PROGRAM REPORT

APRIL 2019

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

Sanofi

Submitted as part of Access Accelerated

Access Observatory

Contents

Program Description

Program Overview

1 Program Name

Sanofi mental health program (FAST – Fight Against STigma) – Myanmar

2 Diseases program aims to address

Mental and Neurological Disorders (Depression; Schizophrenia; Epilepsy)

3 Beneficiary population

General Population

4 Countries

Myanmar

5 Program start date

April 1st, 2017

6 Anticipated program completion date

March 31, 2020

7 Contact person

[No response provided.]

8 Program summary

This is a 3-year pilot program, which combines an integrated approach at the community level leveraging existing staff and resources, with the use of new technologies (smartphone, tablet, telemedicine), to improve access to mental health care in Myanmar. The program's goal is to reduce by 20% the treatment gap for psychotic disorders (including schizophrenia), major depressive disorder (MDD) and epilepsy, in 24 months, in Hlaing Thar Yar a highly populated township, located in the Western part of Yangon. The program's objectives are to:

1. Develop skills and competencies of existing community health workers (CHWs) so that they can

a) identify people with psychoses, depressive disorder and epilepsy, and direct them to seek care from General Practitioners (GPs);

b) support patients and their families; and

c) raise awareness and educate the general population about mental disorders.

2. Empower GPs, and primary healthcare professionals from the township community health centres to diagnose, manage, support people with psychotic disorders, depressive disorder and epilepsy, and if necessary get advice from psychiatrist and/or refer to mental health hospital.

3. Provide township GPs and community health centers with access to a psychiatrist for difficult cases via a simple system of telemedicine. Program activities include:

• Training 75 CHWs and 90 Primary Healthcare Professionals (including 5 doctors field project coordinators, 40 GPs, 8 Medical Officers, 2 Health Assistants, 19 nurses, 17 Midwives, 3 Lady Health Visitors).

• Providing GPs with electronic tablets, equipped with an interactive version of the World Health Organization Mental Health Gap Action Program (WHO mhGAP) intervention guide, and e-medical records, to manage patients and potentially seek advice from psychiatrists for difficult cases.

• Providing CHWs with smartphones equipped with interactive screening questionnaires and empowering them in their pivotal role in informing the population, combating the misbeliefs surrounding mental disorders, and identifying people with these diseases so that they can be referred to GPs.

Beyond the Myanmar Medical Association, the Myanmar Mental Health Society and Sanofi, this program also involves international partners such as the World Association of Social Psychiatry (WASP) and the Université Numérique Francophone Mondiale (UNFM – World Francophone Digital University, which has been developing distance learning and e-health solutions for healthcare professionals in low-resource countries).

Program Strategies & Activities

9 Strategies and activities

Strategy 1: Community Awareness and Linkage to Care

ACTIVITY	DESCRIPTION
Communication	Developing and disseminating health-related information on the various diseases and behavior change communication materials, community meetings, and interactions between CHWs and individual members of the community.
Other, specify	Training CHWs on the use of behavior change communication materials.

Strategy 2: Health Service Strengthening

ACTIVITY	DESCRIPTION
Training	Developing training materials on psychotic disorders, depressive disorder, epilepsy, for the 3 different groups of stakeholders: CHWs, doctors, and other healthcare professionals (nurses, midwives, etc.). Holding 3 different types of training sessions for CHWs, doctors, and other healthcare professionals. Assessing knowledge prior and after training CHWs and doctors on the use of smartphone and tablet applications developed for the program.
Technology	Developing screening tool for smartphone (CHW) and e-medical record / information system for tablet (GPs) to improve identification and management of patients with psychotic disorders, depressive disorder and epilepsy.

Strategy 3: Health Service Delivery

ACTIVITY	DESCRIPTION
Screening	CHWs are provided with smartphones equipped with interactive screening questionnaires for depression, psychotic disorders, and epilepsy so that they can identify people with these disorders and refer them to GPs for diagnosis.

