



HEALTH FACILITIES SURVEY 2022

FACILITY BASED
SURVEY OF
REPRODUCTIVE
HEALTH
COMMODITIES AND
SERVICES IN PAPUA
NEW GUINEA



FOREWORD

MINISTER FOR HEALTH AND HIV/AIDS

HONORABLE DR. LINO TOM, MP

The National Department of Health, in partnership with the United Nations Population Fund, completed the Facility-Based Survey of Reproductive Health Commodities and Services in September 2022, providing details on the availability of reproductive health commodities and services at one in five health facilities in Papua New Guinea. The results cover all levels of care, including primary, secondary, and tertiary facilities. I congratulate the enumerators for their work in gathering this data, particularly from some of our most remote health facilities, where dedicated health professionals are working in very challenging conditions to deliver quality care and services to our rural populations.

I extend my gratitude to the Australian Government for their funding support to this survey through the C-Surge project. This project has contributed significantly to improved commodity supply chain management through capacity building for facility pharmacy managers and staff which has strengthened the coordination between facilities and Area Medical Stores to reduce stock-outs of essential medicines.

Our Constitution calls for improvement in health and wellbeing for all peoples in Papua New Guinea. Improvement is not something we achieve, it is something we continue to work towards. Improvement demands data to show us where we are, to guide where we are going.

Surveys such as this are vital to monitoring and accelerating our progress to ensure every Papua New Guinean has access to quality health services, including sexual and reproductive health services. The recommendations provide a roadmap for how we can strategically invest in our personnel and processes to deliver tangible improvements in the provision of sexual and reproductive health services for patients across all levels of health facilities.



Hon. Dr Lino Tom
Minister for Health and HIV/AIDS

ACKNOWLEDGEMENTS

The United Nations Population Fund (UNFPA) country office in Papua New Guinea (PNG) would like to acknowledge the financial support of the Australian Government Department of Foreign Affairs and Trade (DFAT) under the C-Surge project and thank the experts from the Family Health Services Branch and Medical Supplies Procurement & Distribution branch of the National Department of Health, Enumerators, Family Health coordinators or FP Officers from all Provincial Health Authorities and Provincial Health Offices where the survey was conducted. We would also like to give appreciation to the consultant, Sabrina Mezzaroma, for analyzing and writing this report.

CONTENTS

Acronyms 6

Tables 7

Executive Summary 8

Part 1: Introduction 13

Part 2: National Guidelines, Laws, and Policies 22

Part 3: Survey Findings for Availability of Commodities 25

3.1 General Information about the facilities 26

3.2 Availability and stock-out of family planning commodities 28

3.3 Availability of maternal and reproductive health medicines 40

Part 4: Survey Findings for Facility Resources 45

Part 5: Client Exit Interviews 61

Part 6: Conclusions and Recommendations 69

Annex 1: Remarks from the consultant 80

Annex 2: Listing of facilities surveyed 82

ACRONYMS

AMS	Area Medical Store
ANC	Ante-Natal Care
ART	Anti-Retroviral Therapy
B/w	Between
CMS	Central Medical Store
CHW	Community Health Worker
DHS	Demographic and Health Survey
EOC	Emergency Obstetric Care
EPI	Expanded Programme on Immunization
FBO	Faith Based Organisation
FP	Family Planning
GPRHCS	Global Program to Enhance Reproductive Health Commodity Security
GPS	Global Positioning System
HC	Health Centre
HEO	Health Extension Officer
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HSC	Health Sub Centre
ICT	Information and Communication Technology
IUD	Intrauterine devices
KRA	Key Result Areas
LANs	Local Area Networks
LARC	Long-Acting Reversible Contraceptive
MMR	Maternal Mortality Rate
MDG	Millennium Development Goals
NDoH	National Department of Health
NGO	Non-Governmental Organization
NVD	Normal Vaginal Delivery
OIC	Officer in Charge
PGK	Papua New Guinea Kina (local currency)
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PNC	Post-Natal Care
PNG	Papua New Guinea
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
SDPs	Service Delivery Points
SOP	Standard Operating Procedure
TB	Tuberculosis
UNFPA	United Nations Population Fund
UN MMEIG	United Nations Maternal Mortality Estimation Inter-Agency Group
U5	Under 5 (years old)
VCT	Voluntary, Counseling and Testing
VHF	Very High Frequency
WHO	World Health Organization

TABLES

Table 1. Family Planning Services Required According to Level of Facility	17
Table 2. Health Facility Survey Sample Size by Region and Level of Care	18
Table 3. Health Facility Survey Sample Size by Modules	19
Table 4. Number of Facilities surveyed by location, type, and management	26
Table 5. Availability of Reproductive Health Service by Type of Facility	27
Table 6. Number of Facilities Providing at Least 3 and at Least 5 Modern Contraceptive Methods, by Level, Location, and Management, in line with National Policy and Protocols	30
Table 7. Reported Reasons for 'Stock-out' of contraceptive methods by number of facilities	32
Table 8. Number of Facilities Providing at Least 3 and at Least 5 Modern Contraceptive Methods, by Level, Location, and Management, as part of regular service delivery	32
Table 9. Percentage of facilities reporting stock-out of any one, at least three, and at least five contraceptive methods in the three months preceding the survey (Scen.1)	33
Table 10. Reported Reasons for 'Stock-out' of contraceptive methods in the three months preceding the survey (Scen.1)	34
Table 11. Percentage of facilities reporting stock out of any one, at least three, and at least five contraceptive methods on the day of the survey (Scen. 1)	35
Table 12. Reported Reasons for 'Stock-out' of contraceptive methods on the day of the survey (Scen. 1)	36
Table 13. Percentage of facilities reporting stock out of any one, at least three, and at least five contraceptive methods in the three months preceding the survey (Scen. 2)	37
Table 14. Reported Reasons for 'Stock-out' of contraceptive methods in the three months preceding the survey (Scen. 2)	38
Table 15. Percentage of facilities reporting stock-out of any one, at least three, and at least five contraceptive methods in the three months preceding the survey (Scen. 2)	39
Table 16. Reported Reasons for 'Stock-out' of contraceptive methods on the day of the survey (Scen. 2)	39
Table 17. Availability of 7 Life-saving Maternal/Reproductive Health Medicines at Health Facilities by Level, Location, and Management	41
Table 18. Reasons for unavailability of RH medicines, disaggregated by medicine	43
Table 19. How Quantity for Re-supply of Contraceptive Methods is Determined, by Level, Location, and Management	48
Table 20. Frequency of Re-Supply of Family Planning Commodities, by Level, Location, and Management	49
Table 21. Length of Time Between Ordering and Receiving Stock, by Level, Location, and Management	50
Table 22. Frequency of Supervision Visits by Level, Location, and Management	54
Table 23. Characteristics of clients interviewed for health facility survey	62
Table 24. Frequency of Visits to Health Providers for Family Planning Services	63
Table 25. Percentage of clients reporting paying for family planning services	65
Table 26. Client reports of costs for specified services	65
Table 27. Means of Transport Used to Attend Facilities for Provision of Family Planning Services	66
Table 28. Cost of Transport to Attend Facility for Family Planning Services	66
Table 29. Waiting Times at Health Facilities for Provision of Family Planning Services	67
Table 30. Activities Clients Reported They Would Otherwise be Doing During Time Spent at Facility	67
Table 31. Person responsible for clients' activities during time spent seeking family planning service	67

EXECUTIVE SUMMARY

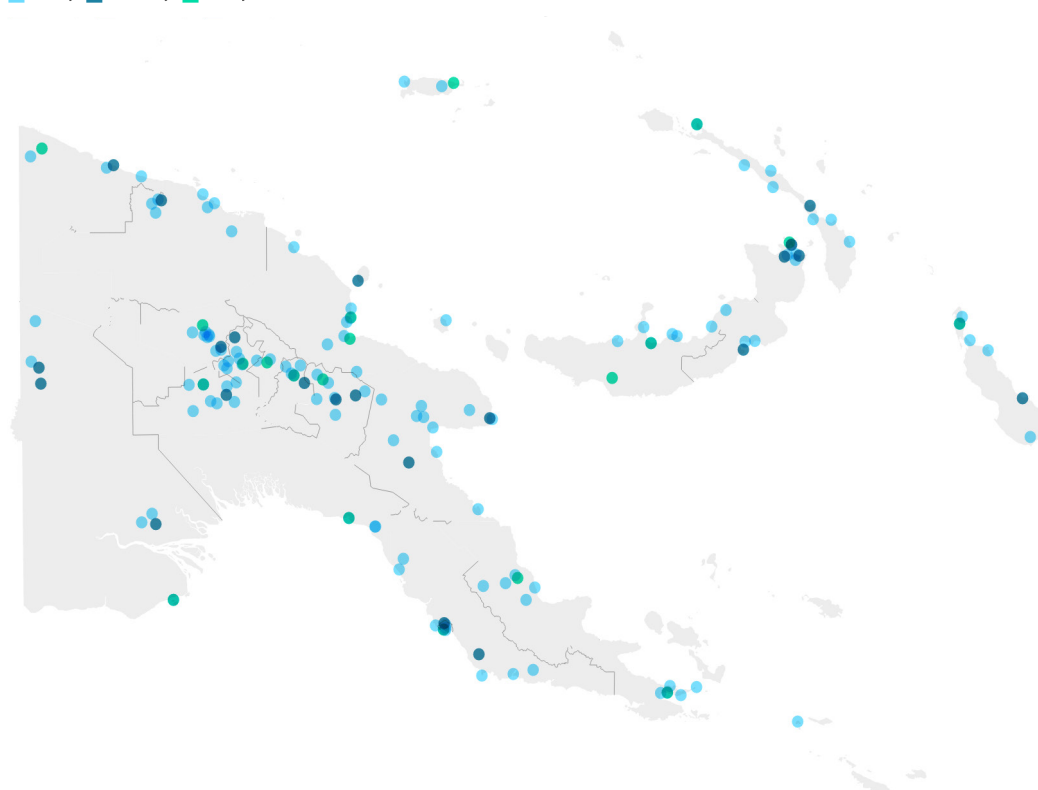
The Facility Based Survey of Reproductive Health Commodities and Services in Papua New Guinea is conducted to assess availability of commodities for family planning and maternal health and relevant aspects of services delivery systems that underpin a good reproductive health program - from policy, environment, control, costs, and capacity, including the satisfaction of clients.

A total of 160 Service Delivery Points (SDPs) were assessed across all regions of Papua New Guinea, representing 21% of the total number of facilities in the country. The survey covered primary, secondary and tertiary facilities.

The survey sample size was determined using the Global Sampling Formula and interviews were conducted using a semi-structured, electronic questionnaire. The questionnaire was also used for on-the-spot interviews with randomly selected clients of each facility to assess the cost of the service and to gather their opinion about the quality of the service received.

Surveyed Health Facilities by Location and Type

Primary Secondary Tertiary



FINDINGS

Availability of family planning commodities

57% of SDPs reported stock out of at least 3 contraceptive methods in the three months preceding the survey, with 91% of SDPs reporting stock out of any one FP method in that same time. On the day of the survey, 88% of SDPs reported they were out of stock of any one method and 67% reported a stock out of 3 methods.

The main reason for the stock outs in the past three months, as reported by 50% of SDPs, was delay in delivery from the Area Medical Store (AMS). This was followed by a 'lack of trained staff' knowing how to order supplies, 'delay in submitting orders' from SDPs, and 'low demand for certain FP method', the latter being particularly common for facilities reporting stock-out of IUDs.

Despite stock outs, 97% of the 149 facilities with family planning services were offering 'at least three modern contraceptive methods', and 82% were providing 'at least five', among a selection of eight methods, in line with the National Policy and Protocol. Female Sterilization is available only at tertiary facilities.

The most available methods, offered at over 90% of facilities, were condoms, oral contraceptives pills and injectables (Depo-Provera). Implants, widely promoted in the country soon after the FP Policy was issued in 2014, was available in 85% of the facilities. Emergency contraceptive pills were available in about 65% of facilities.

Both Intra-Uterine Devices (IUD) and male sterilization were available in fewer than 30% of facilities. 39% of providers reported they did not have staff trained to perform male sterilisation procedures or to insert IUDs. The second most common reason for methods not being offered was 'low or no client demand' (26%), with IUDs, female condoms, and emergency contraceptives reportedly experiencing low demand.

Availability of maternal and RH medicines

Among the SDPs providing maternal health and birth services, 57% of facilities had a full set of at least seven life-saving RH medicines available on the day of the survey. Among the main reasons given for not having the minimum required medicines from the 43% of providers experiencing stock outs, SDPs cited a "lack of trained staff" to provide certain medicines (31%). This was particularly cited as the reason for not providing calcium gluconate, hydralazine, nifedipine and methyldopa. "Delay from the side of the warehouse to distribute medicines" and "Delay from the SDP to order for re-supply", were also prominent reasons for medicine stock-outs (25% each).

Supply chain and storage for RH commodities

The Area Medical Store (AMS) is the main source for commodity supply, with 68% of facilities reporting this as their source and 27% of providers citing their main source as the Central Medical Store (CMS). For 79% of providers, a private logistics company contracted by the government was the main source of transporting supplies from these warehouses.

50% of SDPs reported a delay of supply from area medical stores to health facilities as the main reason for stock-out of contraceptives. This was followed by 'a lack of trained staff', 'delay in submitting orders from SDPs', and 'low demand for FP'. Only 17% of SDPs have a pharmacist/pharmacy technician on staff for drug management. Stock management at the remaining 83% of SDPs is the responsibility of community health workers (CHWs), health officers (HOs), or midwives, with limited knowledge and skills in pharmacy management.

Among those SDPs that received stock within three months of the survey day, only 10% received the complete stock order, while 87% received only partial supplies. Most providers (83%) reported that the quantity of supplies was often determined by the warehouse.

A large majority of facilities (97%) had their own cold chain system for storage of commodities sensitive to temperature. During the surveys it was reported, and observed by the enumerator, that despite cold chain storage being available, certain medicines that should be stored in fridges, such as oxytocin, were found stored at room temperature instead.

Training and supervision

About 50% of SDPs reported staff were trained on using the Logistics Management Information System (LMIS), of which 50% have completed sessions on appropriate storage of supplies and 46% have participated in training on assessing stock status and record keeping.

Overall, 87% of facilities had staff trained on modern contraceptive methods. Among them, 85% reported staff were trained on implants and 68% on IUD. However, 91% reported that their staff received training more than one year ago- in some cases more than three-four years without any refresher. While a great number of facilities have staff trained in family planning, including implants, facilities reported an inequitable distribution of trained staff.

22% of SDPs have never been supervised and 32% were supervised just once or twice a year. 24% of providers reported that supervision occurs once every three months.

On the day of the survey, the respondents were also asked when supervision visits occurred during the latest year. 18% of facilities reported that they were visited within one month before, 25% between one to three months before, and 21% between three and twelve months. 36% of providers did not receive any supervision during the year.

Asked about the major issues that were covered during supervision visits, providers reported “staff clinical practice” and “data compilation and reporting” both at 30%; followed by staff availability and training (19%) and drug stock out and expiry by 17%. Supervision for review and use of RH guidelines and job aids stand at 11%.

Availability of guidelines, checklists, and job aids

Only 26 SDPs (17%) had in the same facilities FP, ANC, and Waste Disposal guidelines (verified) all together. Single copies of guidelines were more frequent for FP Guidelines (on hand- verified) found in 71% of the HFs and the ANC guideline (verified) in 62%. 70% SDPs did not have waste disposal guidelines at all.

Most SDPs (96%) had some types of ICT devices available, such as computers, tablets, and smart phones. The main purpose of using ICT was for Routine Communication (77%) and facility record keeping (70%). The use of ICT specifically for Supply Chain Management is 50%.

Waste disposal

The main methods of health waste disposal by SPDs are burning waste on the ground (38%), burying waste in special dump pit (26%), use of incinerator (25%), and central collection by agency (9%).

Fees for services

17% of providers charge fees for family planning consultations, with 12% charging for medications and 9% charging for specialist services. With respect to maternal health and delivery services, 47% of providers charged fees for consultations. 12% of providers charged fees for medication. 21% of providers charge patients for normal vaginal delivery and 28% charge for caesarian section.

Client perception of family planning service provision

Overall, 95% clients are satisfied with the FP services they received at the facility. Respondents reported that staff are polite and respectful of their chosen methods of family planning. However, 39% clients reported that the waiting time was too long. 12% were not informed of how to use the FP method chosen and 33% were not informed of the common side effects of the family planning methods they were using. 40% reported they were not told what to do regarding the side effects and they were not told what to do in the event of serious complications.

Observations of the survey teams

Survey teams reported that some of the health facilities are underutilized. For example, one facility servicing a population of more than 20,000 reported providing ANC for only 10-15 clients, family planning services for 5-10 clients, and just 2-5 deliveries per month. Enumerators suggested one main reason is the absence of staff and a lack of monitoring and supervision.

Most of the facilities assigned one day of week for RMNCH services (including antenatal care and family planning). It was noted that health workers lack knowledge in the administration of calcium gluconate, magnesium sulfate, and misoprostol. There is no job aid in the facilities to help them. There is also a shortage of life-saving equipment, such as vacuum extraction sets, and a lack of knowledge of how to use it.

There are significant concerns regarding expired medicines and improper storage of medicines. Most facilities stored oxytocin at room temperature or were using expired oxytocin from 2021 that had been stored at room temperature. In the past two years, more than 90% of facilities visited have not conducted any inventory checks. Teams found expired medicine from 2019 stored in the facilities and in one health facility the team found vaccines that expired in 2013 still stored in the cold chain at the facility.

In addition to the expired medicines at the facilities, there is a huge bulk of expired medicine taking up space in all AMSs and it is due to lack of proper instruction from NDOH, lack of budget for this purpose, and lack of infrastructure (standard incinerator) in AMSs.

Enumerators also noted that infection prevention and lack of sterilizers in some of the health facilities is a serious issue.

One main reasons reported for prolonged lead time of supplies from Area Medical Stores to health facilities is the delay in transporting supplies by logistics companies. In most cases, supplies are stored in the logistics company transit storage for months, where there is no temperature control ensure the medicines are kept at the recommended temperatures.

AMSs are under-staffed and the existing staff capacity in terms of ICT and eLMIS should be strengthened. In addition, there is no regular stocktake exercise in AMSs.

RECOMMENDATIONS

The findings of this study indicate a need for greater focus on:

- 1 Secure uninterrupted availability of RH Commodities in the country and at facilities: Expand LMIS Training; improve M&E and encourage systematic supervision mechanisms at all levels.
- 2 Strengthen the supply chain system to reduce stock-outs: Identify and address determinants for “delay” of commodities distribution from warehouse to SDPs and assess quality of logistic and storage conditions of commodities.
- 3 Expand contraceptive choices for clients: Increase investment in training for health workers, particularly for the management of long-acting reversible contraceptive (LARC) and permanent contraceptive methods; boost FP promotion activities at catchment areas.
- 4 Enhance quality of FP and RH services: Update and disseminate FP/ANC guidelines, job aids, and waste disposal guidelines to reduce environmental hazards at health facilities; Disseminate RH Drug Management Guidelines and Standard of Procedures (SOP) to ensure adherence to protocol, standards, and guidelines.
- 5 Ensure family planning and reproductive health services are 100% free of charge and are available throughout the week (not only on dedicated days).
- 6 Strengthen national and local level coordination mechanism: Introduce use of a social platform (wherever feasible) to improve communication, consultation, and information/experience sharing among FP/RH staff.
- 7 Strengthen the capacity for monitoring and encourage systematic supervision mechanisms at all levels. All facilities must set monthly goals for the provision of ANC and FP services. This will help the staff and PHA to measure the performance of health facilities and hold them accountable.
- 8 Integrate oxytocin in the vaccine cold chain system as per existing global agreement between UNFPA, WHO, and UNICEF.
- 9 PHAs should impose a strict policy regarding the absenteeism of staff members. PHAs should strictly monitor staff attendance and performance.
- 10 Establish provincial medical stocks.
- 11 Distribute six months worth of RH/FP supplies to facilities when filling orders.
- 12 Conduct a national Basic Emergency Obstetric and Newborn Care (BEMONC) assessment and develop improvement plan based on findings.
- 13 Initiate a RMNCAH balanced scorecard to monitor RMNCAH indicators.
- 14 Improve the infrastructure of AMS: In particular, infrastructure should consider expired medicine disposal, solar energy (24/7 electricity), storage, cold chain, and security systems.
- 15 Conduct a regular performance review of logistics companies contracted to distribute medical supplies. Several companies should be involved in order to enhance competition.



PART 1

INTRODUCTION

CONTEXT: REPRODUCTIVE HEALTH COMMODITIES IN PAPUA NEW GUINEA

Although the legal and policy framework on maternal health in Papua New Guinea (PNG) has improved over the last two decades, maternal mortality remains one of the highest in the Pacific and second highest in the Asia-Pacific region.

Estimates vary by methods used. Although the estimate of Maternal Mortality Ratio (MMR) in the 2016-18 PNG Demographic Health Survey (DHS) report, indicated 171 deaths per 100,000 live births, the ratio from the United Nations Maternal Mortality Estimation Inter-Agency Group (UN MMEIG) 2015, stands at 215 per 100,000 live births and 7.4% of all maternal deaths were due to direct maternal causes. The life-time risk of maternal death in PNG was estimated at 1 in every 120 mothers while it was 1 in every 880 mothers in the East Asia and Pacific region.

