrenia and depression. • Provide Information Education Communication (IEC) / Behavior Change Communication (BCC) materials to raise awareness among the population and educate families and patients (posters, brochures, flipcharts, comic books). • Provide logistical support and funding for the different activities of the programme (training, development of a care network, awareness campaign) in accordance with the agreement and the budget.

12 Funding and implementing partners

PARTNER	ROLE/URL	SECTOR
Armenia Ministry of Health	• Develop, plan, monitor and evaluate the program in collaboration with implementing partners. • Coordinate the project through its National Mental Health Program Division. • Identify the staff to participate in the project and make available to them the necessary logistic support required to ensure satisfactory implementation of the project. • Endorse meetings to improve the information/awareness of the population. • Delegate implementation of the project to the appropriate main specialist in the Ministry of Health. • Set up a Steering Committee, on which all partners involved in the project will be represented. • Set up a specific monitoring system for the project via the existing follow-up and information system. http://www.moh.am/#3/0	Public
World Association for Social Psychiatry	• Contribute its scientific expertise to compiling materials that will be used to train healthcare professionals. • Make available one or more trainers for the training sessions organized for trainers in the context of the project. Contribute its expertise to developing the awareness campaign. http://www.waspsocialpsychiatry.com/	Voluntary

Companies, Partners & Stakeholders

13 Funding and implementing partners by country

PARTNER	COUNTRY
Armenia Ministry of Health	Armenia
World Association for Social Psychiatry	Armenia

14 Stakeholders

STAKEHOLDER	DESCRIPTION OF ENGAGEMENT
Government	The program engages the Armenia Ministry of Health Care in designing, implementing, and monitoring the program. The Ministry of Health is invited to workshops with other partners and it participates in annual Steering Committee.
Non-government organization (NGO)	The program works with World Association of Social Psychiatry to design and facilitate the training of healthcare providers on the diagnosis and management of schizophrenia and major depressive disorder. World Association of Social Psychiatry participate in workshops and annual Steering Committee meetings with other partners.
Other	The program engages local psychiatrists from various universities and hospitals in adapting / developing training and behaviour change communication materials. They are also involved in defining and setting-up monitoring systems.

Local Context, Equity & Sustainability

15   Local health needs addressed by program

Depression is a very common disease. At a global level, over 300 million people are estimated to suffer from depression, equivalent to 4.4% of the world's population.[4] In Armenia, it is estimated that 5%, or over 142,000 people, suffer from depression.[4] Depression is also ranked by the World Health Organization (WHO) as the single largest contributor to global disability. At its worst, depression can lead to suicide[4]. Schizophrenia is a severe form of mental illness, globally affecting between 0.5% and 1.6% of the adult population.[5] Schizophrenia has a large impact not only on individuals but also on families and communities. In particular, there is considerable burden ion the relatives who care for those who suffer from the disease [5].

Various data sources, reports, and contacts with the Ministry of Healthcare and local psychiatrists have highlighted the need to better integrate mental health care into primary care and to develop skills and competencies of primary healthcare professionals to effectively assess, diagnose, treat, support and refer people with mental disorders. The FAST Armenia program is directly responding to and aims to address the gaps identified in mental health diagnosis, treatment, support, and referral in Armenia.
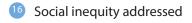
Some of these reports on mental health in Armenia can be found below:
*   WHO-AIMS Report on Mental Health System in Armenia, WHO and Ministry of Health, Yerevan, Armenia, 2009. Accessed from http://www.who.int/mental_health/armenia_who_aims_report.pdfArmenia.
*   Mental health Atlas country profile 2014. Accessed from http://www.who.int/mental_health/evidence/atlas/profiles-2014/arm.pdf?ua=1
*   Van Baelen L, Theocharopoulos Y, Hargreaves S. Mental health problems in Armenia: low demand, high needs. Br J Gen Pract. 2005 Jan 1;55(510):64-5. Accessed from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1266262/pdf/bjpg55-064.pdf

a   How needs were assessed

[No response provided]

b   Formal needs assessment conducted

[No response provided]

16   Social inequity addressed

Yes. By organising training for GPs and nurses in regional areas, where specialized psychiatric resources (mental health professionals as well as mental health facilities) are limited,   as well as in the capital city, the program aims to tackle geographical inequalities in terms of mental health care availability across the country. Additionally, the program aims to raise awareness among the general population and to address some of the beliefs and prejudices surrounding mental disorders.

