PROGRAM REPORT

APRIL 2019

Fight Against STigma – Guatemala (FAST)

Sanofi

Submitted as part of Access Accelerated

Access Observatory

Contents

Program Description 3

Program Overview 4
Program Strategies & Activities 5
Companies, Partners & Stakeholders 6
Local Context, Equity & Sustainability 8
Additional Program Information 10

Resources 11

Program Indicators 12

List of indicator data 13
Value of resources 14
Staff time 15
Population exposed to oral communciation activities 16
Number of people trained 17
Number of patients on treatment 18
Number of radio or TV programs 19
Number of free consultations 20
Beneficiaries of microloans 21
Number of people supported via self-help groups 22

Appendix 23

The information in this report has been submitted by the company concerned to the Access Observatory at Boston University. The information will be updated regularly. For more information about the Observatory go to www.accessobservatory.org

Program Description

Program Overview

1 Program Name

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

2 Diseases program aims to address

- Mental & Neurological Disorders: Depression, Schizophrenia, Bipolar, Mental & Neurological Disorders (General), Sustance Abuse, PTSD, Anxiety Disorders, other Psychotic Disorders

3 Beneficiary population

- Age Group: All ages
- Gender: All genders
- Special Populations: Low income, rural, marginalized/indigenous rural population

4 Countries

- Guatemala

5 Program start date

December 9, 2013

6 Anticipated program completion date

Not specified

7 Contact person

Dr. Alejandro Paiz, alejandropaiz1@gmail.com

8 Program summary

ALAS Pro Salud Mental was founded in 2013 in partnership with the World Association of Social Psychiatry (WASP) and Sanofi with the aim of providing culturally respectful care, rehabilitation, and empowerment to people with mental illness within their communities and to reduce societal stigma and discrimination in the Sololà Department.

Sololà is a mountainous department in the South-West of Guatemala. It has a population of over 450,000 people belonging almost entirely to different Mayan ethnic groups. Sololà is the second poorest department in the country with 75% of the population living below the poverty line and 29% below the extreme poverty line[1].

ALAS has created alliances with the state health service, community health centers, local pharmacies, community leaders and universities.

- ALAS provides Access to Care through free consultations, treatment, and support to underprivileged families.
- ALAS Fights Against Stigma by disseminating information and educating the population to reduce discrimination.
- ALAS trains primary healthcare workers (physicians and other healthcare professionals) on mental disorders.
- Finally, ALAS helps to Rehabilitate & Empower patients, teaching them how to recover their independence and productivity, as well as how to manage their rights.

www.alasprosaludmental.org/home

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 Behaviour Change Communication materials. Developing and conducting information workshops with children and teenagers. Training teachers, educators and social workers on mental health issues and related communication skills. Broadcasting local TV and radio programs.
Mobilization	Holding self-help group sessions for patients and their families, families who have been getting together under ALAS' wings to create an independent association that enables them to lobby and demand their rights to authorities.

Strategy 2: Health Service Strengthening

ACTIVITY	DESCRIPTION
Training	Training primary care physicians on diagnosing and treating mental disorders based on WHO's Mental Health Gap Action Programme (mhGAP).

Strategy 3: Health Service Delivery

ACTIVITY	DESCRIPTION
Treatment	Providing free consultations to the poorest patients by visiting them directly at their home or through an out-patient clinic.

Strategy 4: Financing

ACTIVITY	DESCRIPTION
Linkage to Financing Scheme	Financial empowerment of patients and their families through applying for micro-loans from X-Finance/Ecole Polytechnique. ALAS established a partnership X-Microfinance, a program from Ecole Polytechnique in Paris that grants micro-loans to patients and families. Association with "ConstruCasa" to build basic homes to patient families.

Companies, Partners & Stakeholders

10 Strategy by country

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

11 Company roles

COMPANY	ROLE
Sanofi	To assist ALAS Pro Salud Mental with the development, planning, monitoring and evaluation of the program. To provide funds to ALAS Pro Salud Mental for the purposes of implementing the program. To provide existing behaviour change communication (BCC) materials for adaptation and use in the Project.

