



Access *Observatory* 2018 Report

Results and Reflections on Year One

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Access Observatory

The *Access Observatory* is a new public reporting platform for programs that aim to improve access to disease prevention and treatment services in low- and middle-income countries. Programs in the *Access Observatory* focus on more than just medicines, and include strategies to strengthen health systems and positively influence patient behaviors for better health outcomes.

The *Access Observatory* was created within the scope of Access Accelerated, a collaboration of 23 R&D based biopharmaceutical companies, in partnership with the World Bank and the Union of International Cancer Control, that seeks to reduce barriers to prevention, treatment and care for non-communicable diseases (NCDs) in low- and middle-income countries. Program information available through the *Access Observatory* is authored by program teams and independently reviewed by the *Access Observatory* team to ensure completeness, clarity, and consistency. The *Access Observatory* is a reporting mechanism for Access Accelerated, and is also open to all access programs, including those designed and implemented by public and non-profit organizations. The *Access Observatory* has been designed by and is managed by a team based in the Department of Global Health at the Boston University School of Public Health.

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

Executive Summary

The Access Observatory team designed a new measurement framework, based on public health priorities, that serves as a common language for categorizing, understanding and comparing access programs.

In Year One, 62 Access Accelerated programs operating in 103 countries were registered in the Access Observatory.

In 2017, more than 20 global R&D-based biopharmaceutical companies, in partnership with the World Bank and the Union of International Cancer Control (UICC), launched Access Accelerated, an initiative that seeks to reduce barriers to prevention, treatment and care for non-communicable diseases (NCDs) in low- and middle-income countries. Members of Access Accelerated have committed to measuring their programs and reporting to the global health community. To facilitate these efforts, the *Access Observatory* team designed a new measurement framework, based on public health priorities, that serves as a common language for categorizing, understanding and comparing access programs. The *Access Observatory* (accessobservatory.org) is an online public repository of information on access programs, structured according to the measurement framework.

In Year One, 62 Access Accelerated programs operating in 103 countries were registered in the *Access Observatory*. Programs were geographically clustered in sub-Saharan Africa and Southeast Asia. A majority of programs used a few common strategies: community activities that aimed to increase awareness of disease symptoms and treatment options; health service strengthening activities, most notably health provider training courses; and direct health service delivery. Two-thirds of programs addressed cancer, while diabetes and cardiovascular disease were also the focus of a number of programs. Across the 62 programs, there were 198 partnerships between companies and other organizations; two-thirds of programs having at least one public sector partner. More than half of programs aimed to address income-related inequity. With respect to measurement, one-third of programs submitted at least one 2017 value for a program indicator, nearly all of which were for an input or output indicator. Very few programs submitted a report describing a needs assessment conducted prior to program implementation. More information is needed for local stakeholders to understand how programs are adequately designed for the context in which they are implemented.

Year One of the *Access Observatory* has been one of development and learning, which has created a strong foundation for future success. Looking forward, there is a need for continued engagement on the part of the pharmaceutical industry as well as global health stakeholders. Companies and their partners should strive to design more effective programs and ensure accountability through transparency. The *Access Observatory* is a first-of-its-kind global platform for measurement and reporting on access programs. In securing an independent academic partner to measure and evaluate the progress of Access Accelerated, company CEOs and the Access Accelerated Secretariat clearly communicated to the global health community that measurement and, most importantly, the transparency of the measurement process are vital in order to share program learnings and be held accountable to their beneficiary populations and local stakeholders.

The *Access Observatory* requires the continued commitment from all sectors to become a global reference for shared learning and accountability.

*The Access Observatory
is a first-of-its-kind global
platform for measurement and
reporting on access programs*

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Foreword

This report presents initial results of a measurement framework and reporting platform developed by a team of researchers at Boston University School of Public Health to monitor and document the work of Access Accelerated. In 2017, members of the biopharmaceutical industry, the World Bank, and the International Union for Cancer Control launched a collective commitment to improve access to treatment for non-communicable diseases (NCDs) in low- and middle-income countries. This commitment — formalized through Access Accelerated — is a welcome development and Boston University is proud to be part of this work.

Starting with the publication of the Millennium Development Goals in 2000, the international community has recognized the importance of for-profit sector contributions to global health and development. There has been, however, relatively little work done to formally evaluate the work being conducted by the private sector toward improving global health.

Historically, pharmaceutical industry-led access programs were met with skepticism by members of the global health community, in no small part due to a lack of transparency of these efforts and the absence of independent measurement of their success. The *Access Observatory* was started to address some of these challenges. Observatories are used to study events from a distance, enabling a view of the big picture and helping to identify patterns that one would not see by looking too narrowly. The *Access Observatory* give us the opportunity for the first time to look across programs and study the contributions of an entire sector to achieving important global development goals. The *Access Observatory* is breaking new ground in several ways.

First, the *Access Observatory* does not accept confidential data and makes transparency one of its core principles. The measurement framework and all program data are publicly available without charge. This is in stark contrast to many existing mechanisms that report on industry access activities, which are often confidential or only available for a fee. Reporting transparently through the *Access Observatory* serves to communicate clearly on the ongoing efforts of the industry, which contributes to accountability.



Sandro Galea

 School of Public Health

Second, the *Access Observatory* is independent from Access Accelerated. Development, implementation and publication of the *Access Observatory* and corresponding tools do not require prior approval by any funder. All agreements between the *Access Observatory* and other entities are publicly available. Other projects at the Boston University School of Public Health and elsewhere have followed this new standard in making their agreements publicly available. The text of those agreements can serve as a blueprint for other similar initiatives.

Third, the *Access Observatory* aims to facilitate shared learning. This collaborative approach is distinct from other platforms that use competition between corporations to incentivize reporting on social programs. The standardized measurement framework allows for comparison and synthesis of program information to identify key lessons which cannot be obtained from a single program. The *Access Observatory* is generating a new body of evidence that should inform improvements to existing programs and the design of new ones. The shared learning approach aligns with the strengths of academic institutions like Boston University; the *Access Observatory* contributes to the core of the mission of our School which is reflected in our theme “Think, Teach, Do”.

Fourth, the measurement framework that forms the foundation of the *Access Observatory* serves as a shared language for understanding and discussing programs. Differences in values, institutional cultures and training paradigms between for-profit corporations and not-for-profit or public institutions often result in communication challenges increasing skepticism about industry-led social programs. Having a shared language lays the groundwork for effective communication and mitigates tensions between different stakeholders.

Year One results show substantial investment by the biopharmaceutical industry in programs that aim to address a variety of NCDs. The fact that these programs work with nearly 200 different partners highlights the need to include these partner organizations in efforts to strengthen rigorous, independent measurement and transparent reporting. The results of the first year’s reporting also bolster the argument for pooling funding to facilitate program measurement and evaluation, since public access to new evidence will benefit all stakeholders.

The *Access Observatory* lays the foundation for understanding how access programs work and whether they achieve their intended goals. This has implications beyond improved access to treatment and prevention of NCDs. The work of the *Access Observatory* sets out a new standard for independent measurement and transparent reporting that other industries such as nutrition and education should follow. Together with many other stakeholders, I am delighted that our School is part of this global effort.

Preface

Access Accelerated represents an important next step in the pharmaceutical industry's approach to and investment in access, including a commitment to measurement and publicly transparent reporting through a joint investment in an independent platform, the *Access Observatory*.

The *Access Observatory* can be a key partner to with industry to realize important access objectives. The publicly available information about the different programs, provided through this platform, can facilitate open and constructive dialogue between the companies, the global health community, including funders like the Bill and Melinda Gates Foundation and other implementing partners. The *Access Observatory* can enable learning between companies about successes and failures, accelerating innovation in program design and illuminate best practices to help companies effectively address local priorities in a sustainable manner.

The global community faces great challenges in expanding access to health care services and essential medicines as part of the drive towards universal health coverage, and coordinated and sustained action is needed. While it is early, Access Accelerated appears to offer the opportunity for more collective investments across companies within the industry as well as with other global health organizations. The *Access Observatory* can help to facilitate these interactions by increasing openness and trust between potential partners.

Much work remains to be done. A long-term view towards affecting change requires the building of a body of evidence around what does and does not work. As Access Accelerated and the *Access Observatory* evolve in the coming years, it will be important to increase investments in rigorous program evaluation. The industry has made a clear commitment to contribute to the achievement of the Sustainable Development Goals; the *Access Observatory* provides a means through which they can share with the public not just what they are doing and how but also with what the impact.

The Bill and Melinda Gates Foundation has made long term investments in measurement and reporting with the dual aims of tracking progress, and fostering learning, and innovation to better address global health challenges. Through the *Access Observatory*, the global health, academic and policy communities have a unique opportunity to work with the pharmaceutical industry to promote robust measurement and transparent reporting of its programs, with the shared goal of increasing access and accelerate progress towards the Sustainable Development goals and the vision that every person deserves to live a healthy and productive life.



Hannah Kettler

*Senior Program Officer,
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Bill & Melinda Gates Foundation*

Background

In 2017, more than 20 global R&D-based biopharmaceutical companies, in partnership with the World Bank and the Union of International Cancer Control (UICC), launched Access Accelerated, an initiative that seeks to reduce barriers to prevention, treatment and care for non-communicable diseases (NCDs) in low- and middle-income countries.

Members of Access Accelerated have committed to measuring their programs and reporting to the global health community. To facilitate these efforts, the *Access Observatory* team designed a new measurement framework, based on public health priorities, that serves as a common language for categorizing, understanding and comparing access programs.

The *Access Observatory* (accessobservatory.org) is an online public repository of information on access programs, structured according to the measurement framework.

Access to Prevention and Treatment Services for Non-Communicable Diseases

In 2015, the United Nations published the Sustainable Development Goals (SDGs), which include Goal 3.4 focused on reducing premature mortality from non-communicable diseases (NCDs) by one-third by 2030.¹ Over the last decade, the growing global burden of NCDs has brought increased attention to challenges faced in low- and middle-income countries in accessing affordable prevention and treatment services.² In many countries, a large proportion of NCDs have not been diagnosed. Patients who have been diagnosed face affordability and availability barriers that prevent them from accessing needed treatments.³ Treatments that are accessible are often of poor quality. The chronic nature of NCDs and the need to maintain treatment regimens over a long time period make addressing access barriers particularly important. A multi-faceted set of solutions is required to address the complex and varied causes of poor access to NCD prevention and treatment services. Implementation of solutions often requires partnerships between multiple actors, including governments, civil society, and the private sector.

The Role of the Pharmaceutical Industry in Improving Access

The United Nations has recognized the critical role of the private for-profit sector in achieving global goals, first with the Millennium Development Goals and more recently with the SDGs.⁴ The pharmaceutical industry has a special role as their products have a direct impact on health and wellbeing of populations globally.⁵ While social programs led by for-profit companies including the pharmaceutical industry appear to be increasing in number, little is currently known about their overall scope and impact. The lack of measurement and reporting on these programs is a missed opportunity to demonstrate private sector contributions to key social goals and also to generate learnings on effective strategies and best practices.

While social programs led by for-profit companies including the pharmaceutical industry appear to be increasing in number, not enough is known about their overall scope and impact.

Importance of Measurement and Reporting

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

The Access Accelerated Secretariat asked Boston University (BU) to independently develop a measurement framework for access programs and to support transparent program reporting.

CEOs of the biopharmaceutical industry have confirmed their commitment to partnering with other actors to achieve the SDGs.⁶ Over the past decades, the level of engagement and number of pharmaceutical industry-led access programs targeting the needs of low- and middle-income countries has increased substantially.⁷ However, for most of these programs, detailed information on activities and achievements has either not been collected or has not been made publicly available, making it difficult to assess whether program expansion will translate into stronger health systems, increased patient access, and improved population health.