10 Strategy by country

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

Companies, Partners & Stakeholders

11 Company roles

COMPANY	ROLE
Sanofi	To assist Myanmar Medical Association (MMA) with the development, planning, monitoring and evaluation of the program. To provide funds to MMA for the purposes of implementing the program. To provide existing behavior change communication (BCC) materials and to assist MMA with adaptation of materials for use in the project. To coordinate involvement and support from Université Numérique Francophone Mondiale (UNFM) and World Association of Social Psychiatry (WASP).

12 Funding and implementing partners

PARTNER	ROLE/URL	SECTOR
World Association for Social Psychiatry	To provide ad hoc scientific and training support. http://www.waspsocialpsychiatry.com/	Voluntary
Myanmar Medical Association (MMA)	To develop, plan, monitor and evaluate the program in collaboration with other partners. To appoint project manager to coordinate the program under the supervision of Myanmar Medical Association (MMA). To identify and recruit the necessary staff to participate in the program: community health workers (CHWs), general practitioners (GPs) and other primary healthcare professionals. To develop/adapt material for the training on psychotic disorders, epilepsy and depressive disorder. To develop/adapt Information Education Communication (IEC)/ Behavior Change Communication (BCC) materials to raise awareness among the public, educate patients and families. To organise training sessions for CHWs, GPs and other primary healthcare professionals. To source smartphones and electronic tablets. To organize sessions of telemedicine with psychiatrist when needed. To set-up a monitoring system. To provide logistic and administration support. To provide regular activity and financial report. To conduct the program with all due care and diligence and in strict compliance with all applicable laws, rules and regulations, administrative requirements, codes of practice, good ethical business practices and applicable anti-bribery legislation. http://www.mmacentral.org/	Voluntary

Companies, Partners & Stakeholders

12 Funding and implementing partners cont.

PARTNER	ROLE/URL	SECTOR
Myanmar Mental Health Society	To assist in developing/adapting training and information education communication (IEC)/ behavior change communication (BCC) materials. To assist with the training of community health workers (CHWs), general practitioners (GPs) and other primary healthcare professionals. To provide advice for the development of the smartphone screening application and e-medical records system for GPs tablets. To provide expert advice and help manage difficult cases referred by GPs. http://www.mmacentral.org/societies/mental-health-society/	Voluntary
Université Numérique Francophone Mondiale (UNFM - World Digital Francophone University)	To develop smartphone and tablet application. To train project manager, project coordinators, Community Health Workers (CHWs) and General Practitioners (GPs) on the use of the application. To provide ongoing support to the local team regarding the applications and reporting system. http://www.unfm.org/unfm/	Voluntary

13 Funding and implementing partners by country

PARTNER	COUNTRY
World Association for Social Psychiatry	Myanmar
Myanmar Medical Association (MMA)	Myanmar
Myanmar Mental Health Society	Myanmar
Université Numérique Francophone Mondiale (UNFM - World Digital Francophone University)	Myanmar

14 Stakeholders

STAKEHOLDER	DESCRIPTION OF ENGAGEMENT
Government	In August 2013 during a meeting between Sanofi and the Minister of Health and Sports of Myanmar as well as other members of the Ministry of Health, the Minister of Health encouraged Sanofi to provide assistance to improve access to mental health care in Myanmar.
NGO	We have engaged with the Myanmar Medical Association and Myanmar Mental Health Society in developing the framework for the program, in planning, implementing, monitoring and evaluating the program.

Local Context, Equity & Sustainability

15 Local health needs addressed by program

Mental disorders (such as major depressive disorder, and schizophrenia) and epilepsy are common in Myanmar. Community surveys carried out in 2004 revealed a point prevalence rate for all mental disorders of approximately 8% (85.6/1,000 in one study and 77/1,000 in another).[1] In other words, at any time point, approximately 8% of the Myanmar population would suffer from a mental disorder.

