PROGRAM REPORT

NOVEMBER 2021

Abundant Health

Pfizer Foundation

Submitted as part of Access Accelerated

Access Observatory

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

Program Description

Program Overview

1 Program Name

Abundant Health

2 Diseases program aims to address

- Diabetes: Type 2
- Cardiovascular disease: Hypertension

3 Beneficiary population

- Age Group: Adults age 18+
- Gender: All genders
- Special Populations: Urban and Peri-Urban areas of Ho Chi Minh City

4 Countries

- Vietnam

5 Program start date

March 1, 2016

6 Anticipated program completion date

June 30, 2020

7 Contact person

Claire Maguire (claire.maguire@pfizer.com)

8 Program summary

Preventing and controlling the spread of noncommunicable diseases is a national health priority for the social and economic development of Vietnam.[1] To support the Government of Vietnam in this effort, the Abundant Health project is designed to increase the proportion of people who are aware of the risk factors of such diseases and to increase the proportion of eligible patients who are screened, risk stratified and treated for diabetes and hypertension. This community-based, integrated prevention and control program is being implemented in 11 public commune health stations in the Tan Phu District in Ho Chi Minh City, Vietnam.

FHI 360 leads the project with the Ho Chi Minh City Department of Health and other local stakeholders. The project uses a Collaborative Improvement model to integrate prevention, screening, treatment and management of hypertension and diabetes into the workflow of commune health station (CHS) staff and community collaborators.

In addition to hypertension (HTN) and diabetes (DM) screening at community outreach events, the project supports routine screening for all adults meeting the established criteria at commune health stations, no matter the reason for their visit. The CHS team risk stratifies and diagnoses patients, prescribes first-line treatment for HTN and DM and provides ongoing management. For patients with complicated cases/co-morbidities, they are referred for specialist care.

Other activities of the program include:

1) Training CHS staff on quality improvement, and HTN and DM service provision. It also includes supportive supervision visits to CHS staff and clinical case reviews

2) Development of data management system for HTN and DM services which is linked with existing platforms in the Department of Health system

Note that from March 2016 through May 2017, the pilot phase included five commune health stations. Beginning in June 2017, six additional sites were added. Data reported in calendar year 2017 will include all 11 sites.

By September 2018, the project received official approval to scale at a citywide level. From October 2018 to July 2019, the project expanded to 161 CHSs all of which had health insurance services in place. From August 2019 to June 2020, the total number of CHCs implementing Abundant Health is increasing to 303 CHSs.

Program Overview

8 Program summary

Main goals of this citywide expansion phase include as follows:

1) Strengthen public awareness on prevention and management of risk factors for non-communicable diseases

2) Promote HTN & DM screening, diagnosis, and treatment services at CHSs.

3) Improve the quality of treatment and management services for patients with HTN & DM at the CHSs.

Program URL: https://www.fhi360.org/projects/abundant-health

Program Strategies & Activities

9 Strategies and activities

Strategy 1: Community Awareness and Linkage to Care

ACTIVITY	DESCRIPTION
Communication	Creation of a noncommunicable disease (NCD) website, development of community engagement activities.
Mobilization	NCD support group.

Strategy 2: Health Service Strengthening

ACTIVITY	DESCRIPTION
Training	Training on quality improvement, and hypertension and diabetes service provision, supportive supervision visits to CHS staff, clinical case reviews.
Technology	Development of data management system for hypertension and diabetes services – linked with existing platforms in the DOH system.

Strategy 3: Health Service Delivery

ACTIVITY	DESCRIPTION
Screening	Screening in community and facilities for hypertension and diabetes.
Diagnosis	Diagnosis of hypertension and diabetes by service providers at CHS.
Treatment	Treatment of hypertension and diabetes at CHS or referral to hospitals if indicated.
Retention	Retention and adherence of hypertensive and diabetic patients at CHS.