Access Accelerated

In 2017, more than 20 global R&D-based biopharmaceutical companies, in partnership with the World Bank and the Union of International Cancer Control (UICC), launched Access Accelerated, an initiative that seeks to reduce barriers to prevention, treatment and care for NCDs in low- and middle-income countries.⁸ From the beginning, members of Access Accelerated committed to measuring their programs and reporting to the global health community. However, at the launch of Access Accelerated there were no standard publicly available performance assessment tools for access programs. For this reason, the Access Accelerated Secretariat asked Boston University (BU) to independently develop a measurement framework for access programs and to support program reporting. The agreement between the Access Accelerated Secretariat and Boston University is available for public review at accessobservatory.org/funding.

Measurement Framework

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

The framework includes three main components:

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

Figure 1: Principles Guiding Development of the Measurement Framework and Access Observatory

Independence from Industry



- The measurement framework was designed with independence from the pharmaceutical industry. Representatives from Access Accelerated partners were consulted to ensure usability. All final decisions were made by the Access Observatory team members.
- Analysis and interpretation of program information included in the Access Observatory, including that presented in this report, is done with total independence.

Transparency to the Public



- All information submitted to the Access Observatory is publicly available. No confidential information is accepted.
- Programs must provide clear documentation of data sources and processes.
- Legal contracts have been made public, including clauses governing data transparency, and are available at accessobservatory.org/funding

Methodological Rigor



- The measurement framework was constructed according to a standard “theory of change” approach with a series of logic models that outline pathways to potential program impact.
- The measurement framework includes a standard set of indicators selected from existing and validated public health instruments.
- Submissions to the Access Observatory undergo a thorough review process to ensure completeness, clarity, and consistency within and across programs

Prioritization of Public Health Goals



- The measurement framework is centered around the WHO’s goals of a health system: population health, financial risk protection, and responsiveness⁹.
- Logic models and accompanying indicators were designed to align with the SDGs.
- Programs are asked to describe factors considered during the design process (e.g., alignment with local needs) in accordance with WHO recommendations.

Taxonomy of Strategies

In accordance with our principle of prioritizing public health goals, we derived the structure of the taxonomy from existing access and health systems frameworks published by the WHO and other leading public health experts.^{10,11,12} A preliminary list of strategies was tested and refined by applying it to a variety of existing industry-led access programs found in the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) Partnerships Directory.¹³ In addition, we tested the taxonomy's relevance and comprehensiveness during a set of consultative workshops with Access Accelerated member companies in Tokyo, Geneva and New York.

The taxonomy is organized into four broad strategy categories: community strategies; health system strategies; medicine production strategies; and medicine price strategies. Many pharmaceutical company-led programs do not exclusively focus on access to medicines. Many programs take a broader approach and address a variety of access barriers. Each of the 11 strategies fits within one of these four broader categories. The taxonomy of strategies helps to categorize programs and effectively demonstrate where efforts are being focused. Oftentimes a single program may encompass one or more of these strategies.

Table 1: Taxonomy of Strategies: Categories and Strategies

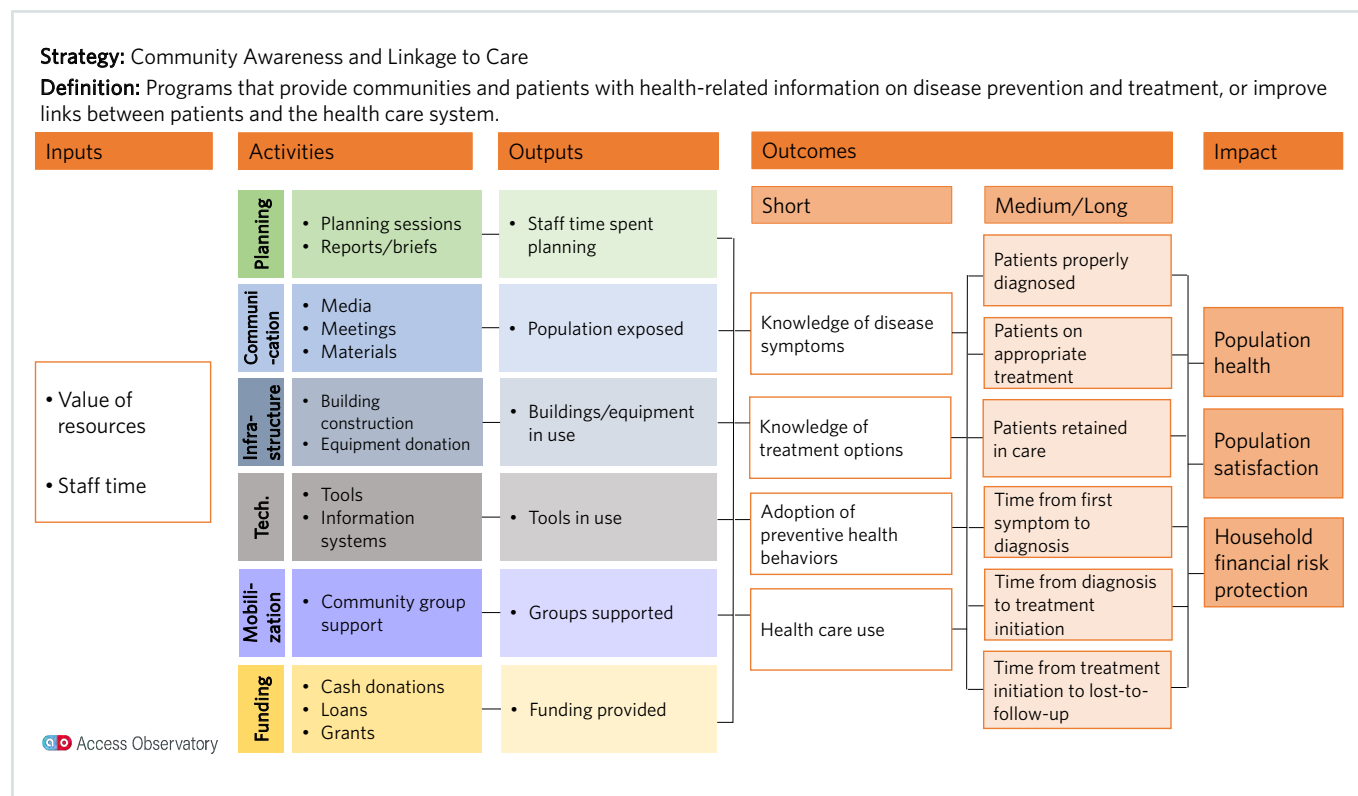
Strategy Category	Strategy
Community Strategy <i>Strategies with a primary focus on communities and community organizations, with a particular focus on patients</i>	Community Awareness and Linkage to Care
Systems Strategy <i>Strategies with a primary focus on aspects of the health system that affect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

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

Logic Models

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

Figure 2: Example of a Logic Model



Indicators

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

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

Item	Description
Indicator Name	<i>Population exposed to community communication activities</i>
Indicator Type	Output
Strategies that Use Indicator	Community awareness and linkage to care
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
Recommended Disaggregation	Disease, intervention type, target audience
Frequency of Reporting	Annually unless otherwise stated
Recommended Data Source	Routine program data Non-routine program data (e.g. target audience survey) Community-based awareness events
Further Info	knightfoundation.org/media/uploads/publication_pdfs/Impact-a-guide-to-Evaluating-Community-Info-Projects.pdf Page 9-11

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

Access Observatory

The *Access Observatory* is an online public repository of information on access programs, structured according to the measurement framework.

With transparency as a core principle, all data reported into the *Access Observatory* is publicly available; confidential data is not accepted.

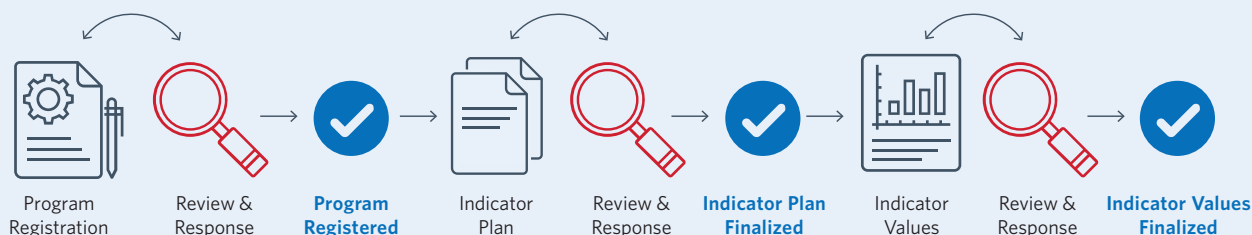
The *Access Observatory* is a reporting mechanism for Access Accelerated programs, though it is open to all access programs, including those designed and implemented by public and non-profit organizations.

Overview of Submission and Review Process

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

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

Figure 3: Reporting and Review Process for the Access Observatory



Program Registration

Programs first complete the Program Registration which captures key descriptors, including overall program goals, diseases addressed, target population, and the strategy or strategies employed (based on the Taxonomy of Strategies). The Program Registration also asks about program alignment with local regulations, health priorities, responsibilities of program partners and program sustainability. For example, sections of the form solicit information on the local health needs that the program aims to address, and whether medicines included in the program are part of national reimbursement lists. These elements are aligned with the WHO checklist recently developed for assessing industry-led access programs.¹⁴

Indicator Plan

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

Indicator Values

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

Table 3: Access Observatory Reporting Components

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

Public Access to Program Information

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



The screenshot shows the homepage of the Access Observatory website. At the top, there is a navigation bar with the logo (a blue square with a white 'a' and a red circle with a white 'o') followed by the text 'Access Observatory'. To the right of the logo are three links: 'About', 'Program Reports', and 'Full Dataset'. Below the navigation bar is a large banner image of a lighthouse on a rocky shore. Overlaid on the right side of the banner is the text 'Public reporting on efforts to improve access to medicines globally' in white, with a 'Learn more' button below it. Below the banner, the page is divided into two columns. The left column is titled 'The Access Observatory is currently reporting on' and lists three statistics: '63 programs' (with a book icon), '103 countries' (with a globe icon), and '17 companies' (with a building icon). The right column is titled 'View the list of programs and download the full set of program information' and contains two buttons: 'Program Reports' and 'Full Dataset'. Below the 'Program Reports' button is a paragraph: 'Program Reports provide a description of each program, including country of operation, focus disease, access strategies and activities, and target populations.' Below the 'Full Dataset' button is a paragraph: 'The Full Dataset allows the download of information from all programs in a single spreadsheet for easier review.' At the bottom of the page, there is a footer with the logo and text 'Access Observatory' on the left, and a 'Contact us' button on the right. Below the logo and text is the address: '801 Massachusetts Avenue, Third Floor, Boston, MA 02118'.

Access Observatory

About Program Reports Full Dataset

Public reporting on efforts to improve access to medicines globally

Learn more

The Access Observatory is currently reporting on

- 63 programs
- 103 countries
- 17 companies

View the list of programs and download the full set of program information

Program Reports

Program Reports provide a description of each program, including country of operation, focus disease, access strategies and activities, and target populations.

Full Dataset

The Full Dataset allows the download of information from all programs in a single spreadsheet for easier review.

Access Observatory

801 Massachusetts Avenue, Third Floor, Boston, MA 02118

Contact us

Results from Year One

In Year One, 62 Access Accelerated programs operating in 103 countries were registered in the *Access Observatory*.

Programs were geographically clustered in sub-Saharan Africa and Southeast Asia. A majority of programs used a few common strategies: community activities that aimed to increase awareness of disease symptoms and treatment options; health service strengthening activities, most notably health provider training courses; and direct health service delivery. Two-thirds of programs addressed cancer, while diabetes and cardiovascular disease were also the focus of a number programs.

Across the 62 programs, there were 198 partnerships between companies and other organizations; two-thirds of programs having at least one public sector partner. More than half of programs aimed to address income-related inequity.