Myanmar has a total population of approximately 52 million people. Therefore, with only 140 psychiatrists in the whole country (2.3 per million population), 156 psychiatric nurses (2.6 per million population), 3 clinical psychologists, 5 psychiatric social workers and 2 occupational therapists trained in mental health, [1] there is a real scarcity of human resources in mental health. Furthermore, there is very little time dedicated to mental health as part of the training of primary healthcare professionals (about 1% for general practitioners).[2]

Another major barrier to access to mental health care are the traditional beliefs surrounding mental disorders and epilepsy, and the stigmatization and discrimination which people with these disorders face. As a result, access to healthcare for people with mental disorders and epilepsy is difficult and the treatment gap is high. For instance, for psychoses, in Myanmar in 2012, the treatment gap was estimated to be 95.8%,[1] in other terms less than 5% of people with psychosis would receive treatment.

The program aims to upskill and empower existing human resources: CHWs to identify people with mental disorders and refer them to GPs, to support patients and families, to raise awareness and educate the general population; GPs, and other primary healthcare professionals, to diagnose and manage patients with psychotic disorders, depressive disorder and epilepsy.

The use of low-cost new technology will help identify people with mental disorders (interactive screening questionnaires available on the smartphones of CHWs), helps referrals from CHWs to doctors (data recorded by CHWs will be available to doctors), and will assist in the diagnosis and management of patients (an interactive version of the WHO mhGAP intervention guide, e-medical records, and contact with psychiatrists are available through the doctors tablets).

16 Social inequity addressed

With an estimated treatment gap of 95.8% for psychotic disorders,[1] there clearly is a social inequity in Myanmar for people with mental disorders which this program is trying to address.

Only 0.3% of health care expenditures by the government are directed towards mental health, and 87% of these are on mental hospitals.[2] By focusing on community based psychiatric care, this program aims to address this inequity.

Moreover, Hlaing Thar Yar, the township selected for the program has a very high poverty rate. It is an area that has attracted waves of refugees, in particular after Cyclone Nargis, which caused widespread damage and loss of life in 2008. It continues to attract labour migrants from various rural parts of Myanmar because of its perceived abundance of jobs. There are many illegal slums and shacks built on public land.

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

The program is based on existing staff, both from the public and private sectors, who are currently working in the Hlaing Thar Yar township, and who will be trained by local experts to identify, diagnose and manage people with mental disorders and epilepsy.

With about 1% of the curriculum dedicated to mental health as part of the training of general practitioners (GPs),[2] there is a real unmet need in terms of mental health training for primary healthcare professionals. The program is leveraging the current health services structure existing within the township with community health workers (CHWs) who will refer suspected cases to private GPs or to public healthcare centres, and doctors who will either diagnose and manage the patients or seek assistance from psychiatrists based in the township hospital.

The program was designed in strict compliance with all applicable laws, rules and regulations, administrative requirements, codes of practice, good ethical business practices and applicable anti-bribery legislation.

Local Context, Equity & Sustainability

18 How program meets or exceeds local standards

General practitioners (GPs) have very little training on mental health as part of their curriculum (less than 1%). So delivering an initial training of 5 half-day sessions on psychoses, depression and epilepsy to the GPs of this township, followed by one full day refresher training, far exceeds local standards. The same is true for other healthcare porfessionals (2 full day training session initially) and community health workers CHWs (2 full days). Similarly, providing CHWs with smartphones equipped with interactive screening questionnaires and empowering them in their pivotal role in informing the population, combatting the misbeliefs surrounding mental disorders, and identifying people with these diseases so that they can be referred to GPs, exceeds local standards. The same applies for providing GPs with electronic tablets, equipped with an interactive version of the WHO mhGAP intervention guide, and e-medical records, to manage patients and potentially seek advice from psychiatrists for difficult cases.

