



Access *Observatory* 2021 Report

Strengthening the Science of Access:
Working Towards Equity



Access Observatory

AUTHORSHIP

The *Access Observatory* 2021 Report was authored by the following (in alphabetical order): Carlotta Cellini, Steven Crimaldi, Anne C. Heerden, Peter C. Rockers, and Veronika J. Wirtz. The views expressed in the report are those of the authors alone.

ACKNOWLEDGEMENTS

Boston University's Biostatistics and Epidemiology Data Analytics Center was instrumental in the development of the *Access Observatory* information management system.

This work was funded by a grant from Access Accelerated. The funder had no role in data analysis, the writing of the report, or the decision to publish it. The agreement governing this work can be found at accessobservatory.org/funding.

SUGGESTED CITATION

Access Observatory. *Access Observatory* 2021 Report. Boston, US 2021 (online) available from www.accessobservatory.org. November 2021.

ADDRESS

Department of Global Health
Boston University School of Public Health
801 Massachusetts Avenue, 3rd Floor
Boston, MA 02118

info@accessobservatory.org

DESIGN

Vervaine Design Studio, Inc.
vervaine.com

Access Observatory

The *Access Observatory* is a public reporting platform for programs that aim to improve access to disease prevention and treatment services in low- and middle-income countries (LMICs). Programs in the *Access Observatory* focus on more than just medicines and include strategies to strengthen health systems and influence patient behaviors. The *Access Observatory* was created within the scope of Access Accelerated, a collaboration of more than 20 biopharmaceutical companies, working in partnership with the World Bank, the City Cancer Challenge (C/Can 2025) and others, that is committed to tackling the growing burden of non-communicable diseases (NCDs) in LMICs.

The *Access Observatory* aims to strengthen the science of access through the development and use of a new framework for measurement and reporting on access programs. 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, though it is open to all access programs, including those designed and implemented by public and non-profit organizations. The *Access Observatory* in 2020 includes both Access Accelerated and non-Access Accelerated company programs. The *Access Observatory* has been designed 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

In 2017, more than 20 biopharmaceutical companies launched Access Accelerated, an initiative that aims to improve access to prevention, care and treatment for NCDs in low and middle-income countries, working in partnership with the World Bank, the City Cancer Challenge (C/Can 2025) and others.

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.

At the end of 2020, 61 active access programs operating in 104 countries were registered in the *Access Observatory*.

Programs were geographically clustered in sub-Saharan Africa and Southeast Asia. Consistent with previous years, most 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. Cancer was the most common disease focus (61%), followed by general NCD care (18%) and diabetes (15%). Across the 61 programs, there were 240 partnerships between companies and other organizations; more than half of programs had at least one public sector partner. Thirty-two programs (52%) submitted data for at least one indicator in 2020, nearly all of which were an input or output indicator. Very few programs submitted documentation of a needs assessment conducted prior to program implementation. More information is needed to understand whether programs are appropriately designed for the context in which they are implemented.

This is the final *Access Observatory* annual report. It is an opportunity to look back over the past four years and identify key lessons that can contribute to the science of access going forward.

In 2017, the first year of the *Access Observatory*, 62 programs were registered by 17 different pharmaceutical companies. The number of registered programs increased to 73 in 2018 and to 75 in 2019. In 2020, the proportion of programs including an indicator plan (n=44, 72%) and indicator values (n=32, 52%) remained similar to 2019. The decline in the number of programs in 2020 was caused by programs ending (n=10), being integrated into other programs (n=11) or being withdrawn or removed from the *Access Observatory* (n=2). The total reduction of programs between 2019 and 2020 (n=23) is not much larger than the reduction in programs between 2018 and 2019 (n=19). However, significantly fewer programs were newly registered in 2020 (n=8) compared with new program registrations in 2018 (n=13) and 2019 (n=17). The number of active programs is not an indicator of success for either the industry or the *Access Observatory*. The unprecedented global health challenge caused by COVID-19 has undoubtedly affected companies' ability to initiate and implement new NCD-related programs. We hope to see a set of new innovative programs being introduced by companies in the coming year.

The COVID-19 pandemic has exacerbated global inequities in access to affordable and safe, quality-assured medicines.

We have seen the importance of data in identifying inequities in the impacts of the virus, and we are now seeing similar inequities in access to the vaccine. The pharmaceutical industry's commitment to measuring and reporting on their access programs is important now more than ever. In light of the pandemic, we encourage companies to explore novel partnership strategies for improving access, including new voluntary licensing agreements to enhance manufacturing capacity. These strategies are part of the *Access Observatory* framework but have not yet been used by registered programs.

Further, we encourage companies to report on how they intend to address sustainability and equity, and to submit data that demonstrates their efforts in doing so. With increasing availability and improvement of program reporting data, there exists an opportunity to build up a strong evidence base on what works to enhance sustainability and equity of programs, including COVID-19 programs. This can inform the design of programs in other disease areas. Tracking progress or driving improvements is not possible without some form of performance measurement, which is why the industry and its partners should strengthen its leadership role in generating and using evidence to improve access globally.

Table of Contents

Executive Summary	4	Results from Year Four	24	Looking Forward	49
Preface	7	Summary of Year Four Findings	25	Conclusion	54
Background	14	Program Geography	26	References	55
Importance of Measurement and Reporting	15	Ended, Withdrawn or Removed, and Integrated Programs	27	Appendices	56
Measurement Framework	16	Program Strategies and Activities	28	Appendix 1: List of Programs Reported into the <i>Access Observatory</i>	56
Principles	17	Disease Scope	31	Appendix 2: Number of Programs by Country	61
Taxonomy of Strategies	18	Medicines and Technology	33	Appendix 3: List of Funding and Implementing Partners	65
Logic Models	19	Role of Pharmaceutical Companies	37		
Indicators and Data Dictionary	20	Partnerships and Stakeholders	37		
Access Observatory	21	Programs Alignment with Local Priorities	39		
Overview of Submission and Review Process	22	Needs Assessments	39		
Program Registration	22	Indicator Results	41		
Indicator Plan	23	Trends in Reporting Between 2017 and 2020	43		
Indicator Values	23	Results from C/CAN 2025	45		
		Program Geography	46		
		Program Strategies and Activities	46		
		Partnerships and Stakeholders	47		
		Next Steps	47		
		Program Indicators	48		

Preface

Why is it important that pharmaceutical companies measure and report on their access efforts?



Cecile Oger

Managing Director, BSR



Aude Ucla

Associate Director, BSR

“Applying a standardized approach is essential to improve program management and impact, resource allocation, cost effectiveness, communications and to assess the replicability and scalability of access initiatives.”

In the past 15 years, pharmaceutical companies have made significant progress on making their medicines and treatments more accessible to patients around the world. Yet, access remains an ongoing challenge that requires continued action. BSR’s Healthcare Working Group has been pushing for progress on the different elements of access throughout this period, from the launch of the Guiding Principles on Access to Health in 2013, to the report on Advancing Access to Healthcare Metrics in 2016, and now through its Access Leadership Ladder, a tool that promotes a shared vision for access and drives alignment towards increased ambition and progress. These, alongside the *Access Observatory*, all point to one thing: that measurement and reporting (or the lack of consistency there) remain core and central to how much progress is achieved.

While no single indicator can grasp the magnitude of access challenges, measurement is indeed crucial to understand the effectiveness of access initiatives, where companies are making progress and where there are still gaps to address. Most companies use performance metrics that vary considerably from one program to another, limiting the potential to compare and aggregate the impacts of these programs at an enterprise-wide level. Similar comparability and aggregation challenges apply when comparing performance of different companies. Applying a standardized approach is essential to improve program management and impact, resource allocation, cost effectiveness, communications and to assess the replicability and scalability of access initiatives.

Reporting on access efforts and publicly sharing learnings from both successes and failures contributes to informing and engaging stakeholders and partners but also enables progress for other organizations, ultimately contributing to public good.



Brendan Shaw

Principal, Shawview Consulting

*Adjunct Senior Lecturer, School of Medical Sciences,
UNSW Medicine, University of New South Wales*

“Developing such metrics can be challenging but, importantly, it is an opportunity for pharmaceutical companies to support human development and become better businesses. The Access Observatory provides an important opportunity for pharmaceutical companies here and its collaboration with the industry on this is to be commended.”

The role of pharmaceutical companies in improving human health has probably never been under more scrutiny than it is today. In the last two years, the contribution pharmaceutical companies make to society has been both ably demonstrated and widely debated. At the same time, companies in all industries across the world are increasingly being called upon to demonstrate how they contribute to important environmental, social and governance issues facing the global community. Where once private sector companies only needed to demonstrate profitability, more and more companies today also need to show how they help make the world a better place. The pharmaceutical industry is no different. This is why pharmaceutical companies need to be able to demonstrate the positive impact they have on the global community. As with many other aspects of modern-day business, pharmaceutical companies reporting on the impact of their access efforts improves their effectiveness and develops best practices. Developing such metrics can be challenging but, importantly, it is an opportunity for pharmaceutical companies to support human development and become better businesses. The *Access Observatory* provides an important opportunity for pharmaceutical companies here and its collaboration with the industry on this is to be commended.



James Hazel

*Research Programme Manager,
Access to Medicines Foundation*

“By providing a platform for reporting, the Access Observatory serves as a complementary resource that helps foster better reporting standards for access programmes and thus, supports information sharing with external stakeholders and facilitates accountability.”

Evaluating the long-term effects of access initiatives on healthcare systems and patients supports the improvement of access to medicine, as it enables pharmaceutical companies to understand what works and build on progress. By providing a platform for reporting, the *Access Observatory* serves as a complementary resource that helps foster better reporting standards for access programmes and thus, supports information sharing with external stakeholders and facilitates accountability.



Sebastien Mazzuri

Managing Director, FSG

“The missing link, and next frontier for the industry, will be the ability to measure and manage the economics of impact for access activities, and systemically, actively, and transparently connect and reconcile the financial and societal objectives of the company.”

A new purpose-led economy is in the making, with purpose anchored in corporate statutes, leadership accountability, and business strategy. In health care, companies are being increasingly held accountable for authentically delivering against their purpose to ‘improve and extend lives for all patients’ by expanding access to their scientific breakthroughs to marginalized communities experiencing inequitable health outcomes. As a result, measuring and reporting consistently on their access efforts has become a necessity for pharmaceutical companies to communicate with their stakeholders.

However, despite pledges to advance access and setting ambitious targets, efforts to improve access and health outcomes for marginalized groups are often peripheral for lack of short-term profitability. Access targets remain disconnected from companies’ financial projections communicated with investors, creating potential for miss-alignment on expectations. And company executives are increasingly under pressure and face a dilemma of managing capital allocation in a way that meets both financial and societal targets.

The missing link, and next frontier for the industry, will be the ability to measure and manage the economics of impact for access activities, and systemically, actively, and transparently connect and reconcile the financial and societal objectives of the company. The first step is to link financial and societal outcomes in order to gain transparency on how the business currently balances potential trade-offs. The next step is to understand the outcome-profit relationship and the factors driving the status quo. Lastly, surfacing trade-offs and their underlying factors will help companies confront the internal and external causes of inequities, focus innovation resources, and create the basis for collaboration to advance access and health equity—building trust, relationships, and solutions with all system partners, from regulators to marginalized communities that do not currently fully benefit from the company’s innovations.



Richard Laing

Retired Professor

*Department of Global Health,
Boston University School of Public Health*

“Learning from successful access strategies empowers all companies to improve their performance. The Access Observatory has provided a clearinghouse in which detailed descriptions of a range of real world access projects and programs have been reported. Learning what has worked or not worked can guide future initiatives.”

External observers frequently group innovative pharmaceutical companies as big PHARMA assuming that the companies are a common network of similar organization. But the reality is very different, every company has a unique culture and each varies in their approach to ensuring universal access to their products. Companies try different approaches and learn from their own and other experiences.

Merck (MSD) was recently praised by Ed Silverman* for a “groundbreaking” approach to making their new COVID-19 therapy widely available by making voluntary licenses available to a number of Indian generic manufacturers to produce and sell the product in a geographically limited number of countries. In addition they have concluded a voluntary license agreement with the Medicines Patent Pool. But this approach was not groundbreaking as it had been used more than ten years previously by Gilead to make their new Anti-Retrovirals (ARV) available. Merck had used a different innovative access strategy by linking the price charged for their ARVs to the [Human Development Index](#) so that low index countries paid less. That approach did not take off but the Gilead initiative has now been broadly duplicated.

Learning from successful Access strategies empowers all companies to improve their performance. The Access Observatory has provided a clearinghouse in which detailed descriptions of a range of real world access projects and programs have been reported. Learning what has worked or not worked can guide future initiatives. These learnings are particularly useful when planning access initiatives for patients with Non-Communicable Diseases (NCDs) in Low and Middle Income countries. Their health systems are transforming to meet the life long care challenges of NCDs. Each innovative pharmaceutical company will be called on to play a part in addressing this global challenge.

*Senior Writer, Pharamlot Columnist at STAT, an American health-oriented news website.

How has the COVID-19 pandemic influenced how you think about the responsibilities of pharmaceutical companies, with respect to their access efforts or their public reporting on those efforts?



Sarbani Chakraborty

Senior Advisor, Health Finance Institute
Senior Health Financing Consultant
World Health Organization

“Robust metrics are key to implementing health systems partnerships.”

Never in the history of medicine has a vaccine been so quickly brought to market. Given the complexities of scientific discovery—mRNA technology development took almost 20 years and partnerships between academia, Governments, and the private sector. Once a platform was available, it was possible to plug and play to fight a deadly virus. Today the main topic is equity. COVID-19 has once again exposed the traditional fault lines of equitable and fast access. But access to medicines is only one piece in the puzzle of driving better health outcomes. Driving better outcomes requires working at the cusp of access to medicines and health system issues. As the *Access Observatory* shows, pharma companies are already working on innovative system partnerships. Yet many of these partnerships remain fragile, small or short-term, thereby reducing country and global impact.

To address access to medicines, pharma companies have to commit to playing a bigger catalytic role in health systems strengthening—this is good for access to medicines, but it is also a shared global commitment. Robust metrics are key to implementing health systems partnerships. Metrics play multiple roles such as developing clear Return on Investment (RoI) cases, and bringing external stake holders (governments, impact investors, donors, civil society) together to commit to common goals for investment. COVID-19 has only reinforced the important role of resilient and sustainable systems for health. In the future, we will all be called upon to do more in this area. The best time to start is now.



Christa Cepuch

*Pharmacist Coordinator,
Medicins Sans Frontieres*

“Lessons learned from the COVID-19 pandemic can be applied to industry access initiatives in many disease areas.”

COVID-19 has highlighted the risks associated with charitable approaches and voluntary measures of pharmaceutical corporations. Reliance on the monopoly of production and supply and non-binding approaches to sharing technology has not resulted in equitable access to COVID-19 technologies—as was promised by the global health community.

Corporations and the high income countries which host them continue to resist initiatives launched by WHO and member states that encourage voluntary sharing of IP and technologies (C-TAP, mRNA vaccines Hub). Instead, they prefer to maintain control over where and how production happens, supply and allocation, and pricing of the medical tools. Such private infiltration into the global public health architecture contributes to a sustained concentration of power and prevents LMICs from achieving self-reliance through strengthening programs, local innovation and technology initiatives, and production capacity.

Lessons learned from the COVID-19 pandemic can be applied to industry access initiatives in many disease areas. Rather than focusing on voluntary and intervention-based strategies, the aspects of industry which make medicines inaccessible in the first place—excessive profiteering, lack of transparency on cost of research, development and production (including failing to factor in public investments in R&D), and discriminatory licensing agreements—should be the primary target of access initiatives and impact evaluations.

Relying on goodwill measures from industry has not only left millions without access to essential COVID-19 medical technologies but has also contributed to the glaring lack of access to NCD medicines prior to and exacerbated by the pandemic. To achieve universal access, the crucial lessons learned during the pandemic must be applied across all communicable and non-communicable diseases.