With respect to measurement, one-third of programs submitted at least one 2017 value for a program indicator, nearly all of which were for an input or output indicator. Very few programs submitted a report describing a needs assessment conducted prior to program implementation. More information is needed for local stakeholders to understand how programs are adequately designed for the context in which they are implemented.

Program Overview

In 2017, Year One of the *Access Observatory*, 62 programs completed a Program Registration. Of these, 30 finalized an Indicator Plan and 23 submitted Indicator Values. Programs are still working to submit Indicator Values for Year One, all of which will be published in late 2018 as an addendum to this report. Program Registrations are rich with valuable information, and are the primary focus of the following analysis.

Figure 4: Number of Programs in the Access Observatory



*Two programs did not submit 2017 data. Updated through May 2018.

Program Geography

Sixty-two registered programs were implemented in 103 countries. The majority were single country initiatives; 19 (30.7%) were implemented in multiple countries. Programs cluster in certain geographic regions, in particular Sub-Saharan Africa and Asia. Furthermore, there are countries with a very high number of programs; for example one third of all programs include Kenya as an implementation country. While the reasons for geographic clustering are not entirely clear, historical relationships between countries and politics may play an important role, e.g., ministries of health in certain countries may be more receptive to working with for-profit private sector partners. The countries with the highest number of programs are not necessarily the countries with the highest NCD mortality or burden.










Key Findings

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

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

Countries with the highest number of programs are not necessarily those with the highest NCD mortality or burden.

Table 5: Countries with the Most Programs and the Non-Communicable Disease (NCD) Mortality and Burden

Country	Number of programs	Total NCD deaths (2016)	NCD death rate/100,000	NCD DALY* 2016	NCD DALY* rate/100,000
 Kenya	20	75,435	162	4,981,014	10,695
 India	11	6,053,648	460	258,525,524	19,644
 South Africa	11	221,836	421	9,864,029	18,699
 Ethiopia	10	294,790	288	14,346,659	14,021
 Tanzania	9	140,546	258	7,302,472	13,396
 Ghana	7	83,314	295	4,388,685	15,542
 Uganda	7	88,030	218	5,031,556	12,458
 Indonesia	6	1,127,544	437	48,782,514	18,914
 Senegal	6	42,755	277	2,343,835	15,167
 Sierra Leone	6	19,591	296	1201093	18,136
 Madagascar	5	82,181	330	4,154,760	16,659
 Malawi	5	48,240	269	2,559,435	14,262

*DALY = Disability adjust life years.

Note: The full list of programs and number of programs in each country can be found in Appendix 1 and 2 respectively.

Source: Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2016 (GBD 2016) Results. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2017. Available from <http://ghdx.healthdata.org/gbd-results-tool>.

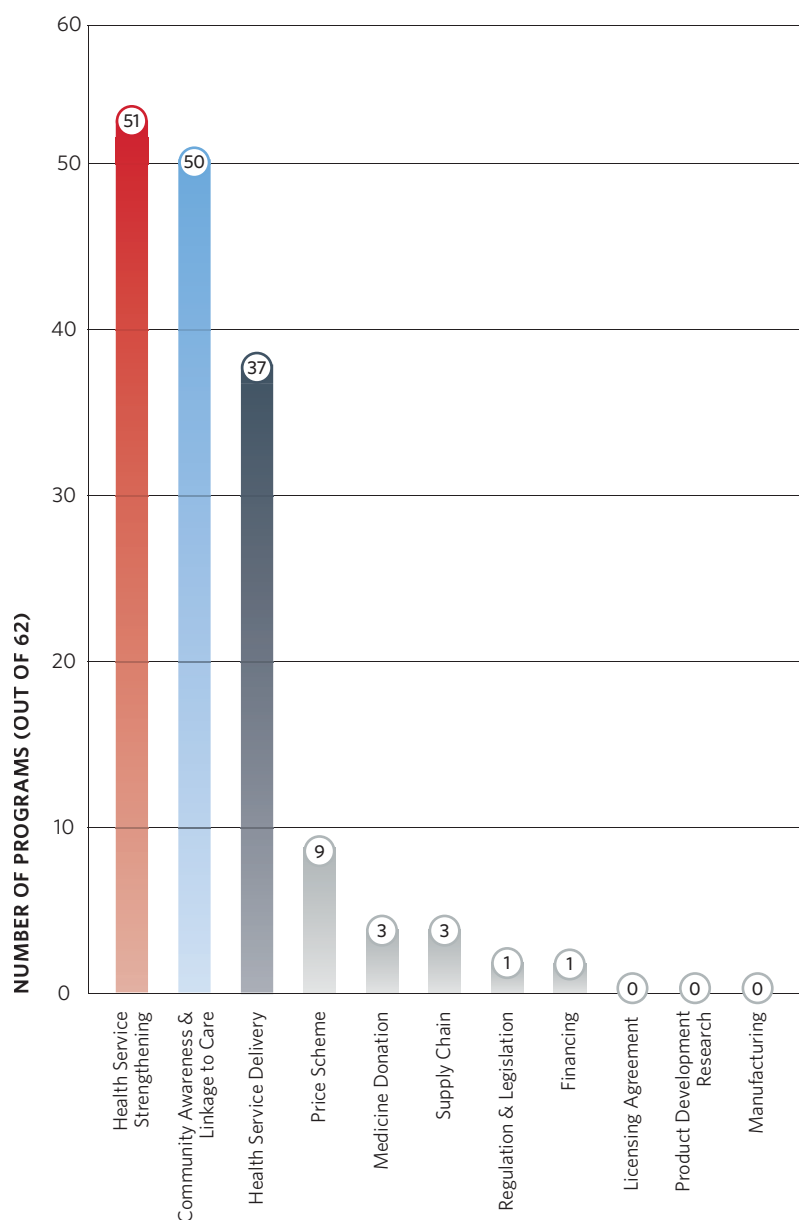
Program Strategies and Activities

In order to more easily describe and compare programs, each program self-identified which one or more of the 11 strategies that it used. Most programs selected between two and three strategies, and analysis found that nearly all of the 62 programs fall into just three strategies: Community Awareness and Linkage to Care, Health Service Strengthening, and Health Service Delivery. Bearing in mind the capacity and expertise of R&D biopharmaceutical companies it is surprising that only a few or none of the reported programs address regulation and legislation, financing, licensing agreement, product development research and manufacturing.

Key Finding

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

Figure 5: Number of Programs by Strategy

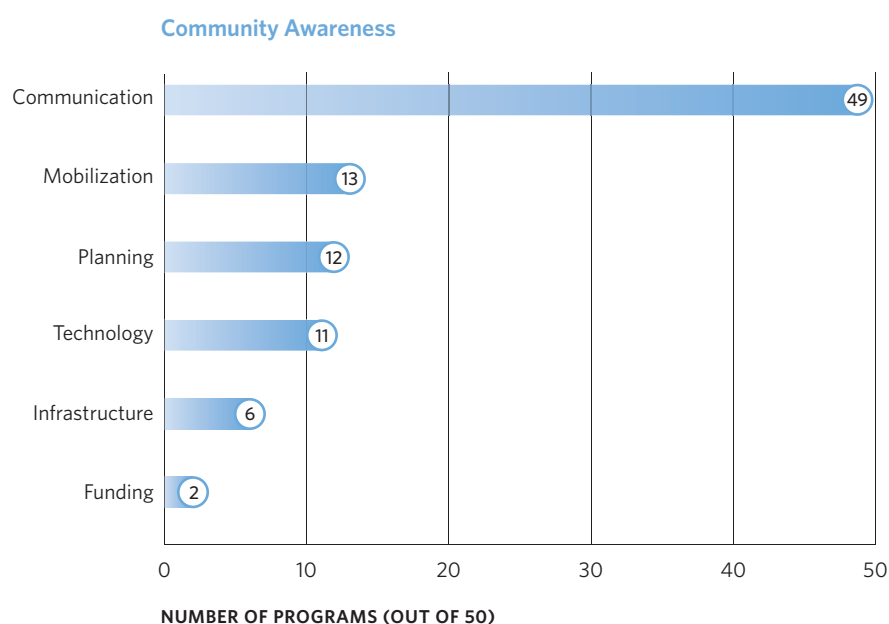


Key Finding

A large number of programs included community meeting activities designed to increase awareness of disease and treatment options.

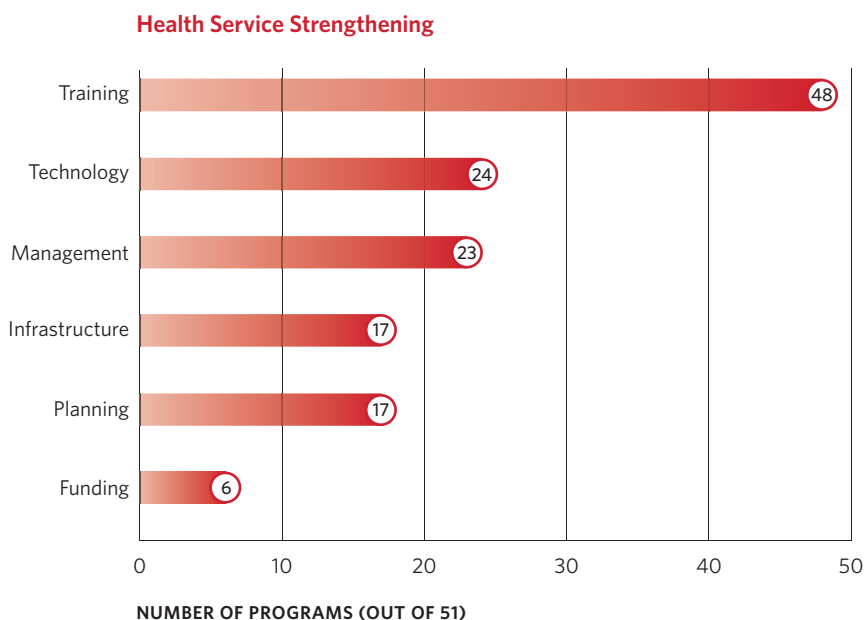
Among programs that used the Community Awareness and Linkage to Care strategy, nearly all informed communities about NCDs through media and community awareness meetings (98%). A smaller number supported community or patient groups (26%), or developed disease education software and websites (22%). Community meetings and outreaches were the most frequently used media of communication (76%), followed by print media such as fliers and posters (32%), internet media such as twitter and websites (22%), and broadcast media such as radio and television (8%).

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



Among programs that used the Health Service Strengthening strategy, nearly all trained health care providers (94%). A smaller number developed treatment and referral protocols (45%), provided technologies such as electronic medical records, screening and diagnostic decision apps (47%) or donated buildings and diagnostic equipment (33%). Most trainings were in-person (90%) while a few were online (10%). A majority of the trainings were for health professionals including doctors, nurses, and pharmacists (73%), followed by community health workers (21%), and health care administrators (15%).

Figure 7: Activities for Programs that Used Health Service Strengthening

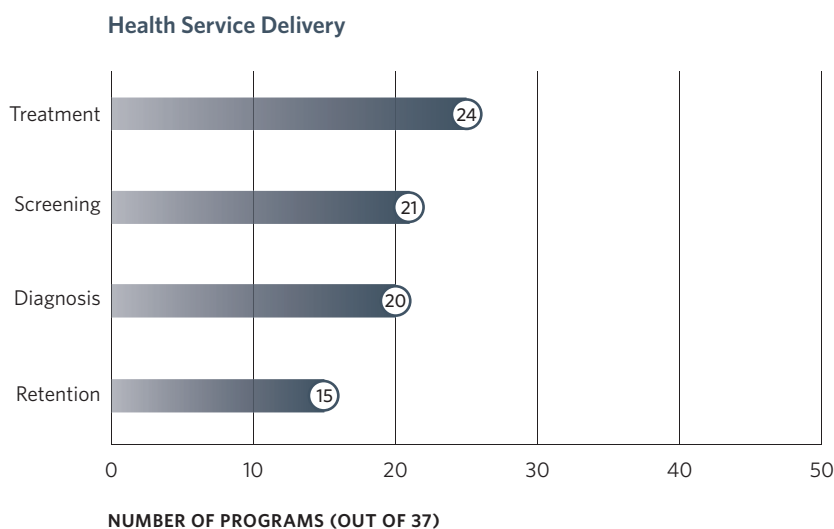


Key Finding

A large number of programs included health worker training activities.