Most of the births in the country go unreported- so mortality rates might in fact be much higher, the range of uncertainty of MMR in PNG was between 98 and 457 per 100,000 live births in 2015 that showed little change over the last 15 years.

The total fertility rate (TFR) in PNG is high. According to the DHS 2016-18, the TFR stands at 4.2 children per woman, a slight decline from the 4.4 births per women rate reported in 2006 DHS. Adolescent fertility rate is also high affecting not only young women and their children's health but also their long-term education and employment prospects. Among teenage females, 12% have started childbearing.

The contraceptive use among currently married women has increased in the past decade, from 32% in 2006 to 37% in 2016-18 DHS report. Use of modern methods has increased over the same period, from 24% to 31%. Among sexually active unmarried women, 18% are using contraceptive methods with 16% using a modern one. One quarter of currently married women (26%) have an unmet need for family planning, while over half (59%) of currently married women have their demand for family planning satisfied.

Family planning services and availability of reproductive health commodities are important compo-

nents of essential health care services to improve maternal health and reduce maternal mortality. The Government of PNG has established reproductive health commodity security and services as an integral component of the National Health Plan and as a key strategy for reducing maternal and neonatal death and preventing the spread of HIV. Reproductive health commodity security is also an embedded component of the National Sexual and Reproductive Policy (2014).

The National Health Plan outlines eight key results areas to improve service delivery and health outcomes. Key Result #5 aims to “Improve Maternal Health” through four objectives:

- Increase family planning coverage
- Increase the capacity of the health sector to provide safe and supervised deliveries
- Improve access to emergency obstetric care
- Improve sexual and reproductive health for adolescents

The UNFPA Papua New Guinea Country Office has been working with the National Department of Health (NDoH) to support the government in realizing its goals to improve maternal health through strategic planning and programming to strengthen the national family planning program, both at the national and provincial level, and increase demand and utilization of family planning services. This is coupled with the development and implementation of an integrated logistics system to improve the supply chain of all health commodities in the country.

The UNFPA Global Program to Enhance Reproductive Health Commodity Security (GPRHCS), now called UNFPA Supplies, was launched in 2007 to address the urgent and ongoing need for reliable supply of contraceptive, condoms, medicines, equipment, and services. Papua New Guinea has been the recipient of funds from the GPRHCS since 2011 and this will be successively phased out. UNFPA has initiated the facility-based assessment for Reproductive Health Commodities Security (RHCS) on an annual basis to monitor the progress towards ensuring success.

The first facility-based RHCS survey in PNG was conducted by NDoH in only Central Province in 2013. Coverage was limited due to logistical challenges and funding constraints. Between 2014 and 2015, the second round of surveys covered nine provinces. In 2016, the survey was conducted throughout the country, with the aim of gathering insights establishing a nationally representative baseline for monitoring stock level and services. The year after, in 2017 the survey covered nineteen out of twenty-two Provinces- three Provinces were inaccessible due to logistical issues affecting accessibility to the health facilities.

In 2018 the survey was not conducted due to the devastating earthquake that took place in the Highlands Region and the outbreak of Polio that diverted resources for emergency interventions. The survey was resumed in 2019 covering twenty-one provinces; Hela Provinces remained inaccessible due to internal disorder. The following years the survey was interrupted due to the global pandemic of Covid-19 that imposed restrictions on physical movement of citizens. In 2022, the full survey was resumed and was able to be completed in 21 out of 22 provinces, as Hela Province was still in a State of Emergency.

RATIONALE

Papua New Guinea became a recipient of the UNFPA Supplies Partnership Fund in 2011. Recipient countries must conduct facility-based RHCS surveys annually. The survey is a means to assess whether UNFPA's support has had an impact on improving availability of contraceptives and other life-saving commodities in the national reproductive health, family planning, and maternal health program.

UNFPA Papua New Guinea fulfills its commitment to making data available for measuring and tracking

results of the RHCS interventions through time. At the same time, the survey results are submitted every year to UNFPA headquarters as part of the UNFPA Global monitoring program for the Global RHCS analysis. Besides availability of the Reproductive Health Commodities, the survey also measures efficiency of relevant aspects of the service providers, such as staff training and supervision; availability of cold chain systems, guidelines, and protocols in use, and so on, aiming at identifying system strengths, gaps and weaknesses to enhance the national reproductive health program. The survey also obtained views of clients about the quality and cost of services through the client exit interviews.

Regarding the availability and stock-out of contraceptives, the survey provided information and indicators of two scenarios: a) the contraceptive methods a facility is expected/supposed to provide to clients in line with national guidelines and protocols; and b) the contraceptive methods a facility regularly provides (irrespective of the prescription of the national protocols/guidelines/laws). Both these perspectives were measured with reference to the last three months and on the day the SDPs were assessed.

OBJECTIVE OF THE SURVEY

The main objectives of this survey are to measure progress of the RH Commodities Security Program in PNG and to provide an overall picture of the availability and level of commodity stock outs, to assess relevant aspects of health facilities resources, client perception about the quality of FP services and appraisal of client's costs incurred to access the services. The specific objectives are:

- Assess the availability and stock out of a list of reproductive health commodities and additional commodities.
- Determine the level of staff training and supervision of reproductive health care
- Assess the availability of guidelines and protocols, ICT as well as methods of waste disposal.
- Determine the incidence of user fees (if any) paid by clients for receiving the FP services.
- Obtain the views of clients about the RH-FP service provided.
- Understand the reasons of lack of product availability and stock out.

SURVEY METHODOLOGY AND LIMITATIONS

Organization and management

The survey was funded by the Australian Government under the C-Surge Project, and it was organized and conducted by the UNFPA PNG country office in close collaboration with the Family Health Services Division and Medical Supplies Procurement & Distribution branch at the National Department of Health (NDoH) and provincial health authorities. Prior to the conduct of the survey and at different stages several technical meetings have been undertaken to discuss methodology and to organize logistics to ensure efficient completion of the survey.

Methodology and limitations

The survey interviews were recorded electronically utilizing the Tablets (Lenovo Tab 4, 8"). Data was uploaded via internet directly into the Systmapp System's Database. The e-questionnaire was divided into three modules:

Module 1 - Commodity resources availability: This component of the survey assessed availability of modern contraceptives, RH medicines, "no stock-out" rates, and reasons for unavailability of commodities and the occurrence of "stock-out".

Module 2 - Health facility resources: This component assessed information related to the current capacity of resources: management of the RH commodities, staff trained, ICT, staff supervised, availability and adherence to RH guidelines, job aids, waste disposal and charging of service fees. Since 2017, the survey incorporated specific questions related to logistics and management of RH supplies to measure the quality of the supply chain system and assess the program performance, including identification of gaps/faults.

Module 3 - Client perception and appraisal of FP services: this part of the study assessed clients’ opinion about the FP services received and its quality. Hence, the analysis of this component aimed to evaluate client satisfaction, perception of client’s knowledge and whether the services met their rights.

Survey design and sampling of facility

In line with the PNG National Policy and Protocols, the health delivery system presents seven levels of health facilities, regrouped in ‘Primary’, ‘Secondary’, and ‘Tertiary’ categories. Levels and type of health facilities govern what specific service is expected to be found at the service delivery points, e.g.: maternal delivery service, and/or methods of contraceptives offered in FP.

Table 1. Family Planning Services Required According to Level of Facility

Primary		Secondary & Tertiary			
Level 2-3-4	Services	Contraceptive Methods	Level 5-6-7	Services	Contraceptive Methods
Community Health Post	FP	1. Male condoms 2. Female condoms 3. Oral	Rural/ Urban District Hospital	FP, RH&D (BEmONC or CEmONC), HIV/AIDS	1. Male condoms 2. Female condoms 3. Oral
Urban Clinic	FP, HIV/AIDS	Contraceptive Pills 4. Emergency Contraceptive Pills	Provincial Hospital		Contraceptive Pills 4. Emergency Contraceptive Pills
Health Centre & Sub-Health Centre	FP, RH&D, HIV/AIDS	5. Injectables 6. Implants 7. IUDs 8. Male Sterilisation			5. Injectables 6. Implants 7. IUDs 8. Male Sterilisation 9. Female Sterilisation

The survey was conducted in all four regions of PNG in twenty-one provinces out of twenty-two provinces. Hela Province was not accessible for this year survey. To determine the sample size the Global Sampling Formula was applied.

$$n = \frac{Z^2 p (1 - p)}{d^2}$$

Whereby:
 n= expected sample size z= score that corresponds to a confidence interval = 1.96 at 5% level.
 p=the proportion of the attribute (type of SDP) expressed in decimal
 d= level of permissible error =0.05.
 The table below indicates the profile of Service Delivery Points by provinces, regions and levels of health care, used to determine the sample size.

Table 2: Health Facility Survey Sample Size by Region and Level of Care

Region	Province	Total number of providers by level of care				Sample size by Region and Province
		Tertiary	Secondary	Primary	Total	
Total		20	37	710	767	160
Highlands	Eastern Highlands	1	2	35	38	9
	Enga	1	2	32	35	10
	Hela*	1	1	27	29	0
	Jiwaka	0	1	28	29	4
	Chimbu	1	2	36	39	8
	Southern Highlands	1	1	39	41	10
	Western Highlands	1	1	32	34	7
	Sub-total	6	10	229	245	48
	Islands	Autonomous Region of Bougainville	1	1	34	36
East New Britain		1	3	30	34	10
Manus		1	0	12	13	3
New Ireland		1	1	33	35	9
West New Britain		1	0	31	32	8
Sub-total		5	5	140	150	37
Momase	East Sepik	1	2	43	46	8
	Madang	1	2	45	48	9
	Morobe	1	3	50	54	12
	Sandaun- West Sepik	1	1	36	38	8
	Sub-total	4	5	174	186	37
Southern	Gulf	1	2	20	23	4
	Milne Bay	1	3	40	44	8
	NCD	1	1	19	21	6
	Central	0	4	33	37	8
	Oro	1	1	16	18	4
	Western	1	3	39	43	8
	Sub-total	5	14	167	186	38

In 2022, the Provincial Health Authorities and Offices assigned a total of twenty-nine professional family planning coordinators or officers as enumerators. Nineteen survey teams were formed to conduct field interviews under the supervision of four UNFPA staff.

Pre-survey workshops were organized and held at each of the four PNG Regions: Highlands, Momase, Islands and Southern. Each training included four days pre-survey exercises and two days planning and field trip organization.

The surveyors attended the workshop and were acquainted with the electronic version of the health facility survey questionnaire and the data entry program. The tablet and the e-questionnaire were also tested during the training days. Pre-testing helped the research teams familiarize themselves with the

questionnaire’s modules, terminology and to become confident with the data collection electronic system.

After the field work, each team conducted a two-day post-survey workshop to provide feedback and present some of the preliminary findings for discussion.

Data analysis process and presentation

Data entry, data cleaning and analysis was done using Ms Excel and Epi Info version 7. The database was split into different modules according to the questionnaire sections. Data was cleaned using computer aided checks, based on summary statistics to identify errors, missing cases, outliers, and extremes, before the final analysis was done. During the data cleaning and validation procedure, one health facility was totally excluded from sampling and analysis due to unreported data (Highland Region: Pabrabuk Health Centre).

The table below provides some detailed information about the distribution of eligible SDPs for the data analysis by sub-components. The full list of the 160 SDPs surveyed and main details it is available at Annex 2.

Table 3. Sample Size by Modules

Module	Sub-component	Number of Validated Units	Remarks
1	Family planning	149	
	Maternal health	134	One health facility did not respond to RH Medicine questions
	HIV services	139	
2	Facility resources	157	Three health facilities did not respond to module 2 questions
3	Client exit interview	300 (clients)	

Data was analyzed using descriptive statistical frequencies, percentages, means, and totals generated in line with indicators provided. Results have been presented in table format and wherever appropriate, with charts.

Limitations of the survey

This is the second time that tablet technology was used to carry out the survey for data collection. To some extent the use of an electronic questionnaire has improved data collection in terms of completeness during the interviews. However, the following areas require attention to improve completeness and accuracy in data collection:

Completeness of data collection; Internet disruption at remote facilities undermined interviews at certain SDPs. The technology used for data collection requires constant internet connection during the interview, to directly record data in the connected global server. However, there was great improvement from those problems reported in the previous survey in 2019, where a significant number of facility records were lost (not recorded). To this end, it is recommended that a field be added to the e-ques-

tionnaire for enumerators to add notes or a comment if such disruptions occur. This would improve the quality of data collection and strengthen the data validation process.

Quality and accuracy of data: there are still important issues to address for the next survey regarding clarification of definitions, terminology and standards to maintain a homogenous approach during data collection. This would make the interviewers more confident in formulating certain questions and minimize inconsistency during data collection, particularly regarding the standard of commodities in line with the national policy and level of the SDPs and with the level of the health facilities.

Contextualisation of the survey: The standard global e-questionnaire was used for the interviews without adaptation to the PNG context. In the future, it is recommended that some sections be reviewed, without altering the global indicators requirements.

OUTLINE OF THE REPORT

This report is divided into the following five main chapters:

Part 1: Gives the introduction to the study, background, and the rational and objectives of the study, the organization and management of the survey, survey methodology, sampling, data collection methods, data analysis and limitations.

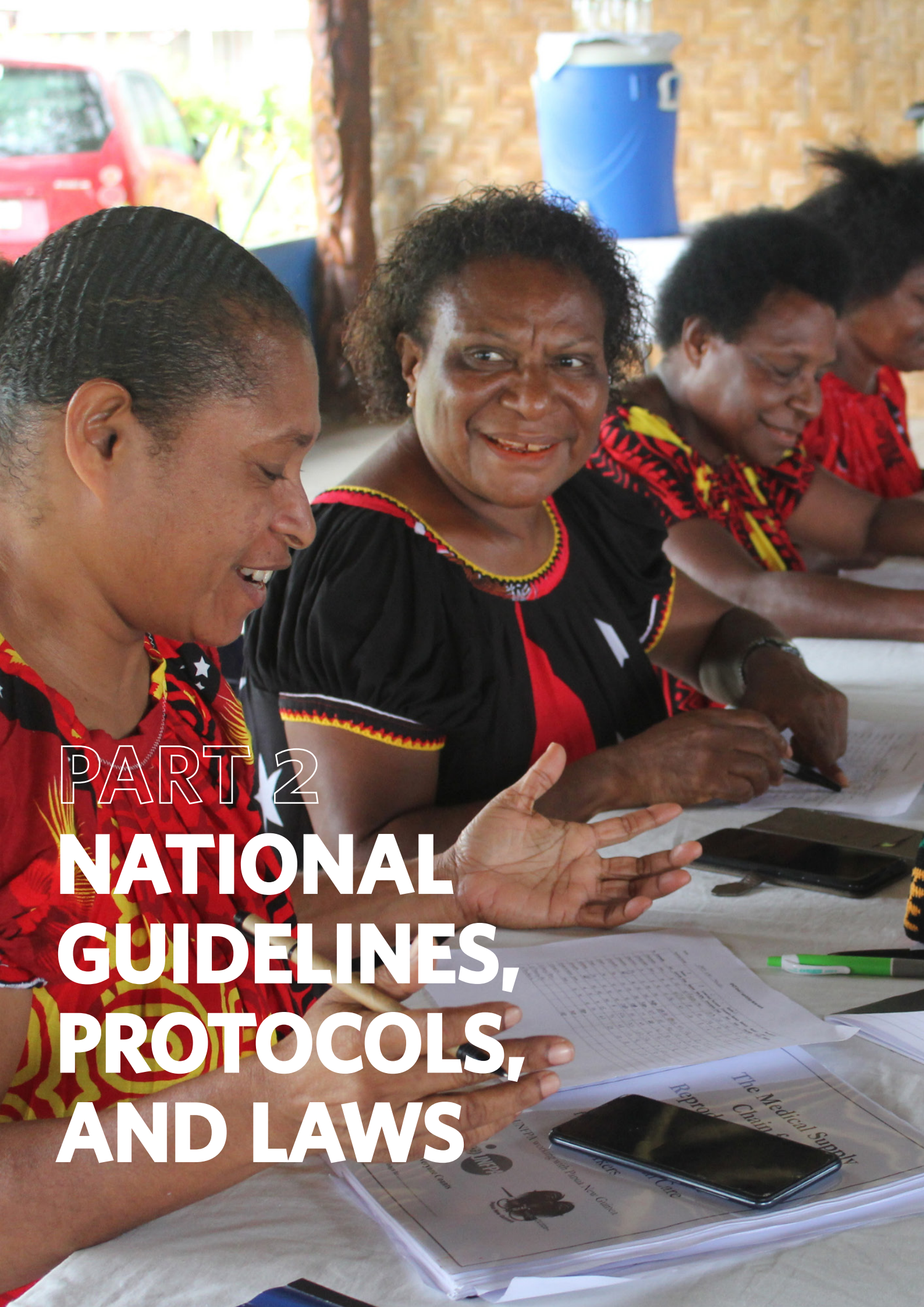
Part 2: Discusses and summarizes the guidelines, protocols, and laws for provision of modern contraceptives; maternal and reproductive health services in PNG

Part 3: Presents the results of the survey on availability of commodities and services

Part 4: Presents results on resources and supply chain management

Part 5: Discusses the exit interview findings on clients' perception of family planning service provisions including cost of services

Part 6: Conclusion and recommendations



PART 2
NATIONAL
GUIDELINES,
PROTOCOLS,
AND LAWS

The Medical Supply
Reprod Chain &
ACRS
New Zealand
New Zealand
New Zealand

NATIONAL LAWS AND POLICIES

The provision of modern contraceptives or family planning services and provision of maternal and reproductive health services in PNG are guided by three current policies:

- The National Health Plan, 2021-2030.
- The National Sexual Reproductive Health Policy, 2013.
- The National Family Planning Policy, 2013.

These national plans and policies are implemented through a series of general and specific operational manuals used in the field, the most relevant of which include:

- The Medical and Dental Catalogue 2012 which serves as supplies list for use at the different levels of health facilities in the country.
- The Manual of Family Planning for Doctors, HEOs, and Nurses.
- The Manual of Standards Management in Obstetrics and Gynecology for Doctors, HEOs, and Nurses in PNG.

There is currently no policy related to midwifery.

NATIONAL HEALTH PLAN 2021-2030

The National Health Plan, 2021-2030 sets out the vision, the goal and the mission for the Department of Health to guide its planning for its activities which are to be achieved under 5 Key Result Areas (KRAs). The provision of family planning or modern contraceptives is captured under KRAs 3 and 4 which aims to improve family health.

This is expected to be achieved through the following four objectives:

- Increasing Family Planning coverage.
- Increasing the capacity of the health sector to provide safe and supervised deliveries.
- Improving access to Essential Obstetric Care (EOC); and
- Improving sexual and reproductive health for adolescents.

NATIONAL SEXUAL AND REPRODUCTIVE HEALTH POLICY

The National Sexual and Reproductive Health Policy details the intent of the government for the provision of Sexual and Reproductive Health Services. It creates an enabling environment for actions aimed at providing the necessary impetus and guidance to national and local initiatives in all areas of Sexual and Reproductive Health.

The Policy aims to foster change and bring about sustainable development that leads to improvement in the quality of life of all PNG citizens by decreasing morbidity and mortality among the sexually active target population.

The objective of the policy is to ensure better sexual and reproductive health through:

- Reducing maternal morbidity and mortality due to pregnancy and childbirth.
- Reducing the level of unplanned pregnancies.
- Reducing the incidence and prevalence of sexually transmitted infections, including HIV/AIDS.
- Reducing the incidence and prevalence of infertility.
- Eliminating all forms of gender-based violence, reducing the gender imbalance in availability of sexual and reproductive health services through men's involvement in sexual and reproductive health (SRH) programs.
- Reducing the incidence and prevalence of reproductive cancers and improving the treatment and care.
- Promoting research on sexual and reproductive health issues.

THE NATIONAL FAMILY PLANNING POLICY

The goal of this policy is to manage changes to population size, composition, and distribution in line with the needs of sustainable development goals for poverty alleviation, national development and improvement in the quality of life of all Papua New Guineans.

It has five policy statements that guide implementation of the family planning services throughout the country:

- Family planning options should be promoted to stabilize population growth rates by attaining replacement fertility levels for optimal population and sustainable national development.
- The PNG health sector must make appropriate, quality client-focused family planning services affordable and accessible to all who need and want them, while maintaining proper client confidentiality.
- The PNG health sector must support couples and individuals to decide freely and responsibly on the number and spacing of their children, providing them with access to accurate information education, and counselling.
- The Government of PNG must ensure the availability of well-trained, supervised and motivated service providers for family planning.
- The Medical and Dental catalogue: This document serves as a national essential medical supplies list required for use at the different levels of health facilities in the country. It also serves as the list to guide the procurement and supply of these essential medical supplies.



