PROGRAM ENDED IN 2018

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

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) – Madagascar

2 Diseases program aims to address

Mental & Neurological Disorders (Depression; Schizophrenia; Bipolar; Epilepsy; Addictions; Childhood psychiatric disorders; Anxiety disorders; Psychosocial support and Management of violent behaviour)

3 Beneficiary population

• General population

4 Countries

• Madagascar

5 Program start date

February 1, 2013

6 Anticipated program completion date

January 31, 2018

7 Contact person

[No response provided]

8 Program summary

This program is part of a five-year partnership between Sanofi and the Department of Non-Communicable Disease in the Madagascar Ministry of Public Health. It covers 15 districts in five pilot regions of Madagascar, which together have an estimated population of 4.3 million.[1] The goal of the project is to improve access to mental health care in the 5 pilot regions. The project has two specific objectives:

1. Training primary healthcare professionals on diagnosing and treating mental health disorders.
2. Raising awareness among the general public about mental health disorders, through a set of interventions based on Information Education Communication (IEC)/Behavior-Change-Communication (BCC) theory.[2]

Primary healthcare professionals are trained to integrate mental health care into primary care, focusing on seven mental health conditions: epilepsy, schizophrenia, addiction disorders, mood disorders, childhood psychiatric disorders, anxiety disorders, and violent behavior. The trainings were designed to develop skills and competencies to effectively assess, diagnose, treat, support and refer people with mental disorders.

Specific activities included:

• The creation of a mental health care network of specialists and trained General Practitioners (GPs) to further reinforce mental health treatment capacity.
• Training sessions on the various diseases for a total of 100 GPs in the 5 pilot regions These include supervised sessions of the trained GPs by psychiatrists.
• An annual scientific event on mental health for health care professionals.
• Annual sponsorship of a University Diploma on mental health training for 10 doctors. The BCC component of the program involves a wide range of interventions that aim to raise awareness, decrease patient stigmatization, promote mental health seeking behavior, and ultimately lead to positive health outcomes.[2]

The BCC component of the program involves a wide range of interventions that aim to raise awareness, decrease patient stigmatization, promote mental health seeking behavior, and ultimately lead to positive health outcomes. [2]

Program Overview

8 Program summary cont.

Activities based on BCC interventions in this program included:

- Development and public dissemination of BCC materials adapted to the local context. For example, booklets with cartoon stories using the local language have made it easier for patients and their families to understand the disease.[3] Similarly educational flipcharts with pictures reflecting local situations have been developed, which can be used for one-on-one sessions, or group interactions, with key messages to be delivered and suggested questions to stimulate dialogue.
- Annual celebration of the mental health week in one of the pilot regions, including awareness sessions, radio campaign, psychoeducation of people with mental disorders and their families, as well as training of healthcare providers.
- Epilepsy information campaigns in schools to reduce the stigma among the young population.

Program Strategies & Activities

9 Strategies and activities

Strategy 1: Community Awareness and Linkage to Care

ACTIVITY	DESCRIPTION
Communication	Development and dissemination to the general public of Behavior Change Communication materials adapted to local context. Annual celebration of mental health week in one of the pilot regions, including awareness sessions, radio campaigns, and psychoeducation of people with mental disorders and their families. Information campaigns in schools on Epilepsy to reduce stigma.
Mobilization	Encouraging the creation of patients' and family associations.

Strategy 2: Health Service Strengthening

ACTIVITY	DESCRIPTION
Training	Training sessions on the various diseases for 100 General Practitioners (GPs) in the 5 pilot regions. Supervision sessions of the trained GPs by Psychiatrists Organizing annual scientific event on mental health for health care professionals Supporting University Diploma on mental health training for 10 doctors every year.

10 Strategy by country

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

Companies, Partners & Stakeholders

11 Company roles

COMPANY	ROLE
Sanofi	• Designs, plans, monitors and evaluates the program in collaboration with implementing partners. • Provides training materials (slide kits and training documents) which are to be locally adapted and used to train healthcare professionals on mental health. • Develops Information, Education and Communication (IEC)/Behavior Change Communication (BCC) materials to raise awareness among the population and educate families and patients (posters, brochures, flipcharts, and comic book). • Provides logistical support and funding for the various activities of the program in accordance with the agreement and the budget.

