

Papua New Guinea Internal Appraisal 2014

1. Brief Description of Process

This Internal Appraisal was conducted for GAVI by independent technical expert **Gordon Larsen**, in close cooperation with GAVI CRO for the country **Raj Kumar**, and is based on reports and documentation supplied to GAVI by the national authorities and institutions in the country for the year 2013. Certain sections of the APR for 2013 have been completed by the country however not formally submitted to GAVI. There is sufficient information available to make a recommendation on continuation of existing Gavi support.

2. Achievements and Constraints

Among the achievements for 2013, administrative coverage for all antigens has improved by 5-8% compared to 2012 and an increasing trend in coverage is evident from 2010. In general, performance continued to follow the long-term trend that has been evident in the programme for the past 10 years. DPT3 coverage reported in 2013 is identical to that reported in 2003 (68%).

The target for Penta3 was apparently missed by a wide margin however (23% pt.), although it appears that this target was incorrectly entered in Table 4, with the numbers of children targeted for Penta1 being identical to that shown for Penta3 (185,019). Penta 3 should have been entered as 137,029 (i.e, the same as for DPT3), and as a result of this error, the target coverage is incorrectly calculated and should have been 65%. Similar errors occur for Penta1 and Penta3 in 2014 and also for PCV1 and PCV3 in both 2013 and 2014, where in each case, the targets set for 1st dose and 3rd dose are identical. The number of births entered are identical to numbers of pregnant women in 3 cases for 2013 and 2014 – again, obviously data errors. All these errors in Table 4 will lead to wrong conclusions regarding programme performance and achievements. The JRF is a more appropriate reference to look at the immunization performance.

Targets for DPT1-DPT3 drop-out rate were not met in 2013 (32% compared to a target of 26%). Presumably as a result of missing the 2013 target by more than 20%, the target drop-out rates for 2014 and 2015 are now revised upwards, and although the new targets appear to be somewhat more realistic, based on the results achieved in 2012 and 2013, it is expected that some explanation and justification should be provided.

For vaccine wastage, no specific data is collected by the National EPI unit to assess the programme level (province or district) specific vaccine wastage, and only the maximum empirical values permitted by GAVI for each vaccine are used in this report.

The programme has been making efforts to improve access and the equity of immunization services through adoption of the Reaching Every District (RED) and Reaching Every Child (REC) Initiatives and by following the Integrated EPI/MCH guidelines. These approaches are among the country's main objectives and priority actions for the EPI programme in 2014 to 2015.

Sex-disaggregated data on immunization is not collected in the country at present and no data on coverage disaggregated by gender is available. The available data in the country does not signify any gender-related barriers in accessing and delivering of immunisation services. However, geo-topographical factors in accessing of services by the population exist. The plan of the government is to conduct regular outreach to all villages and areas in the country to improve the geographical reach of the population (which will provide better access to both genders) to the immunisation services'. MOH plans to collect immunization data in a disaggregated format at some point in the future.

The key challenges in 2013 were:

1. Measles outbreak in West Sepik province, 2. Slow processing of funds by national level and their utilization at provincial level which delayed implementation of EPI activities, 3. Inadequate numbers of human resources in the National EPI unit, 4. Under-reporting of coverage data from health centres to provinces and from provinces to national level for all antigens, and 5. Conduct of outreach sessions has decreased over years leading to decrease in expected coverage.

3. Governance

The ICC membership comprises a cross-section of government, international, bilateral and included 1 CSO organization. The body meets occasionally rather than regularly, and held 3 meetings in 2012 but only 2 in 2013. A total of 11 members are listed in the APR for 2012 and 10 in the APR for 2013.

A NITAG has reportedly been established in the country since 2010, and the APR describes its work on reviewing mortality patterns of rotavirus positive cases and providing recommendations on data generated. There is no mention of NITAG membership however, and no indication of the frequency of its meetings.

There may be a degree of shared membership between ICC and NITAG. It is noted that Ms. Elva LIONEL, named as Deputy Secretary, NHPCS in the National Department of Health, is also named under Minister of Finance (or delegated authority) in the APR.

No minutes of ICC meetings in 2013 or 2014 are available

There are no representatives from provinces or states on the ICC and there is no reference to any kind of beneficiary feedback mechanism.

4. Programme Management

There is no mention of Annual Plans of Action for EPI being developed or used and none are referred to in the APR or supplied as supporting documents.

