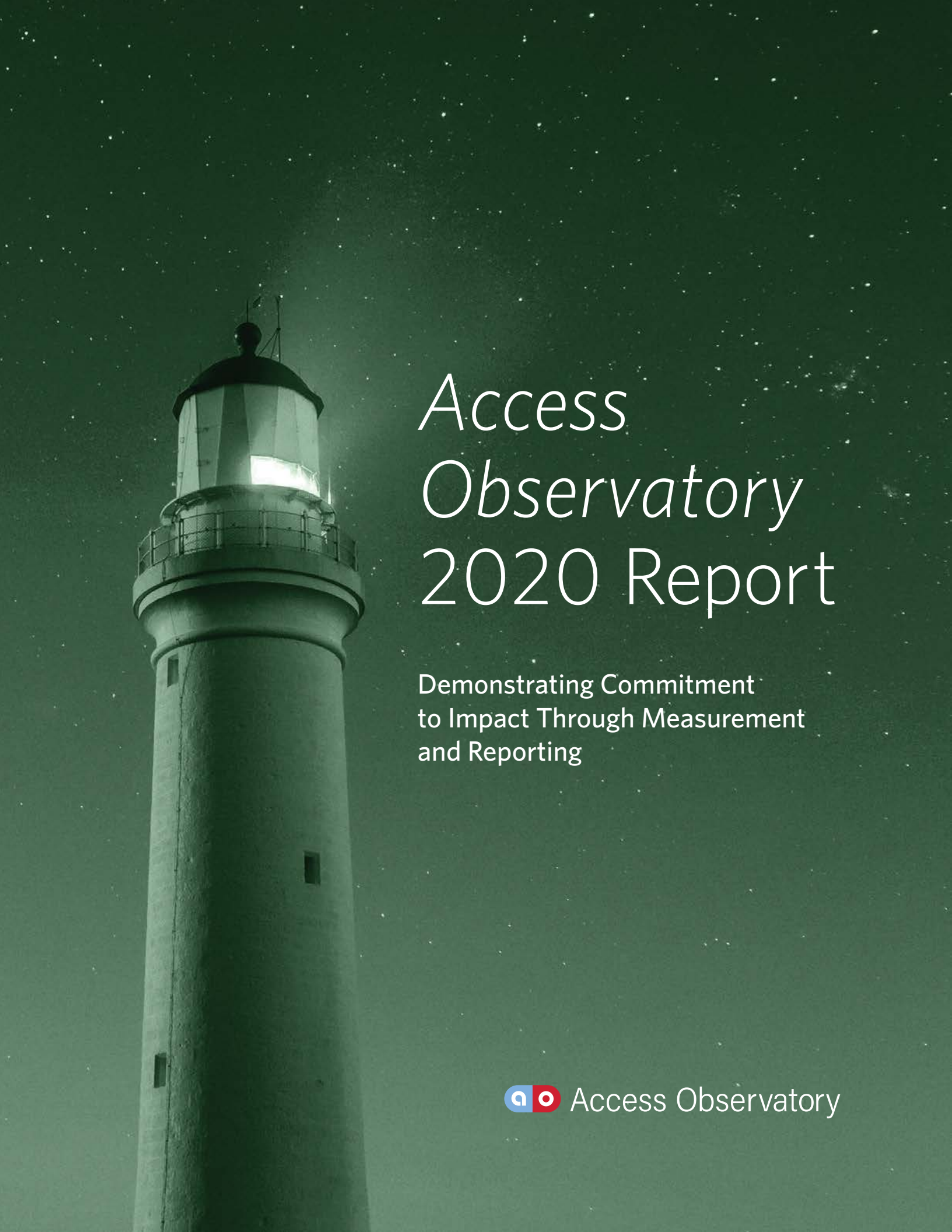

Access Observatory 2020 Report

Demonstrating Commitment to Impact Through Measurement and Reporting

Access Observatory

AUTHORSHIP

The *Access Observatory* 2020 Report was authored by the following (in alphabetical order): Priyanka J. Kulkarni, Richard O. Laing, Peter C. Rockers, and Veronika J. Wirtz. The views expressed in the report are those of the authors alone.

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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 low and middle-income countries.

Program information available through the *Access Observatory* is authored by program teams and independently reviewed by the *Access Observatory* team to ensure completeness, clarity, and consistency. The *Access Observatory* is a reporting mechanism for Access Accelerated, though it is open to all access programs, including those designed and implemented by public and non-profit organizations. The *Access Observatory* in 2019 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 2019, 75 active access programs operating in 114 countries were registered in the *Access Observatory*. Programs were geographically clustered in sub-Saharan Africa and Southeast Asia. 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 (63%), followed by diabetes (19%) and cardiovascular disease (16%). Across the 75 programs, there were 276 partnerships between companies and other organizations; more than half of programs had at least one public sector partner. Thirty-four programs (45%) submitted data for at least one indicator in 2019, 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 for local stakeholders to understand whether programs are appropriately designed for the context in which they are implemented.

Three milestones from the first three years of the *Access Observatory* illuminate critical aspects of a sustainable path forward for measurement and reporting on pharmaceutical industry-led access programs:

1. **The *Access Observatory* has illuminated the scope and scale of industry engagement in access efforts.** Several stakeholders have indicated that the *Access Observatory*'s standardized approach to reporting has facilitated the identification of synergies, redundancies, and gaps in investments for global access. The identification of synergies has led to new multi-company collaborations in specific disease areas (e.g., breast cancer) and geographies (e.g., Kenya).

2. **Several companies significantly increased internal capacity to measure and report on their access programs.** They have done this in a variety of ways, including training existing staff and hiring new staff with relevant prior training; and adapting information and management systems to integrate reporting on social and commercial key performance indicators.

3. **Several companies revised agreements with implementing partners to require collection and reporting of program data.** Most implementing partners are required to collect and report similar data to non-industry funders and have capacity to do the same for industry partners.

The pharmaceutical industry must continue to strengthen its global commitment to access. Companies should strive to design more effective programs and ensure accountability through transparent measurement and reporting.

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Letter to the Biopharmaceutical Companies' CEOs

The COVID-19 pandemic is taking lives, devasting livelihoods, and testing health systems in unprecedented ways. The pandemic has significantly undermined progress toward achieving the Sustainable Development Goals, in part by exacerbating inequities in access to affordable health services and safe, quality assured medicines. Public-private partnerships like Access Accelerated are more critical than ever to address the enormous global challenges we face.

Access Accelerated completed its third full year in 2019. It is an opportune time to reflect on the achievements of the past three years and identify opportunities for improvement.

ACHIEVEMENT #1

Companies have expanded their access efforts. In 2019 alone, 17 new programs were registered in the *Access Observatory*, most of which were newly created. We encourage companies to continue to increase their investments in global access efforts.

ACHIEVEMENT #2

Companies have demonstrated an increasing capacity to measure and report on their access efforts. The percentage of programs with a published reporting plan outlining key performance indicators has increased from 48% in 2017 to 76% in 2019. The percentage of programs submitting data has also increased, though more modestly from 37% in 2017 to 45% in 2019. We encourage all companies to continue to increase investments in measurement and reporting systems as an integral part of their access strategy. Better metrics will support improved internal decision making and will ensure that companies receive external recognition for their efforts, including from institutional investors who, as Yo Takatsuki from AXA Investment Managers describes in the Preface, are increasingly interested in access issues.

ACHIEVEMENT #3

Data submitted to the *Access Observatory* are now used by the Access to Medicines Foundation in determining their Index rankings. This achieves three important goals: it reduces the reporting burden on companies; it improves transparency and accountability through standardization; and it creates opportunities for greater impact through collaboration on measurement.

There are key opportunities to build on the first three years of Access Accelerated.

OPPORTUNITY #1

Expand the range of program strategies and disease focus areas.
The majority of new access programs are employing the same few basic strategies: health system strengthening, particularly provider trainings; and community awareness campaigns. We encourage companies to explore other strategies for improving access, including those that leverage their unique expertise in product development, manufacturing, licensing, and pricing. In addition, most existing programs focus on cancer and many NCDs for which there are significant disparities in access remain unaddressed. Specifically, there are clear opportunities for companies to bring their unique expertise to address access for mental disorders, diabetes, and auto-immune disorders such as arthritis. Access Accelerated was created to address NCDs and nearly all programs registered in the *Access Observatory* are focused on NCDs, but we encourage companies to register and report on all of their access programs, including those for infectious diseases such as COVID-19.

OPPORTUNITY #2

Conduct needs assessments prior to program implementation. Only one-quarter of programs reported conducting a needs assessment, and only nine programs provided documentation describing the assessment they conducted or made use of an assessment conducted by an independent source. We recommend that all new programs base their strategies on learnings from a thorough needs assessment conducted prior to the program implementation. Many companies undertake needs assessments when developing product development and marketing plans and should undertake similar efforts for access programs.

OPPORTUNITY #3

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. Notably, Kenya had 28 active programs in 2019. Geographic and disease-focus concentration creates opportunities for efficient and impactful multi-company collaboration, which is a key goal of Access Accelerated. City Cancer Challenge (C/Can 2025) is an example of such a collaboration. Achieving global scale for multi-company collaborations, which should be the ambition, introduces new challenges. An increased commitment to innovation will be necessary to realize the full potential of multi-company collaborations.

OPPORTUNITY #4

Align on reporting standards with investors and stakeholders. The broad adoption of the *Access Observatory* measurement framework has strengthened standards within the industry. To build on the achievements of the first three years of Access Accelerated, it will be necessary to increase alignment on these standards with investors and stakeholders, to ensure a shared understanding of expectations. We look forward to working with companies, investors, and stakeholders on these efforts moving forward.

We would like to once again convey our gratitude to the many company staff members who graciously responded to our numerous queries during the *Access Observatory* submission process. We would also like to thank you and your fellow CEO's who have provided the leadership and support for the many important access programs detailed in this report.

Preface

Yo Takatsuki

Head of ESG Research and Active Ownership

AXA Investment Managers

The scale of the COVID-19 pandemic is unprecedented but the dynamics of the disease — how it spreads and affects patients — were arguably, predictable. Coronavirus has exploited well-established inequalities in society and vulnerabilities in healthcare systems. So, although this highly infectious disease has impacted all our lives in some way, it has not affected us all equally. These have been long-running concerns in our research and engagement with investee pharmaceutical companies on the issue of access to medicine.

This crisis has reinforced our convictions as a large global investor about the importance of strengthening public health worldwide. This is a reason why the work of the *Access Observatory* is so highly valued by us. That statement may seem obvious to us — but since we get asked frequently by stakeholders about why access to medicine is critical for investors — here are the reasons why:

Firstly, we consider access to healthcare to be a financially relevant issue and hence, it is material to investors' interests. At AXA Investment Managers, we pride ourselves on investing for the long-term. This means that decisions we take today can continue to resonate decades into the future. We also need to assess factors which will shape and influence our investments over many years.

Even from before the pandemic — which has spectacularly re-defined the financial materiality of public health for the world economy — we have closely followed how the rapid growth of emerging economies presents long-term commercial opportunities for the major pharmaceutical companies. This is driven by the rise in healthcare spending as a result of growing middle classes in developing countries in the coming decades. We assess the quality of pharmaceutical companies' access programmes in these markets as an indicator of the future capacity to succeed. Our own research has also illustrated that the increase in intangible value on balance sheets is driven in part by positive access to medicine practices of companies.

Secondly, we believe that the finance industry can play an important role in enabling positive social impact and achieving the United Nations' Sustainable Development Goals. We have made a strong public commitment to responsible investment and hold ambitions to be an industry leader on sustainability. This means we seek to make positive and lasting change through our actions.

Large global asset managers, like us, benefit from the investment expertise across numerous asset classes, broad research capability (including in sustainability issues) and investment opportunities from around the world. This allows for large sums of capital to be deployed efficiently and effectively to help achieve the dual goals of strong financial returns and positive social impact. Identifying companies with innovative products and services to solve public health challenges is a key component of our approach to impact investment. *Access Observatory* is important because it brings independent, academic scrutiny of the pharmaceutical industry's attempts to measure and report on their contributions to global health goals. The importance of this to investors cannot be understated.

Finally, all of our goals following COVID-19 must be to develop a pandemic resilient society. This is partially a humbled recognition of collective failure to do so in the past as much as it is an urgent call-to-action to all of us in society for the future. Yes, we all need to do more. Like many of the major sustainability challenges of our time, the failure to tackle and resolve the situation now will ultimately risk more of our prosperity and well-being in the future. The sobering truth is that we are some way off of achieving Sustainable Development Goal 3 — Good Health and Well Being by 2030. The pandemic has shortened the odds of us failing to achieve it. Better action by the pharmaceutical industry is a critical driver in turning the odds back in all of our favours.