12 Funding and implementing partners

PARTNER	ROLE/URL	SECTOR
Ministry of Public Health of Madagascar	Develops, plans, monitors and evaluates the program in collaboration with other partners. Coordinates activities of the project through its Department of Non-Communicable Disease. Liaises with local specialists to develop/adapt material for the training on mental disorders. Liaises with local specialists to develop/adapt Behavior Change Communication materials and ensure material dissemination. Identifies staff to participate in the project and make available to them the necessary logistic support required to ensure satisfactory implementation of the project. Endorses activities to improve knowledge and awareness among the population. Sets up a Steering Committee, in which all partners involved in the project will be represented. Sets up a specific monitoring system for the project via the existing follow-up and information system. http://www.sante.gov.mg/home/n	Public
World Association of Social Psychiatry	Provides advice on development, monitoring and evaluation of program. Contributes its scientific expertise to compiling materials that will be used to train healthcare professionals. Provides one or more trainers for the train-the-trainers sessions organized in the context of the project. Provides expertise to developing awareness materials and campaign. http://www.waspsocialpsychiatry.com/	Voluntary

13 Funding and implementing partners by country

PARTNER	COUNTRY
Ministry of Public Health of Madagascar	Madagascar
World Association of Social Psychiatry	Madagascar

14 Stakeholders

STAKEHOLDER	DESCRIPTION OF ENGAGEMENT
Government	The program has engaged with the Madagascar Ministry of Public Health in designing, implementing and monitoring the program. Weekly conference calls are organized with the Ministry of Public Health's project team to review progress and discuss any issues. This team takes part in annual Steering Committee meetings as well as in the supervisory missions and regular field visits organized. There have also been workshops organized with the Ministry of Public Health's project team and local specialists to adapt training materials and to adapt/develop Behavior Change Communication materials.
Other	The program has also engaged with local psychiatrists from various hospitals in adapting / developing training and behaviour change communication materials. They are also involved in conducting the training and supervision sessions.

Local Context, Equity & Sustainability

15 **Local health needs addressed by program**

Accounting for 32.4% of years lived with disability (YLDs) and 13% of disability-adjusted life-years (DALYs), mental disorders are having a significant impact on global health, and major social, human rights and economic consequences in all countries of the world.[4] Productivity losses from absenteeism associated with mental health problems are substantial and appear to be increasing,[5] As a result, mental health and substance abuse disorders were included in the Sustainable Development Agenda adopted at the United Nations General Assembly in September 2015.[6] In the African Region, the lack of information, stigma and cultural issues are significant barriers that prevent people from seeking help.[5] The treatment gap for mental disorders (percentage of people with untreated illness) is very high in Africa, reaching an estimated 98 percent in some countries.[7] In Madagascar, the lifetime prevalence of mental disorders has been estimated at 34% among the general population (45.9% in the Antananarivo area), via a door-to-door survey.[8] With only 14 psychiatrists for a total population of 24 million (0.06 per 100,000 population vs 12.4 in the USA) Madagascar's healthcare system is under-resourced to meet the mental health needs of the country.[9] Based on this need assessment and after various contacts with the Ministry of Public Health of Madagascar and local psychiatrists, the programme was developed to focus on training primary care professionals and community awareness campaigns on mental health.

a **How were needs assessed**

[No response provided]

b **Formal needs assessment conducted**

[No response provided]

16 **Social inequity addressed**

Yes, by training healthcare professionals in the four pilot regions where there is lack of specialised psychiatric resources (mental health professionals as well as mental health facilities) as well as in the capital city, the program aims to tackle geographical inequalities in mental health care availability across the country. Furthermore, considering the high stigma associated with mental disorders, people suffering from mental illness are frequently discriminated against. By raising awareness among the general public to improve communities' and individuals' behaviors around these issues, this program aims to reduce the stigma that people with mental disorders face. In turn, it is expected this could further amplify the increased access to care achieved through the program, as people with these disorders feel more confident in seeking help.

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

When designing the program in Madagascar we took into consideration that:

- There is a stand-alone policy /plan for mental health since 2003 that is partially implemented and a law for mental health in existence since 1838 but is not being implemented.
- There is a limited current mental health system focusing on inpatient care. Essentially, psychiatric care is still exclusively provided in specialized mental health institutions that are mainly in the capital, Antananarivo.