Rachel Nugent

*Vice President, Global
Noncommunicable Diseases
RTI International*

“Systems that enable NCD patients to manage their conditions might need reinforcement or retooling, and there is a role for pharmaceutical companies to be involved.”

Due to the COVID-19 pandemic we have become aware of the additional vulnerabilities that people living with NCDs experience, from reduced immunity to infection, challenges accessing health care, and higher cognitive demands to manage their diseases while trying to achieve protection from COVID-19. We know that people living with NCDs have excess deaths and higher risk of infection and severe COVID-19. It is incumbent on all players in the health system to ease this burden on already-challenged people. Systems that enable NCD patients to manage their conditions might need reinforcement or retooling, and there is a role for pharmaceutical companies to be involved. For instance, one of the adjustments in the initial phase of the pandemic was extending the duration of prescriptions for NCD medicines so patients did not need to come to health facilities as frequently.

Pharmaceutical companies may provide guidance to clinicians to encourage extended prescriptions and consider adjusting packaging for ease of use. Another issue is communicating to patients with underlying conditions about the additional risks they face from COVID-19 and providing pop-up testing centers for those who may have limited mobility due to higher risks. These are but a few of the possible actions from pharmaceutical companies that can support their customers during this challenging time. In the long run, such supportive actions are likely to build loyalty and appreciation from people who have extra demands on them during a stressful period.

Background

In 2015, UN member states agreed on the Sustainable Development Goals (SDGs) outlining a roadmap for a more sustainable and prosperous future. The SDGs recognize the specific responsibility of the private sector in contributing to achieving these goals. Part of this responsibility involves documenting private sector contributions in a methodologically sound and transparent manner. The pharmaceutical industry has a special role to play in contributing to the SDGs because their products have a direct impact on the health and well-being of populations. As such, the industry has an increased responsibility to produce robust evidence of their contributions to global health goals.

Historically, very large flagship donation programs by pharmaceutical companies have targeted infectious diseases in low and middle-income countries (LMICs), in particular onchocerciasis (river blindness) and schistosomiasis (snail fever). However, changing population demographics and risk factor exposures have resulted in a growing global burden of NCDs in LMICs, which are exacerbated by challenges in accessing affordable prevention and treatment services. Due to this ongoing shift in disease burden, health systems must transform from addressing acute infectious diseases to providing life-long care for chronic conditions that become more common as individuals live longer. This transformation will require cooperation across sectors, public and private, social and medical and urban and rural. No single institution can do it alone in such a complex situation.

Within this shifting context, pharmaceutical companies are increasing their efforts to strengthen health systems, rather than depending on product donations, as part of their strategy to improve access. Recognizing the complexity of the challenge, they have developed new partnerships with a wide range of governmental and non-governmental organizations to address the many factors impacting the global burden of NCDs. Although the number of industry-led programs targeting NCDs in LMICs has increased substantially in recent years, there is a gap in robust publicly available information for most programs, making it difficult to assess whether program expansion will translate into stronger health systems, increased patient access, and improved population health.

In 2017, more than 20 biopharmaceutical companies, working in partnership with the World Bank, City Cancer Challenge (C/Can 2025), and others, launched Access Accelerated, an initiative that aims to improve access to prevention, care and treatment for NCDs in LMICs.¹ As part of Access Accelerated, companies and partners committed to measuring and publicly reporting on their programs. The Access Accelerated Secretariat asked Boston University (BU) to independently develop a measurement framework for access programs and to support program reporting.

Boston University developed the *Access Observatory*, a reporting platform for private sector-led access programs.

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 collaboration in programmatic areas of common interest
- Inform efficient resource allocation
- Promote public understanding of private sector contributions

The agreement between the Access Accelerated Secretariat and Boston University is available for public view 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:

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

Principles

Principles guiding development of the measurement framework and Access Observatory

Four core principles guided the development of the framework and *Access Observatory*, informing decisions on process and content.



Independence from Industry

- The measurement framework was designed with independence from the pharmaceutical industry.
- 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.
- Legal contracts, including clauses governing data transparency, are publicly 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.



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 responsiveness.²
- Logic models and accompanying indicators were designed to align with the UN SDGs and WHO recommendations.

^{*}A “theory of change” is a method that explains how a given intervention, or set of interventions, is/are expected to lead to a specific development change, drawing on a causal analysis based on available evidence.³

Taxonomy of Strategies

A taxonomy was developed based on existing literature and extensive consultations.⁴ The taxonomy is organized into four broad strategy categories: community strategies; health system strategies; medicine production strategies; and medicine price strategies. Each of the 11 strategies fits within one of these four broader categories. Many pharmaceutical company-led programs do not exclusively focus on access to medicines but take a broader approach to address a variety of access barriers. The taxonomy of strategies helps to categorize programs and effectively demonstrates where efforts are being focused. A single program may encompass one or more of these strategies.

Table 1: Taxonomy of Strategies: Categories and Strategies

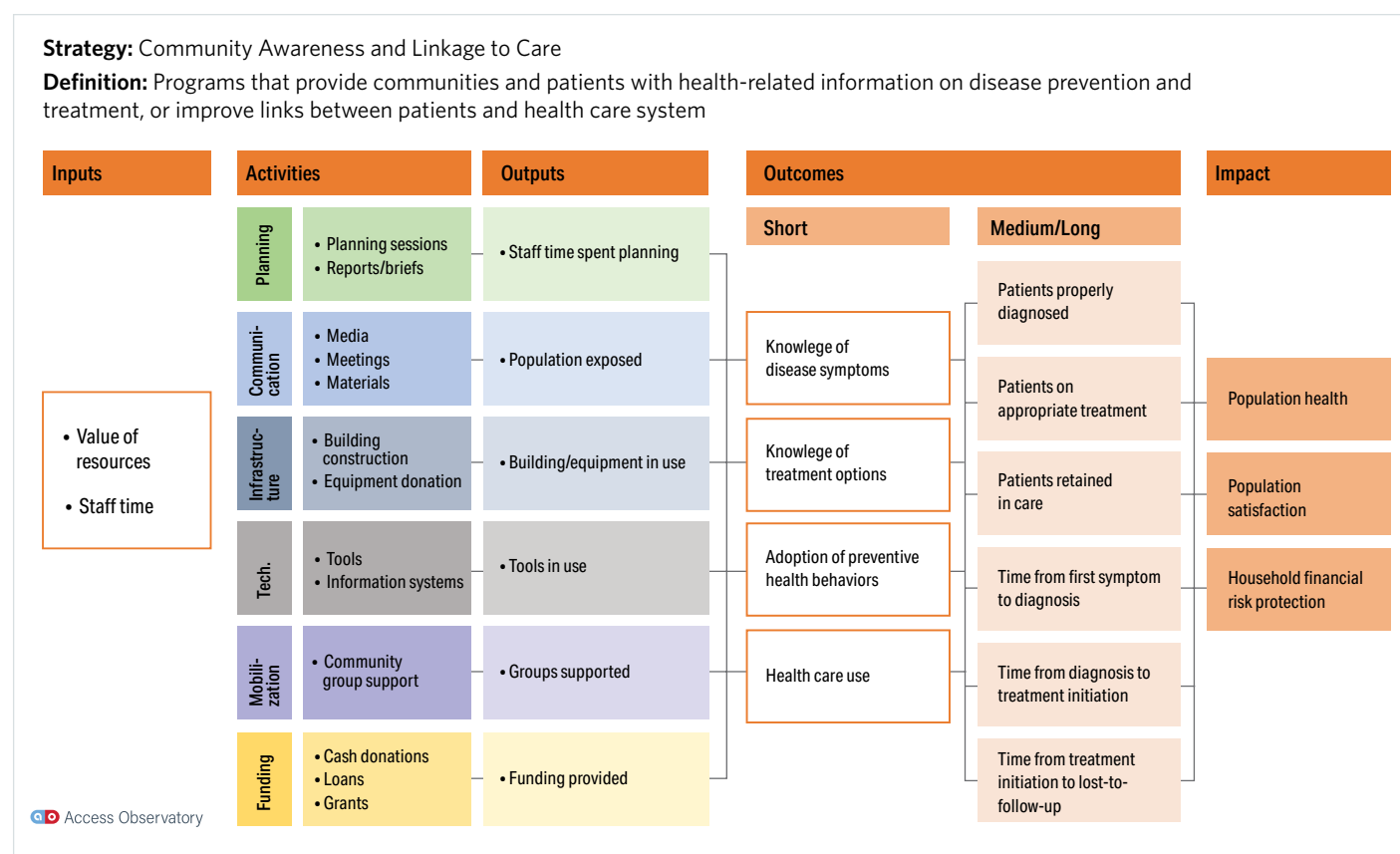
Strategy Category	Strategy	
Community Strategies <i>Strategies with a primary focus on communities and community organizations, with a particular focus on patients.</i>	Community Awareness and Linkage to Care	
Systems Strategies <i>Strategies with a primary focus on aspects of the health system that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

Figure 1: Example of a Logic Model



The complete set of logic models is available at accessobservatory.org.

Indicators and Data Dictionary

For each concept in the logic models, at least one corresponding indicator was developed to allow programs to measure their progress along the logic model pathways. 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.

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

Item	Description
Indicator Name	Number of People Trained
Indicator Type	Output
Strategies that Use Indicator	(1) Product development research; (2) Financing; (3) Health service strengthening; (4) Manufacturing; (5) Regulation & Legislation; (6) Supply chain
Definition	Number of trainees
Method of Measurement	Counting of people who completed all training requirements Calculation: Sum of the number of people trained
Recommended Disaggregation	By institution, sex, geographical region, by cadre
Frequency of Reporting	Annually unless otherwise stated
Recommended Data Source	Training organization records
Other Possible Source	Routine program data
Further Info	Adapted from: Indicator-Based Pharmacovigilance Assessment Tool Manual for Conducting Assessments in Developing Countries. Page 40. pdf.usaid.gov/pdf_docs/PNADS167.pdf

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* are publicly available—confidential data are not accepted. The *Access Observatory* is the primary 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.

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, this includes summary reports for each program as well as the full set of raw information and indicator data in a spreadsheet format.

The screenshot shows the homepage of the Access Observatory website. At the top, the logo (a blue circle with a white 'a' and a red circle with a white 'o') is followed by the text 'Access Observatory'. To the right of the logo are navigation links: 'About', 'Program Reports', 'Datasets', 'C/Can 2025', and 'Annual Report'. Below the navigation bar is a large banner featuring a lighthouse on a rocky island. The banner text reads: 'Public reporting on efforts to improve access to medicines globally' and '2021 Report now available'. A 'Download' button is positioned at the bottom right of the banner. 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: '102 programs' (with a red book icon), '114 countries' (with a red globe icon), and '19 companies' (with a red 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 'Datasets'. Below the 'Program Reports' button, a short description states: 'Program Reports provide a description of each program, including country of operation, focus disease, access strategies and activities, and target populations.' Below the 'Datasets' button, a short description states: 'Datasets allow the download of information from all programs.' At the bottom of the page, the logo and name 'Access Observatory' are repeated, along with the address '801 Massachusetts Avenue, Third Floor, Boston, MA 02118'. A 'Contact us' button is located in the bottom right corner.

The Access Observatory is currently reporting on

- 102 programs
- 114 countries
- 19 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.

Datasets

Datasets allow the download of information from all programs.

Access Observatory

801 Massachusetts Avenue, Third Floor, Boston, MA 02118

[Contact us](#)

Access Observatory website homepage

Overview of Submission and Review Process

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 program information and data posted on accessobservatory.org is authored by the program teams and not by the *Access Observatory* team.

Figure 2: 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.⁵

The Program Registration includes information on program objectives and activities as well as alignment with local needs.

Indicator Plan

After the 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 companies 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	<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) 	

Results from Year Four

In 2020, there were 61 active programs registered in *Access Observatory* by 18 different companies. The same 18 companies had active programs in last year's report. Of the programs, 59 were Access Accelerated programs and two by Novo Nordisk were non-Access Accelerated programs. Eight of the 61 programs were newly registered in 2020 by 6 different companies. Meanwhile, 23 programs previously registered in the *Access Observatory* ended, were withdrawn or removed, or were integrated into other programs prior to 2020. These are not included in this year's report. Out of the 61 programs active in 2020, 44 had an indicator plan and 32 submitted indicator values for 2020.

Summary of Year Four Findings



There were 61 registered access programs active in 2020. This includes 8 programs that were newly registered in the past year. 23 registered programs ended, were withdrawn or removed, or were integrated into other programs prior to 2020 and are not included in this year's report.



Since 2017, no programs have used Manufacturing or Licensing Agreement strategies, which might be considered core strengths of the industry. Since companies have competitive advantages in these areas compared to other global health actors, they provide important opportunities for innovation.

32

Thirty-two (52%) programs reported data for at least one program indicator in 2020. More data is needed to fully capture the pharmaceutical industry's contribution to global access and to demonstrate progress toward commitments made by the industry.



Around 40% of programs included medicines or medical devices as part of their strategy. Most medicines included in programs were for cancer treatment, many of which require well-functioning secondary and tertiary health care infrastructure to deliver.



Programs are concentrated in a relatively small number of countries. For example, Kenya had 23 programs active in 2020. Geographic concentration creates potential opportunities for efficient and impactful multicompany collaboration.



One-third of programs conducted a needs assessment prior to implementation. Needs assessments are critical to appropriate program design and help ensure that programs respond to local needs.



The majority of programs use three strategies: Community Awareness and Linkage to Care; Health Service Strengthening; and Health Service Delivery. This has remained consistent since the inception of Access Observatory in 2017.

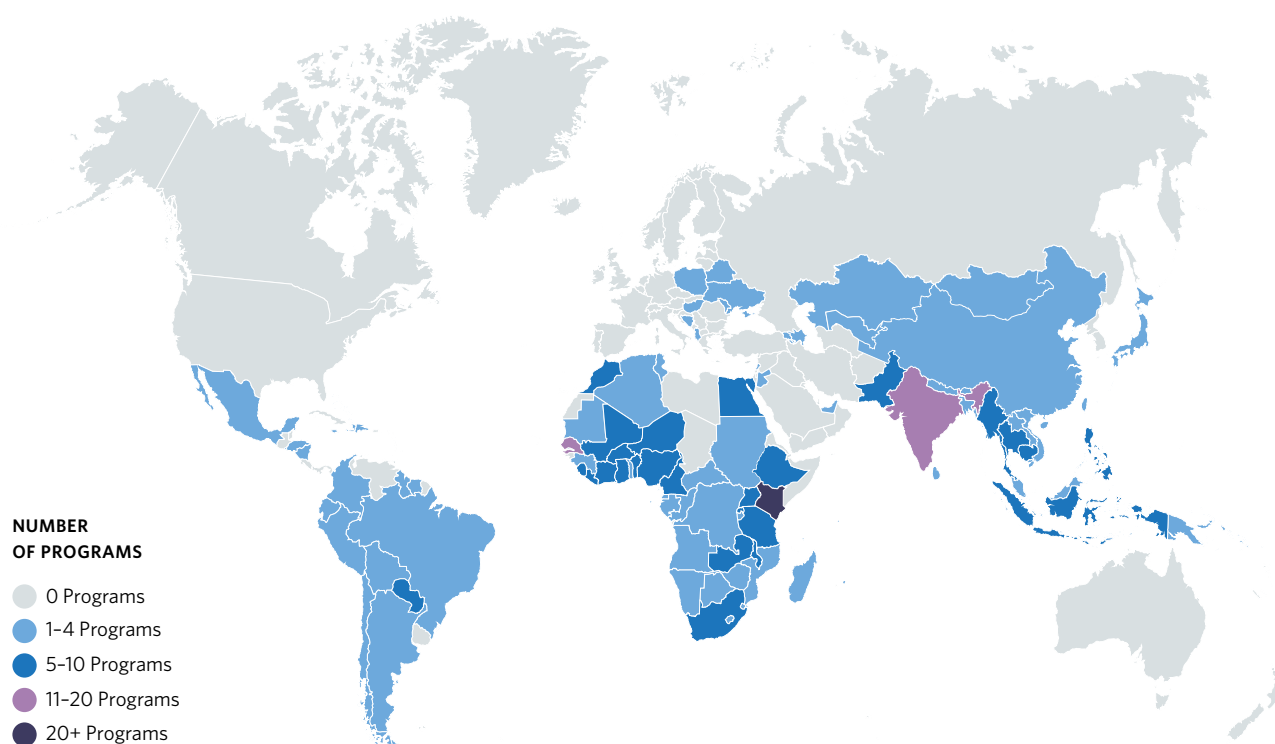
Figure 3: Number of Programs in the Access Observatory*



Program Geography

Sixty-one programs were active in 104 countries (see [Appendix 2](#) for a full list). About two-thirds of programs were active in only one country and one-third were active in multiple countries. Programs were clustered in certain geographic regions, in particular Sub-Saharan Africa and Asia.