Baseline data, performance indicators and future targets are all included in APR Table 4, although as already noted, there appear to be some errors in this data which would affect many of the findings in any appraisal. It is also noted that most future targets in Table 4 are revised downwards by 10% or more, and as justification for this, the APR states that 'for annual targets, changes have been made in expected coverage figures for 2014 based on achievements in the last two calendar years. Numbers for 2015 have been retained the same as the earlier figures, but changes will be done in due time if need be'. It appears that most coverage targets that were originally set for 2014 and 2015 were highly optimistic, compared to long-term performance trends in the country, and that the downward revisions now made thereby bringing targets more into line with what are considered to be realistic expectations. In the case of the target DPT1-DPT3 drop-out rates, these are increased by vastly more than 10% for 2014 and 2015, but as already mentioned in section 2, no explanation or justification is given for making such large changes.

It appears that activities are generally being implemented approximately to schedule, although s already described, and given these realities, it appears that many of targets set recently have tended to be overly ambitious. No information is provided on budgets or incurred costs for the various activities described however, so it cannot be assessed whether these have been implemented according to budget or not.

5. Programme Delivery

The 2013 APR states that no vaccine stock-outs occurred with NVS vaccines at any level during that year. The previous APR for 2012 reports that 'there was no stock-out in the national or sub-national level, but due to non-availability of stocks from the manufacturer and thus the delay in shipment (decision to identify alternate manufacturer), the minimum quantity level in the country could not be maintained. The deficit was taken care by the stock level received late in the year of

2011 and that the country did not attain coverage of 100% in 2012'. It appears from these comments that vaccine over- or under-stocking has not been identified as major concerns in the country, but trends in vaccine management and stock control over a longer time period and any stakeholder views on these issues are not known.

Pneumo vaccine was introduced late during the reporting period, it appears that introduction proceeded generally according to plan although not to the original schedule. The national launch followed training of all health care workers, but was delayed due to a measles outbreak which started in October 2013 in West Sepik province. As a result, very few Pneumo immunizations were given in 2013, and coverage for the year is shown as 0% in baseline Table 4 of the APR, together with substantially reduced coverage targets for 2014. Measles outbreak containment activities in the affected provinces are listed in the APR as priority programme actions for 2014 to 2015, so these may have the effect of further delaying the phased introduction of Pneumo vaccine.

6. Data Quality

The Country has no significant discrepancy between DTP3 admin data and WUENIC 2013, has medium (2 star) GoC on DTP3 WUENIC 2013 estimates.

The last EPI coverage survey was carried out in 2004 and this showed coverage rates for all traditional vaccines to be equal or above those reported through the administrative data system, thus apparently validating the accuracy of national data. There was also a household survey carried out in 2006, but on that occasion, survey data for DTP3 coverage (67%) was below that reported through the administrative data system (75%), thus suggesting that nationally reported data may actually be less reliable. The same survey found measles coverage at 9 months to be 62% from administrative data, compared to 81% according to survey data, perhaps indicating a degree of under-reporting in the administrative data. The country had been identified as priority for coverage survey which is planned to be carried out in 2016.

The census last was conducted in 2011 and projection of the figures of total births has been done using the preliminary census figures from National Statistical Office. However, the National Health information System, due to issues in its database, does not use the population denominator of the new 2011 census. Thus, there is a difference in the denominator used by National EPI unit and the National health Information system.

For data improvement activities, projection of the figures for children under 1 year was made using preliminary 2011 census figures from National Statistical Office. The National EPI unit is in discussion with the National Health Information System to match the programme unit figures with that of the national data base.

A DQSA assessment was conducted in 2013 jointly by the National EPI unit, National Health Information System and WHO. The assessment highlighted the issue of under-reporting in the administrative figures.

7. Global Polio Eradication Initiative, if relevant

The last reported case of wild polio virus was in 1996. Polio immunization is fully integrated into routine immunization in the country and no specific polio eradication activities are carried out. There are no polio-supported field staff engaged in the country and there is no need or justification for having any.

PNG wishes to introduce IPV in last quarter of 2015 and has sent an application for Gavi support. The application will be reviewed in first application round of 2015.

District-specific coverage data for DTP3/Penta3 and identification of polio high-risk districts is not provided in either the APR or the JRF. As noted above, the country has been polio-free since 1996 and no polio high-risk districts are identified.