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

No.

20 Health technologies are part of local standard treatment guidelines

N/A

21 Health technologies are covered by local health insurance schemes

N/A

22 Program provides medicines listed on the National Essential Medicines List

No.

23 Sustainability plan

[No response provided.]

Additional Program Information

24 Additional program information

[No response provided.]

25 Access Accelerated Initiative participant

Yes.

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

Yes.

Resources

1. Win Aung Myint et al. Myanmar; Routledge Handbook of Psychiatry in Asia, 2016.

2. WHO-AIMS Report on Mental Health in Myanmar, 2006.

Program Indicators

PROGRAM NAME

Sanofi mental health program (FAST – Fight Against STigma) – Myanmar

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

	INDICATOR	TYPE	STRATEGY	2017	2018
1	Value of resources	Input	All Program Strategies	$158,103	$130,615
2	Staff time	Input	All Program Strategies	0.39 FTE	0.17 FTE
3	Population exposed to community communication activities	Output	Community Awareness and Linkage to Care	1,250 people	14,291 people
4	Communication materials developed	Output	Community Awareness and Linkage to Care	12 tools	---
5	Number of users receiving tools	Output	Community Awareness and Linkage to Care	133 people	---
6	Number of people trained	Output	Health Service Strengthening	172 people	165 people
7	Percentage of professionals trained out of total number targeted	Output	Health Service Strengthening	101.2%	97.1%
8	Technology tools developed	Output	Health Service Strengthening	3 tools	---
9	Health provider knowledge	Output	Community Awareness and Linkage to Care	---	---
10	New patients diagnosed	Outcome	Health Service Delivery	56 people	781 people
11	Population screened	Output	Health Service Delivery	107 people	950 people
12	Communication materials in use	Output	Community Awareness and Linkage to Care	2,100 tools	46,375 tools

INDICATOR **Value of resources**

STRATEGY ALL PROGRAM STRATEGIES

1

	ITEM	DESCRIPTION
	Definition	Total expenditure by company to operate program, including all expenditures that can reasonably be defined as necessary to operate the program.
	Method of measurement	Program administrative records or accounting or tax records provide details in the expenditures on the program in a defined period of time. CALCULATION Sum of expenditures (e.g., staff, materials) on program in US$
28	Data source	Routine program data.
29	Frequency of reporting	Once per year.

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Myanmar Medical Association (MMA)	A member of the local project team (implementing partner) submits invoices to finance and accounting to be paid. Finance makes the payments and keeps records of payments.	Ongoing
31	Data processing	Myanmar Medical Association (MMA)	A member of the local project team (implementing partner) produces a financial report based on the Program administrative and accounting records. This report is produced every 6 months.	Every 6 months
32	Data validation		Random audits of invoices might be conducted to validate financial records.	

33 Challenges in data collection and steps to address challenges

[No response provided.]

INDICATOR		2017	2018
1	Value of resources	$158,103	$130,615

Comments: 2017 exchange rates: USD 1 = MMK 1342 & EUR 1 = USD 1.13. 2018 exchange rates: USD 1 = MMK 1430 & EUR 1 = USD 1.18.

INDICATOR **Staff time**

STRATEGY ALL PROGRAM STRATEGIES

2

	ITEM	DESCRIPTION
	Definition	The ratio of the total number of paid hours during a year by the number of working hours in that period. This indicator excludes the time of volunteers or staff time for external partners.
	Method of measurement	The ratio is also called Full Time Equivalent (FTE). CALCULATION Sum of the number of paid hours per year Total number of working hours per year
28	Data source	Routine program data.
29	Frequency of reporting	Once per year.

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Company	Our company's staff working on this project track the number of hours they spend on the project.	Every 3 months
31	Data processing	Company	Time spent on the program by vompany staff is evaluated on a quarterly basis, so that data can be consolidated and annual Full Time Equivalent (FTE) estimated.	Once per year
32	Data validation		We do not conduct any further validation of our internal human resources records.	