PART 3

SURVEY FINDINGS FOR AVAILABILITY OF COMMODITIES

3.1 GENERAL INFORMATION ABOUT THE FACILITIES

A total of 160 Service Delivery Points (SDPs) were assessed from four Regions (21 Provinces), representing about 21% of the total facilities in Papua New Guinea. The Region with the larger number of SDPs surveyed is the Highlands with 30% followed by Southern 24% and, Momase and Islands with 37% each. In terms of Residency, majority of the sampled facilities are situated in rural areas (66%) as compared to urban with (34%).

Most of the SDPs surveyed are managed by Government (71%) and about 21% are managed by Faith Based Institutions – these latest are largely located in rural areas.

The remaining facilities are managed by Non-Governmental Organization 6% and Private Sector 3%. Analysis of the categories of SDPs and their distribution indicate that most of the sampled SDPs surveyed are primary level facilities 118 (74%) and consist of Health Centers, Sub Health Centers and Urban Clinics. The Secondary level facilities are 22 (14%) and consist of District Hospitals and the Tertiary level facilities are 20 (12%) and are all Provincial Hospitals.

AVAILABILITY OF SERVICES

The Sexual and Reproductive Health services in PNG are regulated by policy and strategies issued in 2013 & 2014. According to these documents, all Reproductive Health Services including delivery, should be provided free of charge for clients regardless of gender, age or any others socio-economic characteristics. The Family Planning

Table 4. No. Facilities Surveyed by Location, Type, and Management

Region	No. of SDPs
Highlands	48 (30%)
Islands	37 (23%)
Momase	37 (23%)
Southern	38 (24%)
Level	
Primary	118 (74%)
Secondary	22 (14%)
Tertiary	20 (12%)
Residency	
Urban	54 (34%)
Rural	106 (66%)
Management	
Government	114 (71%)
NGO	9 (6%)
Private	3 (2%)
Faith-based Organisation	34 (21%)

Service includes counseling and guidance to ensure a free choice of Family Planning methods as well provision of chosen contraceptive and pertinent medical assistance wherever appropriate.

Table 5: Availability of Reproductive Health Service by Type of Facility

	Total SDPs Surveyed	Offers FP Service	Offers Maternity/Birth Service	Offers HIV/AIDS Service
All SDPS	160	149	134	139
Level				
Primary	118	108	95	98
Secondary	22	21	21	21
Tertiary	20	20	18	20
Residency				
Urban	54	50	30	49
Rural	106	99	104	90
Management				
Government	114	113	94	104
NGO	9	7	7	7
Private	3	3	3	3
Faith-based Organisation	34	26	30	25

Family Planning Service

According to the standards of the NDoH, all the Primary level facilities should provide direct Family Planning services with availability of 8 modern contraceptive methods; the Secondary level facilities should provide a complete nine methods; and the Tertiary, Provincial Hospitals are supposed to provide Family Planning service only to Post-Partum clients at Maternity wards, and function as referral facilities for the Urban Family Planning Clinic associated with them for providing tubal ligation.

However, the tertiary level standard is applied only where the associated Urban Family Planning Clinics are established. As described in Table 5, among all Service Delivery Points surveyed, 93% facilities provide direct Family Planning service (149 SPDs). Regarding the proportion of provision of Family Planning services among the facility levels, as indicated in the chart 3 below among the primary level facility surveyed 92% (108 SDPs) are offering outpatient FP Service; among the secondary level facilities the 95% (21) are providing FP Services; and finally, all the Tertiary level facilities are providing FP Service.

Maternal and Reproductive Health (including deliveries)

According to National Health Policies, all facilities (except the Urban Clinics, Community Health Posts and Mobile Clinics) are expected to provide maternal, reproductive health and delivery service. As indicated in table 5, the findings of this study reveal that 134 (84%) facilities offer maternal health services (including delivery), with 16% not providing this service.

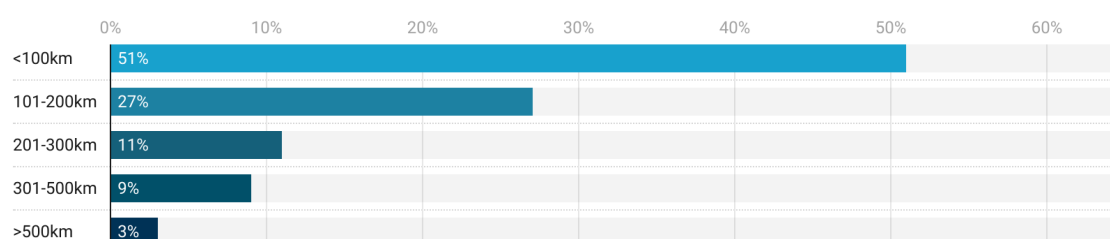
HIV and AIDS Service

The HIV/AIDS service consisting of Voluntary Counselling and Testing (VCT), Prevention of Mother-to-Child Transmission (PMTCT) and provision of Anti-Retroviral Therapy (ART) is an integrated service of Sexual and Reproductive Health Care services in PNG and therefore should be provided by all SDPs. Among all SDPs surveyed it was found that 139 (87%) of SDPs are providing the HIV/AIDS services.

Distance of SDPs from Source of Supplies

The survey assessed the distance (in kilometers) between SDPs and their main sources of commodity supplies. The majority of SDPs are situated at less than 100 kilometers from their warehouses (51%), followed by 27% of facilities that reported a distance between 101-200km. Even though the distance of sources of supplies to SDPs is a valuable indicator for regular and sustainable delivery of service, it should be noted that in Papua New Guinea road connections are very limited in some areas of the country. Most often, transport of goods is via cargo plane or boat.

Distance Between Health Facility and Warehouse



Whilst this was one of the key components of the assessment, it could not be done due to GPS equipment to collect reliable data. Some facilities have reported distance between the SDP and the closer warehouse, but this was not sufficient to undertake proper analysis.

3.2 AVAILABILITY AND STOCK-OUT OF FAMILY PLANNING COMMODITIES

In 2014, the NDoH issued the National Family Planning Policy that establishes services to be delivered at different levels of health services delivery system throughout the country. As previously described in table 1, there are two standards of set of contraceptive methods that should be provided by the Service Delivery Points as per the National Policy and Protocol; one for Primary Level and one for the Secondary and Tertiary Levels which include Female Sterilization – Tubal Ligation- as an additional one.

According to the National Health Policy, the Tertiary Level Provincial Hospitals in Papua New Guinea provide modern contraceptive methods only to inpatient clients at maternity wards after women deliver a baby, and in terms of FP outpatient service, they are supposed to provide only the Female Sterilization Method. In association with the Provincial Hospital, an Urban Family Planning Clinic is established at each Provincial capital town to provide the full set of modern contraceptive methods (apart for the female sterilization contraceptive method. These clients are referred to the nearby Provincial Hospital).

This chapter provides an analysis of the availability of each contraceptive method and the reasons for not offering and providing specific methods, the rate of stock-out, and the reasons for the occurrence of the stock-out.

Specifically, the following indicators are analysed:

- Percentage of SDPs with availability of at least three and/or five methods of modern contraceptives
- Percentage distribution of the reasons for not offering certain contraceptives
- Rate of “Stock-out” of any contraceptive method
- Rate of “Stock-out” of at least three (3) methods
- Rate of “Stock-out” of at least five (5) methods.
- Reasons for the occurrence of “Stock-out” of commodities.

Regarding the Family Planning Service at SDPs, the survey assessed the following two scenarios”

Scenario 1: Availability of Services as per National Health Policy

This section aimed at evaluating the compliance of the SDPs for the provision of FP service within the National Health Policy and Protocols framework. The findings from this scenario would be relevant to enhance the effectiveness and scaling up of the National Reproductive Health Program by identifying factors that hinder the provision of certain contraceptive methods.

The occurrence of stock-out of commodities at the first scenario is characterized by the lack of contraceptive method supposed to be offered by the facilities as per the National Protocol, regardless of the facility’s capacity to provide a certain specific method, for example due to lack of training, equipment, or lack of adequate infrastructure.

Scenario 2: Availability of Services as per Facility Capacity

The second scenario instead aimed at evaluating process and performance of the SDPs capacity based on the actual provision of services on a regular basis. The findings of this scenario would be most relevant to identify key factors that currently affect the management of the reproductive health supplies system.

The occurrence of stock-out of commodities in the second scenario regards the interrupted availability of specific methods that the facility would otherwise be able to provide on a regular basis. For instance, if a provider does not have the capacity to offer male sterilization method due to a lack of trained personnel, this method cannot be provided at all. While the policy may require this facility to maintain certain stock and equipment for this procedure, without trained personnel it would inappropriate for such stock to be distributed to this SDP. In this example, this method should be considered “not appropriate” and excluded when counting for the stock-out methods.

‘No stock-out’ of modern contraceptive methods is defined as the uninterrupted availability of each method that is supposed to be offered at any time over the analysed period.

These indicators measure the regular accessibility of modern contraceptives methods in PNG, causes of stock outs and the efficiency of the supply management system.

AVAILABILITY OF MODERN CONTRACEPTIVE METHODS BASED ON REQUIREMENTS OF THE NATIONAL POLICY AND PROTOCOLS AND THOSE CURRENTLY AVAILABLE ON REGULAR BASIS

In this section, we examine the availability of contraceptive methods at health facilities according to the two survey scenarios: availability in line with the requirements of the National Policy and Protocols and availability of methods offered as part of the facility's regular family planning services.

In both cases, the assessment measured whether the facilities are consistently providing (a) at least three and (b) at least five contraceptive methods. Facilities were then asked about the availability of stock in the three months preceding the survey and on the day of the survey.

As detailed above, the National Policy and Protocols for Family Planning require all primary level facilities to provide a set of eight methods, while secondary and tertiary levels should provide the full set of nine methods, with the additional service being female sterilisation, or tubal ligation. However, in most cases, the enumerators only recorded what methods are available and offered at the facilities as part of their regular service. Consequently, only a small portion of data explained the reasons why certain methods are not provided in line with the National Policy and Protocol.

Availability of modern contraceptive methods at SDPs as required by the National Policy and Protocols (Scenario 1)

The findings of the study indicate that among the SDPs that provide family planning services, 97% have at least 3 modern contraceptive methods available and 86% offer at least 5 methods as required by the National Policy and Protocols.

Table 6: Number of Facilities Providing at Least 3 and at Least 5 Modern Contraceptive Methods, by Level, Location, and Management, in line with National Protocols and Policy

	At least 3 modern contraceptive methods		At least 5 modern contraceptive methods		Total no. offering FP services
All SDPS	145	97%	128	86%	149
Level					
Primary	104	96%	87	81%	108
Secondary	21	100%	21	100%	21
Tertiary	20	100%	20	100%	20
Residency					
Urban	48	96%	42	84%	50
Rural	97	98%	86	87%	99
Management					
Government	110	97%	100	88%	113
NGO	6	86%	4	57%	7
Private	3	100%	3	100%	3
Faith-based Organisation	26	100%	21	81%	26

As described in the table below, 100% of tertiary and of secondary level facilities offer at least five methods, while at primary levels this is 81%. In terms of rural/urban variation, the analysis indicated that 84%

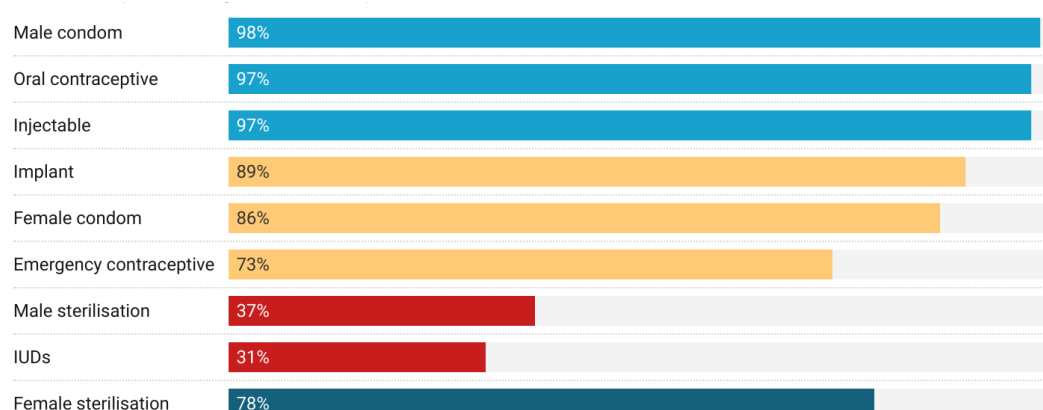
of urban based SDPs provide choice for at least five methods as compared to 87% for SDPs located in rural areas. Finally, 57% of the facilities managed by the NGO sector are providing choice of at least five methods, at the private sector 100% of the facilities provide the same choice, while at government and FBO management 88% and 81% respectively.

Further analysis of availability of specific contraceptive methods indicates that more often short-term contraceptive methods, such as male condoms, oral contraceptive pills and the injectable method (Depo-Provera), are provided by over 90% of SDPs.

Among the nine contraceptive methods, the most recurrent ones (>90% availability) are male condoms, oral contraceptives pills, and injectables. Long-acting reversible contraceptives (LARC), implants and IUD, are instead available only at 89% and only 31% SDPs, respectively.

The emergency contraceptive pill is available at 73% facilities, while vasectomy, which in PNG is supposed to be offered also at primary level facilities, is found only in 37% of facilities. The female sterilization procedure, tubal ligation- only practiced at hospital level- is only available at 73% hospitals. Compared to previous years, the contraceptive indexes did not increase and the range of choice remains limited.

Availability of Contraceptive Methods Across Health Care Facilities Offering Family Planning Services



The most common reason why facilities are not providing the full range of contraceptive services as required by the national policy and protocols is due to the scarcity of trained staff to provide certain methods (39%). This was a common reason for not providing male sterilization or IUD (31%).

In 5% of facilities it was reported that trained staff are not confident in providing the method. Further investigation would be needed to identify why trained staff do not feel confident in performing some procedures. 'Low or no demand' for a specific contraceptive was also a common reason for not providing a particular method (30%), particularly for methods such as female condoms, IUDs and emergency contraceptives.

Table 7: Reported Reasons for Unavailability of Contraceptive Methods by Number of Facilities

	Male Condom	Female Condom	Oral Contraceptive	Injectable	IUD	Implants	Male Sterilisation	Emergency Contraceptive	Total Cases	Female Sterilisation
Delay on part of warehouse	1		1	3	2	1		6	14	
Delay to request for supply		2			1	2		10	15	
Low or no client demand	1	17	2		44		2	10	76	
No trained staff					31	9	56	3	99	3
Lack of equipment					6	2	2	2	12	
Trained staff not confident to provide this method					10	1	2		13	
** Other reasons	1	3	2	1	2	3	5	8	25	1
Total	3	22	5	4	96	18	67	39	254	4

Availability of contraceptive methods currently provided at SDPs (Scenario 2)

Regarding the facilities that provide at least five contraceptive methods as part of a regular and normal service delivery, as shown in table 8 below, 95% of tertiary level facilities, 100% of secondary level facilities, and 76% of primary level facilities offer at least five methods. 4% of rural facilities provide at least five methods, compared to 78% of urban facilities.

Table 8: Number of Facilities Providing at Least 3 and at Least 5 Modern Contraceptive Methods, by Level, Location, and Management, as part of regular service delivery

	At least 3 modern contraceptive methods		At least 5 modern contraceptive methods		Total no. offering FP services
All SDPs	145	97%	122	82%	149
Level					
Primary	104	96%	82	76%	108
Secondary	21	100%	21	100%	21
Tertiary	20	100%	19	95%	20
Residency					
Urban	48	96%	39	78%	50
Rural	97	98%	83	84%	99
Management					
Government	110	97%	100	84%	113
NGO	6	86%	5	71%	7
Private	3	100%	3	100%	3
Faith-based Organisation	26	100%	19	73%	26

Similar to the availability of contraceptive methods in line with the National Policy and Protocol, with a minor decrease, the trend is the same: The availability of specific contraceptive methods like male condoms, oral contraceptive pills, and injections (Depo Provera) are provided at more than 90% of the facilities surveyed. Implants are provided by 86% of facilities and IUDs at only 24%. The Emergency Contraceptive Pill is found available at 65% facilities, while only 26% of structures offer male sterilisation.

STOCK-OUT SITUATION OF MODERN CONTRACEPTIVES OFFERED BY FACILITIES IN ACCORDANCE WITH NATIONAL POLICY AND PROTOCOLS (SCENARIO 1)

This part of the chapter is describing the situation of stock-out of modern contraceptive methods among the SDPs offering Family Planning Service and that are supposed to offer certain methods of contraceptives in line with the national policy and protocols. Tables and graphs summarize the “stock-out” index for (a) at least five methods (b) at least three methods and (c) for any method during the three months before the survey and the situation at the day of the survey.

Availability in last three months before the survey day

Among the 149 facilities surveyed that offer the Family Planning Services, only 9% did not experience a stock-out of any one method. As shown in the table below, among those facilities that experienced stock-out of at least one method, this is most common at secondary level facilities, with 95% experiencing a stock-out. Rural facilities are more likely to experience a stock-out than urban facilities. Regarding the events of stock-out of at least three methods, as well, data indicates higher incidence among the secondary level facilities and rural areas are more affected than urban. Regarding the management of facilities, events of stock-out at government-managed SDPs is lower than in those managed by Faith Based Institutions with 65% and 77% respectively.

Table 9: Percentage of facilities reporting stock-out of any one, at least three, and at least five contraceptive methods in the three months preceding the survey

	Stock-out of any method	Stock-out of at least three (3) methods	Stock-out of at least five (5) methods
All SDPS	139 (91%)	100 (61%)	29 (19%)
Level			
Primary	92%	67%	23%
Secondary	95%	81%	19%
Tertiary	85%	55%	0%
Residency			
Urban	84%	58%	14%
Rural	95%	72%	22%
Management			
Government	91%	65%	19%
NGO	86%	71%	29%
Private	67%	67%	0%
Faith-based Organisation	96%	77%	19%

The situation changed slightly regarding the facilities that are supposed to provide at least five contraceptive methods as indicated by the National Policy and Protocols, where higher stock-out rate occurred at primary level facilities with 23% of cases reported compared to secondary facilities with 19%. Instead, tertiary level facilities did not experience stock-out events of five methods during the three months period before the survey day. Frequency of stock-out in rural areas is most common (22%), and in terms of the type of management of SDPs, stock-out of five methods is most frequently reported by NGO facilities with 29% of cases.

Reasons why modern contraceptive methods were not available in accordance with National Policy and Protocols in the three months before the survey

The survey revealed that the main reason for stock-out is due to delays in delivery of supplies by the warehouse (50%). Stock-out occurrence was reported to be due to lack of trained staff (16%) and low or no client demand with 15%.

As detailed in table 10 the most relevant information is the frequency of disruption of short-term contraceptive methods, particularly oral contraceptives and injectables for which the frequency of demand is 2 to 3 months – these are also the most in-demand methods among the clients in Papua New Guinea.

Table 10: Reported Reasons for 'Stock-out' of contraceptive methods in the three months preceding the survey

	Male Condom	Female Condom	Oral Contraceptive	Injectable	IUD	Implants	Male Sterilisation	Emergency Contraceptive	Total Cases	Female Sterilisation*
Delay on part of warehouse	9	9	49	85	5	37		35	229	1
Delay to request for supply	1	2	4	3	5	12		20	47	
Low or no client demand	2	20	4		37			7	70	
No trained staff					18	11	37	7	73	4
Lack of equipment					2	5	1		8	
Contraceptive not allowed by FBO			1	1	2	3		1	8	
** Other reasons		2	2	2	3	1	5	8	23	2
Total	12	33	60	91	72	69	43	78	458	7

* Only practiced in Secondary and Tertiary Facilities
 ** Staffing is not enough to provide methods (6 cases for female/male sterilization & IUD); Staff is not confident to provide method (4 cases for IUD); Not ordered.

Availability of modern contraceptives on the day of the survey

The chart below shows the situation of stock-out among all the SDPs surveyed that offer the Family Planning Service in line with the National Protocols at the day of the survey.

For any method, only 12% of SDPs did not experienced stock-out. Regarding no stock-out of at least

three methods 43% of facilities did not report stock-out and no stock-out of at least five methods is reported by 80% of health providers.

As described in the table below among those facilities that experienced stock-out of at least one method more commonly it occurs at Secondary level SDPs with 95%. Providers at rural areas are more likely to experience stock-out (93%) as compared to SDPs in urban areas 78%. Regarding the events of stock-out of at least three methods, data indicates it occurred in 62% of secondary level facilities and 61% at primary level SDPs. By location, data reports that rural areas health facilities with 61% are slightly more affected than urban (50%). Regarding the management of facilities, events of stock-out at government managed SDPs is lower than in those managed by Faith Based Institutions with 54% and 73% respectively.