Program Strategies & Activities

10 Strategy by country

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

Companies, Partners & Stakeholders

11 Company roles

COMPANY	ROLE
Pfizer Foundation	The Pfizer Foundation provided grant funding to FHI360 to support implementation of this project. FHI360 is leading the project and they are responsible for the design, management and evaluation of the project. The Pfizer Foundation is a charitable organization established by Pfizer Inc. It is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

12 Funding and implementing partners

PARTNER	ROLE/URL	SECTOR
FHI360	FHI 360 is the implementing partner responsible for overall program management and technical quality of the project. This includes designing and coordinating the data management system, provision of training and other technical capacity strengthening activities, and financial management. FHI 360's staff based in Vietnam is responsible for fulfilling these roles. FHI 360 is a nonprofit human development organization dedicated to improving lives in lasting ways by advancing integrated, locally driven solutions. www.fhi360.org	Voluntary
Commune Health Stations (CHS) in Ho Chi Minh City, Vietnam participating in Abundant Health	The CHS are responsible for direct provision of hypertension and diabetes services to community members and recording data on these services. Service providers include physicians, assistant physicians, nurses, midwives, and community collaborators.	Public
HCMC Department of Health (DOH)	The HCMC DOH works closely with FHI 360 to provide leadership and management/technical guidance for the project. The CHS report to the Tan Phu Medicine Center and the HCMC DOH; in this project, the DOH monitors the data and tracks the provision of services of the Abundant Health project.	Public
Tan Phu Medicine Center	The Tan Phu Medicine Center supervises the quality of services provided by the CHS in its district, which includes the services provided through Abundant Health. The CHS routinely report to the Tan Phu Medicine Center. The Tan Phu Medicine Center jointly (with FHI 360 and HCMC DOH) supervises and monitors the performance of the 11 CHS in the provision of hypertension and diabetes services. The Center also provides critical input in the design of the monitoring and evaluation system for Abundant Health.	Public

13 Funding and implementing partners by country

PARTNER	COUNTRY
FHI360	Vietnam
Commune Health Stations (CHS) in Ho Chi Minh City, Vietnam participating in Abundant Health project	Vietnam
HCMC Department of Health (DOH)	Vietnam
Tan Phu Medicine Center	Vietnam

14 Stakeholders

STAKEHOLDER	DESCRIPTION OF ENGAGEMENT
Government	The HCMC Department of Health (DOH) and Tan Phu Medicine Center have been integral stakeholders in the design and monitoring of the project. Prior to commencing the project, a formal project description was submitted to the People's Committee for review and approval.
Local Hospitals/ Health Facilities, please explain	The main implementers of the project are service providers at government (public) clinics, called commune health stations.

Local Context, Equity & Sustainability

15 Local health needs addressed by program

Vietnam has made enormous development strides over the past two decades, leading to a low-middle-income status and gains in population health. Much of the success in health can be attributed to a primary health care (PHC) system implementing national treatment programs focused on communicable diseases and maternal and child health. These vertical programs, implemented primarily through commune health care centers (CHCs), target single disease areas. Alongside these gains, there has been a notable increase in the prevalence of non-communicable diseases (NCDs). In 1990, NCDs caused 41.8% of deaths in Vietnam, while in 2010 they caused 60.1% of all deaths. The PHC system, while successful at improving health outcomes of single diseases, has created barriers in managing the increasing burden of NCDs across the continuum of care. Currently, less than 25% of CHSs have prevention services around the four-shared risk factors (tobacco and alcohol use, physical inactivity and unhealthy diet).[2] In response to this situation, the Government of Vietnam (GOVN) recently established a National NCD Coordinating Office as part of the National NCD Prevention and Control Strategy 2015-2020, with specific efforts to integrate NCD risk factors and disease treatment, focusing efforts at the CHS level. To support this national effort, and in consultation with the Ho Chi Minh City (HCMC) Department of Health, the Abundant Health Project was designed to establish a community-based, integrated NCD prevention and control program in one district of HCMC. [3]

a How were needs assessed

[No response provided.]

b Formal needs assessment conducted

[No response provided.]

16 Social inequity addressed

[No response provided].

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

The hypertension and diabetes treatment guidelines used in the project are consistent with the national guidelines.Vietnam's 2002-2014 National Strategy on NCDs Prevention and Control created five vertical programs targeting cancer, diabetes, hypertension, chronic pulmonary disease, and mental health. These programs were implemented separately under the control of different national specialty hospitals or institutes. As a result, the programs focused on treatment in hospitals instead of at the community level, with very little attention given to prevention activities. An independent review of the National Strategy and the five individual programs showed that there were no gains in health status, and that the NCD epidemic continued to increase.[3] Currently, less than 25% of CHSs have prevention services around the four-shared NCD risk factors (tobacco and alcohol use, physical inactivity and unhealthy diet).[2] In response to this situation, the Government of Vietnam (GOVN) established a National NCD Coordinating Office as part of the National NCD Prevention and Control Strategy 2015-2020, with specific efforts to integrate NCD risk factors and disease treatment, focusing efforts at the CHS level. This project directly aligns with the national priority to expand NCD services to the CHS level.