Among programs that used the Health Service Delivery strategy — programs designed to deliver health service directly to patients — a majority conducted screenings (57%), provided diagnosis (54%), or provided treatment of NCDs (68%). Several programs promoted patient retention in care through phone calls and text message reminders (42%).

Figure 8: Activities for Programs that Used Health Service Delivery



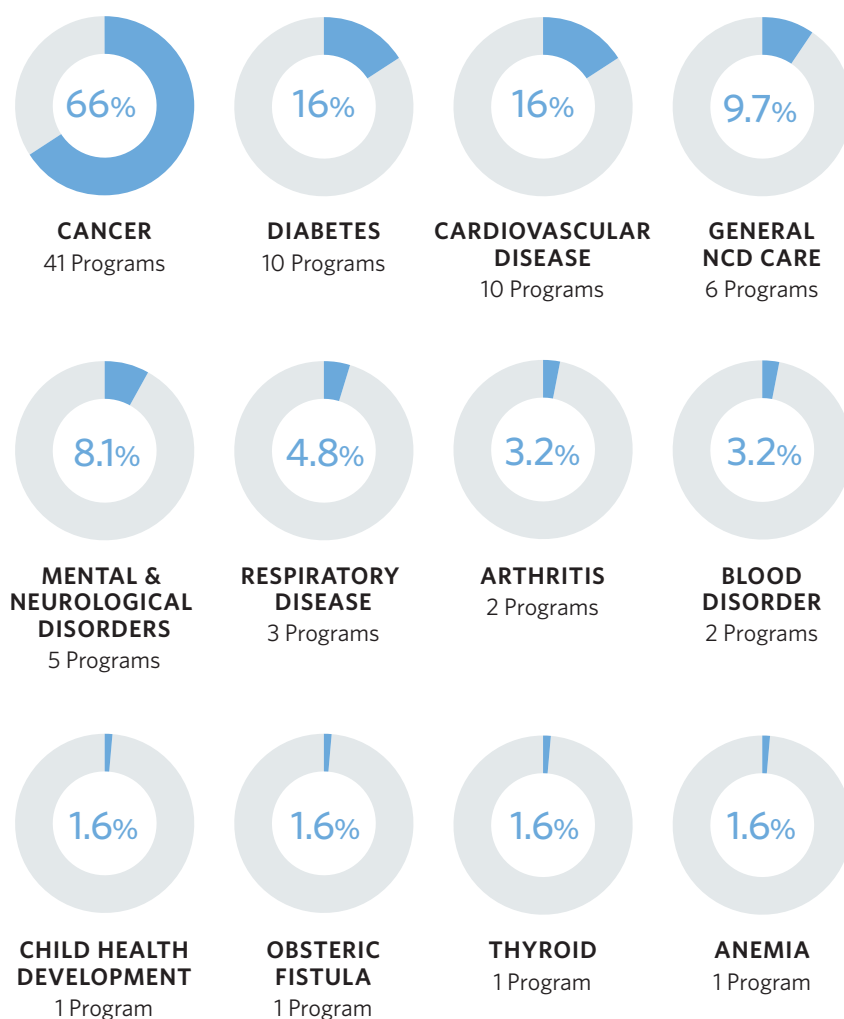
Key Finding

A majority of programs focused on cancer.

Disease Scope

Programs were mainly focused on improving access to cancer care (especially breast, cervical, lung and childhood cancers) (66%), diabetes (16%), and cardiovascular disease (16%). A possible reason for the large number of programs focused on cancer was the decision of Access Accelerated to set up partnerships with organizations specializing in major NCDs, starting with cancer.

Figure 9: Number of Programs by Disease



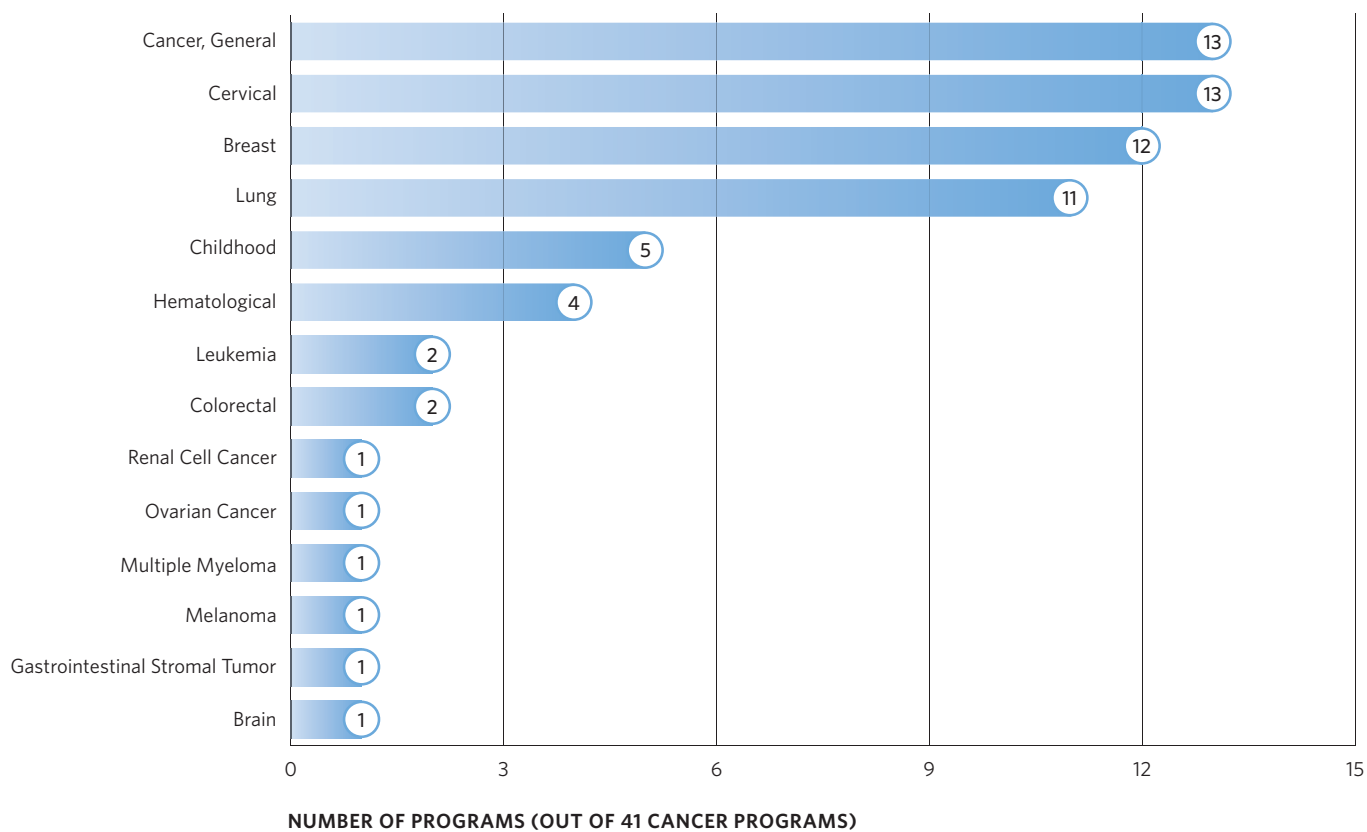
*Some programs target more than one disease.

Out of the 41 cancer programs 31.7% focus on cervical, 29.3% on breast and 26.8% on lung cancer followed by 12.2% childhood cancer and 9.8% on hematological cancer. Globally, lung, breast and colorectal cancer are the most common cancers.

Key Finding

Of the cancer programs, most aimed to address cervical, breast or lung cancer.

Figure 10: Number of Programs by Cancer Type



Key Findings

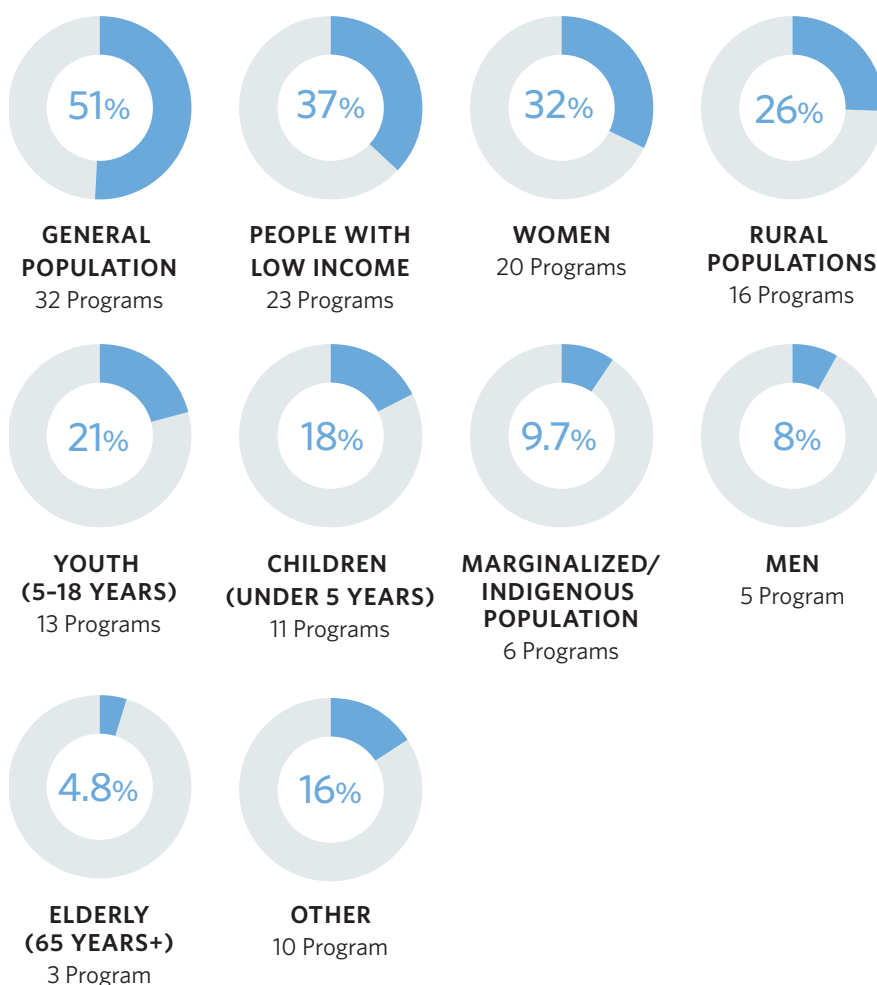
Programs targeted a wide range of beneficiary populations, including children and adults, men and women, and urban and rural residents.

Many programs targeted vulnerable populations, including people with low income, children, women, rural population and marginalized/indigenous population.

Beneficiary Population

Program beneficiary populations ranged from adults to children, men to women, and urban to rural residents. Many of the programs targeted vulnerable populations which we define as people with low income, children, women, rural population and marginalized/indigenous populations. Marginalized people were defined as populations that are especially vulnerable in protracted conflict situations. Specifically, 37% targeted low income populations, 32% women, 26% rural populations, 18% children, and 10% marginalized/indigenous populations. The choice of beneficiary populations reflects the Access Accelerated objective to improve access to NCD care and treatment for people living in low- and middle-income countries.

Figure 11: Number of Programs by Beneficiary Population



Some programs had more than one beneficiary population.