33 Challenges in data collection and steps to address challenges

[No response provided.]

INDICATOR	2017	2018
2 Staff time	0.39 FTE	0.17 FTE

Comments: N/A

INDICATOR

Population exposed to community communication activities

3

STRATEGY COMMUNITY AWARENESS AND LINKAGE TO CARE

	ITEM	DESCRIPTION
	Definition	Number of population reached through a community awareness campaign.
	Method of measurement	Counting of participants that attend campaign meetings or reached by media messaged disseminated. CALCULATION Number of people/participants in the target audience segment participated/attended the community awareness campaign recorded in a given period of time.
28	Data source	Routine program data.
29	Frequency of reporting	Once per year.

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Myanmar Medical Association (MMA)	Community health workers hold small group meetings on a weekly basis. They count the number of attendees per information session on the number of sessions held and attendees per session. Data is recorded on an ongoing basis when sessions occur and reported to each coordinator on a monthly basis.	Ongoing
31	Data processing	Myanmar Medical Association (MMA)	A member of the local team (implementing partner) consolidates on an ongoing basis the number of community members attending these sessions. This will allow to evaluate the total number of people exposed at the end of one calendar year.	Ongoing
32	Data validation		We do not conduct any further validation of these data.	

33 Challenges in data collection and steps to address challenges

[No response provided.]

INDICATOR	2017	2018
3 Population exposed to community communication activities	1,250 people	14,291 people

Comments: Community communication activities only started in November 2017.

INDICATOR **Communication materials developed**

STRATEGY COMMUNITY AWARENESS AND LINKAGE TO CARE

4

	ITEM	DESCRIPTION
	Definition	Number of tools (e.g., behavior change communication materials, training materials, etc.) specifically developed or adapted for and by the program.
	Method of measurement	Counting the number of different communication materials developed for and by the program. CALCULATION Sum of number of communication materials developed for and by the programType of tool (e.g. paper based, electronic).
28	Data source	Routine program data.
29	Frequency of reporting	Once per year.

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Myanmar Medical Association (MMA)	A member of the local team (implementing partner), reports on any new behavior change communication materials developed for the program and provides a copy of the final tool.	Ongoing
31	Data processing	Company	A member of my company consolidates the information provided by partners.	Once per year
32	Data validation		We do not conduct any further validation of these data.	

33 Challenges in data collection and steps to address challenges

[No response provided.]

INDICATOR	2017	2018
4 Communication materials developed	12 tools	---

Comments: The following training materials were prepared: mental health training kit for primary healthcare professionals, mental health training kit for community health workers, smartphone application, and tablet application training kits. The following behavior change communication materials were prepared: 3 types of pamphlets and 3 types of posters on psychosis, depression and epilepsy, one booklet on mental health, and one flip chart for community health workers to use to conduct community meetings.

INDICATOR **Number of users receiving tools** 5

STRATEGY COMMUNITY AWARENESS AND LINKAGE TO CARE

	ITEM	DESCRIPTION
	Definition	Number of users that received the tools produced and/or distributed by the program.
	Method of measurement	Counting the number of users that received the tools produced and/or distributed by the program. CALCULATION Sum of number of users that received the tools produced and/or distributed by the program.
28	Data source	Routine program data.
29	Frequency of reporting	One-time event.

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Myanmar Medical Association (MMA)	Implementing partner keeps record of the number of users receiving tools (smartphones for community health workers with application for screening, and tablets for general practitioners with application for e-health records).	One-time event
31	Data processing	Myanmar Medical Association (MMA); Company	A member of our teams sums the number of users receiving tools.	One-time event
32	Data validation		We do not conduct any further validation of these data.	

33 Challenges in data collection and steps to address challenges

[No response provided.]