We designed this program to be in line with World Health Organization (WHO) recommendations and guidelines regarding mental health care in emerging countries,[10] such as:

- Strengthening effective leadership and governance for mental health.
- Providing comprehensive, integrated and responsive mental health and social care services in community-based settings.
- Implementing strategies for promotion and prevention in mental health.
- Strengthening information systems, evidence and research for mental health.

Local Context, Equity & Sustainability

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

By integrating mental health care into primary care through the training of GPs and the creation of a solid network of providers, the programs promotes leadership in local care centers by GPs acting as stewards of care. Additionally, with the various strategies for community awareness and education, this program relates to the WHO recommendations described above.

18 How diversion of resources from other public health priorities are avoided
[No response provided]

19 Program provides health technologies (medical devices, medicines, and vaccines)
[No response provided]

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

22 Program provides medicines listed on the National Essential Medicines List

N/A

23 Sustainability plan

Training courses are accredited as part of a continuous professional development program for General Practitioners. Based on the outcome and impact of this program, we will work with the Madagascar Ministry of Public Health to develop a national program that will integrate a transition plan.

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. Data from Ministry of Public Health of Madagascar & National Institute of Statistics (INSTAT).

2. BCC: https://www.measureevaluation.org/prh/rh_indicators/service-delivery/bcc

3. Sanofi – For better mental health care in Madagascar.mOnline Video. Retrieved from https://www.youtube.com/watch?v=X-wj-1wl8Or8

4. Vigo D et al. Estimating the true global burden of mental illness. The Lancet Psychiatry. 2016; 3 (2):171-173) . Accessed on. https://www.ncbi.nlm.nih.gov/pubmed/26851330

5. Message of the WHO Regional Director for Africa - . Accessed on http://www.afro.who.int/regional-director/speeches-messages/message-who-regional-director-africa-dr-matshidiso-moeti-16

6. WHO - Mental health included in the UN Sustainable Development Goals - . Accessed on http://www.who.int/mental_health/SDGs/en/

7. Dixon J, Improving the Mental Health treatment gap in Ghana, Africa Portal, Backgrounder n°39, September 2012 - . Accessed on http://dspace.africaportal.org/jspui/bitstream/123456789/33215/1/Africa%20Portal%20Backgrounder%20No%2039.pdf?1

8. Andriantseheno M. La santé mentale à Madagascar . l'Information Psychiatrique. 2003 ; 79 (10), 913-919,

9. WHO – Madagascar - Mental health Atlas country profile 2014- Accessed from http://www.who.int/mental_health/evidence/atlas/profiles-2014/mdg.pdf

10. WHO - Comprehensive mental health action plan 2013–2020. Accessed on http://www.who.int/mental_health/action_plan_2013/en/

Program Indicators

PROGRAM ENDED IN 2018

PROGRAM NAME

Sanofi Mental Health Program (FAST - Fight Against STigma) - Madagascar

27 List of indicator data reported into Access Observatory database

INDICATOR	TYPE	2013	2014	2015	2016	2017	2018
1 Value of resources	Input	$77,300	$68,192	$43,845	$20,113	$60,768	---
2 Staff time	Input	879: 1,664 hours	479: 1,664 hours	479: 1,664 hours	479: 1,664 hours	479: 1,664 hours	386: 1,664 hours
3 Communication materials developed	Output	6 tools	3 tools	1 tool	1 tool	0 tools	---
4 Population exposed to community communication activities	Output	450,617 people	267,725 people	229,084 people	473,084 people	115,084 people	300,904 people
5 Number of people trained	Output	---	76 people	70 people	75 people	---	---
6 Percentage of professionals trained out of total number targeted	Output	---	74.5%	68.6%	73.5%	---	---
7 Health provider knowledge	Outcome	---	89.5%	88.6%	90.7%	---	---
8 New patients diagnosed	Outcome	---	---	11,673 people	19,292 people	20,109 people	18,849 people
9 Communication materials in use	Output	---	10,500 tools	29,445 tools	29,445 tools	29,445 tools	1,050 tools
10 Health provider knowledge change	Outcome	---	24% change	16% change	40% change	---	---

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	Implementing partner: Ministry of Public Health of Madagascar	A member of the project team (implementing partner) submits invoices to finance and accounting to be paid. Finance makes the payments and keeps records of payments.	Ongoing
31	Data processing	Implementing partner: Ministry of Public Health of Madagascar	A member of the local Project Team (implementing partner) produces a financial report based on the Program administrative and accounting records. The expenses for the year are summed at the end of the year.	Ongoing
32	Data validation		Financial reports are audited based on program invoices/receipts.	