Table 11: Percentage of facilities reporting stock-out of any one, at least three, and at least five contraceptive methods on the day of the survey

	Stock-out of any method	Stock-out of at least three (3) methods	Stock-out of at least five (5) methods
All SDPS	130 (88%)	85 (57%)	29 (20%)
Level			
Primary	88%	61%	80%
Secondary	95%	62%	62%
Tertiary	80%	35%	19%
Residency			
Urban	78%	50%	5%
Rural	93%	61%	14%
Management			
Government	88%	54%	18%
NGO	86%	71%	43%
Private	67%	33%	0%
Faith-based Organisation	92%	73%	23%

In terms of the facilities that are supposed to provide at least five contraceptive methods as indicated by the National Policy and Protocols, as indicated for the three methods, the higher stock-out rate occurred at primary and secondary level facilities with 22% and 19% cases reported. However, on the day of the survey, here it is found that also tertiary level facilities experienced stock-out events at 5% of the Provincial Hospitals surveyed. Frequency of stock-out at rural areas is still more common (22%), and in terms of the type of management of SDPs, stock-out of five methods is most frequently reported by NGO facilities with 43% of cases, followed by the facilities managed by Faith Based Institutions with 23% of reported events.

Reasons why modern contraceptive methods were not available in accordance with National Policy and Protocols on the day of the survey

Survey results indicate that the main reasons for stock-out on the day of the survey were 'delay from the warehouse' (45%), which affected almost all contraceptive methods, followed by 'low or no client demand' for a specific contraceptive (16%), 'delay from the side of the health facility to request for resupply

in time’ (15%) and the ‘absence of trained clinicians to provide a specific contraceptives’ (14%) which significantly affected male sterilisation procedures (vasectomy).

“Other reasons” option is reported in 8% of the cases. However, most commonly it is being reported that the warehouse did not provide the full requested stock of commodities and certain facilities did not find/ have the proper code for certain contraceptive to be ordered.

Table 12: Reported Reasons for ‘Stock-out’ of contraceptive methods on the day of the survey

	Male Condom	Female Condom	Oral Contraceptive	Injectable	IUD	Implants	Male Sterilisation	Emergency Contraceptive	Total Cases	Female Sterilisation*
Delay on part of warehouse	11	7	23	42	4	31	2	31	151	1
Delay to request for supply	3	4	6	2	9	8	1	19	52	
Low or no client demand	3	22	6		45	2	2	13	93	
No trained staff					25	11	11	6	84	6
Lack of equipment					1	4	1		6	
Contraceptive not allowed by FBO		1	2	1	2	3		1	10	
** Other reasons		1	2		6	4	5	6	24	2
Total	17	35	39	45	92	63	53	76	420	9

* Only practiced in Secondary and Tertiary Facilities

** Staffing is not enough to provide methods (6 cases for female/male sterilization & IUD); Staff is not confident to provide method (4 cases for IUD); Not ordered.

STOCK-OUT SITUATION OF MODERN CONTRACEPTIVES REGULARLY PROVIDED BY THE FACILITIES (SCENARIO 2)

This section of the report describes the situation of “stock-out” of modern contraceptive methods among those SDPs that are currently offering family planning services on a regular and normal services delivery accordingly to their available resources.

The findings of this chapter are mostly relevant to highlight strengths and weaknesses of the supplies management system. However, the supply chain itself can also be interrupted by unforeseen factors that may negatively impact the availability of contraceptive methods on a regular basis, for instance, the impact of the global pandemic of Covid 19, or natural calamities.

Availability in last three months before the survey day

Table 13 below shows the situation of stock-out among the 149 SDPs surveyed that offer the Family Planning Service. Only 16% of SDPs did not experience a stock-out for any method. Regarding availability of at least three methods, only 59% of facilities did not report stock-out. Regarding availability of at least five methods, 88% of facilities that offer at least five methods reported they did not have a no stock-out.

As described in the table below, among those facilities that experienced stock-out of at least one method more commonly it occurs at Primary and Secondary level SDPs with 86%. Facilities at rural areas are more likely to experience Stock-out (91%) as compared to SDPs in urban areas 72%.

Regarding the events of stock-out of at least three methods, data indicates higher incidence among the secondary level facilities (57%) and rural areas are more affected than urban with 45% and 34% respectively. Regarding the management of facilities, events of stock-out at Private and Faith Based Institutions is higher with 67% and 50% respectively. Government managed SDPs are the least likely to experience a stock-out (38%).

Table 13: Percentage of facilities reporting stock-out of any one, at least three, and at least five contraceptive methods in the three months preceding the survey

	Stock-out of any method	Stock-out of at least three (3) methods	Stock-out of at least five (5) methods
All SDPS	125 (84%)	61 (41%)	14 (12%)
Level			
Primary	86%	39%	15%
Secondary	86%	57%	5%
Tertiary	75%	35%	5%
Residency			
Urban	72%	34%	8%
Rural	91%	45%	13%
Management			
Government	86%	38%	13%
NGO	71%	43%	20%
Private	67%	67%	0%
FBO	85%	50%	5%

The situation changed slightly regarding the facilities that are supposed to provide at least five contraceptive methods on a regular service delivery, where higher stock-out rates occurred at primary level facilities, with 15% reporting stock-out of five methods, as compared to secondary and tertiary facilities, with 5% of facilities in each category reporting stock-out in the preceding the three months. There was no major variation reported by location and management categories, apart from the government-managed facilities where 13% of providers reported stock out of 5 methods.

Reasons why modern contraceptive methods offered as part of regular service delivery were not available in the three months before the survey.

The main reason for the occurrence of stock-out of modern contraceptive methods offered as part of SDPs regular and normal services delivery during the three months preceding the survey are; (a) delays from the warehouse to provide the stock at the right time (71%) followed by the delay from the SDPs to order supplies on time (13%).

Fewer than 10% of providers reported other causes for stock-outs in the three months preceding the survey. This is shown in Table 14.

Table 14: Reported Reasons for 'Stock-out' of contraceptive methods in the three months preceding the survey

	Male Condom	Female Condom	Oral Contraceptive	Injectable	IUD	Implants	Male Sterilisation	Emergency Contraceptive	Total Cases	Female Sterilisation*
Delay on part of warehouse	15	9	56	85		35	1	29	230	1
Delay to request for supply	1	2	9		5	11		10	43	
Low or no client demand	1	16	3	5	10			2	32	
No trained staff						5	2	4	11	1
** Other reasons				2		4	1	2	9	
Total	17	27	68	92	15	55	4	47	325	2

Availability on the survey day

This section of the report describes the frequency of stock-out reported for (a) any modern contraceptives (b) at least three modern contraceptives (c) at least five modern contraceptives offered as part of SDP's regular and normal services delivery, among the surveyed SDPs (164) offering the service of family planning (149).

The availability of contraceptives in store on the day of the survey was verified by enumerators through physical observations and the data was validated prior to analysis. In the tables below, the calculation of the stock-out indices related to "at least of 5 contraceptive methods", are calculated considering the sub-group of "SDPs currently offering choice of at least 5 methods".

27% of facilities reported availability of all contraceptive methods regularly provided by their facility on the day of the survey, with 73% reporting that at least one method was unavailable. 26% reported that at least three methods were not available. Of the facilities that regularly provide at least five methods of family planning, only 4% indicated they were out of stock of at least five methods.

As described in the table below, Secondary health facilities are most likely to be out of stock of any one method (81%), compared to 73% of Primary and 65% of Tertiary facilities. Providers in rural areas are more likely to experience stock-out (79%) of any one methods compared to SDPs in urban areas (62%). 33% of Secondary, 25% of Primary, and 20% of Tertiary facilities experienced stock out of at least three methods. There is little variation in the incidence of stock-out between urban and rural facilities. Regarding the management of facilities, the incidence of stock-out of at least three methods is slightly lower at government-managed SDPs (24%), than the other categories reported.

In terms of the facilities that are offering on a regular basis at least five contraceptive methods, there is very little incidence of stock out of at least five methods of contraception.

Table 15: Percentage of facilities reporting stock-out of any one, at least three, and at least five contraceptive methods in the three months preceding the survey

	Stock-out of any method	Stock-out of at least three (3) methods	Stock-out of at least five (5) methods*
All SDPS	108 (73%)	38 (26%)	5 (4%)
Level			
Primary	73%	25%	5%
Secondary	81%	33%	0%
Tertiary	65%	20%	5%
Residency			
Urban	62%	22%	3%
Rural	79%	28%	5%
Management			
Government	74%	24%	5%
NGO	43%	29%	0%
Private	67%	33%	0%
FBO	77%	31%	5%

*Percentage of those offering at least five methods, not of the total number of respondents.

Reasons why modern contraceptive methods as part of regular services delivery were not available on the day of the survey

The main reason for the occurrence of stock-out of modern contraceptive methods offered as part of SDPs regular service delivery during the three months preceding the survey is delays from the warehouse to provide the stock at the right time (71%); regarding the other causes, the index falls below ten percent with low or no client demand at 8% and delay to request for the supply from the side of some SDPs.

Table 16: Reported Reasons for 'Stock-out' of contraceptive methods on the day of the survey

	Male Condom	Female Condom	Oral Contraceptive	Injectable	IUD	Implants	Male Sterilisation	Emergency Contraceptive	Total Cases	Female Sterilisation*
Delay on part of warehouse	12	11	24	45	1	31	1	26	151	1
Delay to request for supply	4	1	7	2	5	8		10	37	
Low or no client demand	1	16	2		10			3	32	
No trained staff						11	2	3	16	1
Lack of equipment						4	2	2	8	
** Other reasons							1	2	3	
Total	17	28	33	47	16	54	6	46	247	2

3.3 AVAILABILITY OF MATERNAL AND REPRODUCTIVE HEALTH MEDICINES

This section captures the reported availability of 17 maternal health medicines at each facility. The analysis indicates how many facilities are compliant with the minimum global standard requirements of seven life-saving medicines, including two mandatory medicines- Oxytocin and Magnesium Sulphate - in line with the current national protocols, guidelines, and laws, specific for the level of service delivered. Two of the 17 medicines are not in use in PNG, Cefixime and Mifepristone. These were therefore excluded from the questionnaire.

Availability of Seven essential Lifesaving Maternal and Reproductive Health Medicines

Out of the total of 149 facilities that were surveyed, 90% (133 facilities) provide Maternal Health and Delivery Services. On the day of the survey, only 76 SDPs (57%) of these facilities had the seven essential lifesaving medicines in stock. The data reported by the respondents was referenced with the data collected by the enumerators through physical observation at the facilities' stores, and reviewed when necessary.

Facilities reporting availability of seven (including 2 essential) life-saving maternal and reproductive health medicines

The minimum set of seven lifesaving reproductive health medicines is available at 89% of provincial hospitals surveyed. Secondary level facilities, such as district hospitals, reported 70% availability, and 48% of primary level facilities had the seven medicines available.

There is a significant gap between the facilities in urban areas, with 77% availability, and rural facilities, with only 51 % of the latter having the seven lifesaving medicines. Between regions, the highest availability is found in Momase Region (68%) and the lowest rate is in Southern Region (45%).

There is variation in availability of the medicines with respect to facility management. 67% of private providers had all seven medicines in stock, while 29% of NGO operated facilities had the required minimum available.

Results show that Ampicillin, Betamethasone or Dexamethasone, Calcium Gluconate, Hydralazine, Methyldopa and Nifedipine are each found in fewer than 50% of the 133 facilities. One of the reasons is that at primary level facilities, certain listed medicines are not part of their standard list. However, selecting only secondary and tertiary facilities (41 SDPs), the finding shows the scarcity of RH medicines remains, particularly in the facilities in Southern Region where seven in twelve facilities (58%) have very limited medicines available for their maternity/delivery service – in some cases, even fewer than 5 medicines.

Percentage of Facilities Reporting Availability of 7 Lifesaving Medicine

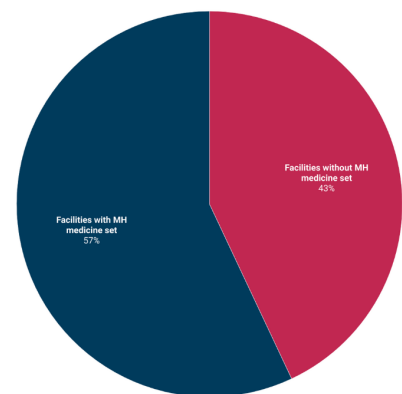
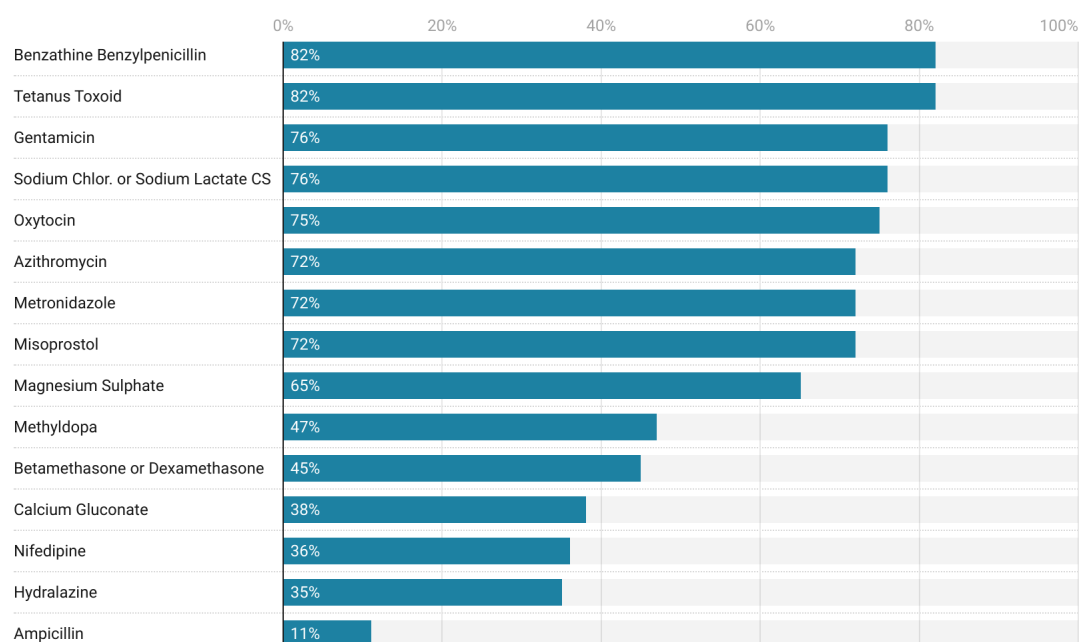


Table 17: Availability of 7 Life-saving Maternal/Reproductive Health Medicines at Health Facilities by Level, Location, and Management

	Available		Not Available		Total
All SDPS	76	57%	57	43%	133
Level					
Primary	44	48%	48	52%	92
Secondary	16	70%	7	30%	23
Tertiary	16	89%	2	11%	18
Region					
Highlands	25	61%	16	39%	41
Islands	17	53%	15	47%	32
Momase	21	68%	10	32%	31
Southern	13	45%	16	55%	29
Residency					
Urban	23	77%	7	23%	30
Rural	53	51%	50	49%	103
Management					
Government	55	59%	39	41%	94
NGO	2	29%	5	71%	7
Private	2	67%	1	33%	3
FBO	17	59%	12	41%	29

The chart below describes the percentage of health facilities reporting availability of each of the 15 reproductive health medicines.

Availability of RH Medicines Across 133 Health Facilities Providing RH Services



Reasons for Unavailability of Certain Lifesaving Maternal & Reproductive Health Medicines

The most cited reason for certain medicines being unavailable is that staff are not trained to administer certain types of medicines (31%). This was particularly common for not providing Calcium Gluconate, Hydralazine, Methyldopa and Nifedipine. The other significant reasons reported are delays from the part of facilities in ordering a re-stock and a delay from the warehouses (AMS/CMS), both causes reported by 25% of respondents. Regarding other issues reported, the most relevant is the unavailability of Ampicillin, with almost all cases of stock-out of the antibiotic were reported from primary facilities.

Reasons for unavailability of maternal health medicines

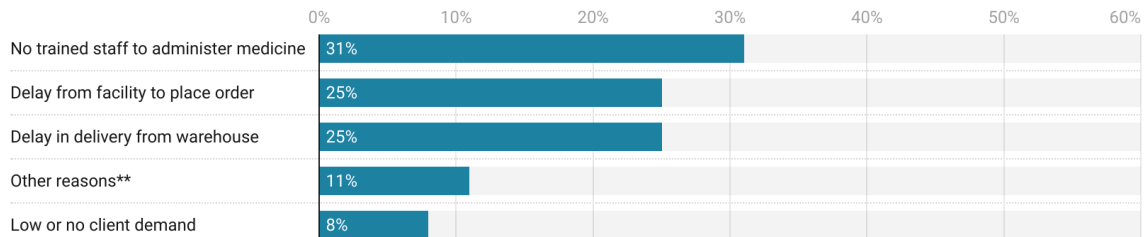


Table 18: Reasons for unavailability of RH medicines, disaggregated by medicine

Main reason for unavailability	Ampicillin	Azithromycin	Benzathine Benzylpenicillin	Betamethasone or Dexamethasone	Calcium Gluconate	Gentamicin	Hydralazine	Magnesium Sulphate	Methyldopa	Metronidazole	Misoprostol	Nifedipine	Oxytocin	Sodium Chlor. or Sodium Lactate CS	Tetanus Toxoid	Total # cases	
Delay on re-supply from warehouse*	28	1	-	7	8	-	7	2	1	1	3	4	4	-	1	67	25%
SDP delay in ordering the medicines	8	2	1	9	11	-	9	4	11	1	1	10	-	1	-	68	25%
No trained staff	4	1	1	6	18	2	18	4	12	1	1	12	1	1	-	82	31%
Low or no demand/need for the medicines	3	-	-	5	5	-	3	2	1	-	-	2	-	-	-	21	8%
* Other reasons	15	-	-	4	3	-	3	-	1	-	-	2	-	-	1	29	11%
Total	58	4	2	31	45	2	40	12	26	3	5	30	5	2	2	267	

** Ampicillin 11 units reported not in supply chain (91% primary level); clients referred to hospital; not available at market (5 units).
 * Impact of 28 cases reporting delay from warehouse for Ampicillin



PART 4
**FACILITY
RESOURCES**

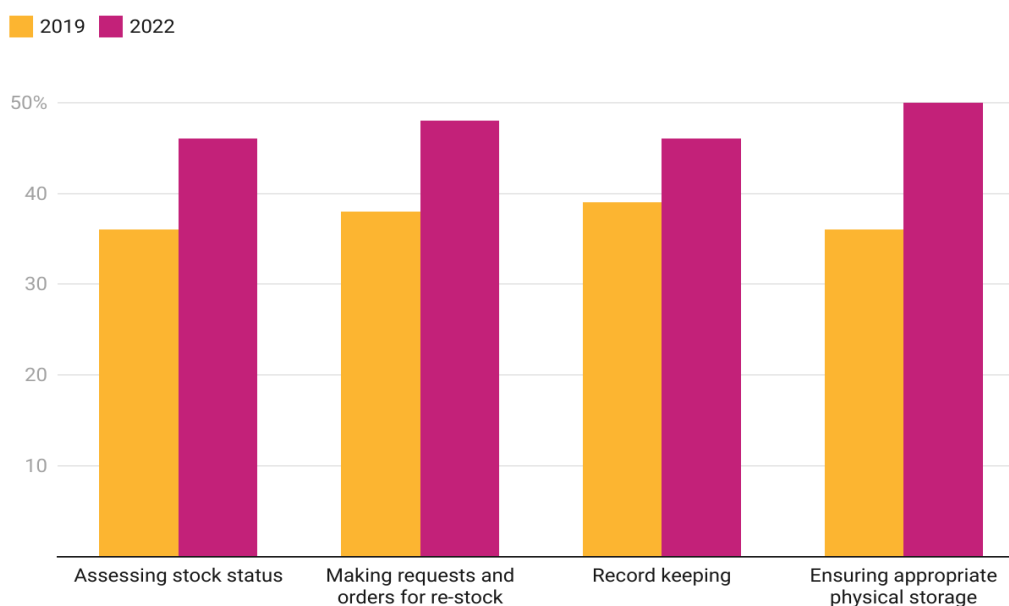
4.1 SUPPLY CHAIN MANAGEMENT

SUPPLY MANAGEMENT TRAINING

Monitoring of the Logistics Management Information System (LMIS) training for the proper management of the family planning commodities was introduced in the survey in 2019. The health staff in charge of supplies at facilities were interviewed to gather evidence about specific components of the training received. Additionally they were asked whether the re-supply stock received within a determined period complied with the order placed.

Half of the staff surveyed reported being trained on “ensuring the appropriate physical storage of FP commodities” and “making requests and ordering re-stock”. In three years, the number of staff trained on LMIS increased by only about 10% (though is also a consequence of the COVID-19 pandemic).

Percentage of Facilities with Staff Trained in Various Areas of Logistics Management Information System (LMIS) 2019 - 2020



REQUESTING SUPPLIES

Who is responsible for ordering supplies?

There is no specific person responsible for ordering the commodities. When a pharmacist is not available, the person responsible varies according to the senior person available. In 38% of facilities, a nurse is in charge of ordering commodities. In 19%, it is the clinical officer, and in others, the responsibility is given to the community health worker (16%) others (9%).

In 17% of facilities, the pharmacist is responsible for ordering supplies.

In 64% of facilities, staff has a form available for ordering supplies, which was verified by the enumerators. In 31% of the facilities, respondents said that a form was available but enumerators were not able to verify the form. 5% of facilities reported not using logistic forms.