12 Funding and implementing partners

PARTNER	ROLE/URL	SECTOR
World Association for Social Psychiatry	To provide ad hoc scientific and training support. www.waspsocialpsychiatry.com	Voluntary
ALAS, Guatemala	ALAS Pro Salud Mental is in charge of the following: Developing, planning, monitoring and evaluating the program in collaboration with other partners. Coordinating all activities. Appointing necessary staff to participate in the program. Providing regular activity and financial reports. Seeking funding from other partners. www.alasprosaludmental.org	Voluntary

Companies, Partners & Stakeholders

13 Funding and implementing partners by country

PARTNER	COUNTRY
World Association for Social Psychiatry	Guatemala
ALAS, Guatemala	Guatemala

14 Stakeholders

STAKEHOLDER	DESCRIPTION OF ENGAGEMENT	REQUESTED OR RECEIVED FROM STAKEHOLDER
Government	ALAS Pro Salud Mental has created alliances with state health services to conduct its activities in the Sololà Department. Furthermore it has been seeking funding and human resources from Government to expand its activities beyond the Sololà Department.	Infrastructure: No Human Resources: Yes Funding: Yes Monitoring or Oversight: No Other resource: No

Local Context, Equity & Sustainability

15 Local health needs addressed by program

Multiple natural disasters, poor infrastructure, high poverty rate and the 36 years of civil war that ended in December 1996 have created deep and severe emotional consequences for thousands of families in Guatemala. There is also the everyday violence that affects almost everyone in Guatemala and keeps people in a constant state of fear and alert.[2]

As a result, the prevalence of mental disorders is high (27.8 %) including substance abuse disorders 7.8%, depression 6.4%, psychotic disorders 2.2%, PTSD 6.9% and anxiety disorders 3.2%.[3] Guatemala has not yet addressed mental health issues in terms of providing legislation or adopting a national policy. However, a strategic plan was developed in 2007 that focused on building a culture of mental health based on healthy life styles and providing mental health services within communities.

Currently, access to mental health care is limited, mainly due to the lack of specialized human resources (0.29 psychiatrists and 0.53 psychologists per 100,000 population)[4], most of them located in Guatemala City[5]; and the lack of economic resources (1.46% of the nation's health budget is dedicated to mental health, 90 percent of this budget funds the national hospital in Guatemala City).[2] This is particularly true in rural areas such as the Sololà Department.

There are no facilities for primary mental health care available at the community level in the Sololà Department. Clinical personnel at primary care level lack training in psychiatry (mental health training is less than 1% of the medical school curriculum), and there are no resources for primary healthcare workers to provide psycho-social support. More importantly, people's lack of knowledge and false beliefs regarding mental diseases (witchcraft, curses, distrust, fear of contagion, craziness) dissuades most of them to seek for clinical attention.[2]

a How needs were assessed

Mental health needs were assessed through a literature review, meeting with local experts, including Dr Alejandro Paiz, ALAS Pro Salud Mental founder, and local health authorities.

b Formal needs assessment conducted

[No response provided.]

16 Social inequity addressed

With Guatemala's long history of trauma including a long civil war, massacres, social cleansing, poverty, and multiple natural disasters, the social inequities that Guatemalan people are faced with are numerous.

Furthermore, in the Sololà Department, the needs of the people are even greater than the national average: it is the second poorest department in the country with 75% of the population living in poverty and 29% in extreme poverty line, compared to the national averages of 56% and 16% respectively[1,6]. Moreover, in Sololà, illiteracy is at 55.8% compared to 36% nationally[6].

Being a rural area in the mountains, specialized healthcare resources are particularly lacking.

This program helps ensure that the 27.8% of people with mental disorders and their families get better access to mental health care.

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

[No response provided.]

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

[No response provided.]

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

No.

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

Not applicable.

21 Health technologies are covered by local health insurance schemes

Not applicable.

22 Program provides medicines listed on the National Essential Medicines List

Not applicable.