Medicines and Technology

Twenty of the 62 programs (32%) provided at least one health technology, and five provided multiple health technologies. About 18% provided medicines, 13% medical devices including diagnostic equipment for cancer and prosthesis and 10% vaccines.

A total of 11 programs included medicines and 5 programs included vaccines. The majority of these medicines were delivered via a price scheme; only a minority of medicines were delivered as donation or through a service delivery strategy. Most of the medicines are used to treat or prevent cancer.

Table 6: Health Technology by Type and Name

Type of Health Technology	Name of Technology	Number of Programs
Medicine	Oncology Medicines	8
	Diabetes Medicines	3
	Hypertension Medicines	3
	Respiratory Disease Medicines	2
Vaccine	HPV vaccine	5
	Childhood vaccines*	1
Medical Device	Cancer Diagnostic Equipment	3
	Hypertension and Diabetes Diagnostic Equipment	1
	Ocular Prosthesis	1
	Android based clinical decision support system platform	1
	Cryotherapy equipment	1
	Fistula treatment equipment	1

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

Note: Some programs provide more than one health technology

Key Findings

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

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

Table 7: Medicines Included in Programs by Therapeutic Group

Key Finding

Most programs that provided cancer medicines were for a limited number of cancers.

Key Finding

Most non-cancer medicines were provided in a broad NCD access program.

Main Therapeutic Group (number of programs)	International Non-Proprietary Name	Number of Programs
Oncology (8)	Alectinib	1
	Anastrozole	1
	Bentruximab vedotin	1
	Bevacizumab	2
	Erlotinib	1
	Capacitabine	1
	Imatinib	1
	Letrozole	1
	Obinutuzumab	1
	Pertuzumab	2
	Rituximab	2
	Tamoxifen	1
	Trastuzumab	3
	Human Papilloma virus vaccine	5
Cardiovascular medicines (3)	Amlodipine	1
	Bisoprolol	1
	Furosemide	1
	Hydrochlorothiazide	1
	Ramipril	1
	Simvastatin	1
	Valsartan	1
Diabetes (3)	Glimeperide	1
	Metformin	1
	Vildagliptin	1
Asthma (2)	Salbutamol	1

Four company programs did not specified the medicines that the programs provide.

Partnerships and Stakeholders

The total number of implementing partners identified across all 62 programs was 198. Seventy-three percent of the programs work with at least one civil society or voluntary sector partner and 66% with at least one public sector partner including 42% of programs working directly with the Ministry of Health. About 34% of programs work directly with hospitals and only 26% with academic partners. The voluntary and public sector partners including hospitals and universities are involved in raising awareness about NCDs, strengthening health service delivery through training of health care professionals, provision of infrastructure and technology and direct health service delivery including screening, diagnosis and treatment of NCDs.

Key Findings

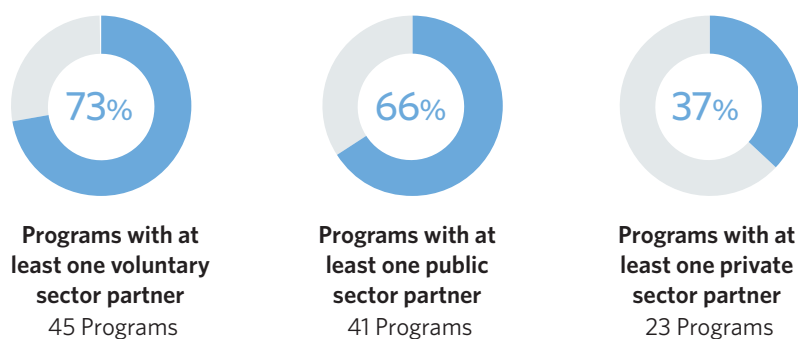
Nearly every program reported working with a funding or an implementing partner.

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

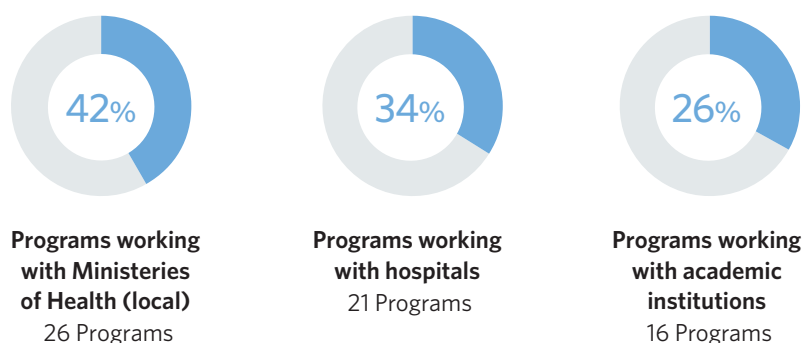
A majority of programs engaged with the government as a local stakeholder.

Figure 12: Number of Programs by Funding and Implementing Partners Sector

Programs By Sector



Programs By Institutions



61

Programs with at least one partner

198

Total number of partners

3.2

Average number of partners per program

Key Findings

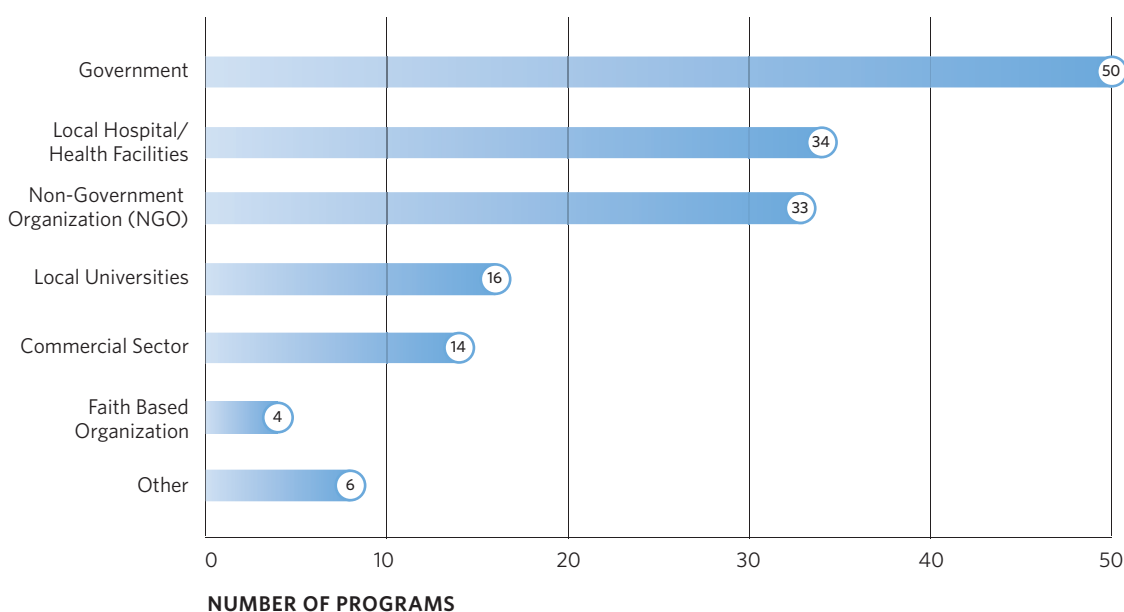
Only one program was reported as a formal multi-company collaboration.

Most programs report engaged with local stakeholders.

Four multi-company programs were registered, of which only one reported a formal collaboration among the participating biopharmaceutical companies and a voluntary sector partner. The others were programs independently supported by different biopharmaceutical companies without any formal collaboration among the companies.

Apart from the implementing and funding partners that companies directly work with, most of the programs also reported different types and levels of engagement with local stakeholders. Most of the programs engaged with the government (81%), about 55% engaged with local hospitals and 53% engaged with local non-governmental organizations.

Figure 13: Number of Programs by Local Stakeholders



Note: The full list of funding and implementing partners reported by programs can be found in Appendix 4.

Program Alignment with Local Priorities

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

Table 8: Program Response to Local Priorities

Local Priority Issue	Number of programs that answered the question* (%)
Local policies, practices and laws were considered during program design (A)	62 (100%)
Program is responsive to local health needs and challenges (B)	61 (98.4%)
Local stakeholders engaged in planning and/or implementation of program (C)	59 (95.2%)
Program planned for sustainability of implementation (D)	49 (79.0%)
Program meets or exceeds local standards (E)	30 (48.4%)
Program that provided a needs assessment report (F)	5 (8.1%)

*The following questions were asked: (A) How have local policies, practices, and laws (e.g. infrastructure development regulations, education requirements, etc.) been taken into consideration when designing the program?; (B) 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)?; (C) Please describe how you have engaged with any of these local stakeholders in the planning and/or implementation of this program; (D) If applicable, please describe how you have planned for sustainability of the implementation of your program; (E) Is there anything else that you would like to report on how your program meets or exceeds local standards?; (F) If available, please attach any needs assessment report (including peer-review publication) upon which the design of your program was based/informed.

Key Findings

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

Few programs provided a needs assessment report.

The most common sustainability strategies reported by programs include:

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

Twenty nine programs (47%) did not have a specified program closing date which potentially means a long-term commitment of the companies to continue to implement the programs. Less than half of the programs described how they meet or exceed local standards and few provided a needs assessment report.

Addressing Social Inequity

In its Commitment Letter, Access Accelerated very clearly states its goal of addressing a key aspect of social inequity — lack of “access to appropriate, quality and affordable prevention, treatments and care⁸.” One question in the *Access Observatory* Program Registration specifically inquires about how the program is addressing social inequity.

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

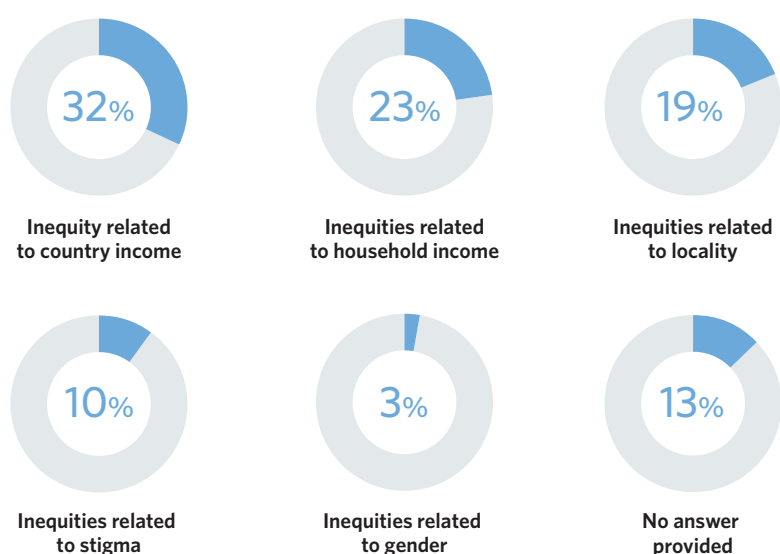
While it is commendable that companies are implementing nationwide programs that address social inequities between low and high income countries, development of future programs, including future nationwide programs, should also take into account the local inequities that exist within the countries.

Key Findings

More than half of programs aimed to address income-related inequity.

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

Figure 14: Number of Programs by Type of Social Inequity Addressed



Key Findings

One-third of programs submitted at least one 2017 Indicator Value.

Nearly all 2017 Indicator Values submitted were for input or output indicators, with very few submitting for an outcome indicator and none for an impact indicator.