Figure 4: Geographic Distribution of Active Programs in the Access Observatory



*4 additional programs newly registered in the Access Observatory began operating in 2021: RACE Risk Factor Awareness drive through CSI Expert's group [Merck KGaA], Vietnam Thyroid Expansion Project [Merck KGaA], Adolescent health project in Zimbabwe [Daiichi Sankyo], and Breast and Cervical Cancer Screening Camp in Nepal [Daiichi Sankyo]. This report is focused on programs active in 2020, and these programs are not included in the summary statistics presented throughout this section.

Ended, Withdrawn or Removed, and Integrated Programs

Twenty-three programs previously registered in the *Access Observatory* ended (n=10), were integrated into other programs (n=11), or were withdrawn or removed from the *Access Observatory* (n=2).

Table 4: List of Previously Registered Access Observatory Programs

Pharmaceutical Company	Program Name	Countries of Implementation	Program Start
Ended			
BMS	Pink Ribbon, Red Ribbon	Ethiopia, Tanzania	2013
Daichii Sankyo	Mobile Healthcare Field Clinic Services in Tanzania	Tanzania	2017
	Cultivating Healthcare Workers in China	China	2015
Merck & Co	SPARTA	Australia, Austria, Belgium, Singapore, India, Switzerland, Ireland, Thailand, Mexico, Philippines, Oman, Russia, Sweden Indonesia, Taiwan, Brazil, Germany, United Arab Emirates, Greece, Vietnam, Malaysia	2009
	SPARSH Healthline	India	2009
Pfizer	Healthy Communities	Myanmar, Vietnam	2017
Sanofi	Sanofi Mental Health Program (FAST – Fight Against STigma) – Madagascar	Madagascar	2017
	Sanofi Mental Health Program (FAST – Fight Against Stigma) – Armenia	Armenia	2017
Takeda	AMPATH Oncology Preceptorships & Telemedicine Program	Kenya, Rwanda, Uganda, Tanzania	2017
	Digital Birth Registration in Kenya	Kenya	2016
Integrated into a New Program			
Bristol-Myers Squibb Foundation	Secure the Future Kimberly Hospital Complex — South Africa ¹	South Africa	2017
	Secure The Future — Tanzania ¹	Tanzania	2017
	Secure The Future — Lung Cancer in Kenya ¹	Kenya	2017
	Secure The Future — Lung Cancer in Swaziland ¹	Swaziland	2017
	Secure The Future — KwaZulu-Natal, South Africa ¹	South Africa	2017
	Secure The Future — Gauteng Province South Africa ¹	South Africa	2017
Takeda	Cancer Education for Primary Healthcare Professionals in Kenya ²	Kenya	2017
	Chronic Care Program in sub-Saharan Africa ²	Kenya	2016
	Integrated Cancer Curriculum ²	Kenya	2018
	Oncology Fellowship in sub-Saharan Africa ²	Kenya	2016
	Patient Support and Palliative Care Training in sub-Saharan Africa ²	Kenya	2017
Withdrawn or Removed from the Access Observatory			
Astellas	Improving Access to our Anticancer Product in India	India	2017
Takeda	Cancer Alliance for Sub-Saharan Africa	Kenya	2017

¹Program is integrated into the program 'Multinational Lung Cancer Control Programme'

²Program is integrated into the program 'BluePrint for Innovative Healthcare Access'

Program Strategies and Activities

Nearly all programs active in 2020 used at least one of three strategies: Health Service Strengthening (n=48; 79%), Community Awareness and Linkage to Care (n=40; 66%), and Health Service Delivery (n=35; 57%). Most programs used two or three strategies.

Figure 5: Number of Active Programs by Strategy

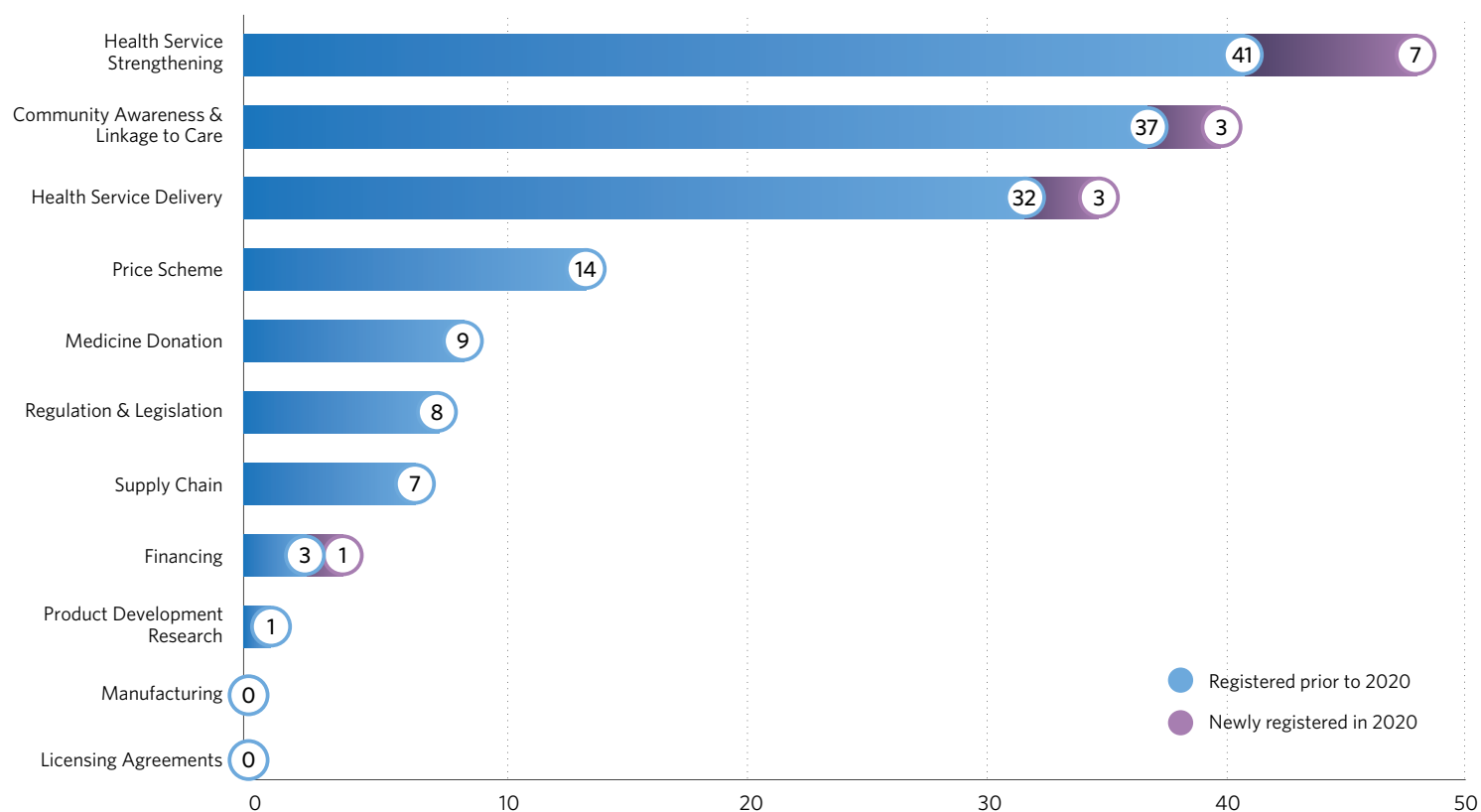
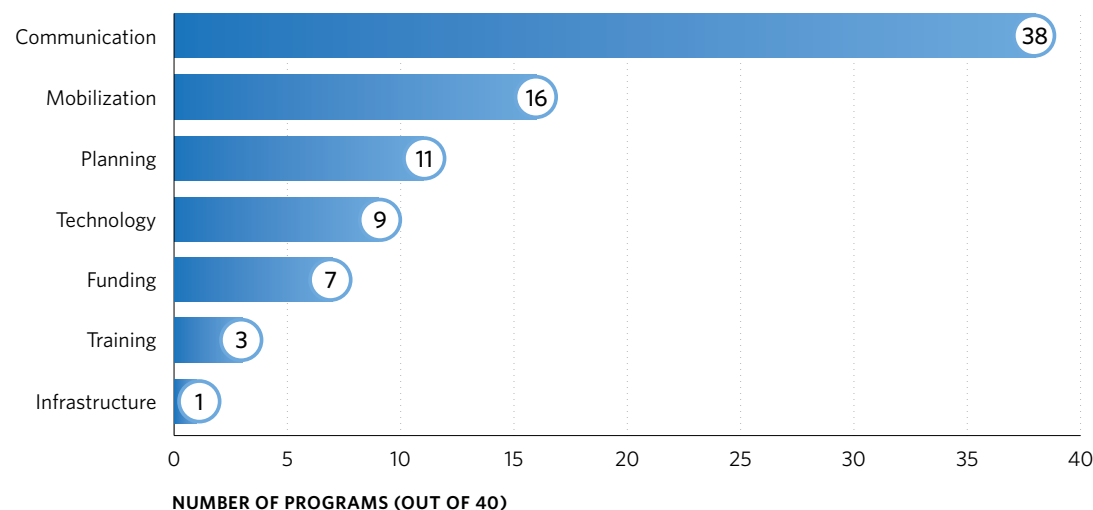
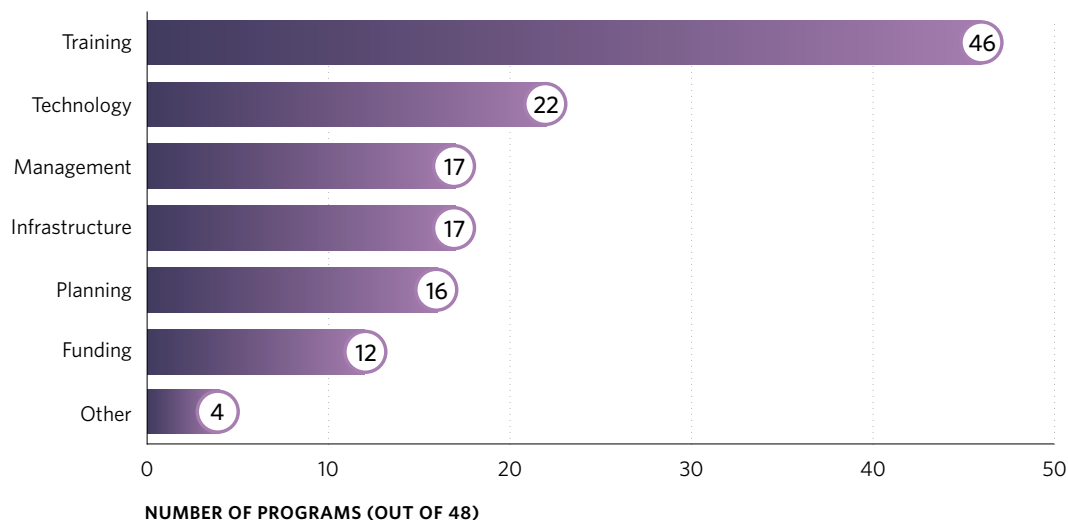


Figure 6: Activities for Programs that Used Community Awareness and Linkage to Care**Figure 7: Activities for Programs that Used Health Service Strengthening**

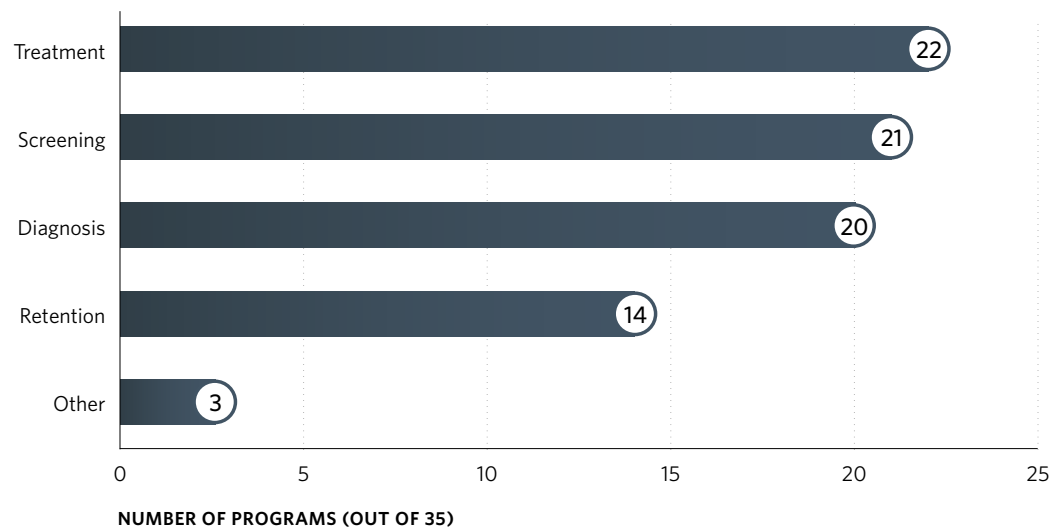
Among programs that used the Community Awareness and Linkage to Care strategy, nearly all had communication activities that used mass media or community awareness meetings to disseminate information to the public (n=38; 95%). Multiple programs included mobilization (n=16; 40%) and planning activities (n=11; 28%). These involved mobilization of community and patient groups, and planning of community awareness events, educational tools and materials. Nine programs (23%) carried out technology activities related to for example disease education software and websites (Figure 6).

Among programs that used the Health Service Strengthening strategy, nearly all had training activities for health care providers (n=46; 94%) (Figure 7). Trainings were mostly conducted in-person, but online trainings as well as combined in-person and online trainings also took place. A majority of the trainings targeted doctors, nurses, or pharmacists (n=39; 85%), followed by community health workers (n=16; 35%) and healthcare administrators (n=5; 11%).

Nearly half (n=22; 48%) of programs that used the Health Service Strengthening strategy provided technology such as electronic medical records, screening and diagnostic decision apps. A smaller number included management activities focused on developing treatment and referral protocols (n=17; 35%) or infrastructure activities such as donation of buildings and diagnostic equipment (n=17; 35%).

Among programs that used the Health Service Delivery strategy, a majority provided treatment (n=22; 63%), conducted screenings (n=21; 60%), or provided diagnosis (n=20; 57%) (**Figure 8**). Several also took steps to retain patients in care through phone calls and text message reminders (n=14; 40%).