23 Sustainability plan

By helping ALAS Pro Salud Mental raise its profile, partners have assisted in gaining international recognition and in securing additional funding: so far, ALAS has won the "Outstanding achievements in the field of mental health" award from the Swiss Foundation for World Health, the "Geneva Prize for Human Rights in Psychiatry", a grant from Stanford School of Medicine to fund training of primary care physicians to diagnose and manage mental disorders... ALAS has also engaged in discussions with the Ministry of Health to secure funding and human resources to extend activities beyond the Solola Department.

Additional Program Information

24 Additional program information

[No response provided.]

a Potential conflict of interest discussed with government entity

N/A

25 Access Accelerated Initiative participant

Yes.

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

Yes.

Resources

1 United Nations Office for Outer Space Affairs – Global Pulse – Rapid Impact and Vulnerability Analysis Fund Project – A Visual Analytics Approach to Understanding Poverty Assessment through Disaster Impacts in Latin America and Africa. 2012

2 https://www.alasprosaludmental.org/the-problem/

3 University of San Carlos, Guatemala - National Mental Health Survey – 2009.

4 WHO - Mental Health Atlas - Country Profile - Guatemala – 2014.

5 WHO - Mental Health Atlas – Guatemala – 2011.

6 Little M. Undercurrent Journal, Vol 9, Issue 1. 2012

Program Indicators

PROGRAM NAME

FAST – Fight Against STigma – Guatemala

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	$22,600	$23,600
2	Staff Time	Input	All Program Strategies	33:208	1:16
3	Population exposed to oral communication activities	Output	Community Awareness and Linkage to Care	683 People	506 People
4	Number of people trained	Output	Health Service Strengthening	393 People	944 People
5	Number of patients on treatment	Outcome	Health Service Strengthening	347 People	519 People
6	Number of radio or TV programs	Output	Community Awareness and Linkage to Care	33 Programs	33 Programs
7	Number of free consulations	Output	Health Service Delivery	683 Procedures	660 Procedures
8	Beneficiaries of microloans	Outcome	Financing	0 People	3 People
9	Number of people supposed via self-help groups	Output	Community Awareness and Linkage to Care	580 People	330 People

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	Non-Routine program data
29	Frequency of reporting	One time per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Implementing partner: ALAS, Guatemala	Members of local Team (implementing partner) keep records of all invoices and expenses paid in an electronic system.	Ongoing
31	Data processing	Implementing partner: ALAS, Guatemala	A member of the local Team (implementing partner) produces a financial report based on the administrative and accounting records. This report is produced at least once a year.	Once per year
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 additional information provided.

INDICATOR		2017	2018
1	Value of resources	$22,600	$23,600

Comments:

1/1/2014 - 12/31/2014 data: $26,600. 2014 average EUR-USD exchange rate 1.33.

1/1/2015 - 12/31/2015 data: $22,200. 2015 average EUR-USD exchange rate 1.11.

1/1/2016 - 12/31/2016 data: $22,200. 2016 average EUR-USD exchange rate 1.11.

2017: 2017 average EUR USD Exchange rate 1.13.

2018: 2018 average EUR USD Exchange rate 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	One time per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Company	Company's staff working on this project track the number of hours they spend on the project.	Ongoing
31	Data processing	Company	Time spent on this project by company staff is evaluated on 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 additional information provided.

INDICATOR	2017	2018
2 Staff time	33:208 hours	1:16 hours

Comments:

1/1/2014 - 12/31/2014 data: 5:104 hours.

1/1/2015 - 12/31/2015 data: 5:104 hours.

1/1/2016 - 12/31/2016 data: 15:104 hours. Including time of staff member (VIE - Volontaire International Entreprise) based in Panama.

2017: Including time of staff member (VIE–Volontaire International Enterpirse) based in Panama.

INDICATOR

Population exposed to oral 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. CALCULATION Number of people/participants in the target audience segment that 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	Implementing partner: ALAS, Guatemala	Various workshops are organized each month with social workers, teachers, children/teenagers by members of the local team (implementing partner). They count the number of attendees at each session. Data is recorded on an ongoing basis when sessions occur.	Ongoing
31	Data processing	Implementing partner: ALAS, Guatemala	A member of the local team (implementing partner) consolidates on an ongoing basis the number of participants at these workshops. This allows to calculate the total number of people exposed at the end of each 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 additional information provided.