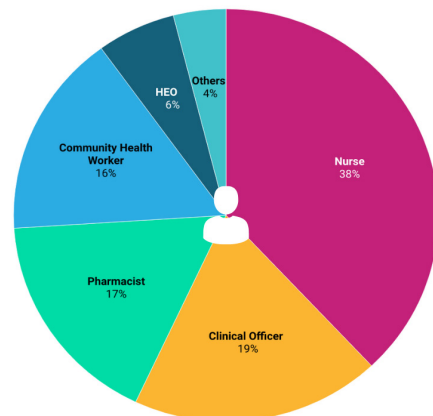
Method to determine quantity of commodity resupply

The use of a formula to determine the quantity of stock required when placing an order is practiced at just 39% of facilities. The most frequently used method to determine re-supply order is estimation, with staff estimating the rate of consumption and stock levels. A significant change from the 2019 results is a reduction in the number of facilities reporting that the re-supply order is determined by the warehouse or institution, 26% in 2019 and 14% in 2022.

In general, the percentage distribution of these results by level of facility (i.e. primary, secondary, or tertiary) indicates that there is not much variation at all levels. However, it is important to note that 25% of tertiary facilities and 45% of secondary facilities are using estimation to complete their orders of supplies.

When assessing methods used by region, only 14% of the facilities located in Southern Region use a formula and 70% of facilities are using estimation. Further enquiry is needed to better understand why this occurs. Southern Region also has some of the least frequent re-supply schedules, with 35% of facilities receiving new stock up to twice a year. This means determining the most correct quantity of commodities for those re-stocks is important to prevent long-term unavailability of contraceptive methods.

Staff Member Responsible for Requesting Supplies



Method for Determining Re-Stock Amount for FP Commodities

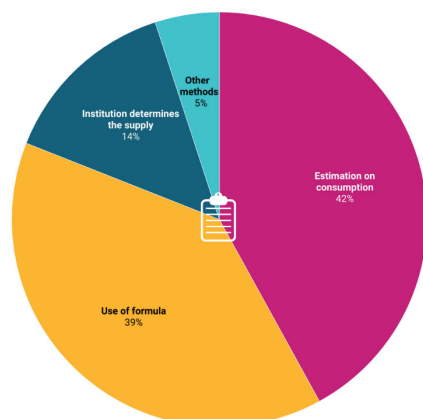


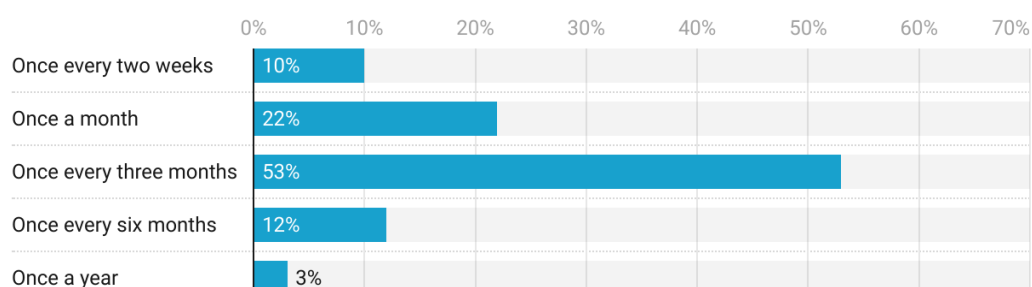
Table 19: How Quantity for Re-supply of Contraceptive Methods is Determined, by Level, Location, and Management

	Health Staff use a formula for calculation		Warehouse determines the supply		Determined on estimation / consumption		Other methods not specified		Total
All SDPS	62	39%	22	14%	66	42%	7	5%	157
Level									
Primary	42	37%	17	15%	51	44%	5	4%	115
Secondary	10	45%	2	10%	10	45%	0	0%	22
Tertiary	10	50%	3	15%	5	25%	2	10%	20
Region									
Highlands	22	47%	9	19%	13	28%	3	6%	47
Islands	13	35%	4	11%	19	51%	1	3%	37
Momase	22	61%	5	14%	8	22%	1	3%	36
Southern	5	14%	4	11%	26	70%	2	5%	37
Residency									
Urban	29	54%	8	15%	14	26%	3	6%	54
Rural	33	32%	14	14%	52	50%	4	4%	103
Management									
Government	47	41%	17	15%	46	40%	4	4%	114
NGO & Private	2	17%	2	17%	7	58%	1	8%	12
FBO	13	42%	3	10%	13	42%	2	6%	31

Placing orders for re-supplies

Most facilities order a re-stock of supplies once every three months (53%). 10% of facilities order new stock every two weeks and 22% place an order once a month. Of those who order less frequently, 12% place an order once every six months and 3% of facilities place an order only once a year.

Frequency of Commodity Re-Supply



Analysis by level of SDPs indicates that apart from the tertiary level facilities that order the re-supply mostly once every two weeks (75%), the majority of SDPs at primary and at secondary level facilities make orders most often every three months 58% and 59% respectively. In terms of residency, facilities in urban areas are more likely to place their orders “once or twice in a month” (46%) and at rural areas

“every three months” (62%).

Table 20: Frequency of Re-Supply of Family Planning Commodities, by Level, Location, and Management

	Once or twice in a month		Every three months		Up to twice a year		Total
All SDPS	50	32%	84	54%	23	5%	157
Level							
Primary	28	24%	67	58%	20	18%	115
Secondary	7	32%	13	59%	2	9%	22
Tertiary	15	75%	4	20%	1	5%	20
Region							
Highlands	16	34%	31	66%	-	0%	47
Islands	12	32%	19	51%	6	17%	37
Momase	9	25%	23	64%	4	11%	36
Southern	13	35%	11	30%	13	35%	37
Residency							
Urban	25	46%	20	37%	9	17%	54
Rural	25	24%	64	62%	14	14%	103
Management							
Government	38	33%	60	53%	16	14%	114
NGO & Private	6	50%	5	42%	1	8%	12
FBO	6	19%	19	61%	6	19%	31

RECEIVING SUPPLIES

Storage and Transportation

In PNG, the Family Health Services Division of the National Department of Health is the national level authority responsible for the provision of supply of reproductive health commodities. The main recipient of the commodities entering the country is the Central Medical Store (CMS) located in Port Moresby. The CMS is directly responsible for providing commodity supplies for the National Capital District and provinces within Southern Region.

At the provincial level, the Area Medical Stores (AMSs) are part of the decentralized distribution network of commodity supplies in the country. These are located in Lae (serving Momase Region), Mount Hagen (Highlands Regions), and Kokopo (New Guinea Islands).

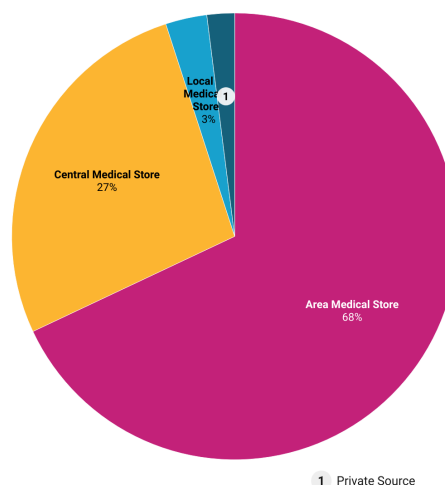
Moreover, some of the primary level facilities, mainly urban clinics, health centres, and subhealth centres, reported receiving stock directly from the provincial hospital warehouses located within their province.

Among the facilities surveyed, around 95% reported a competent national authority (CMS or AMS) as their main supplier of commodities, 3% reported a local medical store, and only 2% declared private sources as their main supplier.

Transportation of supplies to the facilities is managed by the government through private contractors, mainly LD Logistics, and this is particularly important for those facilities residing in certain remote areas, far from their respective Area Medical Stores.

The findings of the survey indicate that about 79% of commodity supplies are transported by National/Central Government (Central Medical Store or Area Medical Store), through a logistics contractor. 16% of facilities indicated that they collect by their own means, and the remaining 5% indicated several sources of transportation such as local administration, NGOs, Donors, and others.

Health Facilities' Main Source of Commodity Supply



Length of time between order and delivery of supply to SDPs

The time between ordering and receiving supplies is important as timely deliveries can help prevent stock outs. Overall, 90% of facilities receive their orders within 6 months. 42% of facilities receive supplies within two months, with 30% receiving supplies between two and four months. 8% of the facilities receive products in less than 2 weeks.

Length of Time Between Placing an Order and Receiving Stock

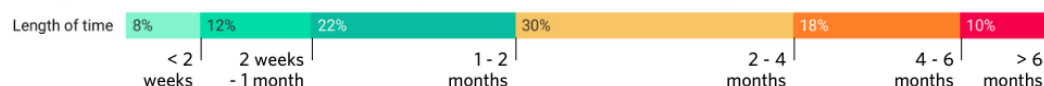


Table 21: Length of Time Between Ordering and Receiving Stock, by Level, Location, and Management

	<2 Months		2 to 4 Months		4 to 6 Months		> 6 Months		Total
All SDPS	67	43%	47	30%	28	18%	15	10%	157
Level									
Primary	46	40%	36	31%	23	20%	10	9%	115
Secondary	7	32%	7	32%	4	18%	4	18%	22
Tertiary	14	70%	4	20%	1	5%	1	5%	20
Region									
Highlands	33	70%	14	30%	-	0%	-	0%	47
Islands	10	27%	14	38%	10	27%	3	8%	37
Momase	19	53%	13	36%	4	11%	-	0%	36
Southern	5	14%	6	16%	13	35%	13	35%	37
Residency									
Urban	25	46%	19	35%	7	13%	3	6%	54
Rural	42	41%	28	27%	21	20%	12	12%	103
Management									
Government	51	45%	34	30%	19	17%	10	9%	114
NGO & Private	4	33%	2	17%	6	50%	-	0%	12

FBO	12	39%	11	35%	4	13%	4	13%	31
-----	----	-----	----	-----	---	-----	---	-----	----

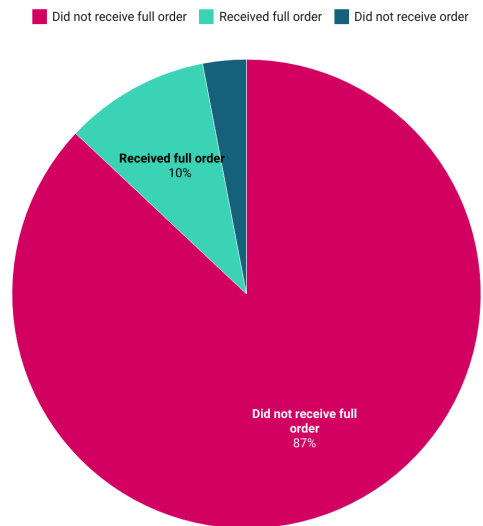
While there is little difference in time taken for orders to be received between urban and rural facilities, there is significant variation in the speed of deliveries between regions. 70% of Highands-based facilities receive their orders within two months, compared to just 14% of facilities in Southern Region.

Compliance of Orders and Supplies Received

Regarding the compliance between having ordered and received the complete stock of commodities within the three months before the survey date, out of 157 respondents about 3% (4 SDPs) did not order or receive any contraceptives during the last three months. 87% did not receive their full order and only 10% received a full stock as per their order.

The respondents were asked why they did not receive the full quantity of stock as per their order. Among the 136 SDPs that did not receive their complete order, 83% (114 providers) indicated that the quantity received was determined by the warehouse. 10% (13 providers) reported that the stock received from warehouse was either not consistent with their order or that there was no stock at the warehouse. 4% (5 units) reported that their order was not entered or uploaded in the M-Supply platform, and 3% (4 units) reported other reasons.

Percentage of Facilities Reporting Not Receiving Full Stock Order



Availability of cold chain

A large majority of facilities (97%) have their own cold chain system for storage of temperature sensitive commodities. Most items stored in the cold chain are medicines such as oxytocin, ergometrine, tetanus toxoid vaccine, other types of vaccines, and specific medicines.

Most of the health facilities, 89%, have an electric fridge, with half of them using the national power grid and the remaining using solar. 8% of providers have ice boxes or gas system fridges and the remaining 5% have solar freezers, mostly used for Extended Program on Immunisation (EPI).

Most rural facilities that have a fridge are using solar power (67% of rural facilities), while in urban areas, 80% of facilities are using the national grid. With respect to management, 52% of government-run facilities use the national grid and 47% use solar power. In contrast, the majority of facilities operated by faith-based organisations are using solar (54%) with 35% powering fridges using the national grid.

4.2 STAFF TRAINING AND SUPERVISION

Besides the availability of contraceptive methods and medicines on shelves and improvement of the chain system, improving staff capacity to provide modern contraceptive methods, and clinical practices are key areas of the RH Program. The PNG Government and its partners, including UNFPA, have continued to support training on family planning, to ensure that the full choice of modern contraceptive methods is available to clients across the country.

TRAINING ON PROVISION OF FAMILY PLANNING

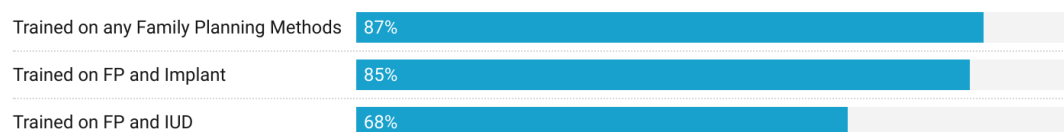
This survey monitors both the coverage of training provided and the quality of the training content for certain LARC methods, showing the specific training provided, the number of personnel trained, and if, during the training, the trainees were able to do practical- that is, insertion and removal- of two methods: Implant and IUD.

As indicated in the chart below, among the 157 facilities who responded to this section, 87% (137 facilities) reported having staff trained in provision of modern contraceptive methods, either pre-service or in-service. At 8% of these facilities the respondents indicated not providing FP services.

A total of 1,508 health workers had received training in family planning (about double of those found in 2019). However, disparity in available trained staff is significant by level of facility, such that:

- 693 trained persons work at 98 primary level structures, among which less than half, 17%, have only up to 2 trained persons and 37% have 3-5 trained staff at each site.
- 557 trained persons work at 20 secondary level structures, among which about half of them (11 hospitals) have up to 5 trained persons at each site.
- 239 trained persons work at 19 tertiary level structures, with 11 facilities having up to 10 trained persons at each site.

Percentage of Health Facilities Reporting They Have Staff Trained to Provide Family Planning



Regarding training on implants, 85% of facilities reported that a total of 410 personnel received training on the management of contraceptive implants, with 97% of those reporting that during the training the trainees practiced on the insertion of implant and 96% reporting practice on the removal of the implant. However, the distribution of the trained staff by level of SDPs demonstrated that at 90 Primary Health Care facilities 35% ratio (trained:SDP) is 1:1 while at remaining 65% the ratio is 2:1. Instead, at 20 Secondary Health facilities (excluding for the calculation 2 Hospitals with total of 49 trained persons), the ratio is 2:1, and at 19 Tertiary, (excluding for the calculation 2 Hospitals with total of 56 trained persons), the ratio is 3:1.

A further analysis provides information about combined training at regional level. Regarding staff trained in both FP and specifically on Implant insertion and removal, among all the facilities surveyed (157 providers) majority of training occurred in Momase with 94% of providers reporting having staff trained in both FP and on Implant method, followed by Southern and Islands Regions with 85% an 84% respectively, and by Highlands Region with 70%.

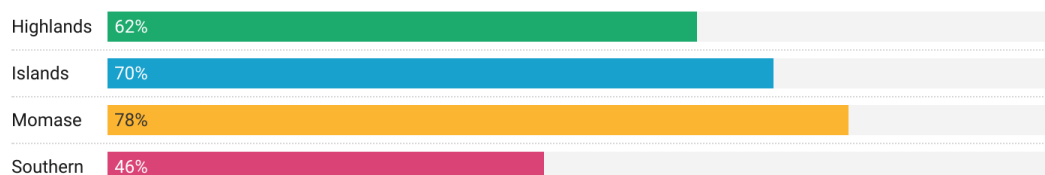
Percentage of Health Facilities with Staff Trained in FP and Contraceptive Implants, by Region



Regarding the training on IUD method, instead, 68% (107 providers) reported that a total of 247 persons received training on the management of IUD methods, 86% reported that the trainees practiced on insertion of IUD and 81% on removal.

As described in the chart below, regarding the staff trained in FP and insertion and removal of IUD method, among the SDPs surveyed (157 providers) Momase is the region with the most staff trained, with 78% of facilities having staff trained in FP including IUD method, followed by the New Guinea Islands with 70%, Highlands with 62% and Southern Region with only 46%.

Percentage of Health Facilities with Staff Trained in FP and IUDs, by Region



The respondents at SDPs with staff trained on FP (137 providers), were also asked to indicate the last time any staff of their facilities received the training. Unfortunately, several interventions in the latest two years, including trainings, have been drastically reduced due to the impact of the Global Covid 19 pandemic. A cumulative number of only 9% SDPs reported that their staff received the training within the last year against 33% reported in 2019 survey.

The chart below summarizes the characteristics of training received by SDPs staff by the time the last training was received:

- Trained in general FP (137 providers)
- Trained in general FP and Implant management (120 providers)
- Trained in general FP and IUD management (100 providers)

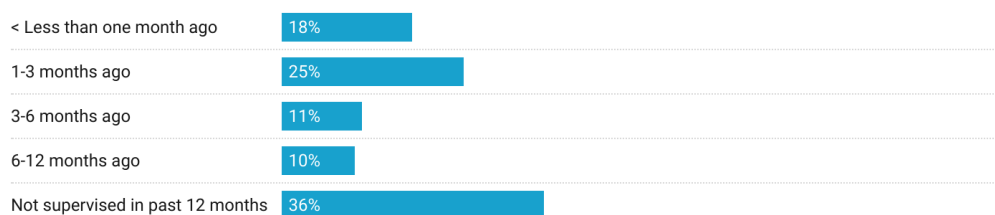
Percentage of Health Facilities with Staff Who Received Training in Family Planning (137 Facilities), by Time of Last Training



SUPERVISION PROGRAM AT SDPs

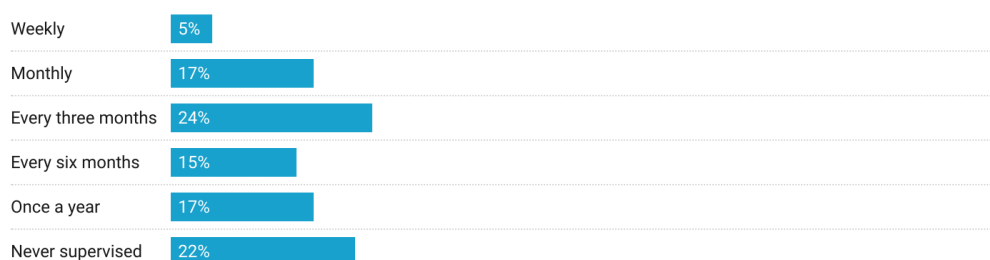
The respondents were asked to provide details about the last supervisory visits received within one-year period from the date of the survey and in general, how frequently the facilities are supervised. Out of 157 SDPs responding to this module, only 64% of the facilities (101 SDPs) reported having received visits from a supervisory authority within 12 months before the survey date, with most of them (25%) between one month and three months, followed by 23% reporting a supervisory visit less than one month before the survey day. However, 36% of SDPs did not receive any supervision visit in a year.

Percentage of Health Facilities Supervised by Time of Last Visit



The majority of the SDPs (24%) reported being supervised generally, every three months, 17% monthly and 5% weekly. Instead, 22% of the SDPs reported that has never been supervised, 17% supervised once a year and 15% every six months.

Percentage of Health Facilities Supervised by Frequency of Supervision Visits



Among the facilities never supervised, 35% are Provincial Hospitals (tertiary level), while Primary and Secondary level stands at 21%. In terms of location, both at Rural and at Urban settings, facilities that have been never supervised do not alter significantly; percentages are 23% and 20% respectively. At the regional level, Momase and Highlands receive visits most often, every six and every 12 months, while in Southern the most relevant data is that 35% of facilities there have never been supervised. There is no relevant variation among the frequency of facilities supervision between government-managed providers and FBI apart those never having been supervised (Government 25% and FBI 19%).