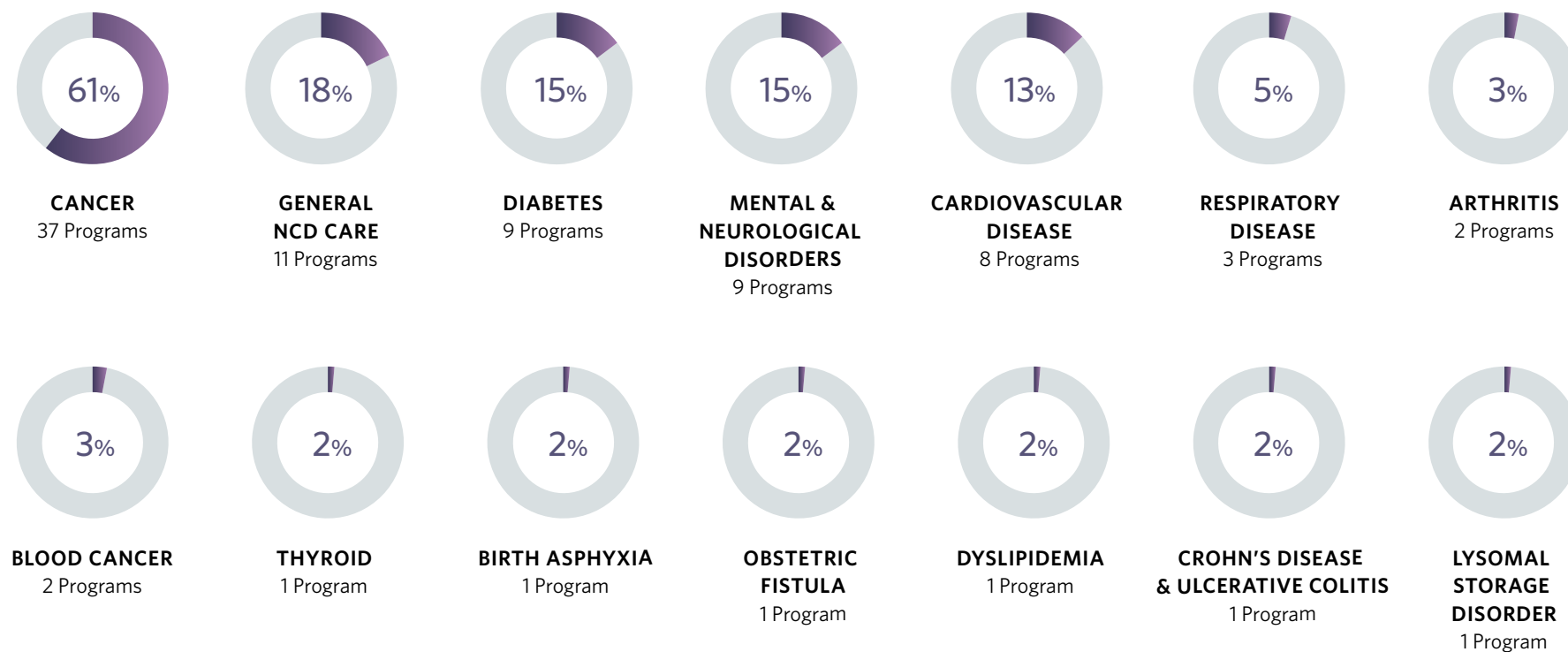
Figure 8: Activities for Programs that Used Health Service Delivery



Disease Scope

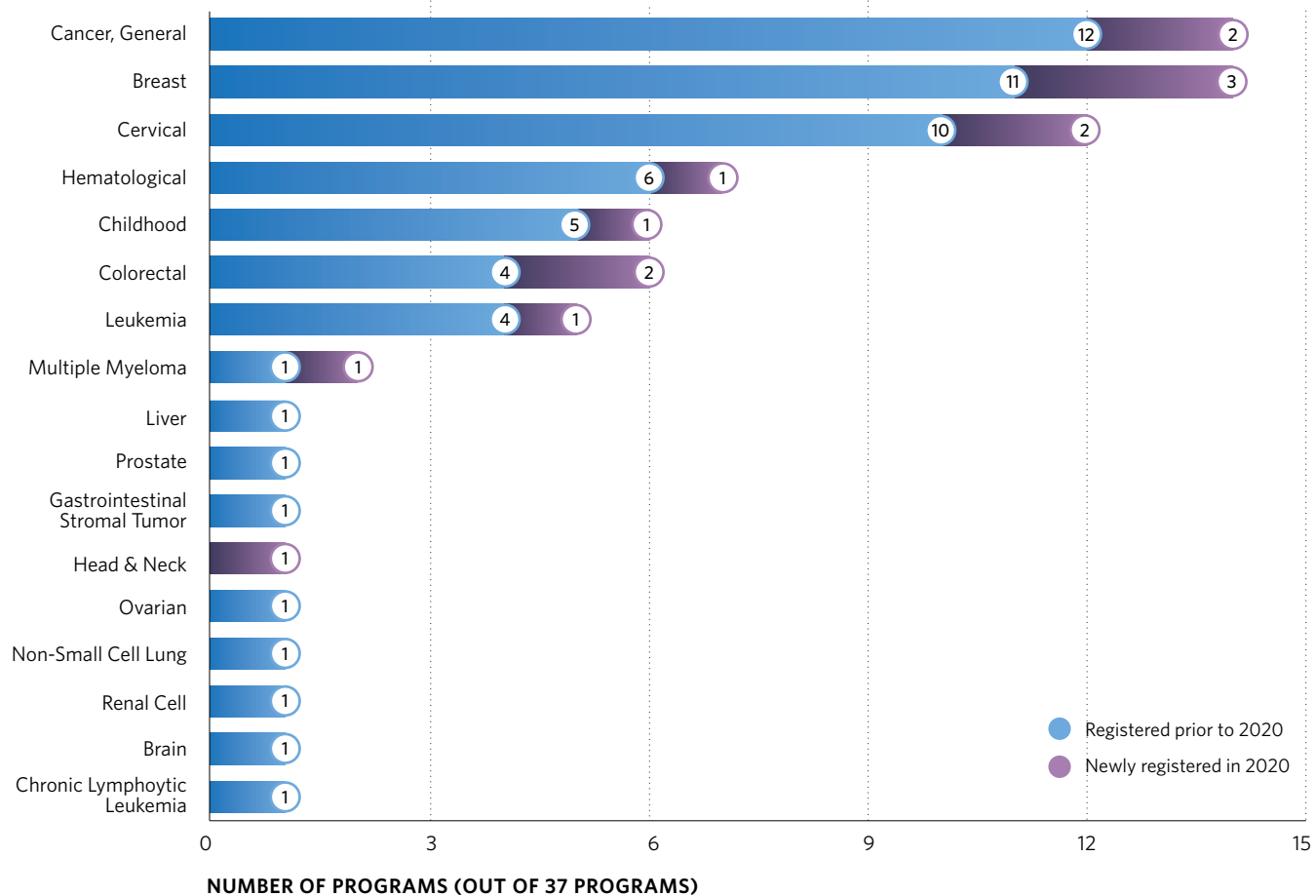
Programs focused mainly on improving access to cancer care (61%), diabetes (15%), or mental and neurological disorders (15%) (**Figure 9**). Six of the eight programs (75%) that were newly registered in this past year focused on cancer care.

Figure 9: Percentages of Active Programs by Diseases



Of the 37 cancer programs, 14 (38%) focused on breast cancer and 12 (32%) on cervical cancer.

Figure 10: Number of Active Programs by Cancer Type



Medicines and Technology

Twenty-five out of the 61 active programs (41%) provided at least one health technology, and 12 (20%) provided multiple health technologies. Twenty programs (33%) provided medicines, 6 programs (10%) provided medical devices, including diagnostic equipment for cancer, diabetes, and hypertension, and one program provided vaccines.

Most medicines included in programs were delivered via the Price Scheme strategy; a minority were in programs using the Donation or Health Service Delivery strategies. Most of the medicines are used to prevent or treat cancer followed by diabetes.

Table 5: Type of Health Technology

Type of Health Technology	Therapeutic Area	Number of Programs
Medicine	Oncology	14
	Diabetes	5
	Antibiotics	2
	Cardiovascular Disease Medicines*	2
	Asthma	1
	Crohn's Disease & Ulcerative Colitis	1
	Multiple Sclerosis/Immunosuppression	1
	Lysosomal Storage Disorder	1
Vaccine	Human Papillomavirus	1
Type of Equipment		
Medical Device	Cancer Diagnostic Equipment	1
	Cancer Treatment Equipment	2
	Diabetes Diagnostic Equipment	4
	Hypertension Diagnostic Equipment	1
	Laboratory Testing Equipment	3

*Including medicines for dyslipidemia, hypertension & heart failure

Table 6: Medicines and Vaccines by Therapeutic Group

Main Therapeutic Group (Number of Programs)	International Nonproprietary Names (INN)	Number of Programs	Program Name [Company]
Oncology Medicine (n=14)	All Trans Retinoic Acid*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Alectinib	1	The Blue Tree, India [Roche]
	Anastrozole*	1	Novartis Access [Novartis]
	Arsenic Trioxide*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Asparaginase*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Atezolizumab	1	The Blue Tree, India [Roche]
	Bevacizumab*	2	The Blue Tree, India [Roche]; UNMOL (Urdu for Precious):Access to Cancer Medicines in Pakistan [Roche]
	Bleomycin*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Brentuximab vedotin	2	Patient Assistance Program for Adcetris [Takeda], Blueprint for Innovative Healthcare Access [Takeda]
	Capecitabine*	2	The Blue Tree, India [Roche], EMPOWER, Kenya [Roche]
	Carboplatin*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Cetuximab	1	India Fights Back [Merck KGaA]
	Cyclophosphamide*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Cytarabine*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Dactinomycin*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Daunorubicin*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Eribulin mesylate	1	Hope to Her in India [Eisai]
	Erlotinib*	1	The Blue Tree, India [Roche]
	Etoposide*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Fludarabine*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Fluorouracil (5-FU)*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Human Papilloma Virus Vaccine*	1	GARDASIL — Gavi [Merck & Co.]
	Hydroxyurea	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Ifosfamide*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Imatinib*	1	CMLPath to Care [Novartis]
	Imatinib Mesylate*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Irinotecan Hydrochloride*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Isotretinoin	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]

*Medicines that are listed in WHO Model List of Essential Medicines (2021).⁶

Table 6: Medicines and Vaccines by Therapeutic Group (continued)

Main Therapeutic Group (Number of Programs)	International Nonproprietary Names (INN)	Number of Programs	Program Name [Company]
Oncology Medicine (n=14) <i>continued</i>	Ixazomib	1	Patient Assistance Program (PAP) - Ninlaro [Takeda]
	Letrozole	1	Novartis Access [Novartis]
	Mercaptopurine*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Methotrexate*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Obinutuzumab	2	UNMOL (Urdu for Precious): Access to Cancer Medicines in Pakistan [Roche], The Blue Tree, India [Roche]
	Paclitaxel*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Pertuzumab	3	UNMOL (Urdu for Precious): Access to Cancer Medicines in Pakistan [Roche], The Blue Tree, India [Roche], Perjeta Patient Support Program [Roche]
	Ponatinib	1	Takeda Max Access Solution [Takeda]
	Rituximab*	3	UNMOL (Urdu for Precious): Access to Cancer Medicines in Pakistan [Roche] The Blue Tree, India [Roche], EMPOWER, Kenya [Roche]
	Tamoxifen*	1	Novartis Access [Novartis]
	Trastuzumab*	4	UNMOL (Urdu for Precious): Access to Cancer Medicines in Pakistan [Roche], The Blue Tree, India [Roche] Save Her, Ghana [Roche], EMPOWER, Kenya [Roche]
	Trastuzumab Emtansine	1	The Blue Tree, India [Roche]
	Tretinoin	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Vinblastine*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
	Vincristine*	1	Global HOPE Africa [Bristol-Myers Squibb Foundation]
Cardiovascular Medicines (n=2)	Amlodipine*	2	Novartis Access [Novartis], Ngao Ya Afya [Sanofi]
	Amlodipine and Irbesartan	1	Ngao Ya Afya [Sanofi]
	Bisoprolol*	1	Novartis Access [Novartis]
	Hydrochlorothiazide*	1	Novartis Access [Novartis]
	Irbesartan**	1	Ngao Ya Afya [Sanofi]
	Irbesartan and Hydrochlorothiazide	1	Ngao Ya Afya [Sanofi]
	Ramipril***	1	Novartis Access [Novartis]
	Simvastatin*	1	Novartis Access [Novartis]
	Valsartan**	1	Novartis Access [Novartis]

Included as therapeutic alternative (C09CA Angiotensin II receptor blockers) to Losartan; *Included as therapeutic alternative (C09AA ACE inhibitors) to Enalapril

Table 6: Medicines and Vaccines by Therapeutic Group (continued)

Main Therapeutic Group (Number of Programs)	International Nonproprietary Names (INN)	Number of Programs	Program Name [Company]
Diabetes Medicines (n=5)	Glibenclamide*	1	Ngao Ya Afya [Sanofi]
	Glimepiride	2	Novartis Access [Novartis], Ngao Ya Afya [Sanofi]
	Glimepiride and Metformin	1	Ngao Ya Afya [Sanofi]
	Insulin [Short-acting, Intermediate and Long-acting Insulin]*	4	Changing Diabetes in Children [Novo Nordisk], Base of the Pyramid [Novo Nordisk], Ngao Ya Afya [Sanofi], Tshwane Insulin Project [Eli Lilly]
	Metformin*	1	Novartis Access [Novartis]
	Vildagliptin	1	Novartis Access [Novartis]
	Furosemide*	1	Novartis Access [Novartis]
MS/Immunosuppressive (n=1)	Ocrelizumab	1	UNMOL (Urdu for Precious): Access to Cancer Medicines in Pakistan [Roche]
Respiratory medicines (n=1)	Salbutamol*	1	Novartis Access [Novartis]
Lysosomal storage disorder (n=1)	Idursulfase	1	Lysosomal Storage Disorder Charitable Access Program [Takeda]
	Agalsidase alfa	1	Lysosomal Storage Disorder Charitable Access Program [Takeda]
	Velaglucerase alfa	1	Lysosomal Storage Disorder Charitable Access Program [Takeda]
Ulcerative Colitis and Crohn's disease (n=1)	Vedoluzimab	1	Patient Assistance Program (PAP) — Entyvio® [Takeda]
Diarrhoea (n=1)	Oral Rehydration*	1	Mobile Healthcare Field Clinic Services in Myanmar [Daiichi Sankyo]
Anemia (n=1)	Iron and Folic Acid*	1	Mobile Healthcare Field Clinic Services in Myanmar [Daiichi Sankyo]
Antibiotics (n=1)	Amoxicillin*	1	Novartis Access [Novartis], Mobile Healthcare Field Clinic Services in Myanmar [Daiichi Sankyo]

Role of Pharmaceutical Companies

Companies were mainly involved in funding, planning and supporting program implementation, while implementing partners were mainly involved in program planning and managing program implementation. Most programs are solely funded by the pharmaceutical company, however some are cofounded by other partners including governments. At times the company's sole role is to provide funding to the program, however in the majority of programs, companies also provide support to various planning and implementation activities.

Partnerships and Stakeholders

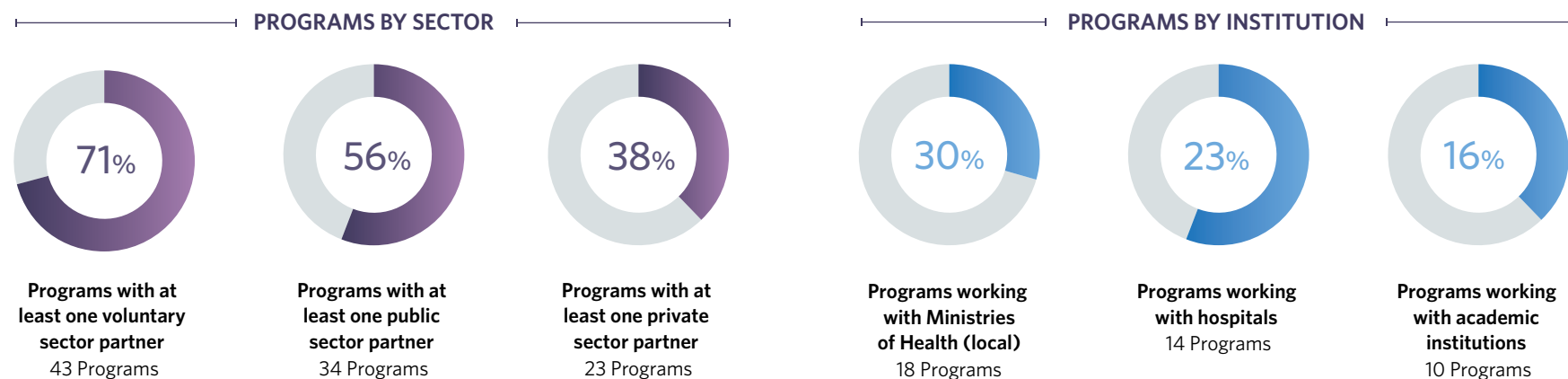
Companies listed 240 unique partners across the 61 active programs. Eighteen were listed as partners for multiple programs. Companies partnered with at least one voluntary sector partner in 71% of programs (n=43); with at least one public sector partner in 56% of programs (n=34) partner in 38% of programs (n=23) (**Figure 12**, p. 39). Voluntary and public sector partners often included ministries of health (n=18; 30%), local hospitals (n=14; 23%) and academic institutions (n=10; 16%). The full list of funding and implementing partners reported by programs can be found in [Appendix 3](#).