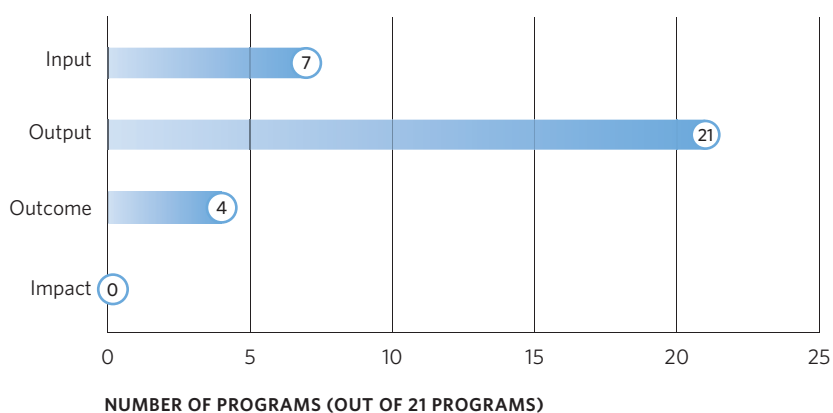
Program Indicators

In total, 21 programs submitted at least one 2017 Indicator Value. Of these, seven (33.3%) submitted for input indicators and 21 (100%) submitted for output indicators. Four programs (19%) submitted for outcome indicators and none submitted for impact indicators.

Figure 15: Access Observatory Program Indicators



Figure 16: 2017 Number of Programs by Type of 2017 Indicator Value Submitted



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

Table 9: Common Submitted Indicator Values

Indicator	Type of Indicator	Number of Programs
Number of people trained	Output	13 (61.9%)
Population exposed to community communication activities	Output	11 (52.4%)
Value of resources	Input	6 (28.6%)
Staff time	Input	5 (23.8%)
Community groups supported	Output	4 (19%)
Communication materials in use supported	Output	3 (14.3%)
Health provider knowledge	Outcome	3 (14.3%)
Number of patients reached with pricing scheme	Output	3 (14.3%)
Population screened	Output	3 (14.3%)
Building/Equipment in use	Output	2 (9.5%)
New patients diagnosed	Output	2 (9.5%)
Number of patients enrolled in patient support program	Output	2 (9.5%)
Number of patients on treatment	Output	2 (9.5%)
Number of users receiving tools	Output	2 (9.5%)
Professionals trained out of total number targeted	Output	2 (9.5%)
Sites in Use	Output	2 (9.5%)

There were 32 other unique indicators such as “communication materials developed” and “number of patients retained in care” that were reported by only one program

Looking Forward

Year One of the *Access Observatory* has been one of development and learning which has created a strong foundation for future success.

Looking forward, there is a need for continued engagement on the part of the pharmaceutical industry as well as global health stakeholders. Companies should strive to design more effective programs and ensure accountability through transparency.

The *Access Observatory* is a first-of-its-kind global platform for measurement and reporting on access programs. In securing an independent academic partner to measure and evaluate the progress of Access Accelerated, company CEOs and the Access Accelerated Secretariat clearly communicated to the global health community that measurement and, most importantly, the transparency of the measurement process are vital in order to share program learnings and be held accountable to their beneficiary populations and local stakeholders.

The *Access Observatory* requires the continued commitment from all sectors to become a global reference for shared learning and accountability.

Increasing Engagement

This report details a first-of-its-kind effort to measure and report on the biopharmaceutical industry's contributions to the prevention and treatment of NCDs globally. During Year One, 62 company programs were reported into the *Access Observatory*, illustrating the substantial investment and variety of activities that biopharmaceutical companies are carrying out in low- and middle-income countries.

Year One of the *Access Observatory* has been one of development and learning which has created a strong foundation for future success. It has provided insights on how to strengthen and expand our approach. Much has been accomplished in Year One which serves as a foundation for a substantive, long-term shift in how the pharmaceutical industry, their implementing partners, non-governmental organizations, governments, and the global health community report and assess the impact of access programs. The *Access Observatory* can play a critical role in supporting these efforts.

All sectors must engage if the large social goals outlined in the SDGs are to be achieved. Private sector companies have a key role to play in the global health sphere going forward. Access Accelerated is a commitment by the biopharmaceutical industry to the type of cross-sectoral engagement that is needed. Of recent note, on January 16, 2018, Larry Fink, CEO, BlackRock, the world's largest financial asset management company, sent his annual letter to CEO's emphasizing the social purpose of a business, signaling that companies have a responsibility to shareholders not simply around profit but also positive contributions to society¹⁵. Following this new charge to deliver on "societal purpose" there will be a need to properly measure and demonstrate social impact. *Access Observatory* is a potential model for how corporate businesses can develop a more rigorous approach to measurement and reporting, to be more publicly accountable for their contributions to society. For Access Accelerated, continued engagement by companies and their partners in reporting into the *Access Observatory* will yield additional data and insight on program contributions to the SDGs.

Year One serves as a foundation for a substantive, long-term shift in how the pharmaceutical industry and other stakeholders report and assess the impact of access programs. The Access Observatory can play a critical role in supporting these efforts.

"Society increasingly is turning to the private sector and asking that companies respond to broader societal challenges. Indeed, the public expectations of your company have never been greater. Society is demanding that companies, both public and private, serve a social purpose. To prosper over time, every company must not only deliver financial performance, but also show how it makes a positive contribution to society."

LARRY FINK
CEO, BLACKROCK, JANUARY 2018

This first-of-its-kind effort may well set the standard for how all pharmaceutical companies will share and report on their access programs in the future, but its success will be based in large part on the commitment of all partners going forward.

Implementing partners have a key role in supporting program measurement and reporting.

Building Trust

A key theme of Year One for the *Access Observatory* was trust. Building trust was and will continue to be essential to the success of the *Access Observatory*. While transparency by the pharmaceutical industry on their access programs helps build trust with the global health sector and local partners, pharmaceutical companies must also trust that the global health community and partners will use program information for the betterment of society and not for the sole purpose of being critical of these efforts. Trust must be built at multiple levels and between many groups.

The strength of the *Access Observatory* comes from its independence and transparency in sharing with the global community the methods and data that access programs are using and collecting to report their progress and impact. Continued support and tailored advising from the *Access Observatory* team will assist companies in their efforts to strengthen their measurement efforts and transparently communicate how information will be shared. Substantial human and financial resources have been devoted this past year in reporting the 62 programs to the *Access Observatory*. There will need to be continued commitment internally in each company in terms of resources and policies, along with commitments from industry CEOs to hold their programs accountable for their societal goals. This first-of-its-kind effort may well set the standard for how all pharmaceutical companies will share and report on their access programs in the future, but its success will be based in large part on the commitment of all partners going forward.

Working with Implementing Partners

The collaboration with implementing partners is a key finding of Year One. Implementing partners have contributed substantially to the Year One reporting of programs. Better reporting of programs requires the involvement of implementing partners in planning prior to the inception of the program. Best practices on reporting should be shared to improve standards in the medium- and long-term. Throughout the submission process, a few companies expressed challenges and submission delays related to what data they could and could not share from their implementing partners. These difficulties reveal that complex and sensitive contractual agreements exist between the companies and partners on what information was able to be shared publicly.

The Access Accelerated team provided companies with language to share with their partners on how data submitted would be shared and used to assuage concerns about abilities to publish after public release of data. A real opportunity exists in Year Two to work with companies and their partners to clarify contractual data-sharing agreements well ahead of reporting deadlines. Clearly, for future projects companies need to agree with their implementing partners about what data will be collected and shared. The *Access Observatory* does not accept any confidential data or requests for conversations to be confidential as this would be against the principles of its work. Companies have agreed to navigate their own systems and processes with the goal in mind to openly share information and data within the confines of their existing procedures and regulations.

Increasing Collection of Outcome and Impact Indicator Values

In order to improve program effectiveness, assessment of program achievements compared to program goals is critical. Currently, most program teams have the capacity and resources to collect and submit information on input and output indicators, but less often for outcome and impact indicators. This limits the questions that can be answered about program effectiveness. We hope, however, that the framework will clarify the need for evidence and will contribute to the prioritization of evaluations in the future that would allow attributing the outcomes and impact to the program intervention. Many existing access programs pursue similar strategies, and pooling resources across programs may make it easier to conduct resource intensive evaluations. In addition, the development of new methodologies that balance rigor with practicality and less costly data collection could produce increased opportunities for efficient evaluation of program outcomes and impacts¹⁶. The framework creates a shared language that should help in identifying potential synergies and opportunities across programs.

Currently, most program teams have the capacity and resources to collect and submit information on input and output indicators, but less often for outcome and impact indicators which limits the questions that can be answered about program effectiveness.

Improving Program Design

We suggest four key considerations for improving the design of access programs:

Choice of strategies should be informed by company expertise

In the past, pharmaceutical companies have often donated medicines for acute diseases that could be eradicated. However, donations are not likely to be a sustainable strategy for preventing and treating most NCDs, and company programs are clearly broader than donations. Instead, many companies have focused on improving community awareness and strengthening health systems. However, many global health organizations are also operating similar programs, which raises the question of whether the industry's resources are best used in these areas. The competitive advantage of the pharmaceutical industry compared to governments and NGOs is their expertise in manufacturing, licensing and pricing of their products. Technical know-how about manufacturing, licensing of products and pricing schemes by pharmaceutical companies can make important contributions to addressing affordability and availability, two key barriers to access to NCD treatment and prevention. While a variety of strategies are needed and companies should select the approach they feel is most appropriate, their particular expertise should inform the choice of strategies.

Choice of country should be informed by need

Clustering of programs in countries which do not have the highest NCD mortality or burden can result in further increasing global inequities. Many considerations influence which countries are selected for program implementation. Future programs should be more focused on countries with a high burden of NCD and a lack of countries' own resources for NCD investment.

A local needs assessment should precede program rollout

Needs assessments, common in the global health sector, provide a nuanced understanding of the health needs in a country or local community. They clarify how companies are planning to address need in a community with the input of local stakeholders. Needs assessments can take a variety of forms ranging from desk-based landscape analysis and epidemiological data analysis to more intensive community surveys and original epidemiological research. All programs should conduct a local needs assessment before rolling their program out in a new setting. This local needs assessment should include the analysis of local inequities that affect access to treatment and prevention. They should also make their needs assessment available to the public for transparency purposes.

Sustainability should be considered from the start

Ensuring sustainability requires more documentation. Currently, reporting on how the program is sustainable after it ends is insufficient to share best practices. Sustainability of pharmaceutical-led programs is a key concern of communities and governments which need to be addressed.

All programs should conduct a local needs assessment before rolling their program out in a new setting and make it publicly available.

Refining the Measurement Framework

The measurement framework was designed to ensure consistency across programs and to facilitate synthesis and learning. In Year One, companies applied the framework to 62 programs with a wide variety of activities and objectives. Their success in doing so provides evidence that the framework is practical and feasible to implement. Company feedback also confirmed the framework's utility, not only for reporting on their current activities but also for designing new programs.

During Year One, companies proposed a few new indicators which have been incorporated into the measurement framework's set of indicators. Companies also reported new activities that have been incorporated into updated versions of the logic models.

Our vision is that the measurement framework will evolve over time in three important respects:

New strategies

As companies innovate and develop new approaches corresponding strategies and logic models will be added to the framework.

New indicators

Companies will continue to propose new indicators as they refine their systems and develop new approaches. The framework will be updated to incorporate these new indicators over time. In addition, the data collection of certain indicators may be found to be infeasible and these will be dropped from the framework. Whenever two companies propose a similar indicator we will combine these into a single common indicator.

Use by non-Access Accelerated programs

Although the framework was developed as part of Access Accelerated, the strategies, logic models, and indicators are applicable outside NCDs and to non-industry programs. The broad adoption of the framework by a large number of program developers and implementers has an enormous potential to increase transparency and shared learning.

As the number and scope of access to medicines programs grows, the demand for an expanded and more refined measurement framework is to be expected. For programs continuing into Year Two, strategies, logic models, and indicators will be reviewed and updated based on Year One feedback. Feedback from all partners involved is critical to better understand the experiences with the Access Observatory and the measurement framework. With this feedback and also based on analysis and observations of the Access Observatory's internal processes, the ultimate aim is to strengthen the framework, maintain a methodological rigor, and also improve user experience and operability.

The broad adoption of the framework by a large number of program developers and implementers has an enormous potential to increase transparency and shared learning.