Table 22: Frequency of Supervision Visits by Level, Location, and Management

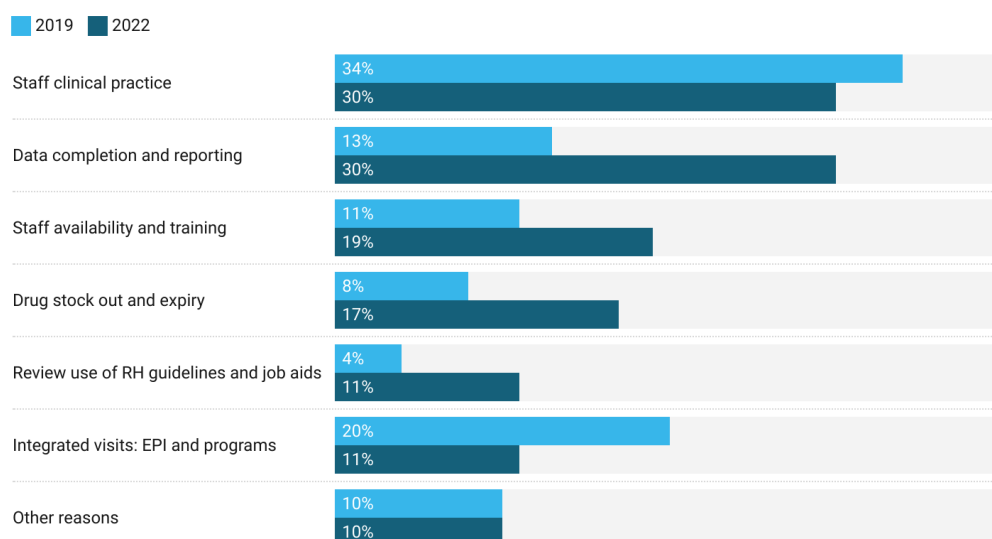
	Weekly		Monthly		Every 3 Months		Every 6 Months		Once a Year		Never		Total
All SDPS	8	5%	26	17%	38	24%	24	15%	26	17%	35	22%	157
Level													
Primary	4	3%	16	15%	29	25%	20	17%	22	19%	24	21%	115
Secondary	-	0%	6	32%	7	37%	-	0%	2	11%	4	21%	19
Tertiary	4	20%	4	20%	2	10%	1	5%	2	10%	7	35%	20
Region													
Highlands	3	6%	5	11%	13	28%	6	13%	12	26%	8	17%	47
Islands	2	5%	12	32%	3	8%	4	11%	6	16%	10	27%	37
Momase	1	3%	1	3%	14	39%	11	31%	5	14%	4	11%	36
Southern	2	5%	8	22%	8	22%	3	8%	3	8%	13	35%	37
Residency													
Urban	6	11%	10	19%	13	24%	7	13%	7	13%	11	20%	54

Rural	2	2%	16	16%	25	24%	17	17%	19	18%	24	23%	103
Management													
Government	7	6%	13	11%	29	25%	17	15%	20	18%	28	25%	114
NGO & Private	1	8%	6	50%	3	26%	1	8%	-	0%	1	8%	12
FBO	1	3%	7	23%	6	19%	6	19%	5	16%	6	19%	31

PURPOSE OF SUPERVISION VISITS

Among those that received a supervision visit (122 providers), the most frequent purpose of the visit regarded “Staff clinical practices” and “Data completeness, quality/timely reporting” both at 30%. Regarding “Data completeness, quality and timely reporting” during the last survey (2019) this topic was reported only by 13% of respondents. It follows the topic of “Staff availability and training” with 19%, and “Drug Stock out & Expiry” that reached 19%, up from 8% reported in the 2019 survey. Supervisory visits to “Review use of RH guidelines and Job Aid” increased from 4% in 2019 to 11%. Other purposes for supervisory visits (10%) included: occasional generic visits, infrastructure development works, and others.

Reasons for Supervision Visits, by Percentage of Facilities Reporting Specified Reason (2019 and 2022)



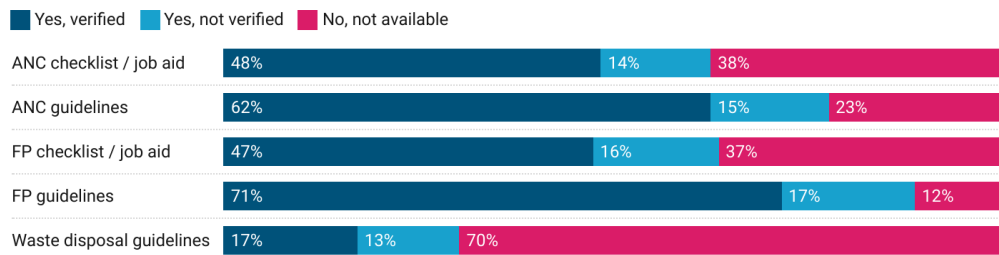
4.3 AVAILABILITY OF GUIDELINES, CHECKLISTS, AND JOB AIDS

The survey assessed whether SPDs have guidelines, checklists and job aids for family planning, antenatal care, and waste disposal. The finding indicates that most SPDs (88%) have FP Guidelines of which 71% have been verified. FP checklists/job aids were less available (63%).

Regarding ANC guidelines and checklist/job aids, 77% of facilities have guidelines available while only 62% have the IEC materials- with 48% able to be verified by enumerators during the survey. The finding indicates also that only 30% of facilities have waste disposal guidelines and in 13% enumerators were not able

to verify. A significant proportion (70%) of facilities do not have waste disposal guidelines available at all.

Percentage of Health Facilities Reporting Availability of Guidelines and Job Aids



A detailed analysis of the findings indicates that only 26 facilities (17%) have all three guidelines (verified). Among this group, the majority (17 providers) are primary level facilities, one is a secondary level facility and the remaining are tertiary.

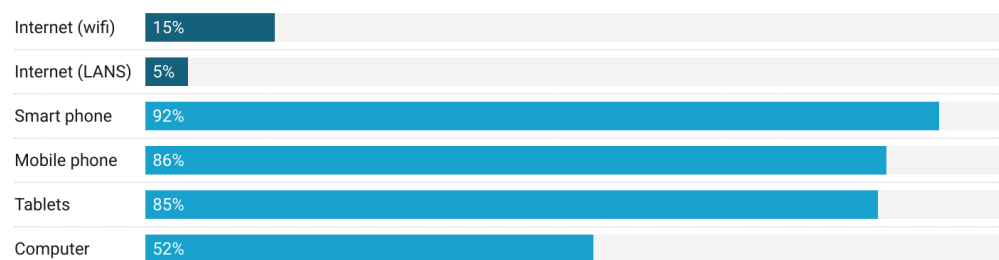
4.4 INFORMATION COMMUNICATION TECHNOLOGY (ICT) AND WASTE DISPOSAL

AVAILABILITY AND USES OF ICT

Most facilities (96%) reported that they have Information, Communication Technology systems and in 85% providers the availability of this equipment was verified by enumerators during the survey.

Almost all facilities have available smart phones (92%). Tablets are available at 85% of facilities and computers at 52%. However, internet connections via Lan or wi-fi is available only at 20% of facilities.

Availability of ICT systems at Health Facilities



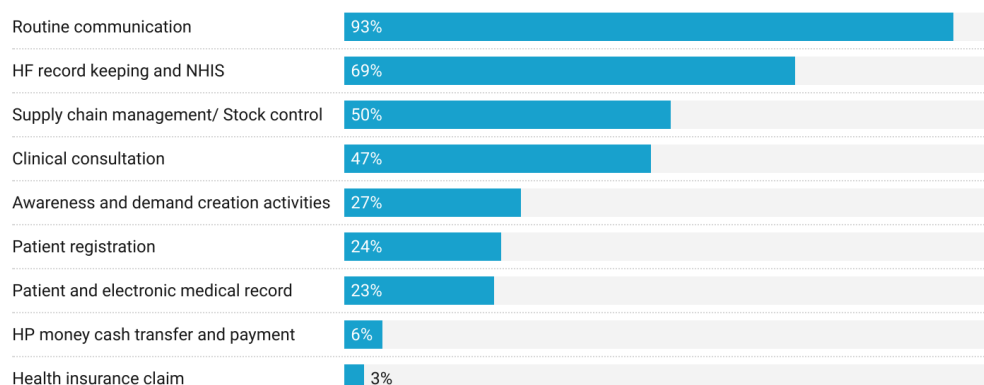
Among the 151 SDPs that have available ICT devices for working purpose, 90% reported using their personal device, 80% provided by Government, 17% received as donation and 9% provided by the proprietor of the SDP.

Reported Sources of Health Facility ICT Equipment, by Percentage of Facilities



The ICTs available at the SDPs are most frequently used for routine communications (93%) and Health Facility Record keeping/NHIS at 69% providers. The use of technology for Commodity Supply Management increased to 50% from 31% in 2019.

Percentage of Health Facilities Reporting Reason for Use of ICT

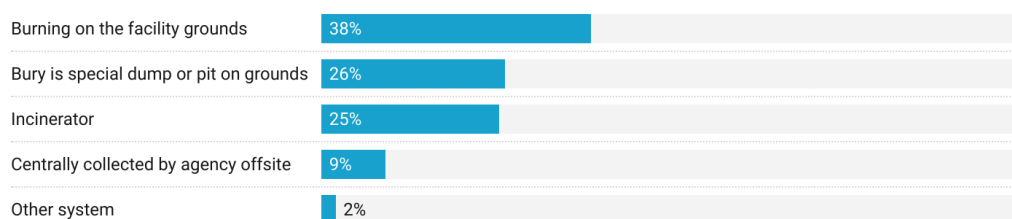


ICT devices are also frequently used for Clinical Consultation (47%) Awareness & Demand creation activities, at 27% of SDPs and for patient registration and individual patient and medical records respectively with 24% and 23%. This year, the use of ICT devices for Supply Chain Management is 50% from 33% reported in 2019 survey. Although with a very limited use, this year's survey revealed that some providers used ICT devices also for Mobile Cash Transaction and Health Insurance Claims.

METHODS OF WASTE DISPOSAL

The main method of Health Waste Disposal by SPDs is burning on the grounds (38%), followed by burying waste in special dump pit (26%), using the incinerator (25%) and centrally collected by agency (9%).

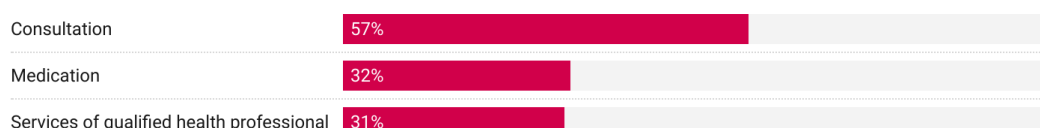
Percentage of Facilities Reporting Specified Method of Waste Disposal



4.5 CLIENT FEES

The Family Planning Policy and the Reproductive Health Policy issued in 2014 indicates that family planning and maternal health services are exempt from fees. However, findings from this and previous studies reveal that many providers continue to apply fees for consultation, medication and for services of qualified health care providers.

Percentage of Health Facilities Reporting Charging Fees for FP and MH Services



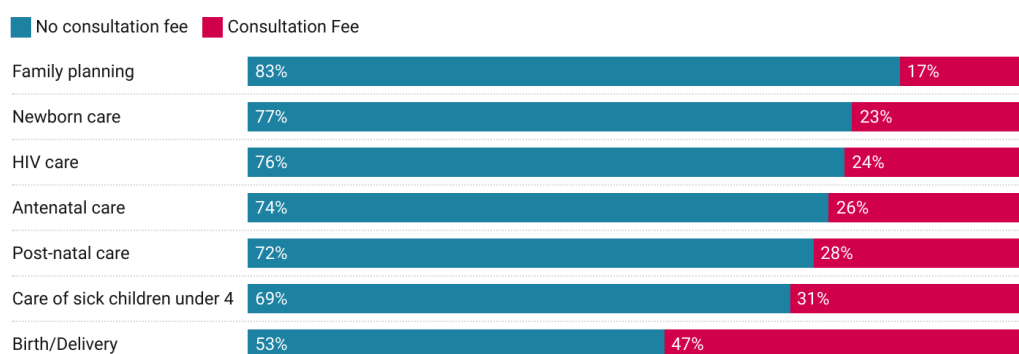
CONSULTATION SERVICES

Among the surveyed facilities, generic service fees for consultation are still applied by 57% of SDPs, while 43% of facilities provides a total free service.

A further analysis is conducted to identify if, and how many, of these 90 SDPs apply fee exemptions during consultation service for FP and certain other specific services such as ANC, Childbirth/Delivery, PNC, HIV/AIDS, <5 Children, and Newborn care. A summary picture is provided below about SDPs offering free Consultation services and applying exemption, against those where Consultation for service is still provided by payment.

As described in the chart below, among all surveyed facilities, still about 50% of providers apply consultation fees to pregnant women for Birth Delivery, and 31% for Under 5 Children care consultation, while for the Ante- and Post-natal care account fee are applied at 28% and 26DPs, respectively. Regarding FP Service, the consultation fees is still applied by 17% Providers.

Percentage of Health Facilities Reporting Charging Consultation Fees for Services



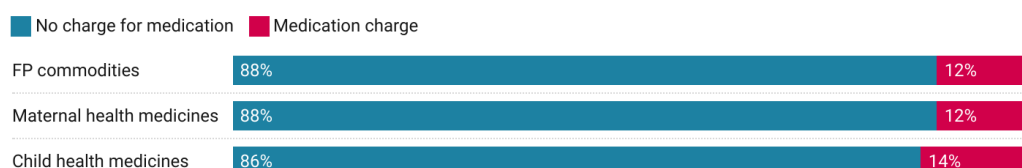
Some other services were also reported exempted for consultation, mostly regarding patients with TB and elders.

MEDICATION

As indicated in the chart below, generic service fees for medication are still applied by 32% of the SDPs surveyed.

Further analysis identifies if, and how many, of these 50 SDPs are applying fee exemptions for commodities such as contraceptives, medicines, and medication, required during the FP, Maternal and Child Health Care services. Maternal Health Service includes during ante-post natal care as well labor and childbirth delivery.

Percentage of Health Facilities Reporting Charging Fees for Medication



The survey is also providing a summary picture of both SDPs giving free medication and those applying exemption for the commodities analyzed against providers where medication fee is not exempted. As described in the chart below, among all surveyed facilities, 12% of providers apply medication fees for

both FP and Maternal & Birth Delivery Services, while still 14% apply fees for Children medicines. Few respondents indicated some additional types of exemption for medication applied to certain patients like TB patients, Asthmatics and chronic ill patients, and medication provided to elders.

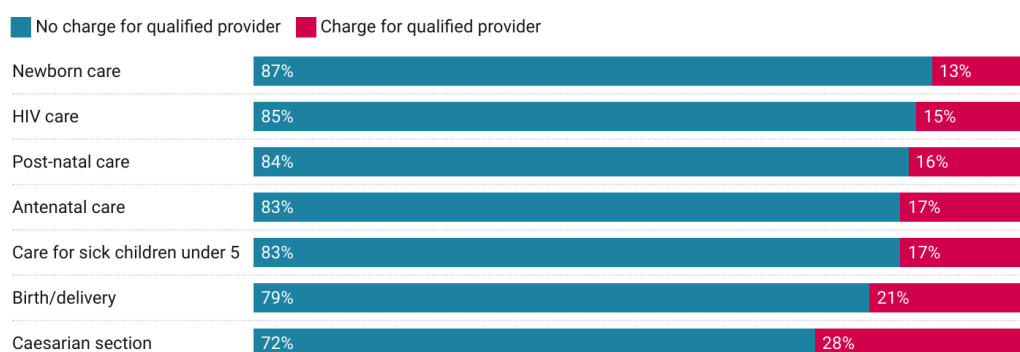
QUALIFIED SERVICE PROVIDERS

Again, a generic service fee for qualified service providers is charged by 31% of SDPs. Part of these SDPs reported also that certain services are exempted.

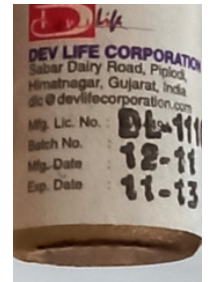
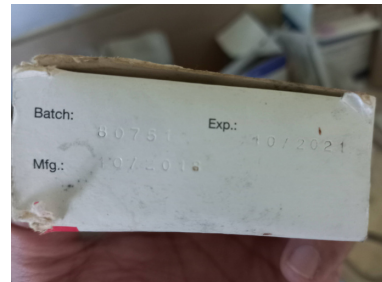
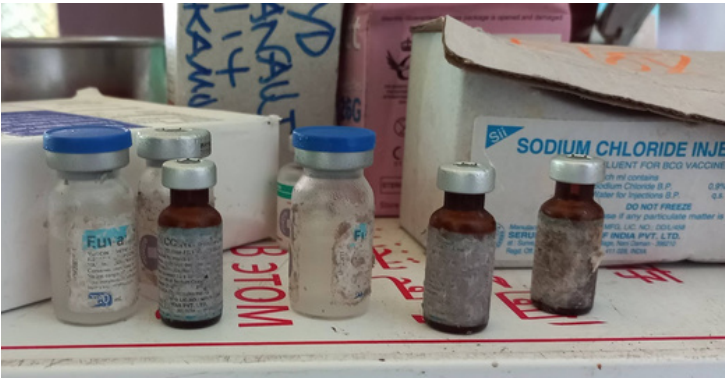
Further analysis should be conducted to assess if, and how many, of these 49 SDPs apply fee exemptions to clients for qualified Reproductive Health services and for health care provided to Newborn and <5 Children. Below, a summary picture of both SDPs providing free services and those practicing fee exemptions against those where specific services are still provided by payment.

As described in the chart below, among all surveyed facilities, 28% of providers demand payment from women who deliver via caesarean section. About 21% for vaginal delivery. Between 16-17% of facilities charge fees for care for children under 5 years-old, ANC and PNC. Only about 9% charge a fee for family planning services.

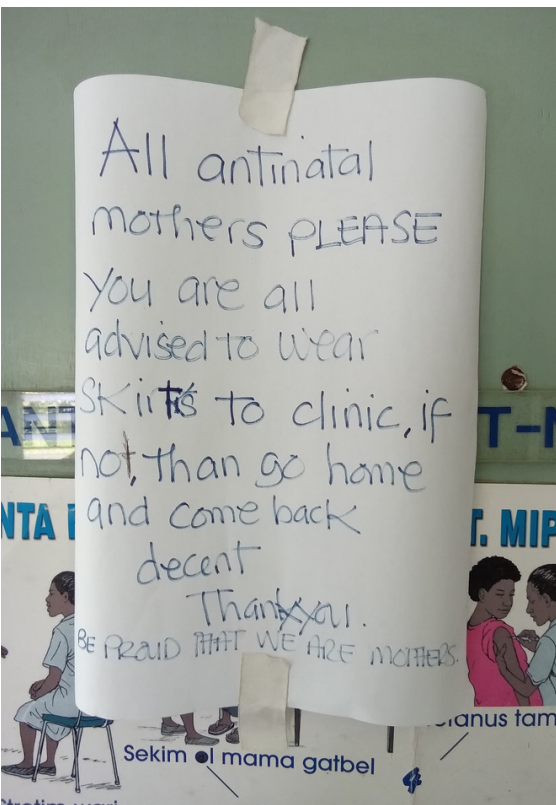
Percentage of Health Facilities Reporting Charging Fees for Qualified Providers



Some other services were also reported exempted for qualified providers, mostly regarding patients with TB, chronic illness and for elderly care.



In addition to stock-outs of family planning and maternal health commodities, enumerators noted proper storage of essential medicines as an area for improvement.





Despite the challenges, most clients report positive experiences of the services at the health facility.





PART 5
**CLIENT EXIT
INTERVIEWS**

5.1 BACKGROUND CHARACTERISTICS OF CLIENTS FOR EXIT INTERVIEWS

Clients' characteristics

This section summarizes findings on the client's background in relation to age, gender, marital status, educational status, and their location. The total number of clients who completed the interview at all levels of health facilities were 298. All the clients interviewed, except two, were female.

Most of the clients are from 25 to 34 years old (51%), followed by the age groups 15-24 (27%) and 35-44 (19%).

The majority of the clients (90%) are either married or in union. In general, 12% of clients surveyed never attended school, while 41% have completed primary education and 47% have secondary or higher-level education.

In terms of location, 69% clients were interviewed at Primary Level SDPs, 17% at Secondary and 14% at Tertiary.

Most of the clients were residing in rural areas (68%), while the rest (32%) were interviewed in urban settings. The distribution of clients among regions indicates that majority of them were interviewed in Highlands region (29%).

Table 23: Characteristics of clients interviewed for health facility survey

All Clients	298	100%
All SDPS	7	157
Age		
15-24	80	27%
25-34	152	51%
35-44	57	19%
45+	9	3%
Gender		
Female	296	99%
Male	2	1%
Marriage		
Never married/ in union	14	5%
Currently married /in union	268	90%
Formerly married	16	5%
Education		
No education	37	12%
Primary	121	41%
Secondary & Higher	140	47%

Frequency of visit to the SDP for FP services

Evidence shows that the majority of clients utilize short-term contraceptive methods, visiting the FP services, more frequently, at least once within three months (total of 63% among respondents), with a number of clients attending the service every three months (44%). Logically, clients who attended at least once between one to five years (27%), reported attending for LARC methods, often indicating for implant, either inserting or removal of implant or IUD.

The remaining 10%, apart from four clients who were currently visiting for tubal ligation and 5% being new clients, did not specify the frequency of their visits.