Figure 11: Funding and Implementing Partners



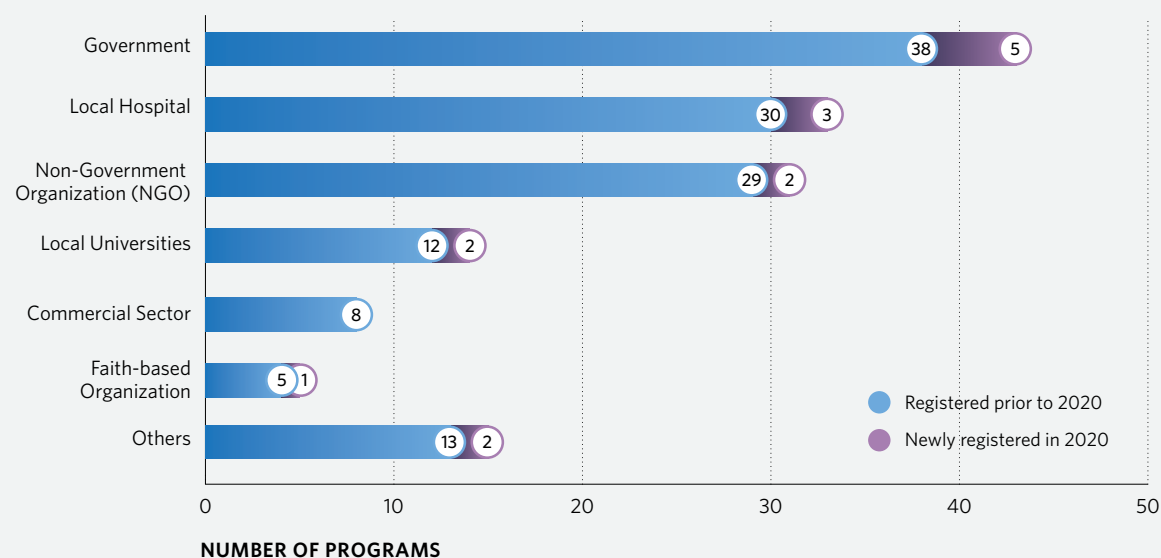
*Unique partners / total number of programs (n=61)

Figure 12: Percentages of Active Programs by Sector and Institution



In addition to partners, most programs also reported engagement with local stakeholders, defined as individuals or entities involved in or affected by the program that may have influence and authority to dictate whether a project is a success or not (ex. Ministry of Health, NGO, Faith-based organization, etc). Most programs indicated engagement with the local government (n=43; 70%), and around half reported engagement with local hospitals (n=33; 54%) or NGOs (n=31; 51%).

Figure 13: Number of Active Programs by Local Stakeholders



Programs Alignment With Local Priorities

It is commonly assumed that access programs align with local priorities, policies, and laws.

Table 7 demonstrates that most companies provide explanations for how local policies, practices and laws have been taken into consideration in their program design (n=40; 66%). Moreover, explanations are provided on how local stakeholders are engaged in program planning and implementation (n=56; 92%), how the company plans for program sustainability (n=54, 89%), and how the program addresses social inequity (n=50; 82%). The explained sustainability strategies and addressed inequities are summarized in **Table 8** and **Figure 14** (p. 40). Nonetheless, public documentation supporting the provided explanations is rarely provided. The *Access Observatory* aims to capture program intentions and efforts to align with local priorities, as well as strategies for sustainability and programs hand-off to local partners.

Needs Assessment

Nearly all companies provided explanations on how their program is responsive to local health needs and challenges (n=60; 99%), however only 21 programs (34%) were based on a formal needs assessment. Public documentation of the needs assessment was only made available for 5 of the 21 programs.

Table 7: Program Response to Local Priorities

Local Priority Issue Questions	Number of programs that responded with explanation	Number of programs that responded "None or Not applicable"	Number of programs that did not respond
How have local policies, practices, and laws (e.g., infrastructure development regulations, education requirements, etc.) been taken into consideration when designing the program?	40	0	21
Please describe how you have engaged with local stakeholders in the planning and/or implementation of this program.	56	0	5
If applicable, please describe how you have planned for sustainability of the implementation of your program.	54	0	7
Does your program aim to address social inequity in any way (if yes, please explain)?	50	4	7
Please describe how your program is responsive to local health needs and challenges.	60	0	1

Table 8: Sustainability Strategies Reported by Programs

Sustainability Strategy	Number of Programs
Transitioning of project activities to local government after end date of program	21
Training of providers and community workers for capacity building/ development	29
Transitioning of project activities to other sponsors or stakeholders after end date of program	18
Incorporating program training curriculum into national curriculum	5
Building and improving existing infrastructure for shared learning and healthcare access	11
Other	14
Unclear	3
No answer provided	6

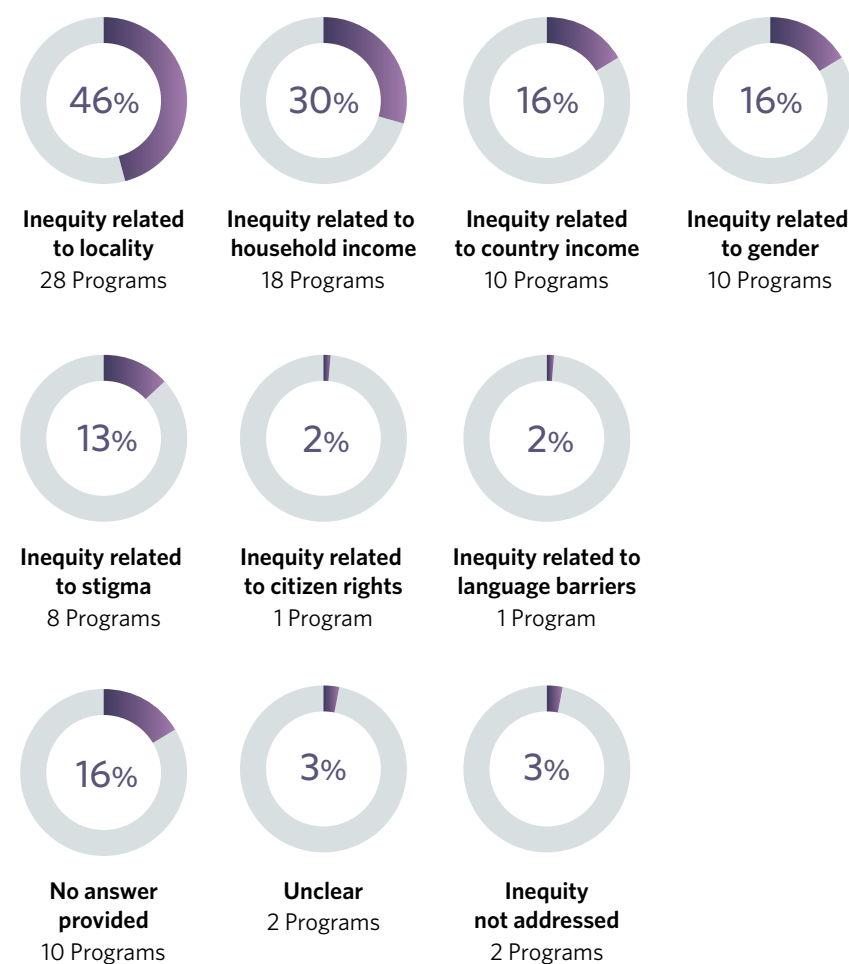
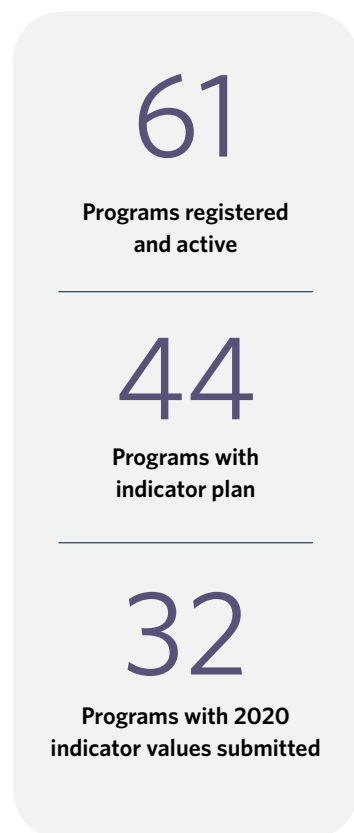
Figure 14: Percentages of Active Programs by Type of Social Inequity Addressed

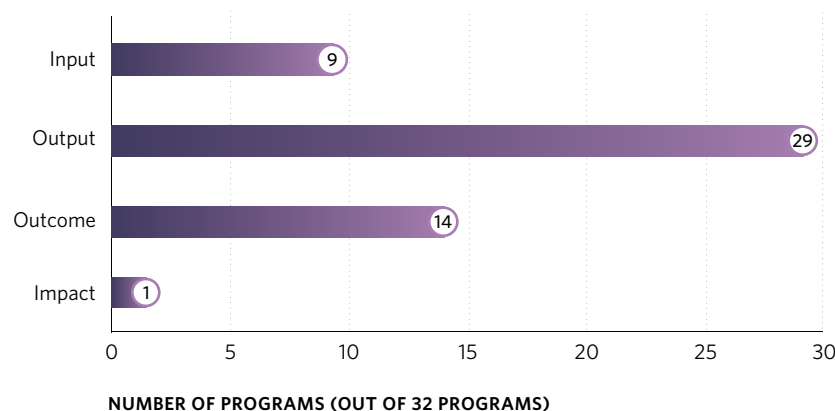
Figure 15: Program Indicator Reporting



Indicator Results

In total, 32 programs (52%) submitted at least one 2020 indicator value (**Figure 15**). Of these, 29 (91%) submitted output indicator values, and 15 (47%) submitted values for outcome or impact indicator values (**Figure 16**). Nine programs (28%) submitted input indicator values.

Figure 16: Number of Active Programs by Indicator Type



The most common input indicators reported in 2020 were “Value of resources” and “Staff time” spent on the project. The most common output indicators were “Tools in use,” “Number of people diagnosed,” “Number of people on treatment,” and “Population exposed to community communication activities.” The most common outcome indicator reported was “Health provider knowledge” and “Patients retained in Care.” “Patients with complete cancer remission” was the only impact indicator reported.

Table 9: Commonly Submitted Indicator Values

Indicator	Type of Indicator	Number of Programs 2017 (n=21)	Number of Programs 2018 (n=25)	Number of Programs 2019 (n=31)	Number of Programs 2020 (n=32)
Value of resources	Input	6 (29%)	10 (40%)	6 (19%)	9 (29%)
Staff time	Input	5 (24%)	7 (28%)	5 (16%)	5 (16%)
Number of people trained	Output	13 (62%)	18 (72%)	14 (45%)	15 (48%)
Tools in use	Output	2 (10%)	4 (16%)	4 (13%)	9 (29%)
Number of patients diagnosed	Output/Outcome	5 (24%)	9 (36%)	9 (29%)	7 (23%)
Number of patients on treatment	Output/Outcome	6 (29%)	7 (28%)	6 (19%)	7 (23%)
Population exposed to community communication activities	Output	10 (48%)	8 (32%)	6 (19%)	4 (13%)
Population screened	Output	3 (14%)	4 (16%)	6 (19%)	3 (10%)
Buildings/equipment in use	Output	3 (14%)	3 (12%)	3 (10%)	3 (10%)
Communication materials in use	Output	3 (14%)	5 (20%)	6 (19%)	2 (6%)
Percentage of professionals trained out of total number targeted	Output	2 (10%)	3 (12%)	5 (16%)	2 (6%)
Sites in use	Output	2 (10%)	2 (8%)	1 (3%)	2 (6%)
Population exposed to oral communication activities	Output	0 (0%)	3 (12%)	4 (13%)	2 (6%)
Volume of medicines sold	Output/Outcome	1 (48%)	1 (4%)	4 (13%)	2 (6%)
Volume of medicines donated	Output/Outcome	0 (0%)	0 (0%)	4 (13%)	1 (3%)
Number of patients enrolled in patient support program	Output	0 (0%)	0 (0%)	2 (6%)	3 (10%)
Number of patients reached with pricing scheme	Output	0 (0%)	0 (0%)	6 (19%)	6 (19%)
Number of patients supported through therapy reminders	Output	1 (5%)	1 (4%)	2 (6%)	2 (6%)
Health provider knowledge	Outcome	3 (14%)	2 (8%)	4 (13%)	2 (6%)
Patients retained in care	Outcome	1 (5%)	2 (8%)	2 (6%)	2 (6%)
Provider awareness of program	Outcome	0 (0%)	0 (0%)	2 (6%)	1 (3%)

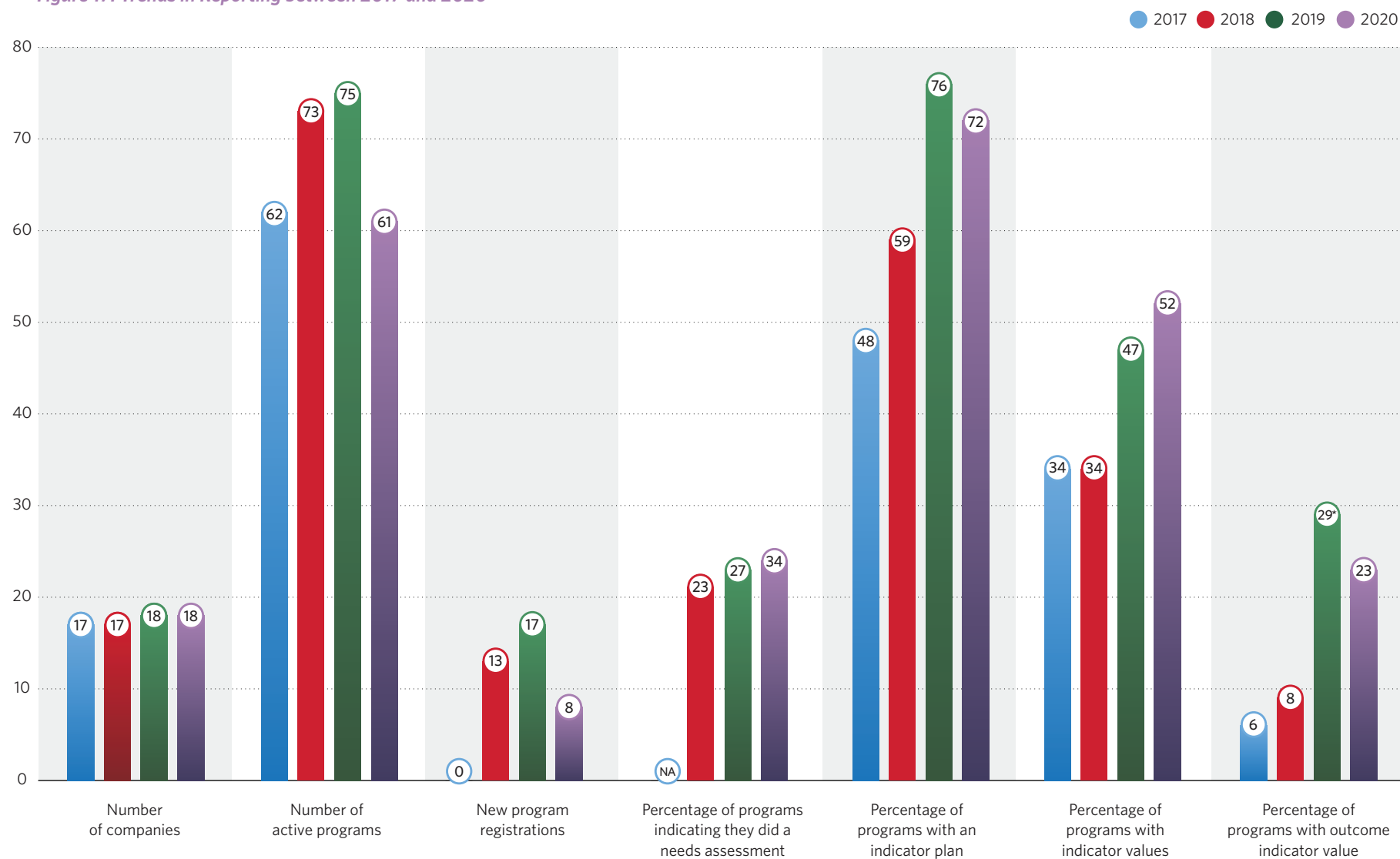
Trends in Reporting Between 2017 and 2020

In 2017, the first year of the *Access Observatory*, 62 programs were registered by 17 different pharmaceutical companies. Less than half of the registered programs (n=30; 48%) included an indicator plan, and even fewer (n=23; 34%) included indicator values (**Figure 17**, p.44). In 2018, the number of pharmaceutical companies reporting to the *Access Observatory* remained the same, meanwhile the total number of programs increased to 73. More program reports included an indicator plan (n=43; 59%), meanwhile the proportion of reports including indicator values (n=25; 34%) remained similar to the year prior. In 2019, an additional company reported on their efforts, resulting in the inclusion of 75 program reports from 18 companies. The proportion of program reports including an indicator plan increased further (n=57; 76%), and so did the proportion of reports that included indicator values (n=34; 47%). In 2020, the proportion of programs including an indicator plan (n=44; 72%) and indicator values (n=32; 52%) remained similar to 2019, however only 61 programs were registered.