So, we hope this explains why access to medicine is such an important agenda for investors. The third Annual Report of the *Access Observatory* provides in-depth analysis of the industry-led access to medicine programme. It reveals the innovative practices undertaken by companies to meaningfully move the dial in low and middle-income countries. The analysis shows evidence of what works and what doesn't. We hope that companies absorb the findings of the report and take steps to continually improve. The scale of the challenge to resolve global health issues are daunting but together, we must work for a better tomorrow.

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*

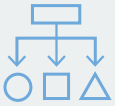
Four core principles guided the development of the framework and *Access Observatory*, informing decisions on process and content.

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

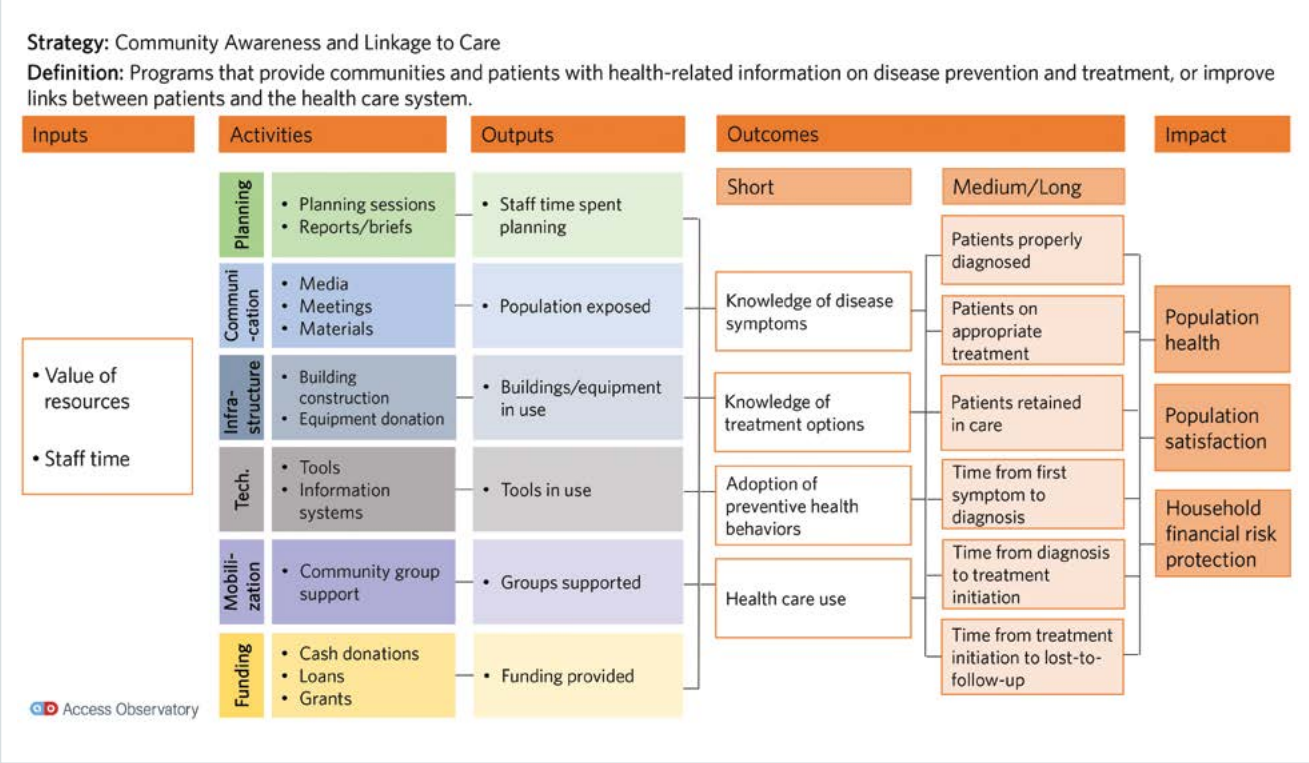
Strategy Category	Strategy	
Community Strategies *Strategies with a primary focus on communities and community organizations, with a particular focus on patients.*	Community Awareness and Linkage to Care	
Systems Strategies *Strategies with a primary focus on aspects of the health system that affect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

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

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

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]

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	• Name • Goals, objectives, activities • Countries • Disease focus • Beneficiary population(s)	• Start and end date • Funding partners • Implementation partners • Contact person
	Program strategies	• Strategies based on framework taxonomy	
	Alignment with local laws and regulations	• Description of relevant local laws and regulation • Confirmation of program alignment	
	Alignment with local health priorities	• Summary of local needs assessments • Description of consultation and collaboration with local partners	• National essential medicines list • Reimbursement lists
	Sustainability plan	• Description for sustainability plan	
Indicator Plan	Indicators to be reported	• Indicators based on framework set	
	Data sources	• Program administrative records • Public information sources • Health records	
	Data collection procedures	• Responsibilities of program implementing partners • Responsibilities of program funding partners	
	Data management procedures	• Responsibilities of program implementing partners • Responsibilities of program funding partners	
Indicator Value	Indicator values	• Value • Time period • Disaggregation (if applicable)	

Public Access to Program Information

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

Results from Year Three

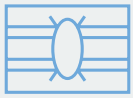
In 2019, there were 75 active programs registered in *Access Observatory*. Of these, 73 were Access Accelerated programs and two by Novo Nordisk were non-Access Accelerated programs. Nineteen programs previously registered in the *Access Observatory* ended prior to 2019 and are not included in this year's report, while 17 new programs were registered this past year and are included. Out of the 75 programs active in 2019, 57 had an indicator plan and 34 submitted indicator values for 2019.

Summary of Year Three Findings

There were 75 registered access programs active in 2019. This includes 17 new programs registered in the past year. 19 registered programs ended prior to 2019 and are not included in this year's report.

34

Thirty-four programs reported data for at least one program indicator in 2019. 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.



Programs are concentrated in a relatively small number of countries. For example, Kenya had 28 programs active in 2019. Geographic concentration creates potential opportunities for efficient and impactful multicompany collaboration.

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.

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

About half 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.

One-quarter 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.

C/Can 2025 expanded to additional cities in 2019. Indicator data from the initiative detailing the experience of cities in improving access to cancer care and treatment has great potential to generate important new learnings.

Figure 3: Number of Programs in the Access Observatory

18	75	57	34
Companies with a program registered	Active programs in 2019	Active programs in 2019 with an Indicator Plan	Active programs in 2019 with indicator values

Seventy-five programs were active in 114 countries.

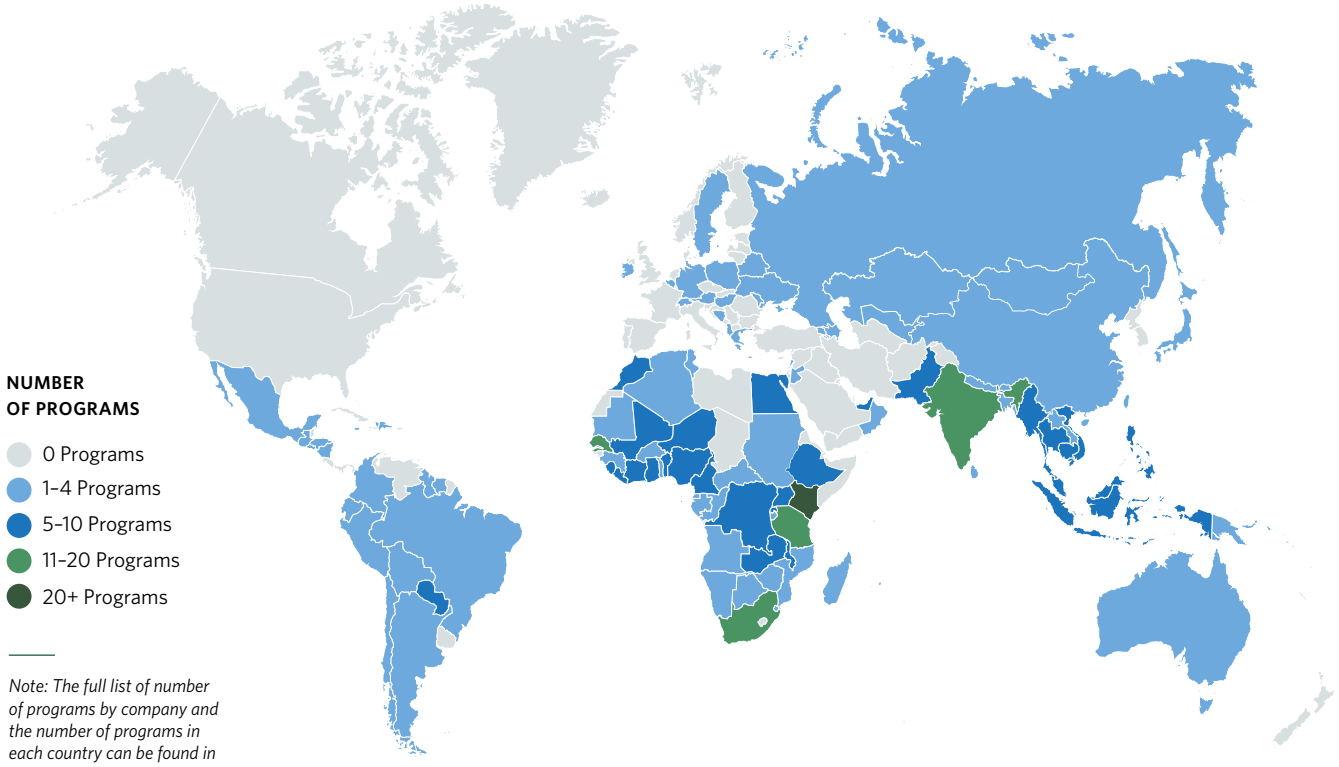
Programs are clustered in certain geographic regions, in particular Sub-Saharan Africa and Asia.

Kenya continues to have the greatest number of active programs with 28, following by India and Tanzania with 14 and South Africa with 13.

Program Geography

Seventy-five programs were active in 114 countries. 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 (see Appendix 2 for a full list).

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



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

Terminated Programs

Nineteen programs previously registered in the *Access Observatory* ended prior to 2019.

Table 4: List of Terminated Programs

Pharmaceutical Company	Program Name	Countries of Implementation	Year of Registration	Year of Termination
Eli Lilly and Company	Project HOPE Centre	South Africa	2017	2018
GlaxoSmithKline	MSI-GSK Cervical Cancer Prevention Project	Bangladesh, Madagascar, Sierra Leone	2017	2018
GlaxoSmithKline	PRRR-GSK Cervical Cancer Prevention Project	Ethiopia	2017	2018
Merck & Co, Pfizer, Novartis	Access and Affordability Initiative	Ghana, Philippines	2017	2017
Merck & Co.	Gardasil — Haiti, Zanmi Lasante	Haiti	2017	2018
Merck & Co.	Gardasil — Peru, CerviCusco	Peru	2017	2018
Pfizer Foundation	SmartHealth Extend	Indonesia, India	2017	2018
Pfizer Foundation	Integrated Approach to Improving	Brazil	2017	2018
Roche	Breast Cancer National Access Programme, Kenya	Kenya	2017	2018
Sanofi	Sanofi Mental Health Program (FAST) — Guatemala	Guatemala	2018	2018
Sanofi	My Child Matters — Telepathology for Childhood Cancer Diagnosis	Benin, Burkina Faso, Cameroon, Cote d'Ivoire, Democratic Republic of the Congo, Mali, Niger, Senegal	2018	2018
Sanofi	Sanofi Mental Health Program (FAST) — Morocco	Morocco	2017	2018
Sanofi	My Child Matters — Retinoblastoma	Cote d'Ivoire, Democratic Republic of the Congo, Madagascar, Mali, Senegal	2017	2018
Sanofi	My Child Matters — Thailand	Thailand	2017	2018
Sumitomo Dainippon	Promoting Sound Child Growth Pilot Project	Cambodia	2017	2018
Takeda	Oncology Nursing Education in Kenya	Kenya	2017	Completion date not specified
Takeda	Cancer Education for Primary Healthcare Professionals in Kenya	Kenya	2017	Completion date not specified
Takeda	HERHealth	China, India, Kenya, Ethiopia	2017	2018
Takeda	Cancer Alliance for Sub-Saharan Africa	Kenya	2017	Completion date not specified