INDICATOR	2017	2018
3 Population exposed to oral communciation activities	683 people	506 people

Comments:

1/1/2015 - 12/31/2015 data: 525 people.

1/1/2016 - 12/31/2016 data: 671 people.

INDICATOR **Number of people trained**

STRATEGY HEALTH SERVICE STRENGTHENING

4

	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	Implementing partner: ALAS, Guatemala	A member of the local team (implementing partner) asks each participants attending a training session to sign their name on an attendance form. Data are collected at the time of each training session.	Ongoing
31	Data processing	Implementing partner: ALAS,Guatemala	A member of the local team of the implementing partner consolidates the data from each session into the total number of people having attended the training.	Once per year
32	Data validation		We do not conduct any further validation of this data.	

33 Challenges in data collection and steps to address challenges

No additional information provided.

INDICATOR	2017	2018
4 Number of people trained	393 people	944 people

Comments:

1/1/2015 - 12/31/2015 data: 400 people.

1/1/2016 - 12/31/2016 data: 250 people.

INDICATOR **Number of patients on treatment**

STRATEGY HEALTH SERVICE STRENGTHENING

5

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

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Implementing partner: ALAS, Guatemala	Every time a patient sees one of the healthcare providers of the local team (implementing partner), data, in particular regarding thier diagnosis and treatment, would get updated in their medical record.	Ongoing
31	Data processing	Implementing partner: ALAS, Guatemala	Once a year, a member of the local team (implementing partner) consolidate the data regarding the total number of patients on treatment.	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 additional information provided.

INDICATOR	2017	2018
5 Number of people on treatment	347 people	519 people

Comments:

1/1/2015 - 12/31/2015 data: 180 people.

1/1/2016 - 12/31/2016 data: 223 people.

INDICATOR

Number of radio or TV programs

6

STRATEGY COMMUNITY AWARENESS AND LINKAGE TO CARE

	ITEM	DESCRIPTION
	Definition	Number of health information programs broadcasted on radio or TV as part of the project.
	Method of measurement	Counting the number of different radio and TV programs broadcasted as part of the project. CALCULATION Sum of number of programs broadcasted.
28	Data source	Non-routine program data.
29	Frequency of reporting	Once per year.

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Implementing partner: ALAS, Guatemala	A member of the local implementing partner records every time a radio program in Tzuthuil or in Spanish, or a TV program is brodcasted as part of the project. The date is recorded.	Ongoing
31	Data processing	Implementing partner: ALAS, Guatemala	A member of the local implementing partner consolidates the information in a table showing the date, the type of program (radio/TV) and the topic discussed.	Ongoing
32	Data validation		We do not conduct any further validation of these data.	

33 Challenges in data collection and steps to address challenges

Unfortunately, it has not been possible to get reliable audience data regarding these local radio / TV programs which would have allowed to estimate the number of people reached.

INDICATOR	2017	2018
6 Number of radio or TV programs	33 programs	19 programs

Comments:

1/1/2015 - 12/31/2015 data: 36 programs.

1/1/2016 - 12/31/2016 data: 50 programs.

INDICATOR

Number of free consultations

7

STRATEGY HEALTH SERVICE DELIVERY

	ITEM	DESCRIPTION
	Definition	The number of free consultations provided as part of the program to the poorest patients by visiting them directly at their home or through an out-patient clinic.
	Method of measurement	Counting of psychiatric consultations provided for free. CALCULATION Sum of the number of consultations.
28	Data source	Routine program data.
29	Frequency of reporting	Once per year.

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Implementing partner: ALAS, Guatemala	A member of the local team (implementing partner) records each free consultation that takes place either at the home of the patient or through an out-patient clinic.	Ongoing
31	Data processing	Implementing partner: ALAS, Guatemala	A member of the implementing partner's team sums the number of free consultations provided within a year period.	Once per year
32	Data validation		We do not conduct any further validation of this data.	

33 Challenges in data collection and steps to address challenges

No additional information provided.