The decline in the number of programs in 2020 is caused by programs ending (n=10), being integrated into other programs (n=11) or being withdrawn or removed from the *Access Observatory* (n=2). The total reduction of programs between 2019 and 2020 (n=23) is not much larger than the reduction in programs between 2018 and 2019 (n=19). However, significantly fewer programs were newly registered in 2020 (n=8) compared with new program registrations in 2018 (n=13) and 2019 (n=17).

In 2020, the proportion of programs including an indicator plan (n=44; 72%) and indicator values (n=32; 52%) remained similar to 2019.

Figure 17: Trends in Reporting between 2017 and 2020



Number of companies indicating that they conducted a needs assessment is not available for 2017. *29 includes both outcome and impact values.

Results from C/Can 2025

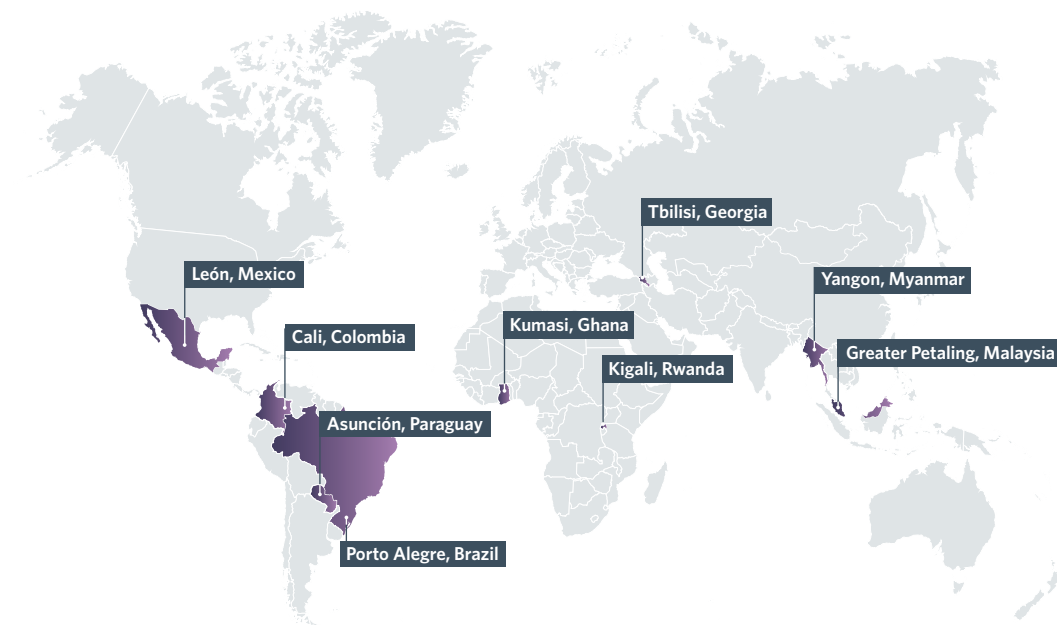
City Cancer Challenge (C/Can 2025) is a multi-sectoral initiative that seeks to engage all city stakeholders including government (local, regional, national), civil society, academia, healthcare facilities and professionals, and private sector in the design, planning and implementation of cancer care solutions. C/Can 2025 supports cities to undertake a comprehensive city-wide assessment to identify current gaps, needs and priorities in cancer care, prioritize objectives, develop a costed activity plan, identify partners and financing solutions to support implementation of plans, and develop a monitoring and evaluation framework.

Program Geography

C/Can 2025 started in 2017 with four key learning cities: Asunción in Paraguay, Cali in Colombia, Kumasi in Ghana, and Yangon in Myanmar (Figure 18).

The initiative is scaling-up support to a wide network of ‘Challenge Cities’ with a population greater than 1 million in every region. In 2020, nine cities were engaged in the C/Can 2025 program.

Figure 18: Geographic Distribution of C/Can 2025 Cities



Program Strategies and Activities

The program strategies and activities include:

Program Strategy	Activity
Health Service Strengthening	Planning Work with cities to conduct a comprehensive needs assessment, prioritize objectives, and develop activity plans.
	Training Support the cities to strengthen their health workforce including training through technical assistance and city-to-city knowledge exchanges.
	Infrastructure, Technology, Management, Funding
Financing	Planning C/Can commissioned a comprehensive market assessment to analyze the need for and opportunity to advance sustainable financing for NCD infrastructure in LMICs through impact investing. Cities work with the C/Can Technical Assistance to understand key information about the health financing landscape, connect with key financing stakeholders, and build capacity among healthcare leaders and policy makers.
Regulation and Legislation	Advocacy C/Can is enhancing advocacy efforts in cities.

Partnerships and Stakeholders

C/Can 2025 works with multiple global partners, from the private sector, public sector and voluntary sector (**Table 10**).

In addition, C/Can 2025 engages with several national, regional, city level and local stakeholders including heads of states and governors, ministries of health, First Ladies, embassies, finance and commerce, national cancer societies, national cancer institutes, local hospitals, and local universities, among others.

Next Steps

To allow other cities to learn from the important experience of C/Can 2025 in improving access to cancer care and treatment, detailed output and outcome indicator data from each city is necessary.

Table 10: Implementing and Funding Partners by Sector and their involvement in C/Can 2025

	Private Sector	Public Sector	Voluntary Sector
Partners			
	Access Accelerated	World Bank	World Economic Forum
	AdvaMed	National Cancer Institute — US	University of Pittsburgh Medical Center (UPMC)
	Amgen	International Atomic Energy Agency (IAEA)	American Society of Clinical Oncology
	Dalberg	University de Valle	American Society of Clinical Pathology
	Icon Group	World Health Organization/Pan American Health Organization	Direct Relief
	Roche		European Society for Radiotherapy and Oncology (ESTRO)
	Bristol-Myers Squibb		World Child Cancer
	Novartis		
	MSD		
	Sanofi		
	Sanofi Espoir Foundation		
	Takeda		
	Chugai		
Sector Involvement			
Program Funding	✓	✓	
Program Implementation	✓	✓	✓
Technical Implementation Support		✓	✓
Capacity Building		✓	✓
Financing Expertise		✓	
Expertise, in-kind and financial support during all phases of the programs' design, development and implementation at global, regional and city level	✓		✓

Program Indicators

C/Can 2025 submitted data for 19 indicators ([Table 11](#)) between 2017 to 2020.

Table 11: C/Can 2025 Indicator Values 2017-2020

Indicator	Value	2017-2020	Comment
Cities collaborating to improve cancer treatment and care	Percentage	100%	Cali, Colombia; Asuncion, Paraguay; Yangon, Myanmar; Kumasi, Ghana; Porto Alegre, Brazil; Tbilisi, Georgia; Kigali, Rwanda
Cities Engaged in the City Cancer Challenge	Cities	9	Cali, Colombia; Asuncion, Paraguay; Yangon, Myanmar; Kumasi, Ghana; Porto Alegre, Brazil; Tbilisi, Georgia; Kigali, Rwanda; Leon, Mexico; Greater Petaling, Malaysia
City development of project implementation plans	Cities	4	Cali, Colombia; Asuncion, Paraguay; Yangon, Myanmar; Kumasi, Ghana
Development and strengthening of cancer policies, protocols and processes	Policies, protocols, guidelines, processes	7	2019: n=2, 2020: n=5
Development of tools, guidance and protocols for cancer treatment and care	Policies, protocols, guidelines, processes	12	2018: n=1, 2019: n=11, 2020: NA
Healthcare professionals supported with technical assistance	People	923	2018: n=317, 2019: n=263, 2020: n=243
Needs assessment completed in cities	Needs assessments	4	Cali, Colombia; Asuncion, Paraguay; Yangon, Myanmar; Kumasi, Ghana
Participation of healthcare professionals in identifying needs in cancer treatment and care	People	817	2018-2019: n=817, 2020: NA
Participation of patients in identifying needs in cancer treatment and care	People	652	2018-2019: n=652, 2020: NA
Percentage of health facilities involved in identifying needs in cancer treatment and care	Percentage	86.3%	Simple (non-weighted) average
Technical assistance in cancer treatment and care provided	Activity/events	55	2017-2019: n=24, 2020: n=31 capacity building workshops
Technical experts contributing to technical support on sustainable financing for cancer treatment and care	People	30	2018-2019: n=30, 2020: NA
Technical experts providing technical assistance in cancer treatment and care	People	98	2018: n=44, 2019: n=54, 2020: NA
Technical support provided to facilitate sustainable financing of cancer treatment and care	Cities	2	Cali, Colombia; Yangon, Myanmar
Delivery of quality, equitable and sustainable cancer solutions in C/Can 2025 cities — Access		—	Data not available until 2021
Number of investment cases and/or business models for project plans finalized and approved	Investment cases	2	
Evidence used to support development of cancer treatment and care solutions		10	10 specialized training packages developed based on evidence gathered and lessons learned
Total Population Covered	People	42.9M	

Looking Forward

Since it began operating in 2017, the *Access Observatory* has aimed to strengthen the science of access through the development and use of a new framework for measurement and reporting on access programs. This section of the final *Access Observatory* Annual Report summarizes key findings and learnings from the past four years.

Positive trends in measurement and reporting have emerged over the years.

Looking forward, companies should consider adopting new access strategies, extending multi-company collaborations, and prioritizing needs assessments and measurement of outcome indicators in addition to input and output indicators.

The COVID-19 pandemic has important implications for access programs.

Globally, the pandemic has exposed critical inequities in access to care. Leveraging successful strategies in addressing NCD care access challenges can reveal innovative ways to address inequities related to COVID and other health emergencies.

Digital health technologies are emerging as potentially important tools for improving access.

Insights into how digital technologies can strengthen health systems, reduce inequities, and promote access can be generated from the *Access Observatory*.

There is need for a deliberative and participatory process to strengthen standards.

The *Access Observatory* was developed through a participatory process involving industry and non-industry stakeholders. Now, an expanded process involving a broader set of stakeholders is necessary to further strengthen standards for measurement and reporting on industry-led access programs.

Trends in measurement and reporting since the launch of the Access Observatory

Since its launch in 2017, the Access Observatory has provided biopharmaceutical companies with a systematic approach to measuring and reporting on their access programs. The total number of active programs in the Access Observatory was significantly lower this year compared with previous years, largely due to fewer new program registrations. The unprecedented global health challenge caused by COVID-19 has undoubtedly affected companies' ability to initiate and implement new NCD-related programs.

The number of active programs is not an indicator of success for either the industry or the Access Observatory. As companies continue to refine their respective approaches to improving access, we should expect existing programs to end and new and hopefully more effective programs to take their place. Developing and implementing new programs takes time, and the COVID-19 pandemic complicates efforts to do so. In addition, several programs were integrated into other programs in 2020. This may reflect an important transformation within companies to set up sustainable structures for managing access programs. Measurement and reporting of social programs requires internal company policies as well as devotion of resources, and it is critical for companies to develop sustainable measurement and reporting practices that are time- and cost-efficient.

The strategies employed by programs have remained largely consistent over the years, as have the diseases targeted and countries where implemented. Health service strengthening, health service delivery, and community awareness continue to be the predominant strategies.

We encourage companies to explore other strategies for improving access, including those that leverage their unique expertise in product development, manufacturing, licensing, and pricing.

Moreover, we also encourage companies to increase the number and scope of multi-company collaborations. Existing programs are concentrated in a relatively small number of countries and focus on a relatively small number of diseases. Geographic and disease-focus concentration creates opportunities for efficient and impactful multi-company collaboration.

The proportion of programs that conducted a formal needs assessment increased from one-fourth in 2019 to one-third in 2020. This is a positive development, but there remains significant room for improvement. All programs should conduct and report on a thorough needs assessment prior to implementation. The proportion of programs that submitted indicator values also increased, but again there is room for improvement. Values for outcome and impact indicators remain limited. Outcome indicator values are essential for assessing program achievements and should be prioritized by companies in their measurement efforts. The Access Observatory was originally designed to include case studies alongside reporting plans and program indicators. This approach was met with enthusiasm from companies and other Access Accelerated partners. We recommend that companies generate case studies to complement indicator data and enhance understanding of programs and their achievements.

The COVID-19 Pandemic: Implications for Access Programs

The COVID-19 pandemic has exacerbated global inequities in access to affordable and safe, quality-assured medicines. We have seen the importance of data in identifying inequities in the impacts of the virus and we are now seeing similar inequities in access to the vaccine. The pharmaceutical industry's commitment to measuring and reporting on their access programs is important now more than ever.

While programs registered in the *Access Observatory* focus on NCDs, they have the potential to generate learnings that can be applied to addressing the COVID-19 pandemic.

The Access Observatory framework is designed to be flexible with respect to disease area and offers an opportunity for companies to learn which strategies have been successfully used for NCDs, and which could work well for COVID-19 and other future health emergencies.

For example, there are several examples of NCD programs that aim to improve access using price strategies, and similar strategies are now being used to enhance the affordability of COVID-19 vaccines and treatments. Furthermore, COVID-19 particularly affected patients with NCD; improving NCD prevention and treatment will also improve COVID-19 response.

Many of the biggest healthcare-related challenges that society faces, including those brought forward by COVID-19, cannot be solved by a single actor or a single company. Partnerships are key to the success of many of the programs registered in the *Access Observatory*: 96% of programs active in 2020 listed some type of partner, be they voluntary, public, or private. Companies sharing innovative ideas and learnings expands opportunities and accelerates innovation in the design and scale-up of new access solutions. With regards to COVID-19, the pharmaceutical industry's unique knowledge and expertise in the development of novel therapeutics and vaccines, as well as building manufacturing capacity and distribution networks, is critical and must be integrated with other partners and stakeholder's capacity and efforts.