Program Strategies and Activities

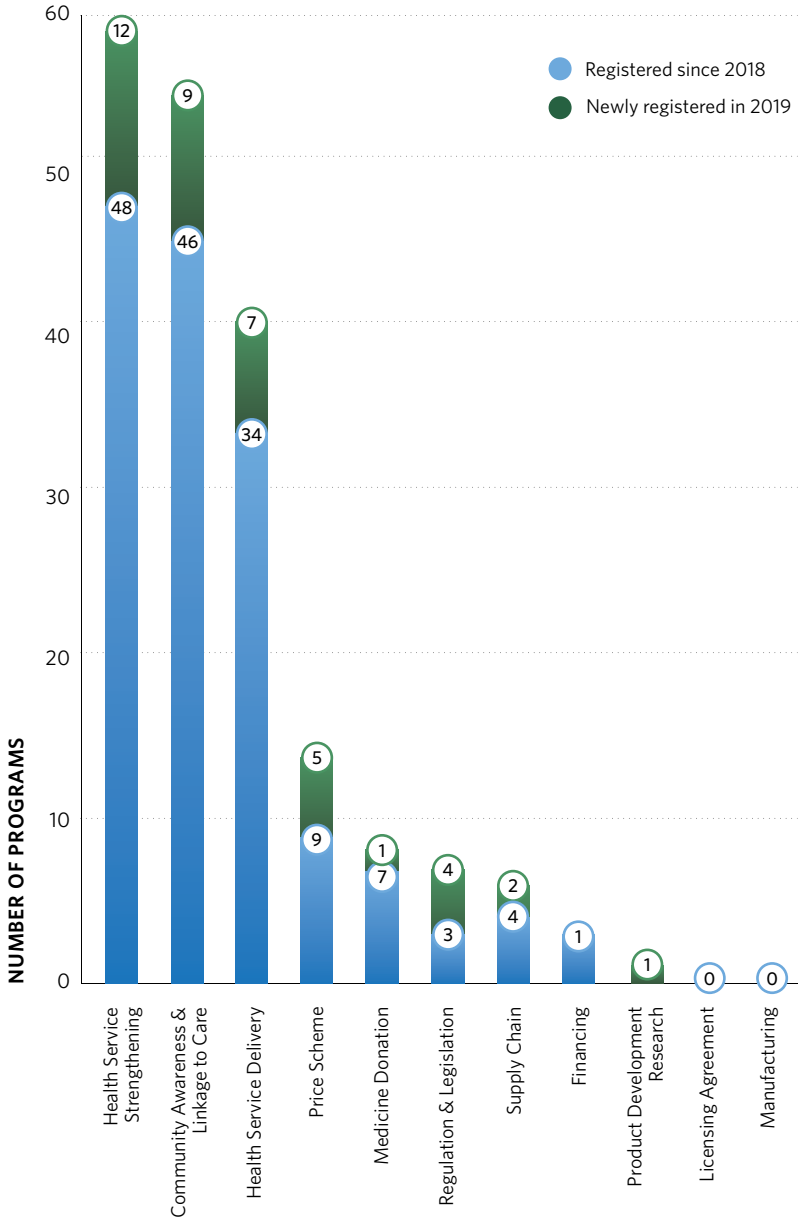
Nearly all programs active in 2019 used at least one of three strategies: Health Service Strengthening, Community Awareness and Linkage to Care, and Health Service Delivery. Most programs used two or three strategies.

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

The number of donation programs increased from 7 in 2018 to 8 in 2019.

The number of programs using a pricing scheme increased from 9 in 2018 to 14 in 2019.

Figure 5: Number of Programs by Strategy

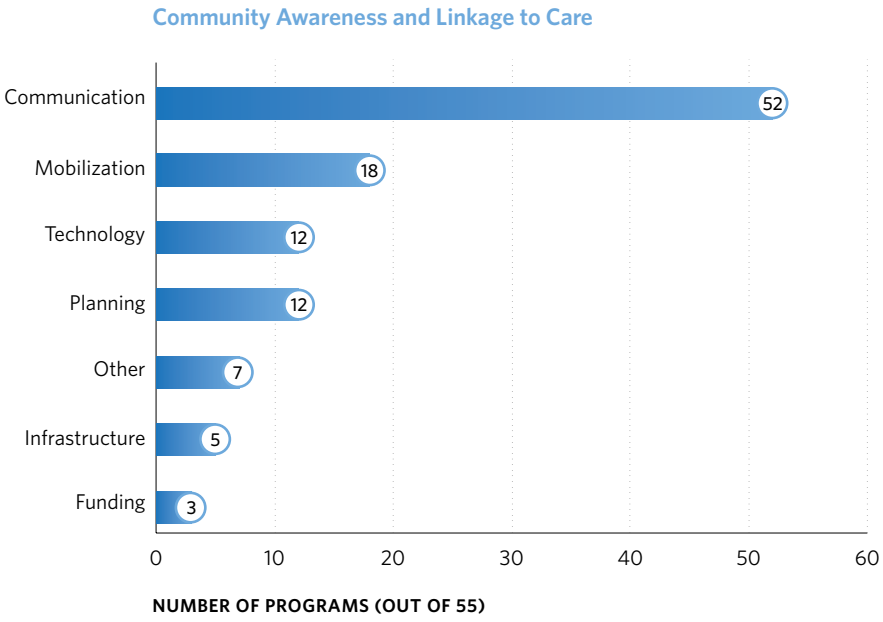


A large number of programs included community meeting activities designed to increase awareness of disease and treatment options.

A large number of programs included health worker training activities.

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 (95%). A smaller number of programs provided support to mobilize community or patient groups (33%) or provided technology such as disease education software and websites (22%) (Figure 6).

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

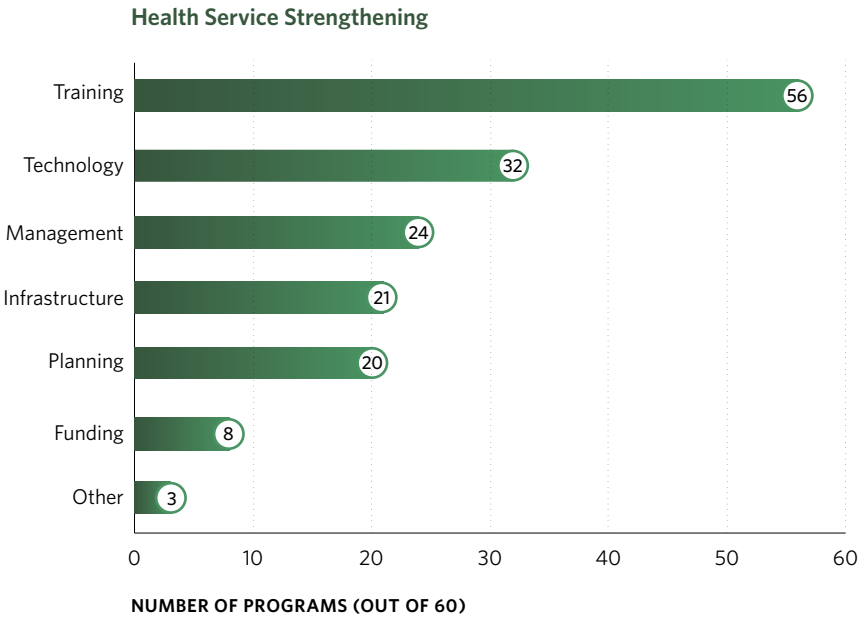


Note: All 7 programs with 'other' activities included training.

Among programs that used the Health Service Strengthening strategy, nearly all had training activities for health care providers (93%) (Figure 7). Most trainings were conducted in-person only (63%); a few were conducted online only (5%) and a handful were conducted both in-person and online (16%). A majority (73%) of the trainings targeted doctors, nurses, or pharmacists (73%).

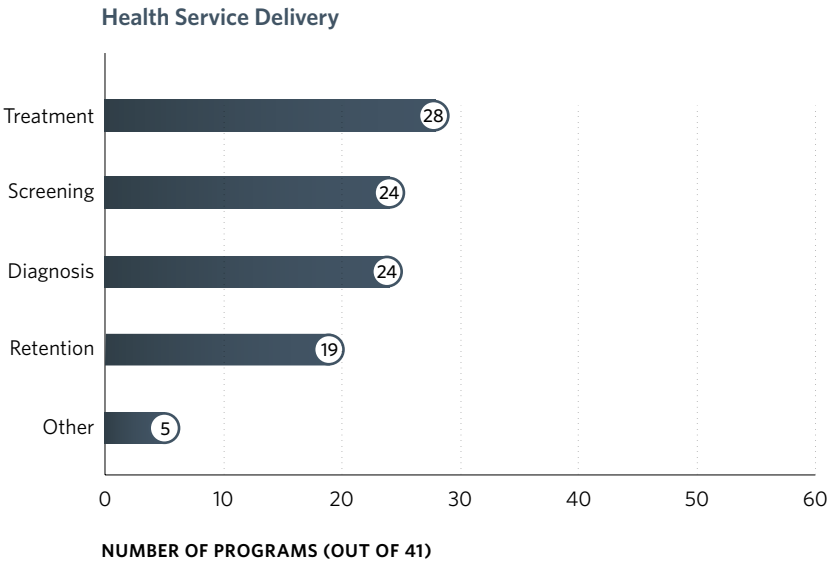
More than half of programs that used the Health Service Strengthening strategy provided technology such as electronic medical records, screening and diagnostic decision apps. A smaller number included management activities focused on developing treatment and referral protocols (40%) or infrastructure activities such as donation of buildings and diagnostic equipment (35%).

Figure 7: Activities for Programs that Used Health Service Strengthening



Among programs that used the Health Service Delivery strategy, a majority conducted screenings (59%), provided diagnosis (59%), or provided treatment (68%) (Figure 8). Several also took steps to retain patients in care through phone calls and text message reminders (46%).

Figure 8: Activities for Programs that Used Health Service Delivery



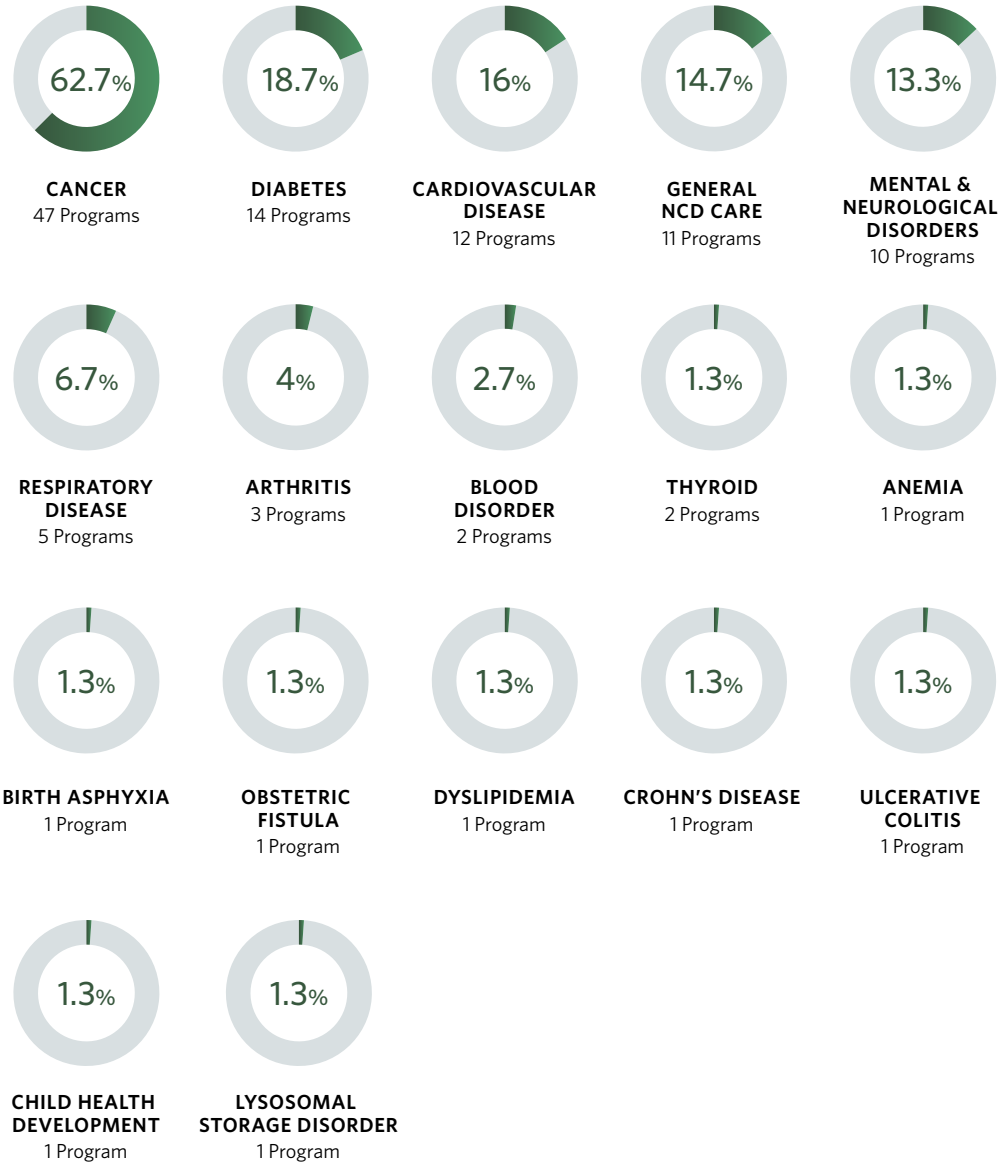
Disease Scope

Most programs focused on cancer.