In Conclusion

Access to prevention and treatment, particularly for NCDs, is a core element of the SDGs. The global community requires that all partners, including the private sector, contribute to achieving these goals.

Measurement and reporting on progress is critical to allocating limited resources and ensuring sustainability. In securing an independent academic partner to measure and evaluate the progress of Access Accelerated, company CEOs and the Access Accelerated Secretariat clearly communicated to the global health community that measurement and, most importantly, the transparency of the measurement process are vital in order to share program learnings and be held accountable to their beneficiary populations and local stakeholders.

In the past, lack of transparency in measurement and reporting on company programs has resulted in a skepticism or distrust of the intentions of pharmaceutical companies in their efforts to do work in improving access to care and treatment.¹⁷ The members of Access Accelerated should be commended for their commitment to transparency. The *Access Observatory* is a first-of-its-kind global platform for measurement and reporting on access programs. It requires the continued commitment from all sectors to become a global reference for shared learning and accountability.

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Appendix 1

List of Non-Communicable Disease Programs Reported into the Access Observatory

Primary Pharmaceutical Company		Name of Initiative	Country or Countries of Implementation
1	Astellas	Action on Fistula	Kenya
2	Bristol-Myers Squibb	Children and Mothers Partnerships (CHAMPS) Initiative – Kenya	Kenya
3	Bristol-Myers Squibb	Global Hope (Africa)	Botswana, Malawi, Uganda
4	Bristol-Myers Squibb	Pink Ribbon, Red Ribbon (Africa)	Ethiopia, Tanzania
5	Bristol-Myers Squibb	Project ECHO for Cancer Care (South Africa)	South Africa
6	Bristol-Myers Squibb	Secure The Future – Lung Cancer in Swaziland	Swaziland
7	Bristol-Myers Squibb	Secure The Future – Gauteng Province, South Africa	South Africa
8	Bristol-Myers Squibb	Secure The Future – KwaZulu-Natal, South Africa	South Africa
9	Bristol-Myers Squibb	Secure The Future – Multinational Lung Cancer Control Program (MLCCP)	Kenya, South Africa, Swaziland, Tanzania
10	Bristol-Myers Squibb	Secure The Future – Senegal	Senegal
11	Bristol-Myers Squibb	Secure The Future – Tanzania	Tanzania
12	Bristol-Myers Squibb	Secure The Future – UThukela District, KwaZulu-Natal, South Africa	South Africa
13	Bristol-Myers Squibb	Secure The Future Lung Cancer in Kenya	Kenya
14	Bristol-Myers Squibb	Secure The Future Kimberly Hospital Complex – South Africa	South Africa
15	Celgene	Celgene AMPATH Oncology Partnership	Kenya
16	Daiichi Sankyo	Cultivating Healthcare Workers in China	China
17	Daiichi Sankyo	Mobile Healthcare Field Clinic Services	Tanzania
18	Eisai	Remember I Love You	China
19	Eli Lilly and Company	Project HOPE Centre – South Africa	South Africa
20	GlaxoSmithKline	MSI-GSK Cervical Cancer Prevention Project	Bangladesh, Madagascar, Sierra Leone
21	GlaxoSmithKline	PRRR-GSK Cervical Cancer Prevention Project	Ethiopia
22	Merck & Co, Inc.	GARDASIL – Gavi	Armenia, Bangladesh, Benin, Bolivia, Burkina Faso, Burundi, Cambodia, Cote d'Ivoire, Ethiopia, Ghana, Guyana, Honduras, Indonesia, Kenya, Lao PDR, Liberia, Madagascar, Malawi, Mali, Niger, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Solomon Islands, Sri Lanka, Tanzania, The Gambia, Togo, Uganda, Uzbekistan, Zimbabwe

Primary Pharmaceutical Company		Name of Initiative	Country or Countries of Implementation
23	Merck & Co, Inc.	GARDASIL – Haiti, Zanmi Lasante	Haiti
24	Merck & Co, Inc.	GARDASIL – Peru, CerviCusco	Peru
25	Merck & Co, Inc.	SPARSH HEALTHLINE	India
26	Merck & Co, Inc.	SPARTA	Australia, Austria, Belgium, Brazil, Germany, Greece, India, Indonesia, Ireland, Malaysia, Mexico, Oman, Philippines, Russia, Singapore, Sweden, Switzerland, Taiwan, Thailand, United Arab Emirates, Vietnam
27	Merck KGaA	Integrated Thyroid NCD Care in the Philippines	Philippines
28	Merck KGaA	Merck Cancer Access Program	Botswana, Egypt, Ethiopia, Ghana, India, Kenya, Liberia, Namibia, Sierra Leone, South Africa, Tanzania, Uganda, Zambia
29	Merck KGaA	Merck Capacity Advancement Program	Angola, Bangladesh, Cambodia, Cameroon, Central African Republic, Congo, Cote d'Ivoire, Equatorial Guinea, Ethiopia, Ghana, India, Indonesia, Kenya, Liberia, Malawi, Mali, Mozambique, Myanmar, Nepal, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Sri Lanka, Tanzania, Uganda, United Arab Emirates, Zambia, Zimbabwe
30	Merck KGaA	Merck Community Awareness Program	Angola, Ethiopia, Ghana, India, Indonesia, Kenya, Mozambique, South Africa, Tanzania, Uganda
31	Merck KGaA	Merck STEM Program for Women and Youth	Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Congo, Egypt, Ethiopia, Gabon, Ghana, Kenya, Liberia, Malawi, Morocco, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Tanzania, Uganda, Zambia, Zimbabwe
32	Novartis	Glivec International Patient Assistance Program (GIPAP)	Argentina, Armenia, Azerbaijan, Bahamas, Bangladesh, Belarus, Benin, Bhutan, Burkina Faso, Cambodia, Cameroon, Central African Republic, Chile, China, Congo, Cote d'Ivoire, Democratic Republic of the Congo, Dominican Republic, Ecuador, El Salvador, Ethiopia, Fiji, Gabon, Georgia, Ghana, Haiti, Honduras, India, Indonesia, Jamaica, Kazakhstan, Kenya, Kyrgyzstan, Madagascar, Malawi, Malaysia, Mali, Mauritania, Mauritius, Mexico, Moldova, Mongolia, Morocco, Mozambique, Nepal, Nicaragua, Niger, Pakistan, Papua New Guinea, Paraguay, Peru, Philippines, Rwanda, Senegal, Seychelles, Sierra Leone, Solomon Islands, South Sudan, Sudan, Suriname, Tajikistan, Thailand, Timor-Leste, Togo, Uganda, Vietnam, Zambia, Zimbabwe
33	Novartis	Novartis Access	Cameroon, Ethiopia, Kenya, Lebanon
34	Pfizer Inc.	Healthy Communities	Myanmar, Vietnam
35	Pfizer Inc.	Improving Oncology Care: Scaling Up Breast Cancer Services in La Libertad Region, Peru	Peru

Primary Pharmaceutical Company	Name of Initiative	Country or Countries of Implementation
36 Pfizer Inc.	Integrated Approach to Improving Oncology Care	Brazil
37 Pfizer Inc.	SMARThealth Extend	India, Indonesia
38 Pfizer Inc.	Abundant Health	Vietnam
39 Pfizer Inc., Novartis, Sanofi, Merck & Co.	Access and Affordability Initiative (AAI)	Ghana, Philippines
40 Roche	Breast Cancer National Access Programme, Kenya	Kenya
41 Roche	Perieta Patient Support Programme	Egypt
42 Roche	The Blue Tree, India	India
43 Roche	UNMOL (Urdu for Precious): Access to Cancer Medicines in Pakistan	Pakistan
44 Sanofi	KiDS and Diabetes in School	Brazil, India, Pakistan, United Arab Emirates
45 Sanofi	My Child Matters – Paraguay	Paraguay
46 Sanofi	My Child Matters – Retinoblastoma	Cote d'Ivoire, Democratic Republic of the Congo,
47 Sanofi	My Child Matters – Thailand	Thailand
48 Sanofi	Sanofi Mental Health Program (FAST – Fight Against STigma) – Armenia	Armenia
49 Sanofi	Sanofi Mental Health Program (FAST – Fight Against STigma) – Madagascar	Madagascar
50 Sanofi	Sanofi Mental Health Program (FAST – Fight Against STigma) – Morocco	Morocco
51 Sanofi	Sanofi Mental Health Program (FAST – Fight Against STigma) – Myanmar	Myanmar
52 Shire	Hemophilia Home Care in India	India
53 Sumitomo Dainippon	Promoting Sound Child Growth Pilot Project	Cambodia
54 Takeda	Beyond Medicines in Ukraine	Ukraine
55 Takeda	Cancer Alliance for sub-Saharan Africa	Kenya
56 Takeda	Cancer Education for Primary Healthcare Professionals in Kenya	Kenya
57 Takeda	HERhealth	China, Ethiopia, India, Kenya
58 Takeda	Mobile Access for Chronic Care in sub-Saharan Africa	Kenya
59 Takeda	Oncology Fellowship in sub-Saharan Africa	Kenya
60 Takeda	Oncology Nursing Education in Kenya	Kenya
61 Takeda	Palliative Care Training in sub-Saharan Africa	Kenya
62 Takeda	Patient Assistance Program for Adcetris® in Malaysia	Malaysia

Appendix 2

Number of Programs by Country

Country	World Bank Region (2017)	Income Group (2017)	Program Count
1 Angola	Sub-Saharan Africa	Lower middle income	3
2 Argentina	Latin America & Caribbean	Upper middle income	1
3 Armenia	Europe & Central Asia	Lower middle Income	3
4 Australia	East Asia & Pacific	High income	1
5 Austria	Europe & Central Asia	High income	1
6 Azerbaijan	Europe & Central Asia	Upper middle income	1
7 Bahamas, The	Latin America & Caribbean	High income	1
8 Bangladesh	South Asia	Lower middle income	4
9 Belarus	Europe & Central Asia	Upper middle income	1
10 Belgium	Europe & Central Asia	High income	1
11 Benin	Sub-Saharan Africa	Low income	3
12 Bhutan	South Asia	Lower middle income	1
13 Bolivia	Latin America & Caribbean	Lower middle income	1
14 Botswana	Sub-Saharan Africa	Upper middle income	3
15 Brazil	Latin America & Caribbean	Upper middle income	3
16 Burkina Faso	Sub-Saharan Africa	Low income	3
17 Burundi	Sub-Saharan Africa	Low income	2
18 Cambodia	East Asia & Pacific	Lower middle income	4
19 Cameroon	Sub-Saharan Africa	Lower middle income	4
20 Central African Republic	Sub-Saharan Africa	Low income	2
21 Chile	Latin America & Caribbean	High income	1
22 China	East Asia & Pacific	Upper middle income	4
23 Congo, Dem. Rep.	Sub-Saharan Africa	Low income	2
24 Congo, Rep.	Sub-Saharan Africa	Lower middle income	3
25 Côte d'Ivoire	Sub-Saharan Africa	Lower middle income	4
26 Dominican Republic	Latin America & Caribbean	Upper middle income	1
27 Ecuador	Latin America & Caribbean	Upper middle income	1
28 Egypt, Arab Rep.	Middle East & North Africa	Lower middle income	3
29 El Salvador	Latin America & Caribbean	Lower middle income	1
30 Equatorial Guinea	Sub-Saharan Africa	Upper middle income	1
31 Ethiopia	Sub-Saharan Africa	Low income	10
32 Fiji	East Asia & Pacific	Upper middle income	1
33 Gabon	Sub-Saharan Africa	Upper middle income	2
34 Gambia, The	Sub-Saharan Africa	Low income	1
35 Georgia	Europe & Central Asia	Lower middle income	1
36 Germany	Europe & Central Asia	High income	1
37 Ghana	Sub-Saharan Africa	Lower middle income	7
38 Greece	Europe & Central Asia	High income	1