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

[No response provided.]

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

No.

Local Context, Equity & Sustainability

20 Health technologies are part of local standard treatment guidelines

Not applicable.

21 Health technologies are covered by local health insurance schemes

Not applicable.

22 Program provides medicines listed on the National Essential Medicines List

No.

23 Sustainability plan

Sustainability has been a key consideration from the beginning. In this effort, the project leverages existing staff at CHS and the Tan Phu Medicine Center to implement the project. Modest funds are dedicated to strengthening local capacity, including supervision, to sustain and institutionalize routine service provision of hypertension and diabetes services at CHS.

Additional Program Information

24 Additional program information

[No response provided].

a Potential conflict of interest discussed with government entity

[No response provided.]

25 Access Accelerated Initiative participant

Yes.

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

Yes.

Resources

1. Vietnam Ministry of Health. Plan for People's Health Protection, Care, and Promotion: 2016-2020. Hanoi, March 2016. Available at: http://www.euhf.vn/upload/Strategic%20documents/82.%20MOH%205-year%20plan%20(Eng).pdf
2. Duong, David B. 2015. Understanding the Service Availability for Non-Communicable Disease Prevention and Control at Public Primary Care Centers in Northern Vietnam. Doctoral dissertation, Harvard Medical School.
3. Harper, C. Vietnam Noncommunicable Disease Prevention and Control Programme 2002-2010 Implementation Review. Report prepared for WHO, 2011.

Program Indicators

PROGRAM NAME

Abundant Health

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

	INDICATOR	TYPE	STRATEGY	2018	2019	2020
1	Population screened	Output	Health service delivery	14,886 people	39,782 people	---
2	Number of patients diagnosed	Output	Health service delivery	340 people	895 people	---
3	Number of patients on treat-	Output	Health service delivery	585 people	6474 people	---

INDICATOR **Population screened**

STRATEGY HEALTH SERVICE DELIVERY

1

	ITEM	DESCRIPTION
	Definition	Number of individuals screened for disease as a result of the screening test or procedure being provided by the program. Screening activities could include any screening procedures (mammogram, cholesterol measurement, colonoscopy, etc.) delivered directly to a specified population, by the program. Screening activities are often preventive in nature and aim to look for diseases or conditions prior to symptoms developing.
	Method of measurement	Counting of people who were screened for disease in the program. CALCULATION: Sum of the number of people screened.
28	Data source	Routine program data
29	Frequency of reporting	Bi-annually

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30 Data collection	Implementing partner: Commune Health Stations (CHS) in Ho Chi Minh City, Vietnam participating in Abundant Health project	Phase II (from July 19, 2017 to May 15, 2018): Screening for hypertension and diabetes is conducted either at the Commune Health Station (CHS) or outside of the CHS in order to attract new community members. At the CHS, hypertension and diabetes screening is routinely offered to all adults based on established criteria – regardless of the reason they are visiting the CHS. Screening data from both facility and community screening is entered into the screening form by the CHS staff (can be nurse, assistant physician or doctor) then transferred into the case management software as soon as possible. Phase III- year one (from October 11, 2018 to July 30, 2019): Individual screening data from both facility and community screening are entered into screening forms by the CHS staff (can be nurse, assistant physician or doctor). This data is then transferred into a project database on monthly basis by the project data entry team.	Ongoing
31 Data processing	Implementing partner: FHI360	Phase II (from July 19, 2017 to May 15, 2018): Through the case management software, the M&E officer will conduct a monthly data review of the number of people screened for HTN and DM at every commune health station, extracted from the case management software. Phase III- year one (from October 11, 2018 to July 30, 2019): The M&E officer will conduct a monthly data analysis of the number of people screened for HTN and DM at every commune health station. This data is extracted from the project database.	Every month

INDICATOR **Population screened**

STRATEGY HEALTH SERVICE DELIVERY

1

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
32 Data validation	Implementing partner: FHI360	Phase II (from July 19, 2017 to May 15, 2018): This process is managed by the lead implementing organization, FHI 360. The process outlined by FHI 360 is as follows: Data management software can automatically check the duplicate cases identifying those already screened. For data quality assurance: On a monthly basis, the M&E officer randomly calls 2% of the screened patients of 11 CHS to confirm that they have been screened during a visit to a CHS. On a quarterly basis, the project M&E officer makes a monitoring visit where she will i) randomly check 10% of the screening/diagnosis paper-based records versus the reported data entered into the software. Phase III- year one (from October 11, 2018 to July 30, 2019): This process is managed by FHI 360. The process for data entry check, data clean and duplication removal are conducted on the excel sheet after downloading dataset from the project database.	