A large number of programs aimed to address cervical cancer, breast cancer, or lung cancer.

Programs focused mainly on improving access to cancer care (63%), diabetes (19%), or cardiovascular disease (16%). Nine new programs that were registered in this past year focused on cancer care.

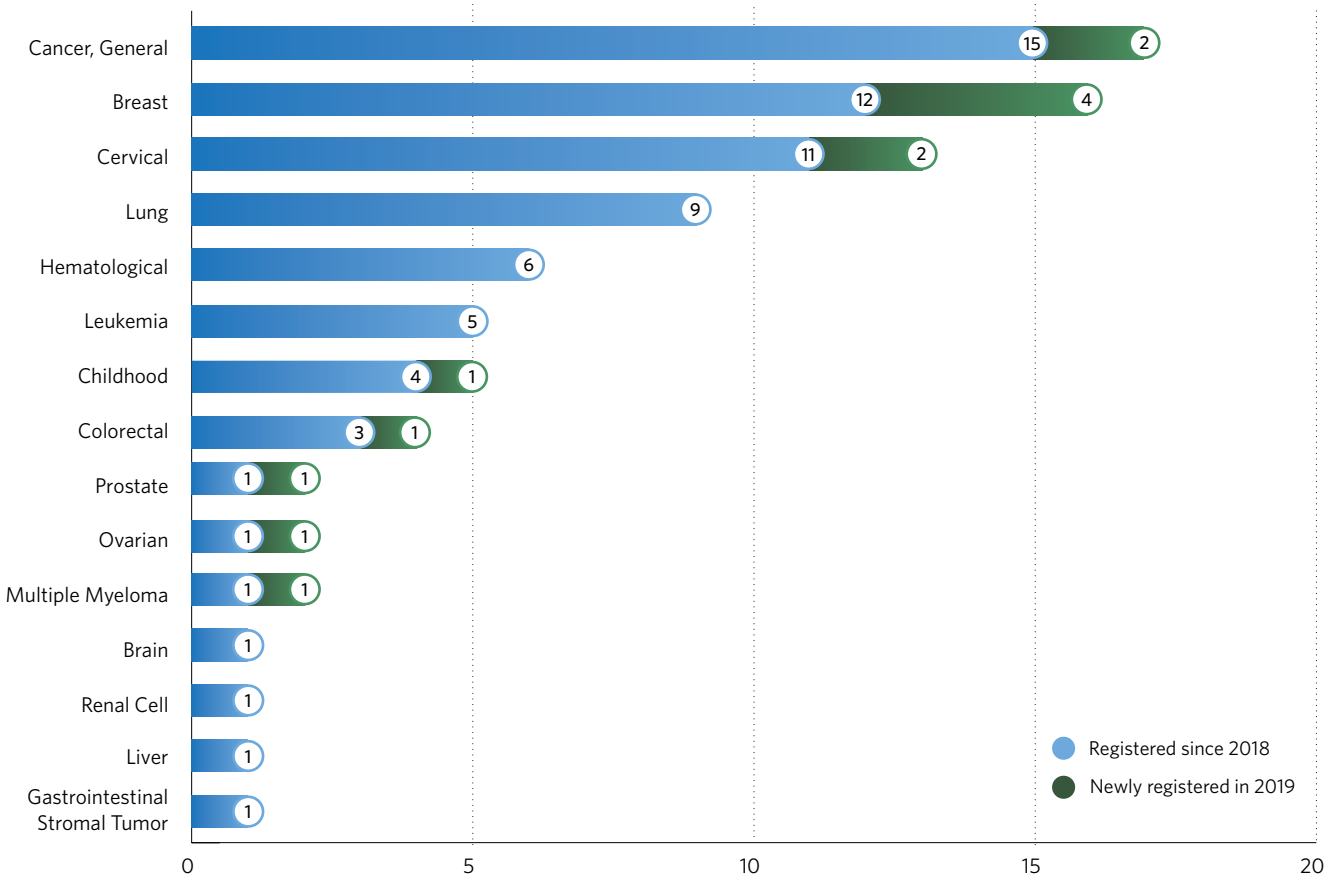
Figure 9: Number of Programs* by Disease



*Some programs target more than one disease.

Of the 47 cancer programs, 34% focused on breast cancer, 28% on cervical cancer and 19% on lung cancer.

Figure 10: Number of Programs by Cancer Type



Medicines and Technology

Thirty-six percent of programs included at least one health technology, i.e., medicine, vaccine, or diagnostic equipment.

Most of the medicines included in programs are used to treat or prevent cancer and were provided via a price scheme strategy.

Twenty-seven programs (36%) provided at least one health technology and 17 provided multiple health technologies. Around one-third of programs included medicines, 13% included medical devices (e.g., diagnostic equipment for cancer) and 3% included vaccines.

Table 5: Health Technology by Type and Name

Type of Health Technology	Name of Technology	Number of Programs
Medicine	Oncology Medicines	13
	Diabetes Medicines	6
	Hypertension Medicines	3
	Respiratory Disease Medicines	1
	Lysosomal Storage Disorder	1
Vaccine	HPV Vaccine	1
	Childhood Vaccines*	1
Medical Device	Cancer Diagnostic Equipment	3
	Diabetes Diagnostic Equipment	5
	Hypertension and Diabetes Diagnostic Equipment	2
	Ocular Prosthesis	1
	Fistula Treatment Equipment	1
	Laboratory Testing Equipment	1

*Program focused on childhood asthma.

Note: Some programs provide more than one health technology

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.

Table 6: Medicines and Vaccines Included in Programs by Therapeutic Group

Main Therapeutic Group (Number of Programs)	International Non-Proprietary Name	Number of Programs
Oncology (12)	Alectinib	1
	Anastrozole	1
	Atezolizumab	1
	Bevacizumab*	2
	Brentuximab vedotin	2
	Capecitabine	2
	Eribulin mesylate	1
	Erlotinib	1
	Imatinib*	1
	Ixazomib	1
	Letrozole	1
	Obinutuzumab	2
	Pertuzumab	2
	Ponatinib	1
	Rituximab*	3
	Tamoxifen*	1
	Trastuzumab*	4
	Trastuzumab emtansine	1
	Human Papilloma Virus Vaccine*	1
Cardiovascular Medicines (2)	Amlodipine*	2
	Amlodipine + Irbesartan	1
	Bisoprolol*	1
	Hydrochlorothiazide*	1
	Irbesartan	1
	Irbesartan + Hydrochlorothiazide	1
	Ramipril	1
	Simavastin*	1
	Valsartan	1
Diabetes (4)	Glibenclamide	1
	Glimeperide	2
	Glimepiride + Metformin	1
	Insulin*	4
	Metformin*	1
	Vildagliptin	1
Asthma (1)	Salbutamol	1
Lysosomal Storage Disorder (1)	Agalsidase alfa	1
	Idursalfase	1
	Velaglucerase alfa	1
Ulcerative Colitis and Crohn's disease (1)	Vedoluzimab	1
Diarrhoea (1)	Oral Rehydration*	1
Anaemia (1)	Iron and folic acid*	1
Antibiotics (2)	Amoxicillin*	1

*Medicines that are listed in WHO Model List of Essential Medicines (June 2019).[6]

Note: Five company programs did not specify the medicines that the programs provide.

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. Eighty-one percent of programs were solely funded by the pharmaceutical company, while 19% were co-funded by other partners including governments. For 31% of programs, the company's sole role was providing funding. In the remaining 69% of programs, companies supported various planning and implementation activities. According to our program typology, 49 (65%) programs partnered directly or indirectly with multiple implementing organizations which delivered the program directly to beneficiaries.

Nearly every program involved a partnership between the pharmaceutical company and another entity.

Non-company partners represented a wide spectrum of the public, private, and voluntary sectors.

For most programs, local governments were identified as a stakeholder.

Partnerships and Stakeholders

Companies listed 276 unique partners across the 75 active programs. Twenty-eight entities were listed as partners for multiple programs. Companies partnered with at least one voluntary sector partner in 75% of programs and with at least one public sector partner in 59% of programs, including partnering with the local Ministry of Health in 24% of programs. Voluntary and public sector partners often included hospitals and universities. The full list of funding and implementing partners reported by programs can be found in Appendix 3.

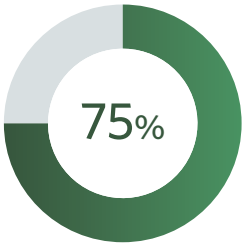
Figure 12: Number of Programs by Funding and Implementing Partner's Sector

74	276	28	4.5
Programs with at least one partner	**Total number of unique partners**	**Number of partners implementing multiple programs**	**Average number of partners per program***

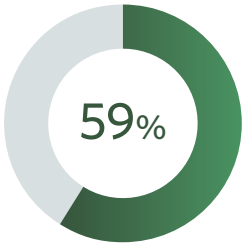
*Some programs had more than one funding or implementing partner. The average number of partners per program was based on 276 partners identified across all programs irrespective of whether the partners implemented multiple programs.

Figure 12: Number of Programs by Funding and Implementing Partner's Sector (Continued)

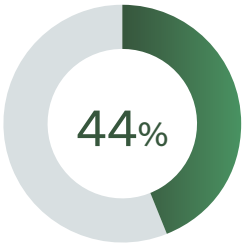
PROGRAMS BY SECTOR



Programs with at least one voluntary sector partner
53 Programs

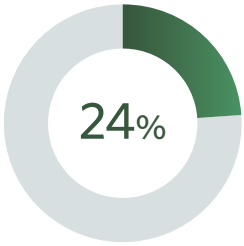


Programs with at least one public sector partner
42 Programs

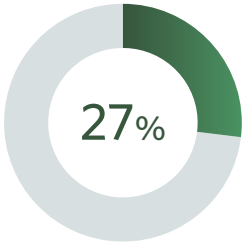


Programs with at least one private sector partner
32 Programs

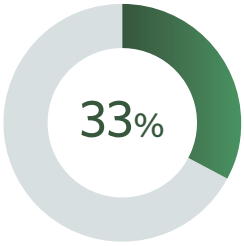
PROGRAMS BY INSTITUTION



Programs working with Ministries of Health (local)
18 Programs



Programs working with hospitals
20 Programs

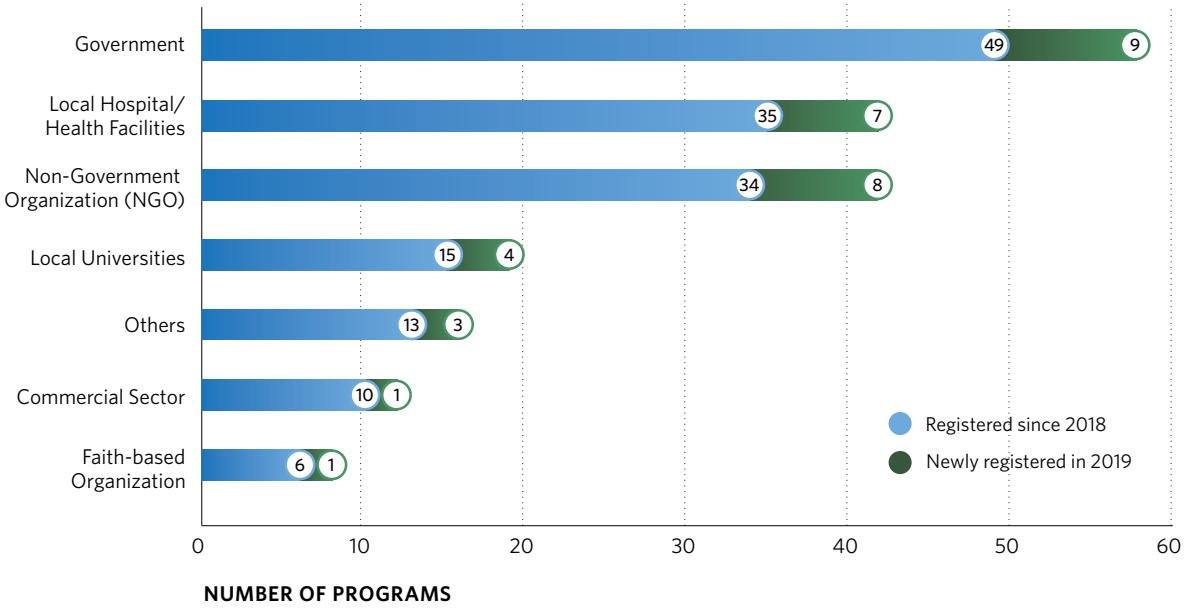


Programs working with academic institutions
25 Programs

Note: A public sector partner is a government organization that is implementing or funding the program, which includes intergovernmental agencies such as World Health Organization (WHO). A private sector partner is a business unit established, owned, and operated by private individuals or organizations for profit that is implementing or funding the program, while a voluntary sector partner is a private organization or private individuals whose purpose is to benefit and enrich society, often without profit as a motive and with little or no government intervention that is involved in implementing or funding the program.

