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Engagement of private providers in immunization in the Western Pacific region

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ABSTRACT

Financial sustainability of national immunization programmes (NIPs) in the Western Pacific is a growing concern. In the face of decreasing donor support for public immunization programmes, the role of private providers is becoming growingly important in attaining and sustaining programme achievements. Two-thirds of Member States in the Region have engaged the private sector in their immunization programmes, however little is known about the range and type of engagement. A survey was conducted in 2016 to map the scope and characteristics of private provider involvement, in order to inform guidance for decision makers. 14 countries participated, with responses from NIPs, national regulatory agencies, national immunization technical advisory groups (NITAGs), and private providers (defined as any entity other than the government).

Findings revealed that most countries have policies and regulations concerning private providers, but 50% of private provider respondents were unaware that such policies are available. In most countries private providers' contribution is limited to less than 10% of the total target population. Private providers in only 6 countries surveyed follow the vaccination schedule recommended by the NIP, with demand by vaccine recipients being the main cause of deviation. A majority (>70%) of private provider respondents believe that clients seeks their services not because of perception of quality, but to access new vaccines unavailable through the NIP. Private providers in all countries received vaccines from the NIP at no cost, for which they only charge clients a service fee. The majority of private providers received training from the NIP, whereas only around 25% of them received training from their own institutions. Private providers from 11 countries share EPI performance data and adverse events following immunization, however, NIPs perceive this data as suboptimal. Private providers have a limited role in decision making processes, such as NITAGs. Further effective engagement of private sector providers has the potential to improve overall efficiency of immunization service delivery.

1. Background

The Global Vaccine Action Plan (GVAP), endorsed by the World Health Assembly in 2012, is a framework to prevent millions of deaths by 2020 through more equitable access to vaccines [1]. The important roles and responsibilities of private providers in achieving the goals of the GVAP have been recognized. The implementation of the GVAP and further improvement of vaccine coverage at sub-national, national and global levels requires optimization of the interaction between public and private health providers. As donor support for immunization programmes decreases, private sector partnerships provide a valuable mechanism to support governments to attain immunization goals. In some countries, the private sector caters better for population groups with specific demands, needs and geographic locations [2,3]. The role that the private sector plays in immunization delivery differs from country to country. It is unclear what percentage of total immunization services is offered through private providers and how this share, and its features, varies by country. It is also acknowledged that the impact of the private sector and its engagement will vary tremendously from one country to another based on the existence and contribution of the private sector to the country's delivery of medical care and preventive interventions such as immunization [4].

The World Health Organization (WHO) Regional Office for the Western Pacific (WPRO) conducted this survey in an attempt to map the scope and characteristics of the provision of immunization services by private providers. The intent was to share the results of the survey with countries and to inform the best use of private providers' contributions to national immunization programmes.

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2. Methods

The survey had a cross sectional study design and was carried out during April–June 2016. This survey was aimed at the 18 countries which had reported in the WHO/UNICEF Joint Reporting Form (JRF) 2015 that they have engaged private providers in immunization service delivery [5]. Two structured self-administered questionnaires (one separate questionnaire for each public and private provider) were developed and pre-tested for data collection by the WPRO Expanded Programme on Immunization (EPI) Unit. The questionnaires focused on five thematic areas: (i) the role, scope and extent of private providers in immunization service delivery, (ii) Contribution to decision making and advocacy by private providers, (iii) Support received by private providers from National Immunization Programme (NIP), (iv) Coordination, Interaction between NIP and private providers and (v) perception on private sector engagement in immunization. The majority of the questions in both questionnaires were the same, in order to collect comparative data, while a few questions were designed to gather specific information from public and private providers. The questionnaires were then shared with WHO Country Office (CO) focal points for them to administrate questionnaires with targeted interviewees.