INDICATOR	2017	2018
5 Number of users receiving tools	133 people	---

Comments: 75 community health workers equipped with smartphones and corresponding application 50 GPs, 5 coordinators and 3 specialists equipped with tablet and corresponding application.

INDICATOR **Number of people trained**

STRATEGY HEALTH SERVICE STRENGTHENING

6

	ITEM	DESCRIPTION
	Definition	Number of trainees.
	Method of measurement	Counting of people who completed all training requirements. CALCULATION Sum of the number of people trained.
28	Data source	Routine program data.
29	Frequency of reporting	Once per year.

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Myanmar Medical Association (MMA)	A member of the local team (implementing partner) asks each healthcare professional attending a training session to sign their name on an attendance form. Data are collected at the time of each training session.	One-time event
31	Data processing	Myanmar Medical Association (MMA)	A member of the local team of the implementing partner reviews the number of attendees per training session and consolidates the data from each session into the total number of people having attended the training for each type of training.	One-time event
32	Data validation		A company member has attended some training sessions, and overseen data collection and processing.	

33 Challenges in data collection and steps to address challenges

[No response provided.]

INDICATOR	2017	2018
6 Number of people trained	172 people	165 people

Comments: 2017: Following health providers were trained: 5 GPs /field coordinators, 50 GPs, 42 other primary healthcare professionals (lady health visitors, nurses, midwives), 75 community health workers.

2018: Follow-up training sessions were held in 2018 for the various health workers involved in the program. The following people were trained: 5 GPs / field coordinators, 47 GPs, 40 other primary healthcare professionals (lady health visitors, nurses, midwives), 73 community health workers.

INDICATOR

Percentage of professionals trained out of total number targeted

7

STRATEGY HEALTH SERVICE STRENGTHENING

	ITEM	DESCRIPTION
	Definition	Percentage of professionals that completed the required requisites of the training out of total number of professionals targeted.
	Method of measurement	Sum of professionals who completed all training requirements divided by the total number of professionals targeted by the program to be trained. CALCULATION $\frac{\text{Number of professionals trained in a defined period}}{\text{Total number of professionals targeted by the program to be trained}} \times 100$
	Data source	Routine program data.
29	Frequency of reporting	Once per year.

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Myanmar Medical Association (MMA)	A member of the local team (implementing partner) asks each health provider attending a training session to sign their name on an attendance form. Data are collected at the time of each training session. Data on the number of health providers we initially planned to train is from our program plan records.	One-time event
31	Data processing	Myanmar Medical Association (MMA)	For each type of training, the total number of health providers who have attended any training session (indicator "number of people trained") will be divided by the number of health providers targeted by the program for each type of training and each category of health provider.	One-time event
32	Data validation		A company member has attended some training sessions, overseen data collection and has checked for any mismatch with observed training sessions.	

33 Challenges in data collection and steps to address challenges

[No response provided.]

INDICATOR	2017	2018
7 Percentage of professionals trained out of total number targeted	101.2%	97.1%

Comments: N/A

INDICATOR **Technology tools developed**

STRATEGY HEALTH SERVICE STRENGTHENING

8

	ITEM	DESCRIPTION
	Definition	Number of technology tools (e.g. smartphone application, eHealth, etc.) specifically developed or adapted for and by the program.
	Method of measurement	Counting the number of different tools developed for and by the program. CALCULATION Sum of number of tools developed for and by the program type of tool (e.g. paper based, electronic).
28	Data source	Routine program data.
29	Frequency of reporting	Once per year.

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Myanmar Medical Association (MMA); Université Numérique Francophone Mondiale (UNFM - World Digital Francophone University)	Implementing partners keep records of number and types of technology tools developed.	Ongoing
31	Data processing	Company; Myanmar Medical Association (MMA)	A member of my company consolidates information from partners.	Ongoing
32	Data validation		We do not conduct any further validation of these data.	

33 Challenges in data collection and steps to address challenges

[No response provided.]