33 Challenges in data collection and steps to address challenges

No information provided.

INDICATOR	2018	2019	2020
1 Population screened	14,886 people	39,782 people	---

Comments:

2018: Total includes people aged 25 and above that were screened for hypertension, or diabetes or screened for both conditions.

2019: Includes people age 18 and above that were screened for hypertension or diabetes or screened for both conditions.

INDICATOR

Number of patients diagnosed

STRATEGY HEALTH SERVICE DELIVERY

2

	ITEM	DESCRIPTION
	Definition	Number of patients that were diagnosed with disease through the program.
	Method of measurement	Counting of people who were diagnosed with disease through the program. CALCULATION Sum of the number of people diagnosed with disease
28	Data source	Routine program data
29	Frequency of reporting	Bi-annually

		RESPONSIBLE	DESCRIPTION	FREQUENCY
30	Data collection	Implementing Partner: Commune Health Stations (CHS) in Ho Chi Minh City, Vietnam participating in Abundant Health project	Phase II (from July 19, 2017 to May 15, 2018): Community members access screening through 1) routine visits to CHS (for any reason); or 2) community outreach events. Following an elevated reading for HTN and/or DM, they are directed to have a second confirmatory measurement taken on another day at a CHS (per the clinical guidelines). The diagnosis of hypertension/ diabetes is made when blood pressure and/or blood glucose is consistently abnormal at the confirmatory measurement. A health worker then documents the confirmatory result into a screening form, then transfers it into a case management software as soon as possible. The second (confirmatory) measurement has a separate field in the screening form and is labelled as such, i.e. the second measurement is clearly distinguished from the initial screening measurement. Phase III- year one (from October 11, 2018 to July 30, 2019): the same procedure as above. However, the difference is the data is transferred into a project database on monthly basis by the project data entry team.	Ongoing
31	Data processing	Implementing Partner: FHI360	On a monthly basis, the M&E officer of FHI 360 reviews all data entered into the software and notifies the CHS if there is any discrepancy or missing information. After the data is verified the patient dataset is extracted and copied to Excel. Further analysis is conducted to determine the proportion of people with elevated measurements (for HTN and/or DM) at their initial screening who were ultimately diagnosed according to the clinical guidelines. The M&E officer reviews the cases of newly diagnosed and confirms that they were diagnosed according to the clinical guidelines. Phase III- year one (from October 11, 2018 to July 30, 2019): the same procedure as above, with extracting data from the project database.	Every month

INDICATOR **Number of patients diagnosed**

STRATEGY HEALTH SERVICE DELIVERY

2

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
32 Data validation	Implementing Partner: FHI360	Phase II with 11 CHS participating in the project (from July 19, 2017 to May 15, 2018): This process is managed by the lead implementing organization, FHI 360. The process outlined by FHI 360 is as follows: For quality assurance: On a quarterly basis, the M&E officer will make a monitoring visit where she will i) check randomly 10% the screening/ diagnosis paper-based records versus the reported data entered into the software; ii) observe at least 2 cases of patient and provider interaction regarding screening/diagnosis activities Phase III- year one (from October 11, 2018 to July 30, 2019): Given the citywide scale-up, data verification is primarily conducted remotely by FHI 360. The M&E officer conducts random reviews of data, checking accuracy of data in the project database. If necessary, follow-up with CHS staff is conducted.	

33 Challenges in data collection and steps to address challenges

No information provided.

INDICATOR	2018	2019	2020
2 Number of patients diagnosed	340 people	895 people	---

Comments:

2018: Value entered reflects newly diagnosed people with hypertension,or diabetes or with both conditions.

2019: Value entered reflects newly diagnosed people (with hypertension or diabetes or with both conditions.