A survey conducted by Médecins Sans Frontières (MSF) among the general population in Armenia regarding the knowledge, attitudes, and behaviour towards people with mental disorders showed that they are strongly discriminated against. Most responders in the survey thought that people with mental illness should be kept in hospital (56%), that they are usually violent and dangerous (63%), or that they cannot do any work (54%)[6]. The majority of the responders said that they would be upset or disturbed about working in the same job as someone with mental health problems (53%), that they would not be able to maintain a friendship with someone with a mental illness (56%), or that they would feel upset or disturbed about sharing a room with him or her (65%).[6]

Local Context, Equity & Sustainability

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

The current mental health system focuses on inpatient care. There is limited potential for providing services at the community level. Essentially, psychiatric care is still exclusively provided in specialized mental health institutions. Psychosocial rehabilitation is under-represented in mental hospitals. Few patients in mental hospitals received one or more psychosocial interventions in the last year prior to a study conducted by the World Health Organization (WHO) in 2009.[7] Continuous medical education for mental health professionals is lacking. Only 17% of psychiatrists had refresher training on the rational use of psychotropic drugs. None of the mental health care staff received refresher training of two days in length or more in the rational use of drugs, psychosocial interventions and child/adolescent mental health issues during the past one year prior to the study by WHO.[7]

WHO reports strongly advocates for mental health screening and services to be included in standard primary health care practices and in particular by:
- Improving referral between primary health care and mental health facilities.
- Developing continuous education and refreshment trainings in psychiatry and psychology for primary health care physicians,which this program aims to do.

Officially approved mental health policy and plans do not exist in Armenia, and mental health is not specifically mentioned in the general health policy. Prescription regulations do not authorize primary care doctors to prescribe psychotherapeutic medicines[8]. Similarly, the Ministry of Health Care does not authorize primary health care nurses to prescribe and/or to continue prescription of psychotherapeutic medicines. Official policy also does not permit primary health care nurses to independently diagnose and treat mental disorders within the primary care system.[8] Officially approved manuals on the management and treatment of mental disorders are not available in the majority of primary health care clinics. Official referral procedures for referring persons from primary care to secondary/tertiary care do not exist. Referral procedures from tertiary/secondary care to primary care also do not exist.[8]

Therefore, the FAST program works with Armenia Ministry of Health Care (MoH) and World Association for Social Psychiatry to improve mental health care delivery by providing:
- Continuing medical education for mental health specialists.
- Training of primary healthcare professionals (GPs & nurses) and non-mental health specialists.
- Development and dissemination of training materials developed by local psychiatrists and endorsed by MoH.
- Development of a monitoring system to better assess the number of patients diagnosed and managed.
- To raise awareness among the general population in order to tackle the stigma and exclusion which people with mental disorders have to face.

The program was designed in strict compliance with all applicable laws, rules and regulations, administrative requirements, codes of practice, good ethical business practices and applicable anti-bribery legislation.

Local Context, Equity & Sustainability

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

[No response provided]

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

No.

20 Health technologies are part of local standard treatment guidelines

N/A

21 Health technologies are covered by local health insurance schemes

N/A

22 Program provides medicines listed on the National Essential Medicines List

No

23 Sustainability plan

[No response provided]

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

Resources

1. WHO - Depression – Factsheet – February 2017.

2. WHO - Schizophrenia – Factsheet – April 2016.

3. Van Baelen L et al. , Mental health problems in Armenia: low demand, high needs. Br J Gen Pract 2005 ; 55(510): 64–65.

4. WHO - Depression and Other Common Mental Disorders - Global Health Estimates. 2017.

5. Rössler W et al. Size of burden of schizophrenia and psychotic disorders. European Neuropsychopharmacology 2005. 15(4): 399-409.

6. Van Baelen L, Theocharopoulos Y, Hargreaves S. Mental health problems in Armenia: low demand, high needs. Br J Gen Pract. 2005 Jan 1;55(510):64-5. Accessed from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1266262/pdf/bjpg55-064.pdf

7. WHO-AIMS Report on Mental Health System in Armenia, WHO and Ministry of Health, Yerevan, Armenia, 2009. Accessed from http://www.who.int/mental_health/armenia_who_aims_report.pdf