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 government (77%) and 45% reported engagement with local hospitals or NGOs.

Figure 13: Number of Programs by Local Stakeholders



Some programs engaged with more than one stakeholder.

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

Twenty programs (27%) indicated that they conducted a needs assessment, of which three uploaded a report.

Program Alignment with Local Priorities

It is commonly assumed that access programs align with local priorities, polices, and laws. However, public documentation demonstrating alignment 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 Assessments

Twenty programs (27%) indicated that they conducted a needs assessment, of which three programs uploaded a report.

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?	73	1	1
Please describe how your program is responsive to local health needs and challenges.	74	0	1
Please describe how you have engaged with any of these local stakeholders in the planning and/or implementation of this program.	71	0	4
If applicable, please describe how you have planned for sustainability of the implementation of your program.	65	3	7
Does your program aim to address social inequity in any way (if yes, please explain)?	67	4	4

Table 8: Sustainability Strategies Reported by Programs

Sustainability Strategy	Number of Programs
Transitioning of project activities to local government after end date of program	29
Training of providers and community workers for capacity building/development	24
Transitioning of project activities to other sponsors or stakeholders after end date of program	14
Incorporating program training curriculum into national curriculum	7
Building and improving existing infrastructure for shared learning and healthcare access	4
Other	13
Unclear	4
No answer provided	10

Other strategies include: Studying effectiveness of interventions to determine future implementation and/or generate evidence to advocate for more government allocation of funds on a longterm basis, costsharing (patients or participants share cost of medicines or trainings), developing disease control strategies, clinical guidelines, and patient tracking and referral systems which will continue to be used after the program has ended.

Addressing Social Inequity

Most programs aimed to address income-related inequity and inequity related to where people lived within countries.

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

In its commitment letter, Access Accelerated very clearly stated its goal of addressing a key aspect of social inequity — lack of "access to appropriate, quality and affordable prevention, treatments and care." The *Access Observatory* captures how programs intend to address social inequity.

Programs indicated that they intend to address five main types of inequity: between high and low and middle-income countries; between affluent and less affluent households; between rural and urban communities (locality); between genders; and between those with and without social stigma.

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

Note: Categories coded based on open text responses. Some programs address more than one type of inequity.

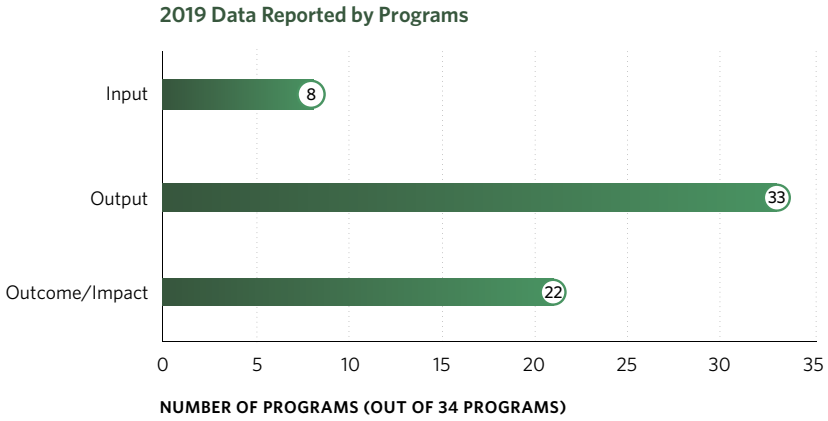
Program Indicators

In total, 34 programs submitted at least one 2019 Indicator Value. Of these, 33 (97%) submitted output indicators, and 22 (65%) submitted outcome or impact indicators. Eight programs (24%) submitted input indicators.

Figure 15: Access Observatory Program Indicators

75	57	34	31
Programs registered and active	**Programs with Indicator Plan finalized**	**Programs with 2019 Indicator Values submitted**	**Programs with 2019 Indicator Values disaggregated from pre-2019 Indicator Values**

Figure 16: Number of Programs by Indicator Type



Nearly half of programs had at least one 2019 Indicator Value.

Almost all 2019 Indicator Values were for output or outcome indicators, with very few submitting for an input indicator and only one for an impact indicator.

The most common input indicators reported in 2019 were "Value of resources" and "Staff time" spent on the project. The most common output indicators were "Number of people trained," "Population exposed to community communication activities," "Number of people on treatment" and "Number of people diagnosed." The most common outcome indicator reported was "Health provider knowledge" and "Health Provider Knowledge Change." "Patients with complete cancer remission" was the only impact indicator reported. There were no impact indicator values submitted in 2017 or 2018.

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 people trained[a]	Output	13 (62%)	18 (72%)	14 (45%)
Population exposed to community communication activities[b]	Output	11 (52%)	14 (56%)	10 (32%)
Value of resources	Input	6 (29%)	10 (40%)	6 (19%)
Number of patients diagnosed[c]	Output	5 (24%)	9 (36%)	9 (29%)
Number of patients on treatment[d]	Output	6 (29%)	7 (28%)	6 (19%)
Staff time	Input	5 (24%)	7 (28%)	5 (16%)
Communication materials in use	Outcome	3 (14%)	5 (20%)	6 (19%)
Population screened[e]	Output	3 (14%)	4 (16%)	6 (19%)
Tools in use	Output	2 (10%)	4 (16%)	4 (13%)
Building/equipment in use[f]	Output	3 (14%)	3 (12%)	3 (10%)
Percentage of professionals trained out of total number targeted	Output	2 (10%)	3 (12%)	5 (16%)
Health provider knowledge	Outcome	3 (14%)	2 (8%)	4 (13%)
Health provider knowledge change	Outcome	1 (5%)	2 (8%)	3 (10%)
Number of patients diagnosed early[g]	Output	1 (5%)	2 (8%)	1 (3%)
Patients retained in care	Outcome	1 (5%)	2 (8%)	2 (6%)
Patients with complete cancer remission	Outcome	1 (5%)	2 (8%)	1 (3%)
Sites in use	Output	2 (10%)	2 (8%)	1 (3%)
Population exposed to oral communication activities	Output	0 (0%)	3 (12%)	4 (13%)

Indicator	Type of Indicator	Number of Programs 2017 (n=21)	Number of Programs 2018 (n=25)	Number of programs 2019 (n=31)
Population exposed to community communication activities	Output	10 (48%)	8 (32%)	6 (13%)
Volume of medicines sold	Output	1 (48%)	1 (4%)	4 (13%)
Volume of medicines donated	Output	0 (0%)	0 (0%)	4 (13%)
Number of patients enrolled in patient support program	Output	0 (0%)	0 (0%)	2 (6%)
Number of patients reached with pricing scheme	Output	0 (0%)	0 (0%)	6 (19%)
Number of patients supported through therapy reminders	Output	1 (5%)	1 (4%)	2 (6%)
Provider awareness of program	Outcome	0 (0%)	0 (0%)	2 (6%)

Note: There were 44 other unique indicators such as "Time between first symptoms and diagnosis" and "Availability of medicines at outlets" that were reported by only one program in 2019.

[a] This indicator is an aggregate of the following indicators: "Number of people trained" and "Number of participants in trainings."

[b] This indicator is an aggregate of the following indicators: "Population exposed to community communication activities" and "Population exposed to oral communication activities."

[c] This indicator is an aggregate of the following indicators: "New Patients Diagnosed," "Number of children impacted by second opinion diagnosis," "Number of diagnosed cases" and "Number of patients diagnosed."

[d] This indicator is an aggregate of the following indicators: "Number of patients initiating treatment," "Number of patients on appropriate treatment per study protocol", "Number of patients on treatment," "Number of patients treated," and "Patients on active treatment."

[e] This indicator is an aggregate of the following indicators: "Population screened" and "Number of women screened/receiving clinical breast exam."

[f] This indicator is an aggregate of the following indicators: "Buildings/equipment in use," "Buildings in use" and "Equipment in use."

[g] This indicator is an aggregate of the following indicators: "Number of diagnosed cases at early stages" and "Patients early diagnosed."

Highlights of Outcome/Impact Data

Routinely collected clinical and supply data can be used to assess the impact of company access programs.

My Child Matters (Sanofi)

My Child Matters operates in several countries and includes activities focused on provider training, health service delivery through satellite clinics, and public campaigns to promote early diagnosis of childhood cancers. Outcome data were reported for three country variants of the program. The reported outcome data were collected in multiple ways, including field surveys, interviews of key personnel, site audits, and population-based and hospital-based registries. Baseline assessments were carried out prior to program implementation. Based on the data reported, the program trained 42 physicians and 100 nurses from 16 countries through the My Child Matters — African School of Pediatric Oncology. The My Child Matters — Paraguay program established four satellite clinics that treated 81 patients in 2009 and expanded to 884 patients in 2015. Through My Child Matters — Retinoblastoma, 201 patients were diagnosed. The 1-year survival of patients with bilateral intraocular disease increased from 0% to 42% over the course of the program. The estimated 5-year survival increased by an estimated median of 5.1% in countries where My Child Matters programs were implemented.[7]

Novartis Access (Novartis)

Novartis Access was implemented in Kenya starting in 2015, providing a basket of NCD medicines at a reduced wholesale price via the public and private non-profit sectors. The impact of Novartis Access on medicine availability and affordability in Kenya was evaluated through a first-of-its-kind cluster-randomized controlled trial*.[8,9] Data were collected before and after implementation of the program using several methods, including household and health facility surveys, site observations, and qualitative interviews. Data were also collected during monthly phone calls to health facilities and sample of households. After 15 months, the program was found to have had a significant positive impact on the availability of two medicines (amlodipine and metformin) at health facilities. The program did not impact prices at facilities or availability at households. In an editorial published along with the paper describing the evaluation of Novartis Access in the Lancet Global Health, editors commented "*... Novartis is setting the standard for how the industry should transparently report on its social programmes.*"[10]

**Members of the Access Observatory team led the independent evaluation of Novartis Access in Kenya.*

Glivec International Patient Assistance Program (Novartis)

The Glivec International Patient Assistance Program (GIPAP) offers Glivec (imatinib) free of charge to patients with chronic myelogenous leukemia (CML) and gastrointestinal stromal tumor (GIST). A retrospective interrupted time series analysis of data collected by the Max Foundation showed that around 63,000 patients in 93 countries received 72 million Defined Daily Doses of imatinib through the program between 2001 and 2014.[11] Impact was assessed in the form of 5-year survival rate of GIPAP patients. The 5-year survival rate of patients enrolled in the program was 89%, which is considered favourable when compared to survival rates in high income countries. The analysis of the GIPAP program demonstrates that routinely collected clinical and supply data can be used to assess the impact of company access programs.

Even in low-resource and remote areas it is possible to collect meaningful outcome data.

Epilepsy Program in Bolivia (Sanofi)

The Epilepsy Program in Bolivia aims to improve awareness of epilepsy in communities in Bolivia. A few studies were recently conducted to assess the program. The first study assessed knowledge, attitudes, and practices (KAP) among community members using an uncontrolled before-and-after design.[12] Seventeen communities receiving the program were selected and a random sample of study participants were drawn from among patients with epilepsy, their relatives, community leaders, and health workers. Participants were administered a survey that collected data on demographics, personal experience with epilepsy including stigma, epilepsy care knowledge, common treatments, practices, and social considerations toward patients with epilepsy. The study found a significant increase in KAP around epilepsy and a significant decrease in stigma after the program as compared to before. A second uncontrolled before-and-after study conducted in the same communities found significant changes in general practitioners' attitudes and practices around epilepsy.[13] The results of both studies may suffer from bias due to a lack of a control group and substantial loss-to-follow-up between the two waves of data collection. However, the studies demonstrate that even in low-resource and remote areas it is possible to collect meaningful outcome data.

Kids and Diabetes in Schools (Sanofi)

Kids and Diabetes in Schools provides training and information on diabetes prevention and management at schools in several countries. Qualitative data were collected for the program in Brazil and India.[14] Semi-structured interviews were conducted with school staff and parents of school children with and without diabetes one month and three months after the program was implemented. Interviews focused on knowledge and behaviors related to diabetes management and quality of care and support for diabetic children in schools. During interviews, school staff emphasized the importance of children's knowledge of health eating habits, whether they have diabetes or not. Staff also recognized that increasing awareness about diabetes among children generally reduces stigma towards children with diabetes. Participants in the program reported changes in individual behavior and improved satisfaction after the program. The insights gained from this study were used to further develop the program.

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 17). The initiative is scaling-up support to a wide network of 'Challenge Cities' with a population greater than 1 million in every region. In 2019 C/CAN 2025 reported nine cities being engaged in the C/CAN 2025 program.

Figure 17: 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 2025 is developing a City Health Financing Lab to support cities to access financing for their cancer priorities.
Regulation and Legislation	**Advocacy** C/Can 2025 is enhancing advocacy efforts in cities.