INDICATOR	2017	2018
7 Number of free consultations	683 procedures	660 procedures

Comments:

1/1/2015 - 12/31/2015 data: 246 procedures.

1/1/2016 - 12/31/2016 data: 411 procedures.

INDICATOR **Beneficiaries of microloans**

STRATEGY FINANCING

8

	ITEM	DESCRIPTION
	Definition	Number of microloans (and other financial empowerment support) attributed to patients or their families through the program
	Method of measurement	Counting the number of microloans attributed through the program CALCULATION Sum of microlans attributed through the program
28	Data source	Routine Program Data
29	Frequency of reporting	One time per year

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Implementing partner: ALAS, Guatemala	A member of the local team (implementing partner) records every time a patient or a family application for a microloan (or for other type of support) is successful.	Ongoing
31	Data processing	Implementing partner: ALAS, Guatemala	A member of the local team (partner) sums the number of microloans attributed within a year period.	Once per year
32	Data validation		We do not conduct any further validation of this data.	

33 Challenges in data collection and steps to address challenges

No additional information provided.

INDICATOR	2017	2018
8 Beneficiaries of microloans	0 people	3 people

Comments:

1/1/2014 - 12/31/2014: 10 people.

1/1/2015 - 12/31/2015: 15 people.

1/1/2016 - 12/31/2016: 11 people.

2017: No new microloans granted.

2018: 3 families benefitted from a new house built by ConstruCasa.

INDICATOR

Number of people supported via self-help groups

9

STRATEGY HEALTH SERVICE STRENGTHENING

	ITEM	DESCRIPTION
	Definition	The number of people who have attended self-help group meetings organized or supported by the program or the implementing partners. Support is defined as any financial or in kind transaction that is aimed to provide money, goods or services to facilitate the activities of self-help groups. Self-help groups can be defined as "groups of people who provide mutual support for each other. In a self-help group, the members share a common problem, often a common disease or addiction."
	Method of measurement	Counting of the number of people attending self-help groups meetings that are organized or supported by the program or its implementing partners. The program administrative records contain information on self-help groups that received funding, goods or services. CALCULATION Sum of the people attending self-help groups meetings that are organized or supported by the program or its implementing partners.
28	Data source	Routine program data.
29	Frequency of reporting	Once per year.

		RESPONSIBLE PARTY	DESCRIPTION	FREQUENCY
30	Data collection	Implementing partner: ALAS, Guatemala	A member of the local team (implementing partner) keeps record of the number of self-help group meetings held as well as the number of participants at these meetings.	Ongoing
31	Data processing	Implementing partner: ALAS, Guatemala	A member of the local team of the implementing partner consolidates data from each session into the total number of people having attended these self-help group meetings.	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 additional information provided.

INDICATOR	2017	2018
9 Number of people supported via self-help groups	580 people	330 people

Comments:

1/1/2015 - 12/31/2015: 490 people.

1/1/2016 - 12/31/2016: 600 people.

Appendix

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

Program Description

PROGRAM OVERVIEW

1 Program Name

2 Diseases program aims to address:

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

3 Beneficiary population

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

4 Countries

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

5 Program Start Date

6 Anticipated Program Completion Date

7 Contact person

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

8 Program summary

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

PROGRAM STRATEGIES & ACTIVITIES

9 Strategies and activities

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

10 Strategy by country

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

COMPANIES, PARTNERS AND STAKEHOLDERS

11 Company roles

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

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

12 Funding and implementing partners

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

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

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

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

13 Funding and implementing partners by country

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

14 Stakeholders

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

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

LOCAL CONTEXT, EQUITY & SUSTAINABILITY

15 Local health needs addressed by program

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

a How were needs assessed

b Was a formal need assessment conducted

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

16 Social inequity addressed

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

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

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

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

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

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

19 Program provides health technologies

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

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

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

21 Health technologies are covered by local health insurance schemes

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

22 Program provides medicines listed on the National Essential Medicines List

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

23 Sustainability plan

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

ADDITIONAL PROGRAM INFORMATION

24 Additional program information

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

a Potential conflict of interest discussed with government entity

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

25 Access Accelerated Initiative participant

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

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

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