8. Mental Health Atlas-2011 country profiles. Accessed from http://www.who.int/mental_health/evidence/atlas/profiles/en/

Program Indicators

Sanofi mental health program (FAST – Fight Against STigma) – Armenia

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

	INDICATOR	TYPE	STRATEGY	2016	2017	2018	2019
1	Value of resources	Input	All Program Strategies	---	$61,063	$106,200	$ 63,214
2	Staff time	Input	All Program Strategies	---	0.4 FTE	0.2 FTE	0.2 FTE
3	Communication and training materials developed	Output	Community Awareness and Linkage to Care	---	8 tools	11 tools	1 tool
4	Population exposed to community communication activities	Output	Community Awareness and Linkage to Care	---	---	0 people	281,250 people
5	Number of people trained	Output	Health Service Strengthening	---	103 people	278 people	601 people
6	Percentage of professionals trained out of total number targeted	Output	Health Service Strengthening	---	85.8%	46.3%	89.8%
7	Health provider knowledge	Outcome	Health Service Strengthening	95%	---	90%	90%
8	New patients diagnosed	Outcome	Health Service Strengthening	---	---	9 people	---
9	Communication materials in use	Output	Community Awareness and Linkage to Care	---	0 tools	3,336 tools	5,400 tools
10	Health provider knowledge change	Outcome	Health Service Strengthening	---	---	160%	132%

INDICATOR Value of resources

STRATEGY   ALL PROGRAM STRATEGIES

	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	Company	A member of the project team submits invoices to finance and accounting to be paid. Finance makes the payments and keeps records of payments.	Ongoing
31	Data processing	Company	A member of the local Project Team (my company) produces a financial report based on the Program administrative and accounting records. The expenses for the year are summed.	Once per year
32	Data validation	Company	We do not conduct any further validation of our company financial reports.	

33 Challenges in data collection and steps to address challenges

[No response provided]

INDICATOR	2017	2018	2019
1 Value of resources	$61,063	$106,200	$ 63,214

Comments:

2017 data: Rate EURO / $: 1,13 Historic annual average rate.

2018: Annual average exchange rate EUR 1 = USD 1.18

2019: Annual average exchange rate EUR 1 = USD 1.12

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	Company	Our company's staff working on this project track the number of hours they spend on the project.	Every three months
31 Data processing	Company	Time spent on the Program by Company staff is evaluated on a quarterly basis, so that data can be consolidated and annual Full Time Equivalent (FTE) estimated.	Once per year
32 Data validation		We do not conduct any further validation of our internal human resources records.	

33 Challenges in data collection and steps to address challenges

[No response provided]

INDICATOR	2017	2018	2019
2 Staff time	0.4 FTE	0.2 FTE	0.2 FTE

Comments:

2017: Does not include any time involved in elaborating /developing program proposal: needs assessment, preparation meetings with partners, developping contract, budget, etc.

Communication and training materials developed

STRATEGY   COMMUNITY AWARENESS AND LINKAGE TO CARE

ITEM		DESCRIPTION
	Definition	Number of materials (e.g., behavior change communication materials, training materials) specifically developed or adapted for and by the program
	Method of measurement	Counting the number of different materials developed for and by the program Calculation: Sum of number of materials developed for and by the program
28	Data source	Routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Company	A member of the local team (my company) keeps a record of any new behavior change communication and training materials developed for the program and provides a copy of the final material.	Ongoing
31	Data processing	Company	We sum the communication and training materials developed at the end of the year based on our records.	Once per year
32	Data validation		We do not conduct any further validation of our internal company records.	

33 Challenges in data collection and steps to address challenges

[No response provided]

INDICATOR		2017	2018	2019
3	Communication and training materials developed	8 tools	11 tools	1 tool

Comments:

2017: 4 Schizophrenia training modules were adapted - 4 Schizophrenia behavior change communications materials (poster, comic book, flipchart, leaflet) were developed.

2018: 1 depression training module was developed as well as 7 videos (patient intreview) translated and dubbed. 3 Depression Behavior Change Commuincation materials were developed (comic book, poster and leaflet)

2019: A total of 6 Tools are available for depression and schizophrenia : 1 comic book, 1 poster and 1 Leaflet for each program.

Population exposed to community communication activities

STRATEGY   COMMUNITY AWARENESS AND LINKAGE TO CARE

	ITEM	DESCRIPTION
	Definition	Number of population reached through a community awareness campaign
	Method of measurement	Counting of participants that attend campaign meetings or reached by media messaged disseminated Calculation: Number of people/participants in the target audience segment participated/attended the community awareness campaign recorded in a given period of time
28	Data source	Routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Company	A member of the local team (my company) keeps record of any TV, radio programs, print media, web-based news item which have been organized. Based on the number of broadcasts, the audience rates estimated for the relevant radio and TV stations and readership for print-media, we calculate the estimated media reach.	Ongoing
31	Data processing	Company	A member of our teams sums the estimated audience reached through our program at the end of the year.	Once per year
32	Data validation		This program is implemented by my company. We do not conduct any further validation of our internal program records.	