Partnerships and Stakeholders

C/CAN 2025 works with 18 global partners, including four private sector, eight public sector and eight voluntary sector partners.

The private sector partners are involved in:

- Program funding
- Implementation

The public sector partners are involved in:

- Program implementation
- Technical implementation support
- Capacity building
- Providing financing expertise funding identifying needs and implementation priorities

The voluntary sector partners are involved in:

- Program implementation
- Technical implementation support
- Capacity building
- In-kind and financial support during all phases of the initiative's design, development and implementation at global, regional and city levels

C/CAN 2025 also works with several national, regional, city level and local stakeholders including heads of states and governors, ministries of health, 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.

Program Indicators

C/CAN 2025 submitted data for 16 indicators (Table 10) between 2017 to 2019.

Table 10: C/CAN 2025 Indicator Values 2017–2019

Indicator	Unit	Value	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	Guidelines, protocols or systems drafted/developed	2	
Development of tools, guidance and protocols for cancer treatment and care	Guidelines, protocols or systems drafted/developed	12	
Healthcare professionals supported with technical assistance	People	680	
Needs assessment completed in cities	Cities	4	Cali, Colombia; Asuncion, Paraguay; Yangon, Myanmar; Kumasi, Ghana
New financial resources committed for sustainable financing of cancer care	Dollars	0	Data available from 2020 onwards
Participation of healthcare professionals in identifying needs in cancer treatment and care	People	817	
Participation of patients in identifying needs in cancer treatment and care	People	757	
Percentage of health facilities involved in identifying needs in cancer treatment and care	Percentage	86.25%	Simple (non-weighted) average
Technical assistance in cancer treatment and care provided	Technical assistance events/activities	24	
Technical experts contributing to technical support on sustainable financing for cancer treatment and care	People	30	
Technical experts providing technical assistance in cancer treatment and care	People	98	
Technical support provided to facilitate sustainable financing of cancer treatment and care	Cities	3	Cali, Colombia; Asuncion, Paraguay; Yangon, Myanmar
Total population covered	People	38,110,000	

Looking Forward

For the first time, many of the world's largest biopharmaceutical companies have jointly committed to measuring and reporting on their access efforts in a transparent way. In just three years, most of these companies have demonstrated that doing so is feasible and generates clear benefits for themselves and society.

Three milestones from the first three years of the *Access Observatory* illuminate critical aspects of a sustainable path forward for measurement and reporting on pharmaceutical industry-led access programs:

1. **The *Access Observatory* has illuminated the scope and scale of industry engagement in access efforts.** Several stakeholders have indicated that the *Access Observatory*'s standardized approach to reporting has facilitated the identification of synergies, redundancies, and gaps in investments for global access. The identification of synergies has led to new multi-company collaborations in specific disease areas (e.g., breast cancer) and geographies (e.g., Kenya).

2. **Several companies significantly increased internal capacity to measure and report on their access programs.** They have done this in a variety of ways, including training existing staff and hiring new staff with relevant prior training; and adapting information and management systems to integrate reporting on social and commercial key performance indicators.

3. **Several companies revised agreements with implementing partners to require collection and reporting of program data.** Most implementing partners are required to collect and report similar data to non-industry funders and have capacity to do the same for industry partners.

The *Access Observatory* has continued to evolve since its inception. It has grown and now provides robust information on nearly 100 access programs operating in 114 countries. However, to realize the full potential of the *Access Observatory*, more programs must report indicator data. Users of the *Access Observatory*, including company shareholders, investors, global health stakeholders, and governments, could increase incentives for companies to report indicator data by clearly stating an expectation that they do so. The World Health Organization has issued guidelines for governments to consider when reviewing company access programs that may serve as a starting point for more thorough efforts in this area.[5]

Company Reflections on the Value of the *Access Observatory*

This past year, 16 companies completed a survey administered by the Access Accelerated Secretariat that elicited their opinions on the *Access Observatory*.

To realize the full potential of the Access Observatory, more programs must report indicator data.

Several companies confirmed that the *Access Observatory* has strengthened their program measurement and reporting efforts. Here are a few examples of what companies said:

"Through the metrics framework, the Access Observatory has enabled our company to better structure, refine and accelerate the integration of measurement in our programs."

"The logic models overall can be a useful tool for any company that is initiating a new project and developing a project level M&E framework for the specific project."

Several companies identified the common language that underlies the *Access Observatory* framework as a particular strength:

"The collection and reporting of standardized data across continents, companies and initiatives is critical."

"Development of the Taxonomy of Strategies was valuable. It allows companies to indicate what the project is focused on using a 'common language."

Companies also indicated that the *Access Observatory* has enabled them to better demonstrate their contribution to society:

"It is a great way to demonstrate how member companies are contributing to reducing the NCD burden in LMICs."

"Our company's activities have been widely introduced to the world."

Increased Alignment with the Access to Medicine Index

In 2019, we collaborated with the Access to Medicine (ATM) Foundation to conduct a joint review of our respective reporting forms to identify overlap in information submitted to the *Access Observatory* and information used in the ATM Index methodology. The joint review determined that most of the information and data fields collected by the *Access Observatory* are valuable as inputs to the ATM Index process. The ATM Foundation confirmed that information and indicator data reported into the *Access Observatory* would be used in determining their 2020 Index rankings.

Increased alignment of the *Access Observatory* and the ATM Index methodology is important for three main reasons.

1. Information sharing reduces the reporting burden on companies. Eliminating redundancy and increasing efficiency should allow companies to invest more resources in strengthening their measurement and reporting systems. Our commitment to full transparency and not accepting confidential information allows us to share information with the ATM Foundation without barriers.

2. Harmonized reporting strengthens standardization, which improves transparency and accountability. Broadening the use of a commonly understood language enhances the utility of information shared in that language and increases opportunities to employ that information in accountability mechanisms.

3. Identifying complementarities of different approaches to measurement and reporting creates opportunities for greater impact. The joint review facilitated shared learning and both organizations identified aspects of the others approach that stimulated ideas for how they might expand their own approach in complementary ways.

Increased alignment with the ATM Index contributed to increased reporting of indicator data into the Access Observatory.

Based on our discussions with companies this past year, we believe that increased alignment with the ATM Index contributed to increased reporting of indicator data into the *Access Observatory*. This year companies reported data for 34 programs and provided nearly 200 unique data points. The ATM Index aims to influence investor analysis and aligning our reporting with the Index should strengthen our link with investor audiences.

Pressure from investors could incentivize companies to strengthen measurement and reporting on their access programs. In the Preface to this report, Yo Takatsuki, Head of ESG Research and Active Ownership at AXA Investment Managers, explained that institutional investors are increasingly interested in seeing rigorous evidence from pharmaceutical companies on whether their access efforts are having social impact. Our approach to measurement and reporting complements the approaches of other standards groups that are frequently used by analysts at investment firms, for example the Sustainability Accounting Standards Board (SASB).

Needs Assessments Required for Future Projects

Over the past three years, the lack of company reporting on needs assessments has been glaring. Of the 75 registered programs active in 2019, only one-quarter reported conducting a needs assessment prior to program implementation. Only three programs provided documentation describing the assessment they conducted.[15-17] Six additional programs made use of analyses conducted by independent sources, including governments and international organizations such as the World Health Organization.[18-23]

There is a glaring lack of company reporting on needs assessments.

Many companies undertake needs assessments when developing marketing plans and should have internal capacity to undertake similar efforts for access programs.

Many companies undertake needs assessments when developing marketing plans and should have internal capacity to undertake similar efforts for access programs. In general, needs assessments should be used to identify barriers to access in local health systems that could be addressed using access strategies the company is capable of utilizing. Companies should also use needs assessments to analyze local policies, practices, and institutional capacity to provide high quality care.

For those programs in the *Access Observatory* that described a needs assessment, companies made use of a diversity of methods, including desktop reviews, site audits, public registries, field surveys, key informant interviews, and focus group discussions. Many programs used a combination of these methods, which is recommended as it allows for a more rigorous analysis by triangulating results. Survey data were collected and analyzed using quantitative and qualitative approaches, which is also recommended.

Undertaking a needs assessment should elucidate opportunities for intervening where a company is best suited to make a difference given their unique capacity in manufacturing, licensing, pricing or product portfolio.

Participants in needs assessment activities included health system payers (public and private sector), clinical providers (oncologists, cardiologists etc.), and health system managers. Key informant interviews tended to focus on patient behaviors and access barriers. Focus group discussions explored patient perceptions and knowledge related to disease management and treatment. Site visits elicited information about health facility capacity to provide care.

Common barriers to access that emerged from needs assessments included poor patient awareness about symptoms and disease management; insufficient resources and infrastructure in health facilities; lack of specialized health professionals; low treatment adherence; stigma associated with care; and low affordability of medicines and procedures.

The results of any needs assessment will highlight the reality that no single company can address all barriers to access in a particular population. Undertaking a formal process should elucidate opportunities for intervening where a company is best suited to make a difference given their unique capacity in manufacturing, licensing, pricing or product portfolio. This will minimize the time and resources that a company wastes on activities that are not needed or that should be addressed by others.

Outcomes Reporting

More outcome data is needed if Access Accelerated is to demonstrate progress toward fulfilling its commitments.

However, still more outcome data is needed if Access Accelerated is to demonstrate progress toward fulfilling its commitments. The ATM Index and investor audiences are increasingly demanding rigorous evidence demonstrating what companies have achieved. Company statements indicating what they intend to achieve are not sufficient. For active programs, it may be difficult for companies or their implementing partners to retrofit new measurement and reporting systems into existing structures. For new programs, outcome reporting using standardized indicators should be built-in from the earliest phases of design and implementation.

A Note on Access to COVID-19 Vaccines and Medicines

The COVID-19 pandemic is an unprecedented global health challenge that is testing health systems worldwide in unprecedented ways. Vaccines and medicines to address this challenge are currently lacking. According to SDG 17, collaboration between public and private sector actors including the pharmaceutical industry is critical to address pressing social challenges, and the COVID-19 pandemic is no exception. Biopharmaceutical companies have a unique role to play in conducting research and developing vaccines and medicines for COVID-19.

The Access Observatory can play a key role in documenting the steps that biopharmaceutical companies take to demonstrate their commitments to access for COVID-19 vaccines and medicines.

In April 2020, as COVID-19 transmission was initially increasing in the United States, investors who are members of the Interfaith Center on Corporate Responsibility (ICCR) called on 14 biopharmaceutical companies, many of which are members of Access Accelerated, to collaborate with other stakeholders "*to ensure equitable access across populations and geographies, and to quickly and safely scale up diagnostic measures, treatments and when available, a vaccine [for COVID-19].*"[24] ICCR is comprised of 300 member organizations, including faith communities, asset managers, pension funds, unions and other socially responsible investors with more than $500 billion in combined assets.

Other investor groups have similarly mobilized to encourage companies to promote access to COVID-19 vaccines and medicines, share data, and ensure supply chain security and functioning.[25] Investment in research and development for infectious disease treatment and prevention has been identified as critical for addressing present and future pandemics. Investors have announced that they will observe biopharmaceutical companies closely and make investment decisions based on company commitments to global access.

The *Access Observatory* can play a key role in documenting the steps that biopharmaceutical companies take to demonstrate their commitments to access for COVID-19 vaccines and medicines, particularly in low- and middle-income countries. Manufacturing, licensing, and price scheme strategies could be critical tools in company efforts, though at this time no programs registered in the *Access Observatory* use either the manufacturing or licensing strategy.

In Conclusion

In 2015, more than 190 countries adopted the SDGs, confirming their commitment to addressing the most pressing global challenges of our time by 2030. Society's key stakeholders, including governments, citizens, and the private sector — companies and investors — must all be held accountable if the SDG targets are to be reached in the next 10 years. In response to the SDGs, more than 20 large biopharmaceutical companies committed to increasing global access to NCD prevention and treatment through Access Accelerated. The companies also agreed to be held accountable by committing to an independent evaluation of their efforts. The *Access Observatory* was developed out of this commitment. Looking forward, the industry should continue to expand their investments in systems that meaningfully demonstrate their social impact.