How often clients attend facility for family planning services

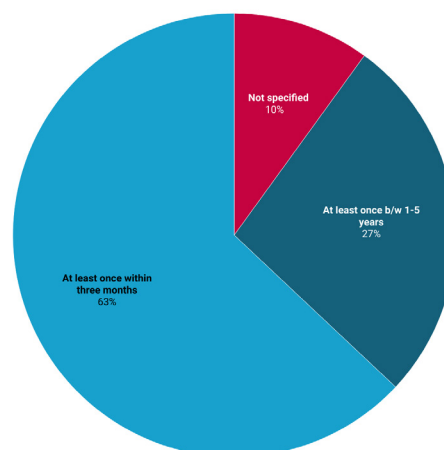


Table 24: Frequency of Visits to Health Providers for Family Planning Services

Visit Frequency	Number of Clients	Percentage
All Clients	298	100%
Once a month	36	12%
Once every two months	21	7%
Once every three months	130	44%
Once in five years (LARC/Implant)	81	27%
New Client	15	5%
Once: Tubal Ligation	4	1%
Others (Not specified, not FP service, etc)	11	4%

5.2 CLIENT'S PERCEPTION OF FAMILY PLANNING SERVICE PROVISION

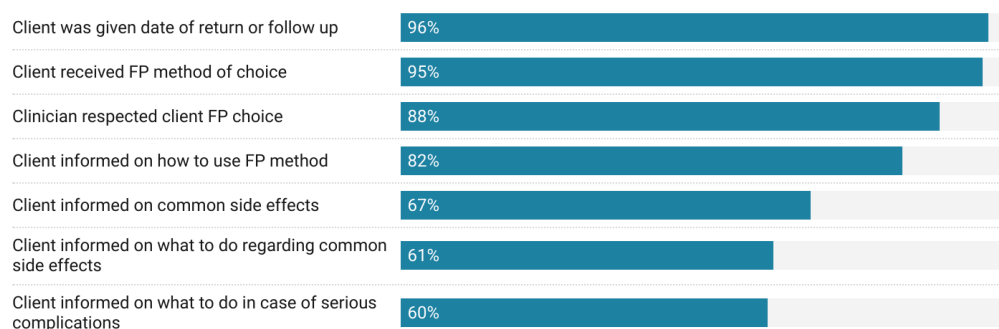
This section provides information on client's perception of FP service provider as it relates to adherence to technical issues; organizational, interpersonal and outcome aspect among the 298 clients who were interviewed.

FP Service Provider's Adherence to Technical Issues

In terms of adherence to technical aspects in the provision of FP services, 95% of the clients reported to have received a method and services of their choice. Also, most clients (88%) agreed that their wishes and preference were taken into consideration, as well as 82% were informed about how to use the FP method chosen.

Comparatively a lower proportion (67%) were told about the common side effect of FP method; only (61%) were informed about what to do regarding the common side effect and 60% on what to do in case of serious complications. Almost all clients (96%) were informed on the date to return to the provider for follow up. There are no major variations by level, residency and management.

Percentage of Clients Reporting Facility Adherence to Technical Provision of FP Services



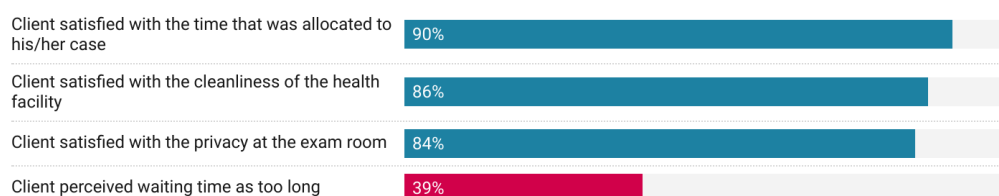
FP Service Organisational Aspects

Four groups of services aspects (client's perception of waiting time; cleanliness of facility; privacy at exam room and time allocated to client's case) were assessed to measure the organizational aspect of FP services. Apart from the waiting time, which was perceived to be long (with 39% clients dissatisfied), most FP clients were satisfied with the organizational aspects of the SDPs. For instance, 86% were satisfied with the cleanliness of the facility; 90% were satisfied with the time allocated to her/his case, and 84% were satisfied with the privacy given at the examination room.

However, there is still a need to address the concerns of 14% of clients who were not satisfied with the cleanliness of the facility, 16% who were not satisfied with the privacy given, and 10% who were not satisfied with the time allocated to their cases.

There were no relevant variations among the findings by characteristics of SDPs, apart from 22% of clients who complained of cleanliness of tertiary level facilities.

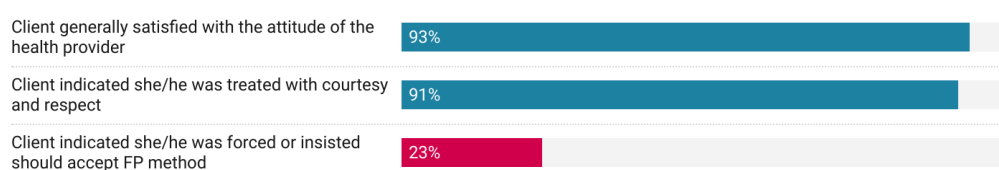
Percentage of Clients Reporting Satisfaction with Facility Organisation



FP Service Inter-Personal Aspect

Evidence from the assessment indicates that staff exhibited great interpersonal communication skills during service provision with 91% of the clients reporting that s/he was treated with courtesy and respect and that they are generally satisfied with the attitude of the health provider (93%), as shown in chart below. However, still about one out of four (23%) clients indicated that s/he was forced or insisted to accept a family planning method, with a great majority reported from clients of urban area SDPs (28%).

Percentage of Clients Reporting on Inter-Personal Aspects of Service Provision



FP Service Outcome Aspect

In order to understand the client’s perception of the FP service quality and outcomes, clients were asked if they were (a) satisfied with the services received, (b) if they would continue visiting in the future, and (c) if they would recommend this SDP to their relatives or friends. Most clients (96%) were satisfied with the services received; 97% expressed willingness to return to the SDP and a similar 97% would recommend the SDP to friends and relatives. There are no major variations by geography, residency, and management.

Percentage of Clients Reporting Satisfaction with Facility and Services



5.3 CLIENT’S APPRAISAL OF COST OF FAMILY PLANNING SERVICE

Payment for Family Planning services and average amount

Table 25: Percentage of clients reporting paying for family planning services	
Clients paid for family planning service	13%
Clients received family planning service free of charge	87%

Among all FP clients interviewed, about 13% paid for the service received, while 87% received the service free of charge.

The clients were also asked the amount they spent for the clinic cards and for certain specific services. Nine clients reported payment for the clinic cards with an average of 4.60 Papua New Guinea Kina (PGK), eight of nine are from rural areas and received service from Government SDPs.

The majority of paying clients indicated being charged for receiving the contraceptive method directly from service providers. Among all the clients interviewed, 8% reported being charged, with the average amount being 11.40 PGK. 1% of clients reported paying for consultations, with an average cost of 5 PGK.

Table 26: Client reports of costs for specified services					
	Clinic cards	Contraceptive	Laboratory	Consultation Fee	Other Purpose
Number of clients	9	24	1	4	4 *
Average reported cost	4.60	11.40	12.00	4.75	17.50
Percent of paying clients (40) by service	22%	60%	2%	10%	13%
Percent of total clients interviewed (298) paying for service	3%	8%	0%	1%	1%

* Source of contraceptive methods not specified.

Source of funds used to pay for FP services

Regarding the source of funds for those who paid the Family Planning Services at the SDP, among the 40 clients that reported having paid the service, only 4 clients reported the amount spent and source of funding, among which 3 of them reported visiting the clinic every three months. Specifically, two clients paid for contraceptive methods received from government service providers (one self-funder and one received money by spouse/partner (5 & 10 PGK respectively)). Two clients paid for other services and were self-funded (20 PGK & 10 PGK respectively).

Due to misinterpretation of the question about the source of funds for family planning services at the SDP, those that reported they did not pay the service, did however report some other types of payments. Some of them (six clients) were reporting the amount paid to the person that was required to cover their work for them while being at the clinic. Three clients reported paying up to 10 PGK, and three less than 10 PGK.

Travel cost and time spent for Family Planning Service

For the majority of the clients the average distance from their home to the SDP were 1-5 Km reported by 62% respondents (186 clients), and 19% indicated less than one kilometer. However, 18% reported more than 6 kilometers.

Most of the clients (60%) walked to the SDP to attend the FP services. Others utilized means of transport such as bus or taxi 34%, and boat or private vehicle (2% each). On average, the time required to reach the SPD and return home was 2 hours. For the fare calculation of the average, one client was excluded as required 23 hours one way to reach the health facility by canoe.

Table 27: Means of Transport Used to Attend Facilities for Provision of Family Planning Services

Means of travel	No. Clients	%
Walk	177	60%
Bus/Taxi	102	34%
Private Vehicle	5	2%
Boat	7	2%
Others*	7	2%

The majority of clients (56%) did not spend any money to reach the SDPs and return home. Most clients walked to the facilities. For those that paid for transportation, the majority (75%) spent less than 10 PGK for a round trip.

Table 28: Cost of Transport to Attend Facility for Family Planning Services

Cost (PGK)	No. Clients	%
< 10	98	75%
10-19	19	15%
20-29	3	2%
30-49	4	2%
> 50	8	6%

Waiting Times at Health Facilities for Provision of Family Planning Services

Most clients waited less than an hour to be seen (60%), with many waiting between one and two hours (35%). Overall, the average time reported to be seen was about 55 minutes. Still, 6% of clients reported

waiting from three to more than six hours in certain circumstances. Considering overall travel time and service time together, on average a person required two hours and fifty-five minutes to complete their visit to the health facility for family planning services.

Waiting Time	No. Clients	%
< 1 hour	180	60
1-2 hours	103	35
3-5 hours	14	5
> 5 hours	2	1

To provide a comprehensive picture, the clients were asked what would have been their daily-routine activities and how these were managed during their absence. As indicated below, the majority of clients reported that their main activity, during the time spent for attending the FP service, would have been doing household chores (58%), followed by working at the household farm (18%), and trading (12%). Among the remaining clients, 5% are employed in professional or clerical work, with 2% as skilled or unskilled labourers. Among those who indicated “other” were students, children’s caretakers, and few who did not specify.

Activity	No. Clients	%
Household chores	174	58%
Household farm	53	18%
Selling in the market / trading	37	12%
Employed as unskilled labourer	3	1%
Employed as skilled labourer	3	1%
Clerical work	14	5%
Others	14	5%

The survey also investigated whether someone else took over the client’s activities during their FP trip and visit to the SDPs. As indicated below, 57% of clients indicated that a family member provided support for their activities during their absence, 3% indicated a co-worker did, and 38% reported that nobody could assume the clients’ duties.

Only eleven clients indicated having paid the person that took over their activities during their absence, among which 6 clients paid up to 10 PGK and 5 clients paid >50 PGK for a helper.

Responsible person	No. Clients	%
Family member	171	57
Co-worker	8	3
Nobody	114	38
Others	5	2



PART 6
**CONCLUSIONS AND
RECOMMENDATIONS**

6.1 SUMMARY OF FINDINGS AND DISCUSSION

A total of 160 Service Delivery Points (SDPs) were assessed, representing 21% of the total facilities in Papua New Guinea. Surveyed facilities included 74% primary level facilities (community health posts, health centers; and urban clinics), 14% secondary level facilities (district hospitals) and 12% tertiary level facilities (provincial hospitals). Most of the SDPs surveyed are managed by Government 71% and about 21% are managed by Faith Based Institutions (FBI). Only 8% of facilities surveyed were managed by NGOs and private sector. The majority of SDPs surveyed (66%) were based in rural areas.

Accessibility to Services

This year, it was found that 93% of surveyed facilities had family planning services available, while 84% offered maternal/birth services, and 87% offered HIV/AIDS services. The analysis of fees charged to clients for these services reveals that 17% of providers charge fees for family planning consultations, 12% charge fees for receiving contraceptive or related medicines, and 9% charge for the services of a qualified family planning service provider.

The findings also reveal that for the delivery service, 47% providers charge fees for consultation and 12% for drugs and medication costs. 21% of facilities charge for vaginal delivery and 28% for caesarian section.

Recommendation: Ensure 100% reach and free of charge access to the services

In PNG, FP and RH services should be granted free of charges in all government-managed health facilities, including those FBI and NGO providers in which a health service is contracted and regulated by the government. All private and NGO SDPs surveyed, except one NGO facility, are providing FP and delivery services to citizens free of charge. However, it is found that FP services are available in 93% SDPs, with 17% of them applying fees for FP consultations and 12% apply fees to access contraceptive methods.

Availability of family planning commodities

In line with the National FP Policy, 97% of SDPs with FP services available offer choices of “at least three modern contraceptive methods” and 86% offer “at least five methods”. Yet, only 82% reported having capacity of providing “at least five methods” on a regular basis.

The major reasons for not offering the full ranges of contraceptive methods as acknowledged by the National FP Policy and standards is due to “absence of trained staff” (reported by 39% facilities), particularly for providing Male Sterilization and Intra-Uterine Device methods. Moreover, an additional 5% of providers indicated that their trained staff are not feeling confident to provide these two methods. The second most common reason reported is “Low or No Clients Demands” (26% facilities), with a large majority indicating this as their reason for not providing IUD, Female Condom and Emergency Contraceptive Pill methods.

Among the nine contraceptive methods on offer, the most common ones (>90% availability) are male condoms, oral contraceptives pills, and injectables (Depo Provera). Long-active reversible contraceptives, such as implants and IUDs, with the advantage of remaining active up to four-five years, are available only at 89% and only 31% SDPs, respectfully. On a regular basis, the emergency contraceptive pill is available at 73% facilities, while male sterilisation procedures, which in PNG should be offered at primary level facilities, is available in only 37% of of facilities. The female sterilization procedure, tubal ligation (only practiced at hospital level), is only available in 73% of hospitals.

Recommendation: Increase contraceptives choices for clients

Unfortunately, compared to previous years, the contraceptive indices did not increase and range of choice remains limited. Training, refresher training, and supervision are still priority interventions to increase contraceptive choices for clients and to provide quality service. Parallel to these interventions, health promotion activities are also required to increase client demand for LARC, female condoms, and oral contraceptive pills.

Availability of RH medicines

The provision of minimum life-saving medicine sets is available only at 57% providing maternal and birth delivery services. This is calculated using medicines available at the day of the survey; at least five medicines among the seventeen listed in the WHO guidelines and two mandatory drugs – magnesium sulfate and oxytocin. However, it is important to highlight here that the standard list of medicines assessed by the surveys was not in line with the Essential Health Package in use in PNG.

Among the main reasons given for not having the minimum required medicines for the set, “lack of trained staff” to provide certain medicines is found in 31% of the cases particularly for provision of Calcium Gluconate, Hydralazine, Nifedipine and Methyldopa. Other reasons are “Delay from the side of the warehouse to distribute medicines” and “Delay from the SDP to order for re-supply in time”, both at 25%. During observation and verification of storage, there is also reported a lack of proper safeguarding of medicines and expiry.

Almost half of SDPs surveyed do not have the set of lifesaving medicine in line with the WHO guidelines. Availability of Nifedipine to reduce Mother to Child Transmission of HIV/AIDS is available at only 36% of facilities. There is no significant improvement against the previous year’s findings.

The main reasons for the shortage of lifesaving medicines are a lack of trained staff to administer certain medicines, weak capacity of ordering supplies in time and delay from the side of the warehouse to resupply stock in due time.

Recommendation: Guarantee 100% stock of lifesaving medicine for safe birth and integrate oxytocin into the vaccine cold chain system

Setting appropriate strategies for the maternal/delivery services is crucial to increase the availability of the lifesaving medicines at service points. Alternative medicines are used instead of those prescribed in WHO guidelines and further assessment is needed to align the list of the national essential drug list to these guidelines. At the same time, there is a need to drastically improve the capacity of commodity resupply management and storage.

Reproductive Health Commodities Stock Out

During the three months before the survey was conducted, the incidence of “no stock-out” of modern contraceptives across all facilities was 16% for any method, 59% for at least three methods, and 88% for at least five methods. On the day of the survey, “no stock-out” was reported at 27% of facilities for any methods, 74% for at least three methods and 96% for at least five methods.

“Delay from the warehouse” to distribute in time the requested supplies is the most common reason for stock-out, reported by 71% of facilities, followed by “delay of ordering for re-supply” (13%), and “low or no demand” for certain methods (10%). Regarding stock-out of specific methods due to delivery delays, 37% of facilities reported delays as the reason for being out-of-stock of oral contraceptive pills, 15% for implants, and 13% for the emergency contraceptive pill.

Limited availability of capacity of LARC methods and persistent disruption of short-term methods may compromise the accountability of the FP service and contribute to client distress, particularly for those residing in rural areas for whom family planning services are less accessible.

Supplies Management and Re-Supply

Most facilities place their order for supplies every three months (53%) and 32% place an order on a monthly basis. 15% of facilities orders commodities every six months or once a year. The person responsible for ordering the commodities varies according to the senior person available at the SDP. Pharmacists are mostly only available at Secondary and Tertiary facilities, and often the person in charge of ordering supplies is a nurse (38%) or clinical officer (19%). Community Health Workers are responsible for ordering supplies at 16% of SDPs located in rural areas.

The methods most commonly used to determine quantity of commodities is “estimation and/or based on consumption” (42%), and “warehouse determines supply” (14%). Logistics forms were available and verified in 64% of SDPs. However, during verification it was often reported by enumerators that stock cards are generally not updated and that staff in charge of providing service are not aware of commodities still in stock. Stocktake is either not systematically conducted or documents are not reconciled with commodities being stored.

The majority of SDPs (51%) are situated less than 100 kms from their respective warehouse. Among those further away, 27% are situated between 100 to 200 kms away and 22% over 200 kms. The main source for supply for all commodities is either the Area Medical Store (AMS) (68%) or the Central Medi-

cal Store (CMS) (27%). Most commodities (79%) are transported directly from these warehouses to the providers through a private logistics company contracted by the government. 16% of providers indicated that the facilities collect the supplies themselves. 30% facilities receive new stock between two to four months from the time of order. However, 28% of SDPs reported that it may take between four to six months or more to receive restock of commodities.

Among those providers that received stock of supplies within three months of the survey day, only 10% of SDPs received the complete stock, while 87% received only part of their order. Most of them reported that quantity is always determined by the warehouse.

A large majority of facilities (97%) have their own cold chain system for storage of commodities sensitive to temperature. Most facilities rely on energy from the national power grid or solar systems. The survey assessed only the availability, not the functionality, of the cold chain system. During the surveys it was reported by the enumerators that even where the cold chain is available, certain medicines, such as oxytocin, are stored at room temperature instead of in the fridge.

Most SDPs (96%) have ICT apparatus, with 92% using mobile or smart phones, 52 % computers, 85% tablets, and 86% basic mobile phones. Internet service, either LAN or Wi-Fi is available at only 20% of health facilities. The majority of the ICT Systems available are either provided by government (80%) or the staffs personal devices (95%). The most common purpose of using ICT is reportedly for routine communication (77%), followed by HF record keeping (70%). This year, the use of ICT devices for Supply Chain Management is reported at 50% of facilities, up from 33% reported in the 2019 survey.

Recommendation: Securing uninterrupted availability of RH commodities at SDPs

Significant work is required to decrease stock-out of contraceptive methods to guarantee uninterrupted services. Continued and frequent disruptions may, in the long run, compromise the accountability of the FP services and contribute to distress for clients, particularly those residing in rural areas that have limited access to alternative sources for family planning services. As conveyed in previous years' reports, the most common reasons identified for disruption of RH commodities are related to the supply from warehouses including: (a) delays in providing re-supplies; and (b) stock consigned was not delivered in terms of types and/or quantity of ordered by the SDPs, and (c) mismanagement of handling and safeguarding the commodities (determined by verification from enumerators).

In addition, the findings identified other factors that may affect the regular availability of commodities such as: (a) several SDPs still determine the required supplies based on estimations; and (b) the warehouse often determines types and quantities of commodity (push system). Investigating the causes and specific bottlenecks of such shortcomings from the side of the Central Medical Store, Area Medical Stores, and distribution chain, is highly recommended. It is also important to enhance the capacity of the SDPs in accurately determining their needs and properly handling commodities in stock.

FP, LMIS, Training and Supervision

FP Training

Overall 87% SDPs had staff trained on FP (modern contraceptive methods). Among them, 85% of SDPs reported their staff to be also trained in insertion and removal of implant method and 68% on IUD. Be-

sides that, 91% of this SDPs reported their staff received training more than one year ago.

A total of 1,508 received training on generic FP (about double of those found in 2019), #410 in Implant method and 249 in IUD. However, disparity in available trained staff is huge by level of SDPs. Regarding the generic FP training, detailed analysis indicated that: among Primary level SDPs about 50% facilities has up to #5 trained staff available (17% are only with 1 trained staff) while 40% has 6 to 20 trained staff and 6% more than 20. At Secondary level, 55% facilities have up to 5 trained staff and 45% 10 to more than 30.

Among the staff trained in management of implants, there is significant inequity in their distribution across the facilities, such that there is one person with training on implants available at only 35% of primary facilities, whereas two hospitals each have more than 20 staff trained to manage implants.

LMIS Training

About 50% of SDPs reported staff trained on Logistics Management Information System, among which 50% and 48 % participated in session of appropriate storage of supplies and managing request respectively. 46% have received training on assessing stock status and record keeping.

Supervision Visit

In terms of frequency of supervision, 22% of SDPs have never been supervised and 32% receive visits once or twice a year. More often, frequency of supervision occurs every three months (24%).

On the day of the survey, the respondents were also asked when supervision visits occurred during the last year, with 18% of facilities reporting that they were visited within the previous month, 25% between one to three months ago, and the remaining between three and twelve months ago. However, 36% of providers had not received any supervision during the year. The major issues covered during supervision visits were staff clinical practice and “data compilation and reporting”, both reported by 30% of facilities, followed by staff availability and training (19%), and drug stock out and expiry (17%). Supervision for review and use of RH guidelines and job aids was reported by 11% of facilities.