INDICATOR	2017	2018
8 Technology tools developed	3 tools	---

Comments: Two web-based applications have been developed: one including interactive screening questionnaires for psychotic disorders, depression and epilepsy to be used by community health workers (CHW) on their smartphone, and the other one for GP tablets (e-medical record / information system). A dashboard has also been developed to allow to have, at any time, an overview of the number of people who have been screened by CHWs and the number who have been seen by GPs.

INDICATOR **Health provider knowledge**

STRATEGY HEALTH SERVICE STRENGTHENING

9

	ITEM	DESCRIPTION
	Definition	Percentage of providers that pass the assessment examining their skills or knowledge. The exam should be designed to assess the possession of the skills and knowledge to be able to comply with predefined standards.
	Method of measurement	The assessment of possession of skills and knowledge occurs through a written, oral, or observational assessment that all providers have to undergo. CALCULATION $\frac{\text{Number of providers who pass the assessment}}{\text{Number of providers trained}} \times 100$
28	Data source	Non-routine program data.
29	Frequency of reporting	Once per year.

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Myanmar Medical Association (MMA)	For the initial training sessions of the various categories of health providers involved in the program, a knowledge questionnaire will be completed before and after each initial training session by each health provider attending the training. The questionnaires will be marked by a member of the local team (implementing partner) based on the correct answers provided by the specialists, and a score will be given to each questionnaire.	One-time event
31	Data processing	Myanmar Medical Association (MMA)	A member of the implementing partner reviews the post-training survey scores and notes the number of participants who scored above a pre-determined pass mark. The proportion of participants who scored above the pass mark is then calculated.	One-time event
32	Data validation		We do not conduct any further validation of these data.	

33 Challenges in data collection and steps to address challenges

Although knowledge questionnaires have been completed pre- and post- the initial training sessions held in September and October 2017, data has not yet been communicated by the implementing partner. It will be reported as soon as available.

INDICATOR	2017	2018
9 Health provider knowledge	---	---

Comments: N/A

INDICATOR **New patients diagnosed**

STRATEGY HEALTH SERVICE DELIVERY

10

	ITEM	DESCRIPTION
	Definition	Number of new individuals diagnosed with the disease through the program.
	Method of measurement	This indicator is either measured through existing health facility medical records, ministry of health reporting systems, or through a specific monitoring system put in place as part of the program to record any new patient diagnosed with the disease.
28	Data source	Routine program data.
29	Frequency of reporting	Once per year.

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Myanmar Medical Association (MMA)	Every time a doctor confirms the diagnosis of a patient who had been screened and referred by a community heath worker, they will record it on their tablet and this will get updated in the central database.	Ongoing
31	Data processing	Myanmar Medical Association (MMA)	A dashboard consolidating the data and showing the number of diagnoses made for each of the three types of diseases the program is targeting, is readily available on the tablets of the project coordinators from the local team (implementing partner).	Ongoing
32	Data validation		A system of docket/stub has been put in place in part to ensure that there are no major discrepancies between what is happening in the field and the data recorded in the system by community health workers through their smartphones and doctors through their tablets. Each patient who has screened positive receives a docket with a unique ID number which they will give to the doctor when they seem them. The number of dockets collected by doctors, and stubs remaining with community health workers are consolidated to ensure that the total are in line with the numbers recorded in the system.	

33 Challenges in data collection and steps to address challenges

The data routinely collected will allow us to see what effect the program is having in terms of number of new people diagnosed. However at this stage, we have no means to know whether individuals have been accurately diagnosed, hence the reason why we are suggesting to have an additional indicator instead of just "Patients properly diagnosed". It is being considered to have a specialist conduct an audit of a random sample of patients and check diagnosis so that the percentage of patients properly diagnosed can be established.