INDICATOR **Number of patients on treatment**

STRATEGY HEALTH SERVICE DELIVERY

3

	ITEM	DESCRIPTION
	Definition	Number of people that received treatment through the program.
	Method of measurement	Counting of people who received treatment through the program. CALCULATION Sum of the number of people treated.
28	Data source	Routine program data
29	Frequency of reporting	Bi-annually

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Implementing partner: Commune Health Stations (CHS) in Ho Chi Minh City, Vietnam participating in Abundant Health project	Phase II (from July 19, 2017 to May 15, 2018): Patient data regarding hypertension/ diabetes treatment is recorded, by the CHS doctors, into facility level treatment records (health logbook and/ or prescription) and the social health insurance software at the time of patient visits. The social insurance database will be used as the data source. Every month FHI 360 staff, in collaboration with the CHS staff, run a report to list the number of patients on treatment. Phase III- year one (from October 11, 2018 to July 30, 2019): hypertension/diabetes treatment data of patients with and without health insurance are submitted to FHI 360 for data analysis. The social insurance database and paper-based prescriptions will be used as the data source. In Phase III, both CHS that accept health insurance and CHS that do not accept health insurance participate in the Abundant Health project. For insured patients, the data source for treatment data is the government mandated social health insurance database. CHS staff are trained on how to enter data and data is recorded per visit/prescription. For uninsured patients, a paper-based system is used to record treatment. Thus, on a monthly basis, the CHSs often submit both kinds of treatment data to FHI 360 for analysis support.	Every month
31	Data processing	Implementing partner: FHI360	Phase II (from July 19, 2017 to May 15, 2018): Health facility staff enter data on treatment into the social health insurance software. On a monthly basis, the FHI 360 M&E officer generates a list of patients on treatment from the social health insurance software. Phase III (from October 11, 2018 to July 30, 2019): On a monthly basis, CHSs submit treatment data to the project for data compilation, duplicate removal, and analysis of patients on treatment.	Every month

INDICATOR Number of patients on treatment

STRATEGY HEALTH SERVICE DELIVERY

3

	RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
32 Data validation	Implementing partner: FHI360	Phase II with 11 CHS participating in the project: (from July 19, 2017 to May 15, 2018): This is managed by the lead implementing organization, FHI 360. The process outlined by FHI 360 is as follows: On a quarterly basis, the M&E officer makes a monitoring visit to check randomly 10% of the facility- level treatment records versus the data entered in the social health insurance software. Phase III- year one (from October 11, 2018 to July 30, 2019): Inconsistent data or major increases or decreases in service statistics are shared with CHSs to confirm accuracy.	

33 Challenges in data collection and steps to address challenges

No information provided.

INDICATOR	2018	2019	2020
3 Number of patients on treatment	585 people	6474 people	---

Comments: Value includes patients on treatment for hypertension, or diabetes or both conditions.

Appendix

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

Program Description

PROGRAM OVERVIEW

1 Program Name

2 Diseases program aims to address:

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

3 Beneficiary population

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

4 Countries

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

5 Program Start Date

6 Anticipated Program Completion Date

7 Contact person

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

8 Program summary

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

PROGRAM STRATEGIES & ACTIVITIES

9 Strategies and activities

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

10 Strategy by country

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

COMPANIES, PARTNERS AND STAKEHOLDERS

11 Company roles

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

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

12 Funding and implementing partners

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

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

b. For each partner, please categorize them as either a Public Sector, Private Sector, or Voluntary Sector partner.

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

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

13 Funding and implementing partners by country

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

14 Stakeholders

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

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

LOCAL CONTEXT, EQUITY & SUSTAINABILITY

15 Local health needs addressed by program

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

a How were needs assessed

b Was a formal need assessment conducted

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

16 Social inequity addressed

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

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

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

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

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

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

19 Program provides health technologies

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

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

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

21 Health technologies are covered by local health insurance schemes

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

22 Program provides medicines listed on the National Essential Medicines List

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

23 Sustainability plan

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

ADDITIONAL PROGRAM INFORMATION

24 Additional program information

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

a Potential conflict of interest discussed with government entity

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

25 Access Accelerated Initiative participant

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

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

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

Program Indicators

INDICATOR DESCRIPTION

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

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

28 Data source

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

29 Frequency of reporting

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

30 Data collection

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

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

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

31 Data processing

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

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

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

32 Data validation

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

33 Challenges in data collection and steps to address challenges

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