Country		World Bank Region (2017)	Income Group (2017)	Program Count
39	Guyana	Latin America & Caribbean	Upper middle income	1
40	Haiti	Latin America & Caribbean	Low income	2
41	Honduras	Latin America & Caribbean	Lower middle income	2
42	India	South Asia	Lower middle income	11
43	Indonesia	East Asia & Pacific	Lower middle income	6
44	Ireland	Europe & Central Asia	High income	1
45	Jamaica	Latin America & Caribbean	Upper middle income	1
46	Kazakhstan	Europe & Central Asia	Upper middle income	1
47	Kenya	Sub-Saharan Africa	Lower middle income	20
48	Kyrgyz Republic	Europe & Central Asia	Lower middle income	1
49	Lao PDR	East Asia & Pacific	Lower middle income	1
50	Lebanon	Middle East & North Africa	Upper middle income	1
51	Liberia	Sub-Saharan Africa	Low income	4
52	Madagascar	Sub-Saharan Africa	Low income	5
53	Malawi	Sub-Saharan Africa	Low income	5
54	Malaysia	East Asia & Pacific	Upper middle income	3
55	Mali	Sub-Saharan Africa	Low income	4
56	Mauritania	Sub-Saharan Africa	Lower middle income	1
57	Mauritius	Sub-Saharan Africa	Upper middle income	1
58	Mexico	Latin America & Caribbean	Upper middle income	2
59	Moldova	Europe & Central Asia	Lower middle income	1
60	Mongolia	East Asia & Pacific	Lower middle income	1
61	Morocco	Middle East & North Africa	Lower middle income	3
62	Mozambique	Sub-Saharan Africa	Low income	4
63	Myanmar	East Asia & Pacific	Lower middle income	3
64	Namibia	Sub-Saharan Africa	Upper middle income	2
65	Nepal	South Asia	Low income	2
66	Nicaragua	Latin America & Caribbean	Lower middle income	1
67	Niger	Sub-Saharan Africa	Low income	3
68	Nigeria	Sub-Saharan Africa	Lower middle income	2
69	Oman	Middle East & North Africa	High income	1
70	Pakistan	South Asia	Lower middle income	3
71	Papua New Guinea	East Asia & Pacific	Lower middle income	1
72	Paraguay	Latin America & Caribbean	Upper middle income	2
73	Peru	Latin America & Caribbean	Upper middle income	3
74	Phillipines	East Asia & Pacific	Lower middle income	4
75	Russia Federation	Europe & Central Asia	Upper middle income	1
76	Rwanda	Sub-Saharan Africa	Low income	4
77	São Tomé and Príncipe	Sub-Saharan Africa	Lower middle income	1
78	Senegal	Sub-Saharan Africa	Low income	6
79	Seychelles	Sub-Saharan Africa	High income	1

Country		World Bank Region (2017)	Income Group (2017)	Program Count
80	Sierra Leone	Sub-Saharan Africa	Low income	6
81	Singapore	East Asia & Pacific	High income	1
82	Solomon Islands	East Asia & Pacific	Lower middle income	2
83	South Africa	Sub-Saharan Africa	Upper middle income	11
84	South Sudan	Sub-Saharan Africa	Low income	1
85	Sri Lanka	South Asia	Lower middle income	2
86	Sudan	Sub-Saharan Africa	Lower middle income	1
87	Suriname	Latin America & Caribbean	Upper middle income	1
88	Swaziland	Sub-Saharan Africa	Lower middle income	2
89	Sweden	Europe & Central Asia	High income	1
90	Switzerland	Europe & Central Asia	High income	1
91	Taiwan, China	East Asia & Pacific	High income	1
92	Tajikistan	Europe & Central Asia	Lower middle income	1
93	Tanzania	Sub-Saharan Africa	Low income	9
94	Thailand	East Asia & Pacific	Upper middle income	3
95	Timor-Leste	East Asia & Pacific	Lower middle income	1
96	Togo	Sub-Saharan Africa	Low income	2
97	Uganda	Sub-Saharan Africa	Low income	7
98	Ukraine	Europe & Central Asia	Lower middle income	1
99	United Arab Emirates	Middle East & North Africa	High income	3
100	Uzbekistan	Europe & Central Asia	Lower middle income	1
101	Vietnam	East Asia & Pacific	Lower middle income	4
102	Zambia	Sub-Saharan Africa	Lower middle income	4
103	Zimbabwe	Sub-Saharan Africa	Low income	4

Source: World Bank. World Bank country and lending groups. Accessed May 23, 2018 from <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups>

Appendix 3

Number of Programs by Other Beneficiary Population

Other Beneficiary Population	Frequency
Adults > 39 years	1
Hard to reach and indigent patients	1
Cancer patients	2
General population 25 years+ in Tan Phu District	1
HIV positive individuals	1
Low income with no reimbursement	1
Low income men and women age 40 and over	1
Marginalized people refers to humanitarian populations that are especially vulnerable in protracted conflict situations	1
Teachers, parents of children with diabetes, parents in general	1
Terminally-ill people and their families	1

Appendix 4

List of Funding and Implementing Partners

Partner	Program Count
Academic Model Providing Access to Healthcare (AMPATH)	2
Addington Hospital	1
African Cancer Registry Network (AFCRN)	5
Alexandria University in Egypt	1
Alzheimer's Disease Chinese	1
AMCC (Alliance Mondiale Contre le Cancer)	1
American Cancer Society (ACS)	1
American Society for Clinical Pathology	1
AMREF Health Africa (African Medical and Research Foundation)	4
Armenia Ministry of Health	1
Associação de Diabetes Juvenil of Brazil (ADJ)	1
Axios International	2
Baylor International Pediatric Aids Initiative (BIPAI)	1
Bhekuzulu Self Sustaining Project (BSSP)	1
Bill and Melinda Gates Foundation	2
Boston University	1
Botswana Ministry of Health	1
Brawijaya University, Malang, Indonesia	1
Bristol-Myers Squibb Foundation	11
Bugando Medical Centre	1
Bugando Medical Centre in Mwanza, Tanzania	1
Business for Social Responsibility (BSR)	1
Cairo Scan Lab	1
Cameroon Baptist Convention Health Services	1
Can Survive Egypt	1
Catholic University of Allied and Health Services	1
Catholic University of Health and Allied Sciences Tanzania	2
Centro de Estudos e Pesquisa do Hospital Perola Byington	1
Cerebrus Consulting	1
CerviCusco	1
Charlotte Maxeke Johannesburg Academic Hospital	1
Cheikh Anta Diop University	1
Cherkasky Onco Dispenser Patient Association	1
China Charity Federation	1
China Population Welfare Foundation	1
Chris Hani Baragwanath Academic Hospital (CHBAH)	1
Christian Health Association of Kenya	1
Commune Health Stations (CHS) of Tan Phu District, Ho Chi Minh City, Vietnam	1

Partner	Program Count
CSD Healthcare Clinic	1
CUAMM Tanzania	1
Curie Institute (Paris, France)	1
Diabetes Association of Pakistan	1
Diagnostic Center of Feofaniva	1
District Health Administration, Jhajjar District, Haryana, India	1
District Health Agency, Malang, Indonesia	1
Doctors with Africa (CUAAM), Ethiopia	1
Elewa Foundation	1
Emmaus Hospital	1
Estcourt Hospital	1
FHI360	1
First Lady Beyond Zero Campaign	1
Fistula Foundation	1
French Ministry of Health	1
GAVI Alliance	1
George Institute for Global Health	1
GERESA (Peru Ministry of Health's Regional Health Administration) including Turjillo Health Network Administration	1
GFAOP (Groupe Franco-Africain d'Onco-Pédiatrie)	1
Ghana Ministry of Health	1
Greys Hospital	1
Grounds for Health (GfH) Mathiwas Wondu, Ethiopia Cancer Society	1
Guangnan County Health Bureau	1
Guangnan County Women's Federation	1
HCL Technologies	1
Ho Chi Minh City (HCMC) Department of Health	1
Helen Joesph Hospital Pulmonology Department	1
Hospital de Cancer de Barretos	1
ICICI [Industrial Credit and Investment Corporation of India] Bank	1
Implementing Partner is PH, Japan	1
Indiana University,USA	1
Inkosi Albert Luthuli Central Hospital	1
Innovative Cancer Care Foundation (ICCF)	1
Instituto Oncoguia	1
International Diabetes Federation (IDF)	1
International Society for Pediatric and Adolescent Diabetes (ISPAD)	1
IREN-Norte (the northern region cancer institute)	1
John Taolo Getsewe Provincial Department of Health	1
Johns Hopkins Bloomberg School of Public Health	1
Kenya Cancer Association (KENCO)	1

Partner	Program Count
Kenya Conference of Catholic Bishops	1
Kenya Medical Research Institute	1
Kenya Ministry of Health	3
Kenya Ministry of Health through Counties-Level	1
Kenya Red Cross	1
Kenyan Network of Cancer Organizations (KENCASA)	1
Kimberly Hospital Complex (KHC)	1
Kimberly District Hospital, Northern Cape, South Africa	1
KwaZulu Natal Non-Communicable Diseases Directorate	1
KwaZulu-Natal Department of Health	2
Ladysmith Hospital	1
Lahore Grammar School	1
Le Dantec University Hospital	1
Local governments in Kilombero District Tanzania	1
M.P. Shah Hospital	1
Malawi Ministry of Health	1
Marie Stopes International	1
Mathiwo Wondu Ye cancer Society (Tanzania)	1
Mathiwo Wondu Ye-Ethiopia Cancer Society (MWECS)	1
Max Foundation	1
MD Anderson Cancer Center	1
Medical Data Management (MDM)	1
Medical/pharmaceutical associations (multiple countries)*	1
Medybiz Pharma Pvt. Ltd.	1
Ministries of Health (multiple countries)*	1
Ministry of Health of Senegal	1
Ministry of Public Health and Social Welfare Paraguay	1
Ministry of Public Health of Madagascar	1
Moi Teaching and Referral Hospital	1
Moi University School of Medicine	1
Moroccan Association of Social Psychiatry	1
Moroccan League Against Epilepsy	1
Moroccan Ministry of Health	1
Mpilonhle Sanctuary Organization (MSO)	1
Multiple hospitals (Public and Private Hospitals)	1
Myanmar Medical Association (MMA)	1
Myanmar Mental Health Society	1
Nairobi Hospital	1
National Cancer Institute of Ukraine - Hematology Department	1
National Health Laboratory Services (NHLS) South Africa	1
National Health Security Office (Thailand)	1

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

Partner	Program Count
Tan Phu Medicine Center	1
Tanzania Ministry of Health	2
Tata Memorial Hospital	1
Tech Mahindra Limited	1
Texas Childrens Cancer and Hematology Centers	1
Thai Pediatric Oncology Group	1
The Medical Women Association of Tanzania (MEWATA)	1
The National Referral Hospital Swaziland	1
The Phillipines Department of Health	1
Third Party (Dimension Research)	1
UAE Ministry of Education	1
UAE Ministry of Health & Prevention	1
Uganda Ministry of Health	1
UNESCO (United Nations Educational, Scientific and Cultural Organization)	1
UNICEF (United Nations Children's Fund)	1
Unique Courier	1
Université Numérique Francophone Mondiale (UNFM - World Digital Francophone University)	1
University of Nairobi	3
University of New Mexico Health Sciences Centers ECHO Institute	1
University of Pretoria	1
University Research Co.,LLC	1
U.S. Agency for International Development (USAID)	1
U.S. National Institutes of Health (NIH)	1
Uthukela District Health Office	1
Wishing Well Foundation	1
Wits Health Consortium	1
WITS/Gauteng Palliative Care Center at CHBAH (Bara PC)	1
World Association for Social Psychiatry	2
World Health Organization (WHO)	7
World Heart Federation	1
Zanmi Lasante	1

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

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