33 Challenges in data collection and steps to address challenges

As media monitoring systems available in Armenia are limited, for the estimation of media reach, the local project team have to rely on data provided by TV and radio stations, print media, etc., and estimated audience and readership rates.

INDICATOR		2017	2018	2019
4	Population exposed to community communication activities	---	0 people	281,250 people

Comments:

2018: Awareness activities have not started yet. Only once they have started will we get data regarding population exposed to these activities. 2019: No awareness media activities were organised. However, all trained GPs have received awareness materials to put in their practices (Poster, Comic book, leaflets...). Based on estimated 7,500 consultations / year / GP, and average 3 annual consultations per patient i.e. 2,500 different patients/GP, and 450 different GPs trained during the 2nd half of 2019, it is estimated that 281,250 patients visiting trained GPs practices would have been exposed to awareness materials.

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	A member of the local team (my company) asks each healthcare professional attending a training session to sign their name on an attendance form. Data are collected at the time of each training session.	Ongoing
31	Data processing	Company	A member of the local team of the implementing partner reviews the number of attendees per training session and consolidates the data from each session into the total number of people having attended the training for each type of training.	Ongoing
32	Data validation		This program is implemented by my company. We do not conduct any further validation of our internal program records.	

33 Challenges in data collection and steps to address challenges

[No response provided]

INDICATOR		2017	2018	2019
5	Number of people trained	103 people	278 people	601 people

Comments:

2017:The objective for 2017 was to conduct two continuing medical education sessions for 120 mental health specialists. 103 attended these sessions.

2018: Includes 111 GPs and 167 nurses.

2019: Includes 151 nurses and 450 GPs.

Percentage of professionals trained out of total number targeted

STRATEGY   HEALTH SERVICE STRENGTHENING

	ITEM	DESCRIPTION
	Definition	Percentage of professionals that completed the required requisites of the training out of total number of professionals targeted
	Method of measurement	Sum of professionals who completed all training requirements divided by the total number of professionals targeted by the program to be trained
		Calculation:
		Number of professionals trained in a defined period x 100
		Total number of professionals targeted by the program to be trained
28	Data source	Routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Armenia Ministry of Health; Other, please specify: Healthcare Providers	A member of the local team (my company) asks each healthcare professional attending a training session to sign their name on an attendance form. Data are collected at the time of each training session. Data on the number of healthcare professionals we initially planned to train are from our program plan records.	Ongoing
31	Data processing	Company	For each type of training, the total number of healthcare professionals who have attended any training session (indicator "number of people trained") will be divided by the number of healthcare professionals targeted by the program for each category of healthcare professionals. Data on the number of healthcare professionals we initially planned to train are from our program plan records.	Once per year
32	Data validation		This program is implemented by my company. We do not conduct any further validation of our internal program records.	

33 Challenges in data collection and steps to address challenges

[No response provided]

INDICATOR	2017	2018	2019
6 Percentage of professionals trained out of total number targeted	85.8%	46.3%	89.8%

Comments: The objective for 2017 was to conduct two continuing medical education sessions for 120 mental health specialists. 103 attended these sessions. 2018: Training in regions has partly implemented because of political changes. 3 years' program target is 600 GPs and nurses. 2019: Political changes induced delays in program implementation.

Health provider knowledge

7

ITEM	DESCRIPTION
Definition	Percentage of providers that pass the assessment examining their skills or knowledge. The exam 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 possession of skills and knowledge occurs through a written, oral, or observational assessment that all providers have to undergo
	Calculation:
	Number of providers who pass the assessment x 100
	Number of providers trained
28 Data source	Routine program data
29 Frequency of reporting	Once per year

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Company	A knowledge questionnaire is completed before and after each training session by each health provider attending the training. The questionnaires are marked by a member of the local team (my company) based on the correct answers provided by the specialists, and a score is given to each questionnaire.	Ongoing
31 Data processing	Company	A member of my company reviews the post-training survey scores and notes the number of participants who scored above a pre-determined pass mark. The proportion of participants who scored above the pass mark is then calculated.	Ongoing
32 Data validation		This program is implemented by my company. We do not conduct any further validation of our internal program records.	

33 Challenges in data collection and steps to address challenges

There is always reluctance from healthcare providers to have their knowledge evaluated through a questionnaire. To overcome this barrier, we have had agreement from the Ministry of Health for the training program to be accredited,and for CME credits to be allocated to the activity.