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-undaf-companion-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/policy-brief-2.0/en/

[6] World Health Organization. WHO Model List of Essential Medicines, 21st List (2019). Available at: who.int/medicines/publications/essentialmedicines/en/

[7] Howard SC, Zaidi A, Cao X, Weil O, Bey P, Patte C, Samudio A, Haddad L, Lam CG, Moreira C, Pereira A. The My Child Matters programme: effect of public–private partnerships on paediatric cancer care in low-income and middle-income countries. Lancet Oncology 2018; 19: e252-e266. Available at: thelancet.com/journals/lanonc/article/PIIS1470-2045(18)30123-2/fulltext

[8] Rockers PC, Laing RO, Ashigbie PG, Onyango MA, Mukiira CK, Wirtz VJ. Effect of Novartis Access on availability and price of non-communicable disease medicines in Kenya: a cluster-randomised controlled trial. Lancet Global Health 2019;7(4):e492-502. Available at: thelancet.com/journals/langlo/article/PIIS2214-109X(18)30563-1/fulltext

[9] Evaluation of Novartis Access. Boston University School of Public Health. Available at: sites.bu.edu/evaluatingaccess-novartisaccess/

[10] Editorial: Access to medicines – Business as usual? Lancet Glob Health 2019; 7(4): e385. Available at: thelancet.com/journals/langlo/article/fulltext

[11] Umeh CA, Garcia-Gonzalez P, Tremblay D, Laing RO. The survival of patients enrolled in a global direct-to-patient cancer medicine donation program: The Glivec International Patient Assistance Program (GIPAP). EClinical Medicine 2020; 19: 100257. Available at: thelancet.com/journals/eclinm/article/PIIS2589-5370(20)30001-8/fulltext

[12] Giuliano L, Cicero CE, Padilla S, Mayaregua DR, Villarreal WM, Sofia V, Zappia M, Bartoloni A, Gómez EB, Nicoletti A. Knowledge, stigma, and quality of life in epilepsy: Results before and after a community-based epilepsy awareness program in rural Bolivia. Epilepsy & Behavior 2019; 92: 90-97. Available at: epilepsybehavior.com/article/S1525-5050(18)30776-5/fulltext

[13] Giuliano L, Cicero CE, Padilla S, Camargo M, Sofia V, Zappia M, Bartoloni A, Gómez EB, Nicoletti A. Knowledge, attitudes, and practices towards epilepsy among general practitioners in rural Bolivia: Results before and after a training program on epilepsy. Epilepsy & Behavior 2018; 83: 113-118. Available at: epilepsybehavior.com/article/S1525-5050(18)30004-0/fulltext

[14] Chinnici D, Middlehurst A, Tandon N, Arora M, Belton A, Franco DR, Bechara GM, Branco FC, Rawal T, Shrivastav R, Sung E. Improving the school experience of children with diabetes: Evaluation of the KiDS project. Journal of Clinical & Translational Endocrinology 2019; 15: 70-75. Available at: sciencedirect.com/science/article/pii/S2214623718301017

[15] Takeda, Blueprint for Innovative Healthcare Access (2020), Access Observatory, Boston, US 2020 (online) available from accessobservatory.org

[16] Sumitomo Dainippon, Promoting Sound Child Growth Pilot Project (2020), Access Observatory, Boston, US 2020 (online) available from accessobservatory.org

[17] Sanofi, Ngao Ya Afya (2020), Access Observatory, Boston, US 2020 (online) available from accessobservatory.org

[18] Sanofi, Mental health program (FAST – Fight Against STigma) — Armenia (2020), Access Observatory, Boston, US 2020 (online) available from accessobservatory.org

[19] Sanofi, Mental health program (FAST – Fight Against STigma) — Madagascar (2020), Access Observatory, Boston, US 2020 (online) available from accessobservatory.org

[20] Sanofi, Mental health program (FAST – Fight Against STigma) — Myanmar (2020), Access Observatory, Boston, US 2020 (online) available from accessobservatory.org

[21] Sanofi, My Child Matters Paraguay (2020), Access Observatory, Boston, US 2020 (online) available from accessobervatory.org

[22] Astellas, ACTION ON FISTULATM (2020), Access Observatory, Boston, US 2020 (online) available from accessobervatory.org

[23] Astellas, Improving Access to our Anticancer Product in India (2020), Access Observatory, Boston, US 2020 (online) available from accessobervatory.org

[24] Bradford, H. ICCR investors call on p harma companies to collaborate in virus fight. Pensions & Investments. April 2020. Available at: pionline.com/governance/iccr-investors-call-pharma-companies-collaborate-virus-fight

[25] Silverman, E. Dozens of financial firms want pharma to place COVID-19 patients over profits. Pharmalot. April 2020. Available at statnews.com/pharmalot/2020/04/17/covid19-coronavirus-gilead-vaccines-achmea/

Appendix 1

List of Programs Reported into the Access Observatory

	Primary Pharmaceutical Company	Name of Initiative	Country or Countries of Implementation
1	Astellas	ACTION ON FISTULA™	Kenya
2	Astellas	Improving Access to our Anticancer Product in India	India
3	Bristol-Myers Squibb Foundation	Celgene AMPATH Oncology Partnership	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	Pink Ribbon, Red Ribbon (Africa)	Ethiopia, Tanzania
7	Bristol-Myers Squibb Foundation	Project ECHO for Cancer Care (South Africa)	South Africa
8	Bristol-Myers Squibb Foundation	Secure The Future — Gauteng Province, South Africa	South Africa
9	Bristol-Myers Squibb Foundation	Secure The Future — KwaZulu Natal, South Africa	South Africa
10	Bristol-Myers Squibb Foundation	Secure The Future — Lung Cancer in Swaziland	Swaziland
11	Bristol-Myers Squibb Foundation	Secure The Future — Multinational Lung Cancer Control Program (MLCCP)	Kenya, South Africa, Swaziland, Tanzania
12	Bristol-Myers Squibb Foundation	Secure The Future — Senegal	Senegal
13	Bristol-Myers Squibb Foundation	Secure The Future — Tanzania	Tanzania
14	Bristol-Myers Squibb Foundation	Secure The Future — Uthukela District, KwaZulu-Natal, South Africa	South Africa
15	Bristol-Myers Squibb Foundation	Secure the Future Kimberly Hospital Complex — South Africa	South Africa
16	Bristol-Myers Squibb Foundation	Secure The Future — Lung Cancer in Kenya	Kenya
17	Chugai	Health Camp against NCDs	Myanmar
18	Chugai	Helping Safer Childbirth	Myanmar
19	Daiichi Sankyo	Cultivating Healthcare Workers in China	China
20	Daiichi Sankyo	Mobile Healthcare Field Clinic Services	Tanzania
21	Daiichi Sankyo	Mobile Healthcare Field Clinic Services in Myanmar	Myanmar
22	Eisai	Hope to Her in India	India
23	Eisai	Remember I Love You	China
24	Eli Lilly and Company	Tshwane Insulin Project (TIP)	South Africa
25	Merck & Co.	GARDASIL — Gavi	Armenia, Bangladesh, Benin, Bolivia, Burkina Faso, Burundi, Cambodia, Cote d'Ivoire, Ethiopia, Ghana, Guyana, Honduras, Indonesia, Kenya, Lao PDR, Liberia, Madagascar, Malawi, Mali, Niger, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, Solomon Islands, Sri Lanka, Tanzania, The Gambia, Togo, Uganda, Uzbekistan, Zimbabwe
26	Merck & Co.	SPARSH HEALTHLINE	India

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

	Primary Pharmaceutical Company	Name of Initiative	Country or Countries of Implementation
40	Roche	EMPOWER, Kenya	Kenya
41	Roche	Perjeta Patient Support Programme, Egypt	Egypt
42	Roche	Pink Consulting Rooms, Colombia	Colombia
43	Roche	Save Her, Ghana	Ghana
44	Roche	The Blue Tree, India	India
45	Roche	UNMOL (Urdu for Precious): Access to Cancer Medicines, Pakistan	Pakistan
46	Sanofi	KiDS and Diabetes in School	Brazil, Egypt, Hungary, India, Japan, Pakistan, Poland, United Arab Emirates
47	Sanofi	My Child Matters – Paraguay	Paraguay
48	Sanofi	My Child Matters: African School of Pediatric Oncology	Algeria, Burkina Faso, Benin, Cote d'Ivoire, Gabon, Guinea, Central African Republic, Congo, Democratic Republic of the Congo, Mali, Madagascar, Mauritania, Morocco, Niger, Senegal, Togo, Tunisia, Cameroon
49	Sanofi	Ngao Ya Afya	Kenya
50	Sanofi	Sanofi Mental Health Program (FAST – Fight Against STigma) — Armenia	Armenia
51	Sanofi	Sanofi Mental Health Program (FAST – Fight Against STigma) — Bolivia	Bolivia
52	Sanofi	Sanofi Mental Health Program (FAST – Fight Against STigma) — Madagascar	Madagascar
53	Sanofi	Sanofi Mental Health Program (FAST – Fight Against STigma) — Mali	Mali
54	Sanofi	Sanofi Mental Health Program (FAST – Fight Against STigma) — Myanmar	Myanmar
55	Sanofi	Sanofi Mental Health Program (FAST – Fight Against STigma) — South Africa	South Africa
56	Servier	Cuomo Pediatric Cardiology Center	Senegal
57	Shionogi	Mother to Mother Project	Kenya
58	Sumitomo Dainippon	Promoting Sound Child Growth Project	Cambodia
59	Takeda	African Consortium for Cancer Clinical Trials (AC3T)	Cameroon, Cote d'Ivoire, Kenya, Nigeria, Rwanda, Senegal
60	Takeda	AMPATH Oncology Preceptorships & Telemedicine Program	Kenya, Rwanda, Tanzania, Uganda
61	Takeda	Beyond Medicines in Ukraine	Ukraine
62	Takeda	BluePrint for Innovative Healthcare Access	Kenya
63	Takeda	Chronic Care Program in sub-Saharan Africa	Kenya
64	Takeda	Digital Birth Registration in Kenya	Kenya
65	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
66	Takeda	Integrated Cancer Curriculum	Kenya

	Primary Pharmaceutical Company	Name of Initiative	Country or Countries of Implementation
67	Takeda	Lysosomal Storage Disorder Charitable Access Program (LSD CAP)	Albania, Belarus, Bosnia and Herzegovina, Egypt, India, Jordan, Morocco, Pakistan, Paraguay, Sudan, Tanzania, Tunisia
68	Takeda	Max Access Solutions (MAS)	Brazil, Ethiopia, Ghana, India, Kazakhstan, Kenya, Malaysia, Nepal, Niger, Paraguay, Philippines, Senegal, Seychelles, Thailand, Tunisia
69	Takeda	Oncology Fellowship in Sub-Saharan Africa	Kenya
70	Takeda	Patient Assistance Program (PAP) — Entyvio®	Brazil, Lebanon, Malaysia, Philippines, Thailand, Ukraine, United Arab Emirates
71	Takeda	Patient Assistance Program (PAP) — Ninlaro®	Lebanon, Thailand
72	Takeda	Patient Assistance Program for Adcetris®	Egypt, Hong-Kong, Indonesia, Kenya, Lebanon, Malaysia, Mexico, Peru, Philippines, Singapore, Thailand, Ukraine, United Arab Emirates
73	Takeda	Patient Support and Palliative Care Training in Sub-Saharan Africa	Kenya
74	Takeda	R&D Access to Medicines Employee Fellowship Program: Knowledge Sharing to Strengthen Healthcare Capacity in LMICs	Haiti, Kenya, Rwanda, Tanzania
75	Not Applicable	City Cancer Challenge	Brazil, Colombia, Georgia, Ghana, Malaysia, Mexico, Myanmar, Paraguay, Rwanda

Appendix 2 Number of Programs by Country

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

	Country	World Bank Region	Income Group	Program Count
41	Greece	Europe & Central Asia	High income	1
42	Guinea	Sub-Saharan Africa	Low Income	2
43	Guyana	Latin America & Caribbean	Upper middle income	1
44	Haiti	Latin America & Caribbean	Low income	2
45	Honduras	Latin America & Caribbean	Lower middle income	2
46	Hong-Kong	East Asia & Pacific	High income	1
47	Hungary	Europe & Central Asia	High income	1
48	India*	South Asia	Lower middle income	14
49	Indonesia	East Asia & Pacific	Lower middle income	6
50	Ireland	Europe & Central Asia	High income	1
51	Jamaica	Latin America & Caribbean	Upper middle income	1
52	Japan	East Asia & Pacific	High income	1
53	Jordan	Middle East & North Africa	Upper middle income	1
54	Kazakhstan	Europe & Central Asia	Upper middle income	2
55	Kenya*	Sub-Saharan Africa	Lower middle income	28
56	Kyrgyzstan	Europe & Central Asia	Lower middle income	1
57	Lao PDR	East Asia & Pacific	Lower middle income	1
58	Lebanon	Middle East & North Africa	Upper middle income	3
59	Liberia	Sub-Saharan Africa	Low income	5
60	Madagascar	Sub-Saharan Africa	Low income	4
61	Malawi	Sub-Sahran Africa	Low income	6
62	Malaysia	East Asia & Pacific	Upper middle income	5
63	Mali	Sub-Saharan Africa	Low income	5
64	Mauritania	Sub-Saharan Africa	Lower middle income	2
65	Mauritius	Sub-Saharan Africa	Upper middle income	1
66	Mexico	Latin America & Caribbean	Upper middle income	3
67	Moldova	Europe & Central Asia	Lower middle income	1
68	Mongolia	East Asia & Pacific	Lower middle income	1
69	Morocco	Middle East & North Africa	Lower middle income	5
70	Mozambique	Sub-Saharan Africa	Low income	4
71	Myanmar	East Asia & Pacific	Lower middle income	8
72	Namibia	Sub-Saharan Africa	Upper middle income	3
73	Nepal	South Asia	Low income	3
74	Nicaragua	Latin America & Caribbean	Lower middle income	1
75	Niger	Sub-Saharan Africa	Low income	5
76	Nigeria	Sub-Saharan Africa	Lower middle income	6
77	Oman	Middle East & North Africa	High income	1
78	Pakistan	South Asia	Lower middle income	5
79	Papua New Guinea	East Asia & Pacific	Lower middle income	1
80	Paraguay	Latin America & Caribbean	Upper middle income	5
81	Peru	Latin America & Caribbean	Upper middle income	4
82	Philippines	East Asia & Pacific	Lower middle income	6
83	Poland	Europe & Central Asia	High income	1
84	Republic of the Congo	Sub-Saharan Africa	Lower middle income	2