8. Health System Strengthening

A grant of \$3,072,923 was approved for PNG in 2013. The grant covers 8 out of 21 provinces with 14 districts from a total of 89 districts in the country. First tranche was disbursed in June 2014 only due to long time taken in completion of the FMA and agreement on the aide memoir. Consequently, the implementation could not be started in 2013. The next tranche of \$538,107 is already approved and will be transferred after ensuring that the implementation is in place.

The main objective of the HSS proposal is to take EPI/MNCH health services delivery closer to the community in the rural areas. An outreach/patrol team will provide a set of five integrated packages of services at village level where they visits- linked to the EPI and MNCH national strategies. The HSS grant is largely focused on supporting outreach in target districts - 66% of the HSS budget goes to Integrated EPI/MNCH outreach and 25% for Human resources for supervision (fuel and per diem). 8% of the budget is allocated to cold chain spare parts and running costs.

Additional TA to support PNG is needed. Under the BP for 2014, no support was provided for coverage and equity, although the country was identified for priority. WHO IVB has proposed for BP 2015 to include coverage improvement work for PNG.

A graduation assessment was carried out in April 2014, identifying the issues of weak health systems and low Gavi funding by Gavi. The recommendations are being followed up with a higher cash envelope for HSS taking into account high costs of service delivery in PNG.

9. Use of non-HSS Cash Grants from GAVI

As no APR has been submitted, no financial reports have been provided for use of vaccine introduction grant for PCV introduction.

10. Financial Management

Due to non-implementation of the HSS grant last year, no financial information is expected for this window of support. The agreement for the aide memoir after the FMA took almost nine months underscoring the slow processes in the country.

11. NVS Targets

As already mentioned, the future targets are revised downwards by 10% or more for Penta3 as compared to those originally set for 2014 and 2015. However, it most coverage targets that were originally set for 2014 and 2015 were highly optimistic compared to the long-term trends reported by the country, and was not realistic. The proposed downward revisions therefore have the effect of bringing targets more into line with realistic expectations, and it is considered that the revised future targets are likely to be achievable.

12. EPI Financing and Sustainability

The relevant information has not been provided by the country. It is, however, confirmed that PNG fulfilled its co-financing requirements for year 2013. PNG has been exceeding its co-financing obligations to GAVI to date. PNG crossed GAVI's eligibility threshold at the beginning of 2014. From 2015-18, co-financing will begin to ramp up quickly and GAVI's contributions will phase out so.

Government's share of the total EPI budget was 83% in 2012 and this increased to at least 91% in 2013, although it is noted that no costs for injection supplies are included in Table 5.5a of the 2013 APR, so the full extent of government's contribution in 2013 cannot be evaluated. Over this period, the total EPI budget decreased somewhat from US\$39.8 million in 2012 to slightly more than US\$35 million in 2013, so the dollar value of Government's share was actually reduced a little also, from some US\$33 million in 2012 to just over US\$31.75 million in 2013. GAVI's contribution more than doubled over this period however, from 2.6% of the total EPI budget in

2012 to 6.2 % of the total in 2013. Country procured 100% of its traditional vaccine needs in 2013, which was an increase from the 88% of traditional vaccines that it funded in 2012.

Gavi carried out a graduation assessment in early 2014. The findings highlighted low coverage as the most critical issue. It happens to be the Gavi graduating country with least coverage estimates. The report can be referred for details. As a result there is active discussion on increasing the HSS envelope for PNG to support interventions which could strengthen immunization coverage. It should be noted that PNG crossed the eligibility threshold as per its GNI per capita in 2013.

EPI performance is likely to continue following eventual graduation from GAVI support. It seems likely that EPI performance will continue to maintain the long-term trend evident over the past 10 years, following the country's eventual graduation from GAVI support. There is commitment from government to continue and probably to expand its contributions, even if the trend from 2012 to 2013 does not actually demonstrate any expansion, as expressed by the government during graduation assessment.. Country is currently classified as a graduating country, with a GNI in 2013 estimated at US\$2,010.

13. Renewal Recommendations

Topic	Recommendation
NVS - Penta	Renewal without a change in presentation
NVS - Pneumo	Renewal without a change in presentation following confirmation of correct targets

14. Other Recommended Actions

Topic	Action Point	Responsible	Timeline
APR	APR for 2013 to be completed and submitted to GAVI together with all required supporting documents	Country	Asap