33 Challenges in data collection and steps to address challenges

N/A

INDICATOR	2013	2014	2015	2016	2017	2018
1 Value of resources	$77,300	$68,192	$43,845	$20,113	$60,768	---

Comments:
2013: EURO / $: 1.33 annual average exchange rate.
2014: EURO / $: 1.33 annual average exchange rate.
2015: EURO / $: 1.11 annual average exchange rate.
2016: EURO / $: 1.11 annual average exchange rate.
2017: EURO / $: 1.13 annual average exchange rate.
2018: The program was completed in February 2018.

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 $$\frac{\text{Sum of the number of paid hours per year}}{\text{Total number of working hours per year}}$$
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

N/A

INDICATOR	2013	2014	2015	2016	2017	2018
2 Staff time	879: 1,664 hours	479: 1,664 hours	479: 1,664 hours	479: 1,664 hours	479: 1,664 hours	386: 1,664 hours

Comments:

2013: Does not include any time involved in elaborating /developing program proposal: needs assessment, preparation meetings with partners, developing contract, budget, etc.

Communication materials developed

3

	ITEM	DESCRIPTION
	Definition	Number of communication materials (e.g., Behavior Change Communication materials...) specifically developed or adapted for and by the program.
	Method of measurement	Counting the number of different tools developed for and by the program. CALCULATION Sum of number of tools 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	Implementing partner: Ministry of Public Health of Madagascar	A member of the local team (implementing partner) keeps a record of any new Behavior Change Communication materials developed for the program, and provides a copy of the final tool.	Ongoing
31	Data processing	Company	We sum the tools developed at the end of the year based on our records.	Ongoing
32	Data validation		We do check that the number of tools recorded match the actual number of tools which we have a copy of.	

33 Challenges in data collection and steps to address challenges

N/A

INDICATOR	2013	2014	2015	2016	2017	2018
3 Communication materials developed	6 tools	3 tools	1 tool	1 tool	0 tools	---

Comments:

2013: This includes mental health flip chart, epilepsy flip chart, leaflet on epilepsy, schizophrenia and epilepsy comic books.
2014: This includes epilepsy poster, quiz on epilepsy.
2015: This is a leaflet on depression.
2016: This is a mental health poster.
2017: There was no material developed in 2017.
2018: Program completed in February 2018.

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 or participants in the target audience segment who participated or 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	Implementing partner: Ministry of Public Health of Madagascar	Depending on the type of activity: 1. A member of the local team (the implementing partner), or someone asked by a member of the local team will count the number of attendees per session and will record the number of sessions held, and attendees per session. Data is collected on an ongoing basis when sessions occur. 2. For TV, radio programs, and Community Service Announcements, the local team (the implementing partner) calculates the estimated media reach based on the number of broadcasts and the audience rates estimated for the radio and TV stations.	Ongoing
31 Data processing	Company	A member of the team of the implementing partner gathers on an ongoing basis the number of attendees per session / event / broadcast. This allows consolidating at the end of one calendar year the total number of people exposed.	Ongoing
32 Data validation		We do not conduct any further validation of these program records.	

33 Challenges in data collection and steps to address challenges

As there are no media monitoring systems available in Madagascar, for their estimation of media reach, the local team (implementing partner) have to rely on data provided by TV and radio stations and estimated audience rates.

Population exposed to community communication activities

STRATEGY   COMMUNITY AWARENESS AND LINKAGE TO CARE

INDICATOR	2013	2014	2015	2016	2017	2018
4 Population exposed to community communication activities	450,617 people	267,725 people	229,084 people	473,084 people	115,084 people	300,904 people

Comments:

2013: These data combine estimated number of people reached through community based activities / events as well as through radio and TV.

2014: These data combine estimated number of people reached through community based activities / events as well as through radio and TV.

2015: These data combine estimated number of people reached through community based activities / events as well as through radio and TV.

2016: These data combine estimated number of people reached through community based activities / events as well as through radio and TV.

2017: These data combine estimated number of people reached through community based activities / events as well as through radio and TV.

2018: One event took place in 2018 with money left over from 2017 budget. It was an awareness week where 300,000 people were reached by radio messages, and 904 by awareness sessions.