	Country	World Bank Region	Income Group	Program Count
85	Russia	Europe & Central Asia	Upper middle income	1
86	Rwanda	Sub-Saharan Africa	Low income	8
87	Sao Tome and Principe	Sub-Saharan Africa	Lower middle income	1
88	Senegal	Sub-Saharan Africa	Low income	11
89	Seychelles	Sub-Saharan Africa	High income	2
90	Sierra Leone	Sub-Saharan Africa	Low income	5
91	Singapore	East Asia & Pacific	High income	2
92	Solomon Islands	East Asia & Pacific	Lower middle income	2
93	South Africa*	Sub-Saharan Africa	Upper middle income	13
94	South Sudan	Sub-Saharan Africa	Low income	1
95	Sri Lanka	South Asia	Lower middle income	2
96	Sudan	Sub-Saharan Africa	Lower middle income	3
97	Suriname	Latin America & Caribbean	Upper middle income	1
98	Swaziland	Sub-Saharan Africa	Lower middle income	2
99	Sweden	Europe & Central Asia	High income	1
100	Switzerland	Europe & Central Asia	High income	1
101	Taiwan	East Asia & Pacific	High income	1
102	Tajikistan	Europe & Central Asia	Low income	1
103	Tanzania*	Sub-Saharan Africa	Low income	14
104	Thailand	East Asia & Pacific	Upper middle income	6
105	Timor-Leste	East Asia & Pacific	Lower middle income	1
106	Togo	Sub-Saharan Africa	Low income	3
107	Tunisia	Middle East & North Africa	Lower middle income	3
108	Uganda	Sub-Saharan Africa	Low income	10
109	Ukraine	Europe & Central Asia	Lower middle income	4
110	United Arab Emirates	Middle East & North Africa	High income	5
111	Uzbekistan	Europe & Central Asia	Lower middle income	1
112	Vietnam	East Asia & Pacific	Lower middle income	5
113	Zambia	Sub-Saharan Africa	Lower middle income	5
114	Zimbabwe	Sub-Saharan Africa	Low income	4

* Countries with greater than 10 programs

Source: World Bank. World Bank country and lending groups. Accessed May 23, 2019 from https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups

Appendix 3 List of Funding and Implementing Partners

Partner	Program Count
Academic Model Providing Access to Healthcare (AMPATH)	3
Access Accelerated	1
Addington Hospital	1
AdvaMed	1
Africa Cancer Foundation	1
African Cancer Registry Network (AFCRN)	4
African Organization for Research & Training in Cancer (AORTIC)	1
Alexandria University in Egypt	1
AMDA-MINDS	2
American Cancer Society (ACS)	1
American Society for Clinical Pathology	1
American Society of Clinical Oncology (ASCO)	1
American Society of Clinical Pathology (ASP)	1
Amgen	1
AMREF	2
AMREF Health Africa	4
Argentina Society of Diabetes	1
Armenia Ministry of Health	1
Arogya Finance	1
Associação de Diabetes Juvenil of Brazil (ADJ)	1
Association Senegalaise de Soutien Aux Diabetiques (ASSAD)	2
Axios International	4
Baylor International Pediatric Aids Initiative (BIPAI)	1
BDOM — Bureau Diocésain des Oeuvres Médicales	1
Bhekuzulu Self Sustaining Project (BSSP)	1
Bill and Melinda Gates Foundation	1
Bio Ventures Global Health	2
Botswana Ministry of Health	1
Bristol-Myers Squibb Foundation	11
Bugando Medical Centre	1
Bugando Medical Centre in Mwanza, Tanzania	1
Cairo San 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 Centres in LMICs	1
CarePay	1
Catholic University of Allied and Health Services	1
Catholic University of Health and Allied Sciences	2

Partner	Program Count
Cerebrus Consulting	1
Charitable Fund I Will Live	2
Charlotte Maxeke Johannesburg Academic Hospital	1
Cheikh Anta Diop University	1
Cherkasky Onco Dispenser Patient Association	1
China Charity Federation	1
China Population Welfare Foundation	1
Chris Hani Baragwanath Academic Hopsital (CHBAH)	1
Christian Health Association of Kenya	2
Christian Health Association of Nigeria	1
Collage Solution	1
Commune Health Stations (CHS) in Ho Chi Minh City, Vietnam participating in Abundant Health Project	1
CORDAID	1
CSD Healthcare Clinic	1
CUAMM Tanzania	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
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
Elewa Foundation	1
Emmaus Hospital	1
Estcourt Hospital	1
Ethiopian Diabetes Association	2
Ehiopian Ministry of Health	1
European Society of Radiotherapy and Oncology (ESTRO)	1
FCCT — Foundation for Cancer Care Tanzania	1
Federal Ministry of Nigeria	1
FHI360	1
First Lady Beyond Zero Campaign	1
Fitsula Foundation	1
Foundation for Professional Development	1
GAVI Alliance	1
GERESA (Ministry of Health's Regional Health Administration) including Trujillo health network administration	1
GFAOP (Groupe Franco-Africain d'oncologie pédiatrique, French-African Pediatric Oncology Group)	1

Partner	Program Count
Ghana Health Service (GHS)	1
Greys Hospital	1
Guangnan County Health Bureau	1
Guangnan County Women's Federation	1
HCL	1
HCMC Department of Health (DOH)	1
Health Department of the State of Goa	1
Healthcare Partners of Access (HPA)	1
Heart Institute Vietnam	1
Helen Joesph Hospital Pulmonology Department	1
HoPiT — Health of Population in Transition Cameroon	1
Hospital Fann in Dakar	1
Hungarian Diabetes Association	1
ICICI Bank	1
Icon Group	1
Indiana University	2
Inkosi Albert Luthuli Central Hospital	1
International Atomic Energy Agency (IAEA)	1
International Cancer Institute	1
International Diabetes Foundation (IDF)	1
International Society for Pediatric and Adolescent Diabetes (ISPAD)	2
IREN-Norte (The Northern Region Cancer Institute)	1
JAD (I Help The Diabetic)	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)	2
Kenya Defeat Diabetes Association (KDDA)	1
Kenya Diabetes Management and Information Center	1
Kenya Hospices and Palliative Care Association (KEHPCA)	3
Kenya Medical Research Institute	2
Kenya Ministry of Health	5
Kenya Ministry of Health through Counties-Level	1
Kenya Red Cross	1
Kenyan National Cancer Institute	1
Kenyan Network of Cancer Organizations	1
Kenyatta National Hospital	1
Kimberley Hospital Complex (KHC)	1
Kimberly District Hospital, Northern Cape, South Africa	1
KwaZulu Natal Non-Communicable Diseases Directorate	1
KwaZulu-Natal Department of Health	2
La Chaîne de l'Espoir	1
Ladysmith Hospital	1
Lahore Grammar School	1

Partner	Program Count
Le Dantec University Hospital	1
Le Ministre de la Santé et de l'Action Sociale de la Republique Du Senegal	2
LetsMD	1
Malawi Ministry of Health	1
Mastology Colombian Association	1
Mathiwos Wondu Ye cancer Sociary (Tanzania)	1
Max Foundation	2
MD Anderson Cancer Center	1
Medical Data Management (MDM)	1
Medical/pharmaceutical associations	1
Medtronic Labs	1
Medybiz Pharma Pvt. Ltd.	1
Memisa, DRC	1
Ministere De La Sante Et De L´Hygiene Publique, Ivory Coast	1
Ministries of Health	2
Ministry of Health Ghana	1
Ministry of Health of Senegal	1
Ministry of Public Health and Social Welfare	1
Ministry of Public Health of Madagascar	1
Mission for Essential Drugs and Supplies	2
Moi Teaching and Referral Hospital	3
Moi University School of Medicine	2
Mpilonhle Sanctuary Organization (MSO	1
Multiple hospitals (Public and Private Hospitals)	1
Myanmar Medical Association (MMA)	1
Myanmar Mental Health Society	1
Myanmar Ministry of Health and Sports	1
Myanmar Peadiatric Society	1
National Cancer Institute — US	1
National Cancer Institute of Ukraine — Hematology Department	1
National Cancer Registry (South Africa)	1
National Catholic Health Service (NCHS)	1
National Health Laboratory Services (NHLS)	1
National Institute for Occupational Diseases (NIOH)	1
Novo Nordisk Education Foundation	1
Oncquest Laboratories	1
One Drop Foundation (Egy Csepp Figyelem Alapitvany)	1
Pakistan Bait-ul-Maal	1
Palb Pharmaceuticals	1
Paris 6 University (DIUOP)	1
Partners in Health (PIH)/ Partners in Health Haiti (Zanmi Lasante)	1
PATH	1
Patient Behbud Society	1

Partner	Program Count
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
Pilipinas Shell Foundation Inc.	2
Pink Ribbon Red Ribbon	1
Plan International	4
Polish Association of Diabetics, Bialystok	1
Population Services International (PSI)	1
Portea Medical	1
PriceWaterhouseCoopers	1
Project ECHO	1
Project HOPE	1
Provincial Government of South Africa	1
PSI/Myanmar	1
PSI/Vietnam	1
Public Health Foundation of India	1
Rabat University (Morocco)	1
Radiology Colombian Association	1
Raya Call center	1
ReNACI Foundation	2
Right to Care	1
Royal Danish Embassy (Ghana)	2
Royal Danish Embassy (Kenya)	1
Royaume du Maroc Ministère de la Santé	1
Rwanda Military Hospital (RMH)	1
S.K. Distributors	1
Saint Chads Community Health Center	1
Saint Kizito Hospital	1
Sanofi Espoir Foundation (SEF)	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
Senegal Ministry of Education	1
Sociedad Brasilea de Diabetes (SBD)	1
Society for Family Health (SFH)	1
South Africa Ministry of Health	1
South African National Department of Health	1
St. Francis Hospital — Nsambya	1

Partner	Program Count
Strand Life Sciences Pvt. Ltd	1
Sudan Ministry of Health	1
Super Specialities Pharma Warehousing Pvt. Ltd	1
Swaziland Ministry of Health	2
Swaziland National Cancer Registry	1
Tan Phu Medicine Center	1
Tanzania Ministry of Health	3
Tanzanian Diabetes Association	1
Tata Memorial Hospital	1
Tech Mahindra Limited	1
Texas Childrens Cancer and Hematology Centers	1
The County First Ladies Association	1
The Medical Women Association of Tanzania (MEWATA)	1
The National Cancer Control Program, Kenya	1
The National Cancer Institute of Kenya	1
The National Referral Hospital	1
The Nursing Council of Kenya	1
The Philippines Department of Health	1
The Shaukat Khanum Memorial Trust	1
The World Bank	1
The World Economic Forum	1
Therapeutic Area Experts, Oncologists	1
Third-parties like financial assessment agencies and public foundations	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
Unique Courier	1
Univeristy of Conakry, Donka Teaching Hospital	1
Université Numérique Francophone Mondiale (UNFM - World Digital Francophone University)	1
University de Valle	1
University of Catania	1
University of Nairobi	2
University of New Mexico Health Sciences Centers ECHO Institute	1
University of Pittsburgh Medical Center (UPMC)	1
University of Pretoria	1
University of Rzeszow	1
University Research Co., LLC	1
US Agency for International Development (USAID)	1
US National Institutes of Health (NIH)	1

Partner	Program Count
Uthukela District Health Office	1
Vardhaman Distributors	1
Wits Health Consortium	1
WITS/Gauteng Palliative Care Center at CHBAH (Bara PC)	1
Women 4 Cancer	1
World Association for Social Psychiatry	4
World Child Cancer	1
World Diabetes Foundation (WDF)	1
World Health Organization (WHO)	7
World Heart Federation	1
World Vision Japan and World Vision Kenya	1
World Wide Commercial Ventures Limited	1
Zindagi Trust	1

*Some programs have local government and universities as funding and implementing partners

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