In light of the COVID-19 pandemic, we encourage companies to explore novel partnership strategies for improving access, including new voluntary licensing agreements to enhance manufacturing capacity. These strategies are part of the *Access Observatory* framework but have not yet been used by registered programs. Further, we encourage companies to report on how they intend to address sustainability and equity, and to submit data that demonstrates their success in doing so. With increasing availability and improvement of program reporting data, there exists an opportunity to build up a strong evidence base on what works to enhance sustainability and equity of programs. Tracking progress or driving improvements is not possible without some form of performance measurement, which is why the industry and its partners should strengthen its leadership role in generating and using evidence to improve access globally.

Promoting Access Using Digital Health Technologies

The World Health Organization has identified digital health solutions as holding great potential for increasing access to health services in LMICs⁷. Digital health solutions typically leverage communication networks, including the internet, social media platforms, and mobile phones, to achieve global reach. These networks can be used to overcome geographic inaccessibility of health care. In 2019, more than 4 billion people accessed the Internet. More than 7 billion people lived in an area covered by a mobile-cellular network and 6 billion smartphones were used around the world.⁸ However, limited knowledge exists on the application of digital health within the health sector.⁷

The Access Observatory has the potential to serve as a learning platform to generate insights on how digital health technologies can be used to strengthen health systems and to promote access.

Among all 107 programs registered in the *Access Observatory* since 2017, 44 (41%) use digital health technologies as an integral part of their access program strategies. The digital health solutions have been implemented through novel partnership models at different health system levels. At the patient level, solutions include: establishing innovative communication platforms to increase disease awareness and connect patients with providers; designing personal health tracking apps to inform and educate patients; and providing mobile health wallets to enable patients to save on health care costs. At the provider level, solutions include: virtual trainings that build capacity of

the health workforce; decision support tools; telemedicine and telepathology services; and innovative platforms for provider communication. Other areas targeted by digitalization include health system management, where digital solutions are applied to optimize management of health financing, human resources, supply chains, healthcare equipment and assets, as well as civil registration and vital statistics. For many programs, digital tools also facilitated increased collection and analysis of program indicator data, which can serve to accelerate learning. Digital tools may have the potential to further strengthen measurement and reporting of access programs by companies. We encourage companies and partners to be strategic and harness the advantages of digital tools for measurement, reporting and learning.

Need for a Deliberative and Participatory Process to Further Strengthen Standards

The original design of the framework that underlies the *Access Observatory* was developed through a process that involved a selection of industry and non-industry stakeholders.

Now, an expanded deliberative and participatory process, one that involves a broader set of stakeholders, is necessary in order to further strengthen standards for measurement and reporting on industry-led access programs.

Over the past several years, we have seen members of the private investment community advance their preferred “ESG” (Environmental, Social, and Governance) framework for company reporting on access efforts. While investors are a key audience for access program reporting, the ESG approach has important limitations. First, ESG frameworks tend to prioritize company-level rather than program-level measurement and reporting. Aggregating meaningful program-level indicators to generate company-level ESG metrics often leads to the loss of important information. This inhibits the potential of program reporting to strengthen our understanding of the science of access, i.e., to generate valuable learnings that can be applied more generally. Second, company-level ESG metrics are often

made generic to the point where they cease to provide meaningful information, making them susceptible to “greenwashing”, i.e., to conveying misleading information about the success of industry-led access efforts. This can undermine trust, create wasteful investments, and jeopardize the long-term vision of developing effective access programs.

With COVID-19 bringing the issue of access to the forefront of our public discourse, now is an opportune time to revisit this issue. The development of standards is often path dependent, and if the pharmaceutical industry fully adopts an ESG approach, it may be difficult to reverse course. We encourage the industry and relevant stakeholders to establish an open and deliberative process with a broad set of stakeholders, to cement measurement and reporting standards around global access. The standards should achieve the dual purpose of strengthening industry accountability and facilitating learning on what works to make access program more effective. The industry should play a lead role in this effort, as companies will benefit greatly from having a single, uniform standard.

Conclusion

The COVID-19 pandemic has brought the issues of access and equity to the forefront of our global society. The pharmaceutical industry has a special role to play in addressing these issues, in part by expanding access to life-saving medicines and services, particularly in low- and middle-income countries. Companies have continued to confirm their commitments to achieving the SDGs by 2030, and while 2020 was a challenging year for everyone, the industry made progress in strengthening its access efforts. The *Access Observatory* serves as a public platform where the industry documents many of its efforts and demonstrates progress toward fulfilling its commitments. The industry should continue to increase investments in access efforts as we come out of the pandemic in the coming years. It will be important for stakeholders to establish a participatory process to further strengthen standards for measurement and reporting on industry-led access programs.

References

- ¹ Access Accelerated. Access Accelerated: Moving NCD Care Forward. Available at: accessaccelerated.org/
- ² World Health Organization. Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action. Geneva, Switzerland, World Health Organization 2017. Available at: who.int/healthsystems/strategy/everybodys_business.pdf
- ³ United Nations Sustainable Development Group. Theory of Change UNDAF Companion Guidance. June 2017. Available at: unsdg.un.org/resources/theory-change-undafcompanion-guidance
- ⁴ Rockers PC, Laing RO, Scott N, Ashigbie P, Lucca EH, Umeh CA, Wirtz VJ. Evaluation of pharmaceutical industry-led access programmes: a standardised framework. BMJ Global Health. 2019; 4(4):e001659.
- ⁵ World Health Organization. Responding to Industry Initiatives to Increase Access to Medicines and Other Health Technologies in Countries. EMP Policy Brief Series No.2. Geneva, Switzerland, World Health Organization, 2017. Available at: who.int/medicines/areas/policy/policy-briefs/policybrief-2.0/en/
- ⁶ World Health Organization Model List of Essential Medicines – 22nd List, 2021. Geneva: World Health Organization; 2021 (WHO/MHP/HPS/EML/2021.02). Licence: CC BY-NC-SA 3.0 IGO.
- ⁷ Global strategy on digital health 2020-2025. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO.
- ⁸ WHO guideline: recommendations on digital interventions for health system strengthening. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO.

Appendix 1

List of Active Programs Reported into the Access Observatory

	Primary Pharmaceutical Company	Name of Program	Country or Countries of Implementation
1	Astellas	ACTION ON FISTULA™	Kenya
2	Bristol-Myers Squibb Foundation	Celgene AMPATH Oncology Partnership	Kenya
3	Bristol-Myers Squibb Foundation	Academic Model Providing Access To Healthcare — The Multiple Myeloma Project	Kenya
4	Bristol-Myers Squibb Foundation	Children And Mothers Partnerships (CHAMPS) Initiative — Kenya	Kenya
5	Bristol-Myers Squibb Foundation	Global HOPE Africa	Botswana, Malawi, Uganda
6	Bristol-Myers Squibb Foundation	Impiloyami Growing up and Living with HIV (IGAH) Project End Report [previously: 'Secure The Future—Uthukela District, KwaZulu-Natal, South Africa']	South Africa
7	Bristol-Myers Squibb Foundation	Multinational Lung Cancer Control Programme	Ethiopia, Kenya, Lesotho, South Africa, Swaziland, Tanzania
8	Bristol-Myers Squibb Foundation	Project ECHO for Cancer Care (South Africa)	South Africa
9	Bristol-Myers Squibb Foundation	Groupe Franco-Africain d'Oncologie Pédiatrique [previously: 'Secure The Future—Senegal']	Benin, Burkina Faso, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Gabon, Guinea, Madagascar, Mali, Mauritania, Niger, Senegal, Togo
10	Chugai	Delivering quality and patient-centred cancer care through multidisciplinary teams	Myanmar
11	Chugai	Health Camp against NCDs	Myanmar
12	Chugai	Helping safer childbirth	Myanmar
13	Chugai	Workshop on Multidisciplinary Team Care in Cambodia	Cambodia
14	City Cancer Challenge (C/Can)	C/Can 2025: City Cancer Challenge	Rwanda, Georgia, Malaysia, Brazil, Mexico, Ghana, Myanmar, Colombia, Paraguay
15	Daiichi Sankyo	Mobile Healthcare Field Clinic Services in Myanmar	Myanmar
16	Eisai	Hope to Her in India	India
17	Eisai	Remember I Love You	China

**Appendix 1: List of
Active Programs Reported
into the Access Observatory**
(continued)

	Primary Pharmaceutical Company	Name of Program	Country or Countries of Implementation
18	Eli Lilly and Company	Tshwane Insulin Project (TIP)	South Africa
19	Sumitomo Dainippon	Promoting Sound Child Growth Project	Cambodia
20	Merck & Co.	GARDASIL — Gavi	Armenia, Bangladesh, Benin, Bolivia, Burkina Faso, Burundi, Cambodia, Côte 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
21	Merck KGaA	India Fights Back	India
22	Merck KGaA	Integrated Thyroid NCD Care in the Philippines	Philippines
23	Merck Foundation, Darmstadt, Germany	Merck Cancer Access Program	Botswana, Egypt, Ethiopia, Ghana, India, Kenya, Liberia, Namibia, Sierra Leone, South Africa, Tanzania, Uganda, Zambia
24	Merck Foundation, Darmstadt, Germany	Merck Capacity Advancement Program	Angola, Bangladesh, Cambodia, Cameroon, Central African Republic, Congo, Côte 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
25	Merck Foundation, Darmstadt, Germany	Merck Community Awareness Program	Angola, Ethiopia, Ghana, India, Indonesia, Kenya, Mozambique, South Africa, Tanzania, Uganda
26	Merck Foundation, Darmstadt, Germany	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

**Appendix 1: List of
Active Programs Reported
into the Access Observatory**
(continued)

Primary Pharmaceutical Company	Name of Program	Country or Countries of Implementation
27 Novartis	CMLPath to Care [<i>previously: Glivec International Patient Assistance Program (GIPAP)</i>]	Argentina, Armenia, Azerbaijan, Bahamas, Bangladesh, Belarus, Benin, Bhutan, Burkina Faso, Cambodia, Cameroon, Central African Republic, Chile, China, Congo, Côte 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
28 Novartis	Novartis Access	Cameroon, El Salvador, Ethiopia, Kenya, Nigeria, Pakistan, Rwanda, Uganda
29 Novo Nordisk	Base of the Pyramid	Ghana, Kenya, Morocco, Nigeria, Senegal
30 Novo Nordisk	Changing Diabetes in Children	Bangladesh, Cambodia, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Guinea, India, Kenya, Myanmar, Senegal, Sudan, Tanzania, Uganda
31 Pfizer Foundation	Abundant Health	Vietnam
32 Pfizer Foundation	Improving Oncology Care: Scaling Up Breast Cancer Services in La Libertad Region, Peru	Peru
33 Roche	EMPOWER, Kenya	Kenya
34 Roche	Perjeta Patient Support Programme	Egypt
35 Roche	Pink Consulting Room	Colombia
36 Roche	Save Her, Ghana	Ghana

**Appendix 1: List of
Active Programs Reported
into the Access Observatory**
(continued)

	Primary Pharmaceutical Company	Name of Program	Country or Countries of Implementation
37	Roche	The Blue Tree, India	India
38	Roche	UNMOL (Urdu for Precious): Access to Cancer Medicines in Pakistan	Pakistan
39	Sanofi	Community-based epilepsy awareness and training program in rural Bolivia	Bolivia
40	Sanofi	KiDS and Diabetes in School	Argentina, Brazil, Egypt, Hungary, India, Japan, Pakistan, Philippines, Poland, United Arab Emirates
41	Sanofi	MY CHILD MATTERS - AFRICAN SCHOOL OF PEDIATRIC ONCOLOGY	Algeria, Benin, Burkina Faso, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Gabon, Guinea, Madagascar, Mali, Mauritania, Morocco, Niger, Senegal, Togo, Tunisia
42	Sanofi	MY CHILD MATTERS - PARAGUAY	Paraguay
43	Sanofi	Ngao Ya Afya	Kenya
44	Sanofi	Sanofi mental health program (FAST - Fight Against STigma) — eLearning	Mali, Senegal
45	Sanofi	Sanofi mental health program (FAST - Fight Against STigma) — Mali	Mali
46	Sanofi	Sanofi mental health program (FAST - Fight Against STigma) — Myanmar	Myanmar
47	Sanofi	Sanofi mental health program (FAST - Fight Against STigma) — South Africa	South Africa
48	Servier	Cuomo Pediatric Cardiology Center	Senegal
49	Servier	Training of caregivers for children with Noma in Burkina Faso	Burkina Faso
50	Shionogi	Mother to Mother Project	Kenya
51	Shionogi	Mother to Mother SHIONOGI Project in Kilifi — Kenya	Kenya
52	Takeda	African Consortium for Cancer Clinical Trials (AC3T)	Cameroon, Côte d'Ivoire, Kenya, Nigeria, Rwanda, Senegal
53	Takeda	Beyond Medicines in Ukraine	Ukraine

**Appendix 1: List of
Active Programs Reported
into the Access Observatory**
(continued)

Primary Pharmaceutical Company		Name of Program	Country or Countries of Implementation
54	Takeda	BluePrint for Success — Meru County	Kenya
55	Takeda	Instrumental Access Program (IAP): Building Research Capacity in LMICs	Benin, Cameroon, Dominican Republic, India, Liberia, Malawi, Namibia, Nigeria, Peru, South Africa, Tanzania, Ukraine, Vietnam, Zambia, Zimbabwe
56	Takeda	Lysosomal Storage Disorder Charitable Access Program (LSD CAP)	Albania, Belarus, Bosnia and Herzegovina, Egypt, India, Jordan, Morocco, Pakistan, Paraguay, Sudan, Tanzania, Tunisia
57	Takeda	Patient Assistance Program (PAP) — Entyvio®	Brazil, Lebanon, Malaysia, Philippines, Thailand, Ukraine, United Arab Emirates
58	Takeda	Patient Assistance Program (PAP) — Ninlaro®	Lebanon, Thailand
59	Takeda	Patient Assistance Program for Adcetris®	Egypt, Hong-Kong, Indonesia, Kenya, Lebanon, Malaysia, Mexico, Peru, Philippines, Singapore, Thailand, Ukraine, United Arab Emirates
60	Takeda	R&D Access to Medicines Employee Fellowship Program: Knowledge Sharing to Strengthen Healthcare Capacity in LMICs	Haiti, Kenya, Rwanda, Tanzania
61	Takeda	Takeda Max Access Solution (MAS)	Brazil, Ethiopia, Ghana, India, Kazakhstan, Kenya, Malaysia, Nepal, Niger, Paraguay, Philippines, Senegal, Seychelles, Thailand, Tunisia

Appendix 2

Number of Programs by Country

Country	World Bank Region	Income Group	Program Count
Albania	Europe & Central Asia	Upper middle income	1
Algeria	Middle East and North Africa	Lower middle income	1
Angola	Sub-Saharan Africa	Lower middle income	3
Argentina	Latin America & Caribbean	Upper middle income	2
Armenia	Europe & Central Asia	Upper middle income	2
Azerbaijan	Europe & Central Asia	Upper middle income	1
Bahamas	Latin America & Caribbean	High income	1
Bangladesh	South Asia	Lower middle income	4
Belarus	Europe & Central Asia	Upper middle income	2
Benin	Sub-Saharan Africa	Lower middle income	5
Bhutan	South Asia	Lower middle income	1
Bolivia	Latin America & Caribbean	Lower middle income	2
Bosnia & Herzegovina	Europe & Central Asia	Upper middle income	1
Botswana	Sub-Saharan Africa	Upper middle income	3
Brazil	Latin America & Caribbean	Upper middle income	3
Burkina Faso	Sub-Saharan Africa	Low income	5
Burundi	Sub-Saharan Africa	Low income	2
Cambodia	East Asia & Pacific	Lower middle income	5
Cameroon	Sub-Saharan Africa	Lower middle income	8
Central African Republic	Sub-Saharan Africa	Low income	3
Chile	Latin America & Caribbean	High income	1
China	East Asia & Pacific	Upper middle income	2
Colombia	Latin America & Caribbean	Upper middle income	2
Congo, Republic of	Sub-Saharan Africa	Lower income	4
Cote d'Ivoire	Sub-Saharan Africa	Lower middle income	5
Dominican Republic	Latin America & Caribbean	Upper middle income	2
Democratic Republic of Congo	Sub-Saharan Africa	Low income	2
Ecuador	Latin America & Caribbean	Upper middle income	1
Egypt	Middle East & North Africa	Lower middle income	6
El Salvador	Latin America & Caribbean	Lower middle income	2