Recommendation: Expanding FP, LMIS Training and improving Supervision

Besides a great number of respondents reporting availability of staff trained in FP for modern contraceptives and management of implant method, the distribution of trained staff among facilities is unequal. Unequal distribution of human resources is reported among all levels of SDPs. Further assessment and mapping of trained staff should be considered to expand training to under-served areas, particularly in LARC methods for rural service providers. Findings suggests that introducing follow up/refresher training for certified staff could ensure sustainable delivery of quality of service. The LMIS training for RH commodities management covered about half of the SDPs surveyed, but progress is low as compared to the 2019 survey report.

Results indicate that supervision is low and infrequent. More than one third of SDPs stated that they did not receive a supervision visit in the past year and 22% have never been supervised. Therefore, it is recommended that the NDoH scale up the LMIS training program and invest further on a strategic supervision plan, along with the provincial and district health authorities to improve SDPs supervision on Reproductive Health Commodity Security, eventually considering inter-sectoral supervision visit programs.

Guidelines and Job Aids

Availability of Guidelines, Checklists, and Job Aids

Only 26 SDPs (17%) had verified FP, ANC, and Waste Disposal guidelines. The most commonly available guidelines were FP guidelines, available in 71% of the HFs, and the ANC guidelines, available in 62%. 70% of SDPs did not have waste disposal guidelines. In addition, during the verification of these tools, the enumerators reported that where copies were available, they often outdated. The team also indicated lack of guidelines for administration of RH medicines at maternal health/delivery services.

Medical Waste Management

The main methods of waste disposal by SPDs are (a) burning waste on the facility grounds (38%), (b) burying waste in special dump pit (26%), (c) use of incinerator (25%), and (d) centrally collected by agency (9%).

Recommendation: Guidelines and Job Aids

Very few SDPs were found to have all required job aids and guidelines available (17%) Beyond verification of availability of job aids and guidelines, it would be very relevant for the next survey to assess the use of these tools and receive feedback.

There are serious concerns regarding the scarcity of waste disposal guidelines at health facilities, with only 30% of facilities having these guidelines available. Distribution of waste management guidelines should be taken into consideration to reduce potential hazards at SDPs.

Client's Satisfaction of Family Planning Service

Overall, 95% clients are satisfied with the FP services received. They agree that staff exhibited great interpersonal communication skills during service provision and report having received a method and services of their choice. In terms of quality of services and outcomes, 86% of clients were satisfied with the cleanliness of the facility, 90% were satisfied with the time allocated to her/his case, and 84% were satisfied with the privacy given at the examination room.

However, there are several areas for improvement. For example, 39% clients report that the waiting time is too long; 12% were not informed on how to use the FP method chosen; 33% were not told about the common side effects of the FP method they received; and about 40% on what to do regarding side effects and what to do in case of a serious complication. These areas need to be addressed during training and supervisory visits.

6.2 CONCLUSION AND RECOMMENDATIONS

Besides certain commodities that are largely available at family planning services, the uninterrupted availability of contraceptive methods on a regular basis it is highly jeopardized by the frequent commodities stock out.

The majority of contraceptives available are short-term methods. While there is some evidence of progress in the availability of a wider range of contraceptive choices, availability and provision of LARC and permanent contraceptive methods is significantly affected by the lack of, and unequal distribution of, trained staff. In most health facilities surveyed, just one staff is trained on LARC methods, and most of those staff members received training more than two years ago.

Client satisfaction for family planning services is high. However, findings clearly portray certain specific areas that require attention, mostly regarding the service accountability. Clients should be properly informed about side effects of contraception methods, signs of complications, and how to manage potential side effects or complications. Areas for improvement also include waiting times and cleanliness of the health facilities.

For those providing maternal health and delivery services, only 57% of facilities have the full set of life-saving medicines required to reduce mortality at childbirth. Even at these facilities, high incidence of stock-out of medicines was reported on the day of the survey. The main reason for frequent stock-out was a delay from the warehouse in providing resupplies in reasonable time. The “Push System”, whereby the warehouse determines the supply to be sent to the facilities, is largely practiced and the stock received is very often not consistent with the stock ordered.

Findings identified several additional factors affecting stock-out, such as weaknesses in the management of supply and a dysfunctional supply chain system. Such weaknesses included: low capacity to properly determine the quantity of commodity for resupply; length of time between ordering and receiving the commodity; commodities are kept in the facility store and health workers are unaware of availability. Enumerators also noted difficulties in accessing the facility store to verify the availability of commodities during working hours, infrequent stocktake, stock cards not available or out-of-date, and inappropriate conditions of preserving medicines and equipment, as concerns.

There is a need for greater focus on (a) strengthening the supply chain system to reduce the stock-out and (b) expanding FP, LMIS training and improving supervision to enhance the quality of both services at all levels of care.

Efforts should also be made to provide services 100% free of charge for clients, not only for the government managed facilities but also in the facilities managed by faith-based institutions and non-governmental organizations, which are the frontline providers for family planning and reproductive health services in the most remote and under-served areas.

In light of this, the following recommended areas for improvements have been identified through this survey:

Strengthen the capacity for monitoring and encourage systematic supervision mechanisms at all levels of SDPs; consider regular and timely two-way feedback. Review and/or standardise checklists and tools for supervision to capture all relevant aspects to ensure quality services, including the efficiency of the cold chain system as this is not captured in the questionnaire.

Strengthen the supply chain system to reduce stock-out; expand eLMIS Training; identify and address causes of delays in distribution from warehouse to SDPs; assess quality of logistics and storage conditions of commodities.

Establish standards for the resupply system and update ordering/logistics forms; it is recommended that at least two focal persons are appointed in each facility for consistency of management. Tasks and responsibility at SDP level should be clearly communicated to improve the

'pull system' mechanisms particularly for local level quantification, forecasting and ordering of commodities. Regular monitoring of the company which is subcontracted for the commodity distribution system should be conducted.

Expand contraceptive choices for clients; Increase investment in Family Planning training for health staff particularly for the management of long-acting reversible contraceptive and permanent contraceptive methods; boost FP promotion activities at catchment areas.

Enhance quality of FP and RH services; update and disseminate FP/ANC guidelines, job aids; waste disposal guidelines should be available at all levels of facilities and health staff should be properly trained to minimize environmental and occupational hazards. Disseminate RH Drug Management Guidelines and Standard of Procedures (SOP). Ensure compliance with protocols, standards, and guidelines through routine monitoring and supervision system.

Conduct a national Basic Emergency Obstetric and Newborn Care (BEMONC) assessment and develop an improvement plan based on findings.

Ensure 100% free of charge access to the FP, RH Services.

Establish provincial level medical stocks.

Integrate oxytocin in the vaccine cold chain system.

Health facilities should receive at least six months' supply of RH/FP commodities

FP and RH services should be provided by health facilities 7 days a week.

Review the performance of the logistics company contracted by the government for distribution of supplies to provinces. Hire several firms in order to reduce the burden on one company and to increase competition for better performance and timely delivery of supplies to provinces.

NDoH and PHAs should address the bulk of expired medicines taking up space in the AMS.

Finally, it is also recommended to strengthen national and local level coordination mechanisms; possibly introduce use of a social platform (wherever feasible) to improve, also communication, consultation, information/experience sharing among FP/RH staff.

ANNEX 1

REMARKS FROM THE CONSULTANT

This is the second time that tablets were used to carry out the survey. To some extent, the use of an electronic questionnaire has improved data collection in terms of completeness of the interviews. However, the following areas require attention to improve completeness and accuracy during the data collection stage:

The electronic questionnaire used for the interviews is not adapted to the PNG context. In the future, it is recommended that some sections be reviewed to make this questionnaire user-friendly and appropriate to the local context.

Internet disruption at remote facilities undermined interviews at certain SDPs. The technology used for data collection requires constant internet connection during the interview, to directly record data in the connected global server. It is recommended to assess possible solutions with the UNFPA global technology developer, or enable the enumerators to collect data offline and upload when internet connection is available.

To improve accuracy in data gathering, there are still important issues to address. During the training of enumerators, it is advised to emphasize definitions, terminology and standards to maintain a homogeneity during data collection. This would make the interviewers more confident in communicating certain questions and minimize inconsistencies, particularly regarding the standard of commodities in line with the national policy and level of the SDPs, and with the level of the health facilities. Simulation exercises could be introduced to the enumerator training, before field pre-testing. Client exit interview questionnaires should also be pre-tested.

To improve methodologies and minimize constraints, feedback should be sought from the enumerators regarding challenges in reaching the targeted facilities and making contact with the facilities' correct focal person.

This survey could be also a good opportunity to get a more comprehensive pictures about the health facilities surveyed. To take advantage of the field data collection phase, I would advise developing a simple checklist for the enumerators and/or team supervisor to gather certain pertinent information not captured by the questionnaire, such as availability and quality of the water supply, condition of storage areas, and the functionality of cold chain.

ANNEX 2

LIST OF HEALTH FACILITIES SURVEYED

Surveyed Health Facilities: Highlands Region

Region	Province	Facility	Residency	Level of Health Care	Management	FP Services	MAT Services	HIV/AIDS Services
Highlands	Chimbu	Chuave Rural District Hospital	Rural	Secondary	Government	Yes	Yes	Yes
		Gembogl Health Centre	Rural	Primary	Government	Yes	Yes	Yes
		Kerowagi Health Centre	Rural	Primary	Government	Yes	Yes	Yes
		Koge Health Centre	Rural	Primary	Government	Yes	Yes	Yes
		Kundiawa General Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
		Kundiawa Urban Clinic	Urban	Primary	Government	Yes	No	Yes
		Segima Sub Health Centre	Rural	Primary	Government	Yes	Yes	Yes
		Wandi Sub Health Centre	Rural	Primary	Government	Yes	Yes	Yes
Eastern Highlands		Asaro Health Centre	Rural	Primary	Government	Yes	Yes	Yes
		Fore Sub Health Centre	Rural	Primary	FBI	Yes	Yes	No
		Goroka Base Provincial Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
		Kainantu District Hospital	Urban	Secondary	Government	Yes	Yes	Yes
		Kassam Health Centre	Rural	Primary	FBI	Yes	Yes	Yes
		Lufa Health Centre	Rural	Primary	Government	Yes	Yes	Yes
		SIL Urban Clinic	Urban	Primary	NGO	Yes	No	Yes
		Unggai Health Centre	Rural	Primary	Government	Yes	Yes	No
Enga		Yasubi Sub Health Centre	Rural	Primary	Government	Yes	Yes	Yes
		Kasi Community Health Post	Rural	Primary	Government	Yes	Yes	Yes
		Lakopenda Sub Health Centre	Rural	Primary	Government	Yes	Yes	Yes
		Mambisanda District Hospital	Rural	Secondary	FBI	Yes	Yes	Yes
		Sangurap Urban Clinic	Urban	Primary	FBI	No	No	No
		Sopas Health Centre	Rural	Primary	Government	Yes	Yes	Yes
		Topak Sub Health Centre	Rural	Primary	Government	Yes	Yes	Yes
		Unda Sub Health Centre	Rural	Primary	Government	Yes	Yes	Yes
		Wabag Provincial Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
		Wapenamanda Urban Clinic	Rural	Primary	Government	Yes	No	Yes
Yampu Health Centre	Rural	Primary	FBI	Yes	Yes	Yes		

Southern Highlands	Ialibu District Hospital	Urban	Secondary	Government	Yes	Yes	Yes
	Imbonggu Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Kagua Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Kaupena Health Centre	Rural	Primary	FBI	Yes	Yes	Yes
	Mendi Provincial Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
	Mendi Urban Clinic	Urban	Primary	Government	Yes	No	Yes
	Nipa Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Pangia Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Pimaga Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Uma Sub Health Centre	Rural	Primary	Government	Yes	Yes	Yes
Jiwaka	Banz 2 Urban Clinic	Urban	Primary	FBI	No	No	Yes
	Kudjip Provincial Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
	Kindeng Health Centre	Rural	Primary	Government	Yes	Yes	Yes
Western Highlands	Dona Sub Health Centre	Rural	Primary	FBI	Yes	Yes	Yes
	Alkena Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Bukapena Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Mt Hagen Provincial Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
	Tambul Health Centre	Urban	Primary	Government	Yes	Yes	Yes
	Rebiamul Urban Clinic	Urban	Primary	FBI	No	No	Yes
	Tinsley Rural District Hospital	Rural	Secondary	FBI	Yes	Yes	Yes
	Tomba Community Health Post	Rural	Primary	FBI	Yes	Yes	No

Surveyed Health Facilities: Momase Region

Region	Province	Facility	Residency	Level of Health Care	Management	FP Services	MAT Services	HIV/AIDS Services
Momase	East Sepik	Angoram Health Centre	Urban	Primary	Government	Yes	Yes	Yes
		Bewani Health Centre	Rural	Primary	Government	Yes	Yes	No
		Boram Provincial Hospital	Urban	Tertiary	Government	Yes	No	Yes
		Brigiti CHP	Rural	Primary	Government	Yes	Yes	Yes
		Dapu Urban Clinic	Urban	Primary	Government	Yes	No	No
		Drekikir Health Centre	Rural	Primary	Government	Yes	Yes	No
		Ilahita Health Sub-Centre	Rural	Primary	FBI	Yes	Yes	No
	Maprik Rural District Hospital	Urban	Secondary	Government	Yes	Yes	Yes	
	West Sepik	Baro Community Health Post	Rural	Primary	Government	Yes	Yes	Yes
		Pes Health Centre	Rural	Primary	FBI	Yes	Yes	Yes
Raihu District Hospital		Urban	Secondary	FBI	Yes	Yes	Yes	
	Taul Community Health Post	Rural	Primary	Government	Yes	Yes	Yes	
	Tumarau Health Centre	Rural	Primary	Government	Yes	Yes	Yes	

	Ulau Health Centre	Rural	Primary	FBI	Yes	Yes	No
	Vanimo Provincial Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
	Wombisa Health Centre	Rural	Primary	Government	Yes	Yes	Yes
Madang	Bawak Health Centre	Urban	Primary	Government	Yes	No	No
	Bogia Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Gaubin Rural District Hospital	Rural	Secondary	FBI	Yes	Yes	Yes
	Gusap Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Malala Health Centre	Rural	Primary	NGO	No	Yes	Yes
	Modilon Provincial Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
	Walium Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Yagaum Health Centre	Rural	Primary	FBI	Yes	Yes	Yes
	Yomba Health Centre	Urban	Primary	Government	Yes	No	Yes
Morobe	Angau Provincial Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
	Boana Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Braun District Hospital	Rural	Secondary	FBI	Yes	Yes	Yes
	Bulolo Rural District Hospital	Rural	Secondary	Government	Yes	Yes	Yes
	Gagidu Urban Clinic	Urban	Primary	Government	Yes	No	Yes
	Kitoc Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Milforhaven Urban Clinic	Urban	Primary	Government	Yes	No	Yes
	Mumeng Health Centre	Rural	Primary	Government	Yes	Yes	No
	Mutzing Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Salamaua Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Wampar Health Sub-Centre	Rural	Primary	Government	Yes	Yes	Yes
	Watut Health Centre	Rural	Primary	FBI	Yes	Yes	No

Surveyed Health Facilities: New Guinea Islands Region

Region	Province	Facility	Residency	Level of Health Care	Management	FP Services	MAT Services	HIV/AIDS Services
New Guinea Islands	East New Britain	Butuwin Urban Clinic	Urban	Primary	Government	Yes	Yes	Yes
		Gelegele Health Centre	Rural	Primary	NGO	Yes	Yes	Yes
		Kerevat Rural District Hospital	Rural	Secondary	Government	Yes	Yes	Yes
		Napapar Health Centre	Rural	Primary	FBI	No	Yes	Yes
		Nonga Base Provincial Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
		Palmalmal Rural District Hospital	Rural	Secondary	Government	Yes	Yes	Yes
		Pomio Health Centre	Rural	Primary	Government	Yes	Yes	Yes
		Rabaul Urban Clinic	Urban	Primary	Government	Yes	No	Yes
		St Mary Vunapope Dist.Hospital	Urban	Secondary	FBI	No	Yes	Yes
		Warongoi Rural District Hospital	Rural	Secondary	Government	Yes	Yes	Yes
Manus		Lessau Health Centre	Rural	Primary	NGO	No	Yes	No
		Lorengau Provincial Hospital	Urban	Tertiary	Government	Yes	No	Yes

	Lorengau Provincial Hospital	Urban	Tertiary	Government	Yes	No	Yes
	Tingou Health Centre	Rural	Primary	Government	Yes	Yes	Yes
New Ireland	Kabanut Health Centre	Rural	Primary	FBI	Yes	Yes	Yes
	Kavieng Provincial Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
	Kavieng Urban Clinic	Urban	Primary	Government	Yes	No	Yes
	Kimadan Health Centre	Rural	Primary	FBI	Yes	Yes	Yes
	Lipek Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Manga Health Centre	Rural	Primary	FBI	No	Yes	Yes
	Messi Health Centre	Rural	Primary	FBI	Yes	Yes	Yes
	Namatanai Rural Distr. Hospital	Rural	Secondary	Government	Yes	Yes	Yes
	Panaras Health Centre	Rural	Primary	Government	Yes	Yes	Yes
Autonomous Region of Bougainville	Arawa District Hospital	Urban	Secondary	Government	Yes	Yes	Yes
	Buin Health Centre	Urban	Primary	Government	Yes	Yes	Yes
	Buka Provincial Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
	Buka Urban Clinic - MCH	Urban	Primary	Government	Yes	No	Yes
	Hanahan Sub Health Centre	Rural	Primary	Government	Yes	Yes	No
	Hantoa Health Centre	Rural	Primary	Government	Yes	Yes	No
	Tearouki Health Centre	Rural	Primary	FBI	Yes	Yes	Yes
West New Britain	Bialla Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Bola Health Sub Centre	Rural	Primary	Government	Yes	Yes	Yes
	Kimbe Provincial Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
	Kimbe Urban Clinic	Urban	Primary	Government	Yes	Yes	Yes
	Malalia Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Navo Clinic	Rural	Primary	Private	Yes	Yes	Yes
	Silovuti Private Clinic	Rural	Primary	Private	Yes	Yes	Yes
	Valoka Health Centre	Rural	Primary	NGO	Yes	Yes	Yes

Surveyed Health Facilities: Southern Region

Region	Province	Facility	Residency	Level of Health Care	Management	FP Services	MAT Services	HIV/AIDS Services
Southern	Gulf	Kerema Provincial Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
		Kerema Urban Clinic	Urban	Primary	Government	Yes	No	Yes
		Malalaua Health Centre	Rural	Primary	Government	Yes	Yes	Yes
		Terapo Health Centre	Rural	Primary	FBI	No	Yes	Yes
	Western	Adiba Health Centre	Rural	Primary	FBI	Yes	No	No
		Awaba Health Centre	Rural	Primary	FBI	Yes	Yes	No
		Balimo District Hospital	Urban	Secondary	FBI	Yes	Yes	No
		Daru Provincial Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
		Daru Urban Clinic	Urban	Primary	Government	Yes	No	No
		Kiunga District Hospital	Rural	Secondary	Government	Yes	Yes	Yes
		Matkomnai Health Centre	Rural	Primary	NGO	Yes	Yes	Yes
		Rumginae Rural District Hospital	Rural	Secondary	NGO	Yes	Yes	Yes

Milne Bay	Alotau Provincial Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
	Alotau Urban Clinic Goilanai	Urban	Primary	Government	Yes	No	Yes
	Bubuleta Community Health Post	Rural	Primary	Government	Yes	Yes	Yes
	East Cape Health Centre	Rural	Primary	FBI	Yes	Yes	No
	Garuahi Health Centre	Rural	Primary	FBI	Yes	Yes	Yes
	Gurney Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Misima District Hospital	Rural	Secondary	Government	Yes	Yes	Yes
	Panaeti Health Centre	Rural	Primary	Government	Yes	Yes	No
Central	Bereina Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Hula Health Centre	Rural	Primary	FBI	Yes	Yes	Yes
	Kupiano Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Kwikila District Hospital	Rural	Secondary	Government	Yes	Yes	Yes
	Moreguina Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Porebada Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Saiho Health Centre	Rural	Primary	Government	Yes	Yes	Yes
	Veifaa Health Centre	Rural	Primary	FBI	No	Yes	Yes
National Capital District	Gerehu Hospital	Urban	Secondary	Government	Yes	No	Yes
	Gordons Urban Clinic	Urban	Primary	Government	Yes	No	Yes
	Kaugere Urban Clinic	Urban	Primary	NGO	Yes	No	Yes
	Lawes Road Urban Clinic	Urban	Primary	Government	Yes	No	Yes
	Morata Urban Clinic	Urban	Primary	Government	Yes	No	Yes
	Port Moresby General Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
Oro	Kokoda Health Centre	Rural	Primary	Government	No	Yes	Yes
	Oro Bay Health Centre	Rural	Primary	NGO	Yes	Yes	Yes
	Popondetta Provincial Hospital	Urban	Tertiary	Government	Yes	Yes	Yes
	Siroga Health Centre	Rural	Primary	Private	Yes	Yes	Yes