Number of people trained

5

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	Implementing partner: Ministry of Public Health of Madagascar	A member of the local team (implementing partner) 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	Implementing partner: Ministry of Public Health of Madagascar	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		The consolidated data is cross-checked with individual training sign in sheets by a second member of the team.	

33 Challenges in data collection and steps to address challenges

N/A

INDICATOR	2014	2015	2016	2017	2018
5 Number of people trained	76 people	70 people	75 people	---	---

Comments:

2014: Training took place in 2014, 2015 and 2016.The same goup of GPs (102) were trained on several mental disorders, 76 of them were trained in 2014.

2015: Training took place in 2014, 2015 and 2016.The same goup of GPs (102) were trained on several mental disorders, 70 of them were trained in 2015.

2016: Training took place in 2014, 2015 and 2016.The same goup of GPs (102) were trained on several mental disorders, 75 of them were trained in 2016.

2018: Program completed in February 2018.

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	Implementing partner: Ministry of Public Health of Madagascar	A member of the local team (implementing partner) 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 is 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 over the five regions (100 in the case of GPs)	Ongoing
32	Data validation		The consolidated data is cross checked with individual training sign in sheets by a second member of the team.	

33 Challenges in data collection and steps to address challenges

N/A

STRATEGY   HEALTH SERVICE STRENGTHENING

INDICATOR	2014	2015	2016	2017	2018
6 Percentage of professionals trained out of total number targeted	74.5%	68.6%	73.5%	---	---

Comments:

2014: Training took place in 2014, 2015 and 2016.The same goup of GPs (102) were trained on several mental disorders, 76 of them were trained in 2014.

2015: Training took place in 2014, 2015 and 2016.The same goup of GPs (102) were trained on several mental disorders, 70 of them were trained in 2015.

2016: Training took place in 2014, 2015 and 2016.The same goup of GPs (102) were trained on several mental disorders, 75 of them were trained in 2016.

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 $\dfrac{\text{Number of providers who pass the assessment}}{\text{Number of providers trained}} \times 100$
28	Data source	Non-routine program data
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Implementing partner: Ministry of Public Health of Madagascar	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 given to each questionnaire.	Ongoing
31	Data processing	My 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.	One-time event
32	Data validation		We do not conduct any further validation of these program records.	

33 Challenges in data collection and steps to address challenges

Data has been retrospectively processed to meet the definition of this indicator.

INDICATOR	2014	2015	2016	2017	2018
7 Health provider knowledge	89.5%	88.6%	90.7%	---	---

Comments:
2014: Percentage of providers that pass the assessment. Please note that classroom style training sessions were followed by individual supervision sessions conducted by a specialist.
2015: Percentage of providers that pass the assessment. Please note that classroom style training sessions were followed by individual supervision sessions conducted by a specialist.
2016: Percentage of providers that pass the assessment. Please note that classroom style training sessions were followed by individual supervision sessions conducted by a specialist.

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	External Non-Public Data (e.g. administrative records)
29	Frequency of reporting	Once per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Implementing partner: Ministry of Public Health of Madagascar	Health providers keep record of patients' diagnosis. Every 6 months, data are obtained from the Statistics Department of the Ministry of Public Health, detailing for each Heath District the number of new cases diagnosed for each disease.	Ongoing
31	Data processing	Company	The average number of new patients diagnosed in districts with no trained GP is divided by the number of GPs in these districts. This calculated number is assumed to be the diagnosis rate of un-trained GPs. Then the average number of new patients diagnosed per trained GP, in districts with trained GPs, is calculated.The difference between the two can be calculated, and could serve as a raw estimate of the number of new individuals diagnosed with the disease through the program (difference between trained GP and un-trained GP). By multiplying this number by the number of trained GPs, the total number of new individuals diagnosed with the disease through the program can be estimated.	Every 6 months
32	Data validation		We do not conduct any further validation of these program records.	

33 Challenges in data collection and steps to address challenges

The data collected will allow us to see what effect the program is having in terms of number of new people diagnosed per trained GPs, compared to untrained GPs. Unfortunately a change in the mental diseases classification in the Ministry of Health Statistics System in January 2015 didn't allow us to do a "before & after" comparison. Nevertheless, data from districts with trained GPs and data from districts

without trained GPs can provide an estimate of the number of new individuals diagnosed with the disease through the program.At this stage however, we have no means of knowing whether individuals have been accurately diagnosed, hence the reason why we are suggesting to have an additional indicator instead of just "Patients properly diagnosed". We are currently discussing the possibility of implementing a number of additional initiatives (surveys etc…) to get a better evaluation of this program. This would potentially include an audit of a random sample of patients conducted by a specialist allowing to check whether diagnoses have been made appropriately. That way, the percentage of patients properly diagnosed could be established.