Appendix 2: Number of Programs by Country

(continued)

Country	World Bank Region	Income Group	Program Count
Equatorial Guinea	Sub-Saharan Africa	Upper middle income	1
Ethiopia	Sub-Saharan Africa	Low income	10
Fiji	East Asia & Pacific	Upper middle income	1
Gabon	Sub-Saharan Africa	Upper middle income	3
Gambia, The	Sub-Saharan Africa	Low income	1
Georgia	Europe & Central Asia	Upper middle income	1
Ghana*	Sub-Saharan Africa	Lower middle income	10
Greece	Europe & Central Asia	High income	0
Guinea	Sub-Saharan Africa	Low income	2
Guyana	Latin America & Caribbean	Upper middle income	1
Haiti	Latin America & Caribbean	Low income	2
Honduras	Latin America & Caribbean	Lower middle income	2
Hong Kong	East Asia & Pacific	High income	1
Hungary	Europe & Central Asia	High income	1
India*	South Asia	Lower middle income	12
Indonesia	East Asia & Pacific	Upper middle income	5
Jamaica	Latin America & Caribbean	Upper middle income	1
Japan	East Asia & Pacific	High income	1
Jordan	Middle East & North Africa	Upper middle income	1
Kazakhstan	Europe & Central Asia	Upper middle income	2
Kenya*	Sub-Saharan Africa	Lower middle income	23
Kyrgyzstan	Europe & Central Asia	Lower middle income	1
Lao PDR	Middle East & North Africa	Upper middle income	1
Lebanon	Sub-Saharan Africa	Low income	3
Lesotho	Sub-Saharan Africa	Lower middle income	1
Liberia	Sub-Saharan Africa	Low income	5
Madagascar	Sub-Saharan Africa	Low income	3
Malawi	Sub-Saharan Africa	Low income	6
Malaysia	East Asia & Pacific	Upper middle income	4

Appendix 2: Number of Programs by Country

(continued)

Country	World Bank Region	Income Group	Program Count
Mali	Sub-Saharan Africa	Low income	7
Mauritania	Sub-Saharan Africa	Lower middle income	3
Mauritius	Sub-Saharan Africa	High income	1
Mexico	Latin America & Caribbean	Upper middle income	2
Moldova	Europe & Central Asia	Lower middle income	1
Mongolia	East Asia & Pacific	Lower middle income	1
Morocco	Middle East & North Africa	Lower middle income	5
Mozambique	Sub-Saharan Africa	Low income	4
Myanmar	East Asia & Pacific	Lower middle income	7
Namibia	Sub-Saharan Africa	Upper middle income	3
Nepal	South Asia	Lower middle income	3
Nicaragua	Latin America & Caribbean	Lower middle income	2
Niger	Sub-Saharan Africa	Low income	5
Nigeria	Sub-Saharan Africa	Lower middle income	5
Pakistan	South Asia	Lower middle income	5
Papua New Guinea	East Asia & Pacific	Lower middle income	1
Paraguay	Latin America & Caribbean	Upper middle income	5
Peru	Latin America & Caribbean	Upper middle income	4
Philippines	East Asia & Pacific	Lower middle income	6
Poland	Europe & Central Asia	High income	1
Russia	Sub-Saharan Africa	Lower middle income	0
Rwanda	Europe & Central Asia	Upper middle income	7
Sao Tome and Principe	Sub-Saharan Africa	Low income	1
Senegal*	Sub-Saharan Africa	Lower middle income	11
Seychelles	Sub-Saharan Africa	High income	2
Sierra Leone	Sub-Saharan Africa	Low income	5
Singapore	East Asia & Pacific	High income	1
Solomon Islands	East Asia & Pacific	Lower middle income	2
South Africa*	Sub-Saharan Africa	Upper middle income	10

Appendix 2: Number of Programs by Country

(continued)

Country	World Bank Region	Income Group	Program Count
South Sudan	Sub-Saharan Africa	Low income	1
Sri Lanka	South Asia	Lower middle income	2
Sudan	Sub-Saharan Africa	Low income	2
Suriname	Latin America & Caribbean	Upper middle income	1
Swaziland	Sub-Saharan Africa	Lower middle income	1
Tajikistan	Europe & Central Asia	Low income	1
Tanzania*	Sub-Saharan Africa	Lower middle income	10
Thailand	East Asia & Pacific	Upper middle income	5
Timor-Leste	East Asia & Pacific	Lower middle income	1
Togo	Sub-Saharan Africa	Low income	3
Tunisia	Middle East & North Africa	Lower middle income	3
Uganda	Sub-Saharan Africa	Low income	9
Ukraine	Europe & Central Asia	Lower middle income	4
United Arab Emirates	Middle East & North Africa	High income	4
Uzbekistan	Europe & Central Asia	Lower middle income	1
Vietnam	East Asia & Pacific	Lower middle income	3
Zambia	Sub-Saharan Africa	Lower middle income	5
Zimbabwe	Sub-Saharan Africa	Lower middle income	4

Appendix 3

List of Funding and Implementing Partners

Partner	Program Count
Academic Model Providing Access to Healthcare (AMPATH)	3
Access Accelerated	1
AdvaMed	1
Africa Cancer Foundation	1
African Organization for Research & Training in Cancer (AORTIC)	1
Alexandria University in Egypt	1
Alzheimer's Disease Chinese	1
AMDA-MINDS	2
American Cancer Society (ACS)	1
American Society for Clinical Oncology	1
American Society for Clinical Pathology	2
Amgen	1
AMREF	1
AMREF Health Africa	1
Argentina Society of Diabetes	1
Arogya Finance	1
Associação de Diabetes Juvenil of Brazil (ADJ)	1
Association Guinéenne d'Education et d'Aide aux Diabétiques (AGEAD)	1
Association of Representatives of Ethical Pharmaceutical Industries (AREPI)	1
Association Sénégalaise de Soutien et d'Assistance Aux Diabétiques (ASSAD)	1
Axios International	4
Baylor International Pediatric Aids Initiative (BIPAI)	1
BDOM — Bureau Diocésain des Oeuvres Médicales	1
Bhekuzulu Self Sustaining Project	1
Bill and Melinda Gates Foundation	1
Bio Ventures Global Health	1
Boston University	1
Botswana Ministry of Health	1
Bristol-Myers Squibb Foundation	3
Bugando Medical Centre	1

Appendix 3: List of Funding and Implementing Partners

(continued)

Partner	Program Count
Cairo Scan Lab	1
Cambodia Ministry of Health	1
Cameroon Baptist Convention Health Services	1
Cameroon Ministere de la Sante Publique	1
Can Survive Egypt	1
Cancer Charity Workers/Robert Mangaliso Sobukwe Hospital (Former Kimberley Hospital Complex) (KHC) Oncology Department	1
CarePay	1
Catholic University of Health and Allied Sciences	1
Center of Expertise and Research in Telemedicine and eHealth (CERTES)	1
Cerebrus Consulting	1
Charitable Fund I Will Live	2
Cheikh Anta Diop University	1
Cherkasky Onco Dispenser Patient Association	1
China Charity Federation	1
China Population Welfare Foundation	1
Christian Health Association Kenya (CHAK)	1
Christian Health Association of Kenya	1
Christian Health Association of Nigeria	1
City Cancer Challenge	1
Collage Solution	1
Commune Health Stations (CHS) in Ho Chi Minh City	1
CSD Healthcare Clinic	1
Cuomo Foundation	1
Dalberg	1
Democratic Republic of Congo Ministry of Health	1
Department of Public Health (DoPH)	1
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)	1
Diabetes Association of Pakistan	1
Diabetes Care Organization	1
Diabetic Association of Bangladesh	1

Appendix 3: List of Funding and Implementing Partners

(continued)

Partner	Program Count
Diagnostic Center Feofaniya	1
Dimension Research	1
Direct Relief	2
Education Department of the State of Goa	1
Egyptian Association for Comprehensive Development	1
Egyptian Society of Pediatric Endocrinology and Diabetes	1
Emmaus Hospital	1
Employees State Insurance Corporation	1
Estcourt Hospital	1
Eswatini Hospice at Home	1
Eswatini National Cancer Control Unit and Cancer Registry	1
Ethiopian Diabetes Association	1
Ethiopian Ministry of Health	1
European Society for Radiotherapy and Oncology	1
Faculty of Medecine of Bamako (FMOS)	1
Federal Ministry of Nigeria	1
FHI360	1
First Lady Beyond Zero Campaign	1
Fistula Foundation	1
Foundation for Cancer Care Tanzania	1
Foundation for Professional Development	1
GAVI Alliance	1
GERESA (Ministry of Health's Regional Health Administration)	1
Ghana Health Service (GHS)	1
Ghana National Drug Programme	1
Groupe Franco-Africain d'oncologie pédiatrique	1
HCMC Department of Health (DOH)	1
Health Department of the State of Goa	1
Healthcare Partners for Access (HPA)	1
Heart Institute Vietnam	1
HoPiT — Health of Population in Transition Cameroon	1

Appendix 3: List of Funding and Implementing Partners

(continued)

Partner	Program Count
Hospital Fann in Dakar	1
Hungarian Diabetes Association	1
ICICI Bank	1
Icon Group	1
Indian Railways	1
International Atomic Energy Agency	1
International Cancer Institute	1
International Diabetes Federation (IDF)	1
International Society for Pediatric and Adolescent Diabetes (ISPAD)	1
IREN-Norte (the northern region cancer institute)	2
JAD Association of Côte d'Ivoire	1
Japan Association for Diabetes Education and Care (JADEC)	1
John Taolo Getsewe Provincial Department of Health	1
KCMC — Kilimanjaro Christian Medical Center	1
Kenya Conference of Catholic Bishops (KCCB)	1
Kenya Defeat Diabetes Association (KDDA)	2
Kenya Diabetes Management and Information Center	1
Kenya Hospices and Palliative Care Association (KEHPCA)	1
Kenya Medical Research Institute	1
Kenya Ministry of Health	1
Kenya Red Cross	3
Kimberly District Hospital, Northern Cape, South Africa	1
KwaZulu-Natal Department of Health	1
La Chaîne de l'Espoir	1
Ladysmith Hospital	1
Lahore Grammar School	1
Le Dantec University Hospital	1
LetsMD	1
Malawi Ministry of Health	1
Management Service Center Co., Ltd.	1
Mastology Colombian Association	1

Appendix 3: List of Funding and Implementing Partners

(continued)

Partner	Program Count
Mathiwo Wondu Ye Ethiopia Cancer Society	1
Max Foundation	2
MD Anderson Cancer Center	1
Medical Data Management (MDM)	1
Medtronic Labs	1
Medybiz Pharma Pvt. Ltd.	1
Memisa, DRC	1
Ministere De La Sante Et De L'Hygiene Publique, Ivory Coast	1
Ministry of Health Ghana	2
Ministry of Health of Senegal	4
Ministry of Public Health and Social Welfare	1
Mission for Essential Drugs and Supplies	1
Moi Teaching and Referral Hospital	1
Mpilonhle Sanctuary Organization	4
Myanmar Medical Association (MMA)	1
Myanmar Mental Health Society	1
Myanmar Ministry of Health and Sports	1
Myanmar Paediatric Society	1
National Cancer Institute of Ukraine — Hematology Department	1
National Cancer Institute, USA	1
National Catholic Health Service (NCHS)	1
National Education Foundation	1
National Health Laboratory Services	1
National University of Lesotho, Faculty of Health Sciences	1
New Dimension Consulting (NEDICO)	1
Novo Nordisk Education Foundation	1
Oncquest Laboratories	1
One Drop Foundation (Egy Csepp Figyelem Alapitvány)	1
Pakistan Bait-ul-Maal	1
Palb Pharmaceuticals	1
Pan-American Health Organization (PAHO)	1

Appendix 3: List of Funding and Implementing Partners

(continued)

Partner	Program Count
Partners in Health (PIH)/ Partners in Health Haiti (Zanmi Lasante)	1
PATH	1
Patient Behbud Society	1
Pediatric Hematology and Oncology Department — National University of Asuncion	1
PharmAccess Foundation	1
Pharmacie Nationalé d'Approvisionnement (PNA)	1
Philippines Thyroid Association	1
Philips Pharmaceuticals	1
PH-Japan	1
Phyllyps Medical	1
PhysioNoma	1
Pilipinas Shell Foundation Inc.	2
Plan International	1
Polish Association of Diabetics, Bialystok	1
Polish Association of Diabetics, Pomorze	1
Project HOPE	1
Provincial Government of South Africa	1
Public Health Foundation of India	1
Radiology Colombian Association	1
Raya Call center	1
ReNACI Foundation	1
Right to Care	1
Royal Danish Embassy (Ghana, Kenya)	1
Royaume du Maroc Ministère de la Santé	1
Rwanda Military Hospital	1
S.K. Distributors	1
Sanofi Espoir Foundation	1
Sante Sud	1
SAYLANI	1
School of Excellence for the Prevention of Breast Cancer — INEN (The National Cancer Institute in Lima)	1
Seeding Labs	1

Appendix 3: List of Funding and Implementing Partners

(continued)

Partner	Program Count
Senegal Ministry of Education	1
Sentinelles	1
Sociedad Brasileira de Diabetes (SBD)	1
Society for Family Health (SFH)	1
South African National Department of Health	1
St. Francis Hospital — Nsambya	1
Strand Life Sciences Pvt. Ltd	1
Sudan Ministry of Health	1
Super Specialities Pharma Warehousing Pvt. Ltd	1
Tan Phu Medicine Center	1
Tanzania Ministry of Health	1
Tanzanian Diabetes Association	1
Tata Memorial Hospital	1
TB HIV Care/Eastern Cape Collaborative Community Cancer Initiative	1
Tech Mahindra Limited	1
Texas Children's Hospital	1
The County First Ladies Association (Kenya)	1
The First Lady of Ghana	1
The Philippines Department of Health	1
The Shaukat Khanum Memorial Trust	1
Tropical Health and Education Trust (THET)	1
UAE Ministry of Education	1
UAE Ministry of Health & Prevention	1
Uganda Ministry of Health	2
Uganda Protestant Medical Bureau (UPMB)	1
UNECSO	1
UNICEF	1
Univeristy of Conakry, Donka Teaching Hospital	1
Université Numérique Francophone Mondiale (UNFM — World Digital Francophone University)	1
University of Catania	1
University of Kwazulu-Natal and Provincial Department of Health/ Addington Regional Hospital	1

Appendix 3: List of Funding and Implementing Partners

(continued)

Partner	Program Count
University of Nairobi	1
University of New Mexico Health Sciences Centers ECHO Institute	1
University of Pittsburgh, Medical Center	1
University of Pretoria	1
University of Rzeszow	1
University Research Co.,LLC	1
University de Valle	1
US Agency for International Development (USAID)	1
US National Institutes of Health (NIH)	1
Uthukela District Health Office	1
Vardhaman Distributors	1
Wits Health Consortium (Pty) Ltd — Centre of Respiratory Excellence	1
Wits Health Consortium (Pty) Ltd/Chris Hani Baragwanath Academic Hospital	1
Wits Health Consortium (Pty) Ltd/Health Economics and Epide	1
Women 4 Cancer	1
World Association for Social Psychiatry	3
World Bank	1
World Child Cancer	1
World Diabetes Foundation	1
World Economic Forum	1
World Francophone Digital University (UNFM-WFDU)	1
World Health Organization	1
World Vision Japan	2
World Vision Kenya	2
World Wide Commercial Ventures Limited	1
Zindagi Trust	1

Get in touch with the *Access Observatory*

We welcome your comments and suggestions.
Please contact us at info@accessobservatory.org