Interviewees included EPI managers in NIPs, vaccine focal points at National Regulatory Agencies (NRAs), National Immunization Technical Advisory Group (NITAG) Chairs and selected members, and a convenience sample (based largely on respondents accessible and known to WHO COs) of private immunization service providers who agreed to participate in the survey. We expected at least 1–2 private providers to respond from each country where private providers are engaged in immunization. In countries where no WHO CO is available, national authorities (NIP and/or NRA focal points) were contacted directly to assist with coordinating the administration of questionnaires with targeted interviewees. All completed questionnaires were sent to the WPRO EPI Unit for analysis.

In this survey, the term "private provider" refers to the provision of vaccination (and other health services) by any entity other than the government. This can be either an individual person or an institution. It can include full time or part time private practitioners (General Practitioners, Physicians, Pediatricians, Nurses, Pharmacists or even Midwives), private (for-profit and non-for profit) hospitals as well as non-governmental organizations (not funded by the government or by international donors).

3. Results

Eighteen countries were invited to participate in the survey. Of the 14 countries that responded, 5 are in the high income category (Australia, Japan, Korea, New Zealand, Singapore), 3 are in the upper middle income category (China, Fiji, Palau) and 6 are in the lower middle income category (Cambodia, Kiribati, Papua New Guinea, Philippines, Solomon Islands, Vanuatu) [6].

Sixty respondents (32 public sector and 28 private providers) from the 14 participating countries completed the self-administered questionnaires (Table 1). Public sector responses were received from all countries, but private provider responses were only received from 6 countries. Of the 28 private providers, 11 were full time private practitioners while 12 were from private hospitals. Since the authors had no direct access to the study participants, the follow up and response rate were limited. Also possible response bias is not ruled out, particularly due the convenience sampling method used to select the respondents.

We present data related to the contribution of the private providers in the following areas; (i) system in place to regulate private providers' immunization service delivery, (ii) scope and extent of immunization service by private providers (iii) partnerships between NIP and private providers.

(i) System in place to regulate private providers' immunization service delivery

According to the respondents, 13 out of 14 countries have policies and/or laws and/or guidelines on the provision of immunization services by private providers (Table 2). The majority of countries have system(s) or institution(s) to regulate (n = 12/14) and monitor (n = 10/14) immunization services by private providers. This includes all 5 high income countries. However, around 50% of private providers who responded to this survey were unaware that such policies, laws or guidelines are available in their respective countries, indicating there is a need for better communication and likely implementation of such regulations. Service fees for immunization service by private providers are regulated by the governments in most (n = 11/14) countries.

(ii) Scope and contribution of private providers in immunization service delivery

In all 14 countries, private providers are providing traditional vaccines (against tuberculosis, poliomyelitis, diphtheria, pertussis, tetanus and measles) and new or underutilized vaccines (against cholera, haemophilus influenza type b, Hepatitis B, Human papillomavirus, Japanese encephalitis, serogroup A meningococcal disease, pneumococcus, rotavirus, rubella and typhoid) to the public. They give vaccines which are available through the NIP as well as those that are not available through the NIP. In addition to service delivery, in some countries (5/14, 35%) private providers are also involved in vaccine storage, transport and distribution.

The public visits private providers mostly for underutilized or new vaccines, irrespective of their availability in the NIP. Private providers obtain vaccines either from the NIP or purchase them from private franchises. Therefore, sometimes private providers use vaccines from different manufacturers or in different product

Table 1
Profile of survey respondents.

Respondents	High Income countries	Upper Middle Income countries	Lower Middle Income countries
Public sector respondents[a] (n = 32)	10	6	16
Private provider respondents[b] (n = 28)	6	10	12
Private Hospital Staff	–	4	8
Full time private practitioner	6	3	2
Nurse/Pharmacist/Midwife	–	3	2

High Income (Australia, Japan, Korea, New Zealand, Singapore).
Upper Middle Income (China, Fiji, Palau).
Lower Middle Income (Cambodia, Kiribati, Papua New Guinea, Philippines, Solomon Islands, Vanuatu.
[a] Public sector respondents include; National Immunization managers, Regulatory author higher officials, National Immunization Technical Advisory Group (NITAG) members.
[b] All 28 respondents were from only 6 countries: (2 High income countries, 1 Upper Middle Income countries, 3 Low Middle Income countries).