INDICATOR	2015	2016	2017	2018
8 New patients diagnosed	11,673 people	19,292 people	20,109 people	18,849 people

Comments:

2015: Sectorial data provided by the Ministry of Health. Whereas an average of 141 patients/GP were diagnosed/managed by trained GPs in pilot areas, only an average of 14 patients/GP were diagnosed/managed by GPs that had not been trained in other areas. For that period, this translates into 11,673 additional patients diagnosed/managed by trained GPs.

2016: Sectorial data provided by the Ministry of Health. Whereas an average of 232 patients/GP were diagnosed/managed by trained GPs in pilot areas, only an average of 22 patients/GP were diagnosed/managed by GPs that had not been trained in other areas. For that period, this translates into 19,292 additional patients diagnosed/managed by trained GPs.

2017: Sectorial data provided by the Ministry of Health. Whereas an average of 241 patients/GP were diagnosed/managed by trained GPs in pilot areas, only an average of 23 patients/GP were diagnosed/managed by GPs that had not been trained in other areas. For that period, this translates into 20,109 additional patients diagnosed/managed by trained GPs.

2018: Sectorial data provided by the Ministry of Health during the period January 2018 to October 2018, extrapolated to 12 months. Whereas an average of 225 patients/GP were diagnosed/managed by trained GPs in pilot areas, only an average of 20 patients/GP were diagnosed/managed by GPs that had not been trained in other areas. For that period, this translates into 18,849 additional patients diagnosed/managed by trained GPs.

	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	Implementing partner: Ministry of Public Health of Madagascar	Implementing partner keeps record of the number of Behaviour Change Communication tools disseminated.	Ongoing
31	Data processing	Implementing partner: Ministry of Public Health of Madagascar	A member of our teams sums the number of tools developed and in use within a year period.	Ongoing
32	Data validation		Annual data are cross-checked against data from stock takes and printing records.	

33 Challenges in data collection and steps to address challenges

No particular challenge with these data.

INDICATOR	2014	2015	2016	2017	2018
9 Communication materials in use	10,500 tools	29,445 tools	29,445 tools	29,445 tools	1,050 tools

Comments:

2014: Communication materials started being used in 2014. Annual numbers have been estimated based on cumulative 2014-2017 data.

2015: Communication materials started being used in 2014. Annual numbers have been estimated based on cumulative 2014-2017 data.

2016: Communication materials started being used in 2014. Annual numbers have been estimated based on cumulative 2014-2017 data.

2017: Communication materials started being used in 2014. Annual numbers have been estimated based on cumulative 2014-2017 data.

2018: Tools distributed during awareness week.

Health provider knowledge change

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

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Implementing partner: Ministry of Public Health of Madagascar	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 given to each questionnaire.	Ongoing
31	Data processing	Ministry of Public Health of Madagascar	For each type of training (each disease) and each region, the various knowledge scores pre and post- training have been averaged, allowing to see for each region, and each disease, the average level of knowledge for each group prior to the training and after the training, and therefore the change in knowledge resulting from the training.	Ongoing
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 particular challenge with these data.

INDICATOR	2014	2015	2016	2017	2018
10 Health provider knowledge change	24%	16%	40%	---	---

Comments:
2014: Average knowledge gain for the training performed during the year.
2015: Average knowledge gain for the training performed during the year.
2016: Average knowledge gain for the training performed during the year. Overall for the entire program period, the gain in knowledge for each disease area was as follows: + 24% for epilepsy + 19% for schizophrenia + 27% for addictive disorders + 34% for depression + 45% for anxiety disorders.

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.

Company-submitted Situation Analysis

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1. Andriantseheno M. La santé mentale à Madagascar. l'Information Psychiatrique. 2003; 79 (10): 913-919. Available at: https://www.jle.com/fr/revues/ipe/e-docs/la_sante_mentale_a_madagascar__261577/article.phtml?cle_doc=0003F-DC9

2. WHO – Madagascar - Mental health Atlas country profile 2014- Accessed on http://www.who.int/mental_health/evidence/atlas/profiles-2014/mdg.pdf