INDICATOR	2016	2017	2018	2019
7 Health provider knowledge	50%	---	90%	90%

Comments: 2016: 95% of participants pass the assessment (score >=7/13) Overall the participants gained +21% in knowledge on average. 2018: On average, accross the 3 regions where trainings were held, 90% of participants passed the test (82% success rate for GPs and 99% for nurses). 2019: On average, accross all regions where trainings were held, 90% of participants passed the test (95% for GPs and 78% for nurses).

ITEM	DESCRIPTION
Definition	Number of new individuals diagnosed with the disease through the program
Method of measurement	This indicator is either measured through existing health facility medical records, ministry of health reporting systems, or through a specific monitoring system put in place as part of the program to record any new patient diagnosed with the disease
28 Data source	Routine program data
29 Frequency of reporting	Once per year

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Armenia Ministry of Health; Healthcare providers	We are still discussing with the Ministry of Health the best way of recording the number of patients diagnosed with the disease by doctors who have been trained through the program. Whether it will be measured through existing ministry of health reporting systems or through a specific monitoring system put in place as part of the program to record any new patients diagnosed with the disease is not decided at this stage.	Ongoing
31 Data processing	Company	Data collection methods and data processing plans have not been finalized yet. We will sum the number of patients diagnosed during a one year period.	Every month
32 Data validation		This program is implemented by my company. We do not conduct any further validation of our internal program records.	

33 Challenges in data collection and steps to address challenges

For healthcare providers to report any new patient diagnosed with the disease will represent additional work, which they might be reluctant to do. To overcome this, the Ministry of Health has agreed to have CME credit points attributed to those who will complete this activity.

INDICATOR	2017	2018	2019
8 New patients diagnosed	---	9 people	---

Comments: 2017: Training of primary healthcare professionals has not started yet. Only once training has been completed will we start monitoring new patients diagnosed. 2018: Reporting system based on docket collection is not completely rolled out and the training of GPs took started late in 2018.

INDICATOR Communication materials in use

STRATEGY   COMMUNITY AWARENESS AND LINKAGE TO CARE

	ITEM	DESCRIPTION
	Definition	Number of communication materials introduced and in use by the program
	Method of measurement	Counting the number of communication materials created and in use by the program Calculation: Sum of communication materials created by the program
28	Data source	Routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Company	A member of the local team (my company) keeps record of the number of materials disseminated.	Ongoing
31	Data processing	Company	A member of our teams sums the number of communication materials disseminated within a year period.	Once per year
32	Data validation		This program is implemented by my company. We do not conduct any further validation of our internal program records.	

33 Challenges in data collection and steps to address challenges

[No response provided]

INDICATOR	2017	2018	2019
9 Communication materials in use	0 tools	3,336 tools	5,400 tools

Comments:

2017: Behavior change communication materials are currently being developped. Once they are ready and communication activities have started, we will get data on communication materials in use.

2018: 4 different types of Schizophrenia Behavior Change Communications materials distributed to trained HCPs

2019: 3 different types of Depression Behavior Change Communications materials distributed to trained GPs

Health provider knowledge change

10

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: $$\frac{\text{Change in score} \times 100}{\text{Pre-training score}}$$
28 Data source	Routine program data
29 Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Company	A knowledge questionnaire is completed before and after each training session by each health provider attending the training. The questionnaires are marked by a member of the local team (implementing partner) based on the correct answers provided by the specialists, and a score ia given to each questionnaire.	Ongoing
31	Data processing	[No response provided]	For each training, the individual knowledge changes (post vs pre-training) have been averaged, allowing to see the change in knowledge resulting from the training.	[No response provided]
32	Data validation		Percentage changes in score calculated by local team are re-calculated independently by a second member.	

33 Challenges in data collection and steps to address challenges

[No response provided]

INDICATOR	2017	2018	2019
10 Health provider knowledge change	---	160%	132%

Comments: 2018: 160% increase in knowledge based on the average combining both GPs and nurses of weighted average for GPs (+153%) and weighted average for nurses (+161%). 2019: 132% increase in knowledge score, based on the weighted average combining both GPs and Nurses (GPs +111% - Nurses +152%).

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.

Company-submitted Situation Analysis

1. WHO-AIMS Report on Mental Health System in Armenia, WHO and Ministry of Health, Yerevan, Armenia, 2009. Available at: http://www.who.int/mental_health/armenia_who_aims_report.pdf

2. Armenia. Mental health Atlas country profile 2014. Available at: http://www.who.int/mental_health/evidence/atlas/profiles-2014/arm.pdf?ua=1

3. Van Baelen L, Theocharopoulos Y, Hargreaves S. Mental health problems in Armenia: low demand, high needs. Br J Gen Pract. 2005 Jan 1;55(510):64-5. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1266262/pdf/bjpg55-064.pdf