INDICATOR	2017	2018
10 New patients diagnosed	56 people	781 people

Comments: 2017 data: Field activities only started in November 2017. 2018 data: In 2018, out of the 929 people who were referred by a CHW to see a GP, 806 had seen a GP and 781 were diagnosed with a mental disorder.

INDICATOR **Population screened**

STRATEGY HEALTH SERVICE DELIVERY

11

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

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Myanmar Medical Association (MMA)	Every time a community health worker completes a screening questionnaire on their smartphone though the web-based application, this will get recorded in the central database.	Ongoing
31	Data processing	Myanmar Medical Association (MMA)	A dashboard consolidating the data, and showing the number of positive and negative screening made by the community health workers, is readily available on the tablets of the project coordinators from the local team (implementing partner).	Ongoing
32	Data validation		A system of docket/stub has been put in place in part to ensure that there are no major discrepancies between what is happening in the field and the data recorded in the system by community health workers through their smartphone and doctors through their tablet. Each patient who has screened positive receives a docket with a unique ID number which they will give to the doctor when they seem them. The number of dockets collected by doctors and remaining with community health workers are consolidated to ensure that they are in line with the numbers recorded in the system.	

33 Challenges in data collection and steps to address challenges

We did not do a baseline; therefore, there are limitations to saying diagnoses were a result of a screening or awareness campaign.

INDICATOR	2017	2018
11 Population screened	107 people	950 people

Comments: 2017 data: Screening activities only started in November 2017.

INDICATOR **Communication materials in use**

STRATEGY COMMUNITY AWARENESS AND LINKAGE TO CARE

12

	ITEM	DESCRIPTION
	Definition	Number of communication materials introduced and in use by the program.
	Method of measurement	Counting the number of communication materials created and in use by the program. CALCULATION Sum of communication materials created by the program
28	Data source	Routine program data.
29	Frequency of reporting	Once per year.

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Myanmar Medical Association (MMA)	Implementing partner keeps record of the number of communication materials disseminated.	Ongoing
31	Data processing	Myanmar Medical Association (MMA)	A member of our teams sums the number of communication materials disseminated within a year period.	Ongoing
32	Data validation		We do not conduct any further validation of these data.	

33 Challenges in data collection and steps to address challenges

[No response provided.]

INDICATOR	2017	2018
12 Communication materials in use	2,100 tools	46,375 tools

Comments: 2017 data: Community communication activities only started in November 2017.

Appendix

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

Program Description

PROGRAM OVERVIEW

1 Program Name

2 Diseases program aims to address:

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

3 Beneficiary population

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

4 Countries

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

5 Program Start Date

6 Anticipated Program Completion Date

7 Contact person

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

8 Program summary

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

PROGRAM STRATEGIES & ACTIVITIES

9 Strategies and activities

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

10 Strategy by country

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

COMPANIES, PARTNERS AND STAKEHOLDERS

11 Company roles

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

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

12 Funding and implementing partners

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

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

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

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

13 Funding and implementing partners by country

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

14 Stakeholders

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

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

LOCAL CONTEXT, EQUITY & SUSTAINABILITY

15 Local health needs addressed by program

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

16 Social inequity addressed

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

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

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

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

18 How program meets or exceeds local standards

Is there anything else that you would like to report on how your program meets or exceeds local standards?

19 Program provides health technologies

Does your program include health technologies (health technologies include medical devices, medicines, and

vaccines developed to solve a health problem and improve quality of lives)? (Yes/No)

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

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

21 Health technologies are covered by local health insurance schemes

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

22 Program provides medicines listed on the National Essential Medicines List

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

23 Sustainability plan

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

ADDITIONAL PROGRAM INFORMATION

24 Additional program information

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

25 Access Accelerated Initiative participant

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

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

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

Program Indicators

INDICATOR DESCRIPTION

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

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

28 Data source

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

29 Frequency of reporting

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

30 Data collection

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

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

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

31 Data processing

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

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

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

32 Data validation

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

33 Challenges in data collection and steps to address challenges

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