Public-Private Partnership to Accelerate Family Planning Uptake in Pakistan

A Conceptual Framework

July 2019

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Population Council
3rd Floor, NTC Building (North), Sector F-5/1
Islamabad, Pakistan
Tel: +92 51 920 5566
Fax: +92 51 282 1401
Email: info.pakistan@popcouncil.org
http://www.popcouncil.org

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Authors

Rehana Ahmed
Ali Mohammad Mir
Iram Kamran
Rehan Niazi

Acronyms

ADP	Annual Development Program
BCC	Behavior Change Communication
BHU	Basic Health Unit
BMC	BioMed Central
BMGF	Bill and Melinda Gates Foundation
CCI	Council of Common Interests
CIP	Costed Implementation Plan
CPR	Contraceptive Prevalence Rate
CMW	Community Midwife
CSR	Corporate Social Responsibility
DoH	Department of Health
DKT	Deutsche Kautschuk Tagung
ESSI	Employees Social Security Institution
FP	Family Planning
FBO	Faith-based Organization
FWA	Family Welfare Assistant
FWW	Family Welfare Worker
GSM	Greenstar Social Marketing
HANDS	Health and Nutrition Development Society
HLFPPT	Hindustan Latex Family Planning Promotion Trust
IHS	Integrated Health Services
IUCD	Intrauterine Contraceptive Device
LHV	Lady Health Visitor
LHW	Lady Health Worker
LMIC	Low- and Middle-Income Countries
LAM	Lactational Amenorrhea Method
MCH	Mother and Child Health
MIS	Management Information System
MSI	Marie Stopes International
MSS	Marie Stopes Society
MSU	Mobile Service Unit
MoU	Memorandum of Understanding
MVA	Manual Vaccum Aspiration
mCPR	Modern Contraceptive Prevalence Rate
MNCH	Maternal Neonatal Child Health
MWRA	Married Women of Reproductive Age
NGO	Non-Governmental Organization

PPHI	People Primary Health Initiative
PWD	Population Welfare Department
PPIUCD	Postpartum Intrauterine Contraceptive Device
PDHS	Pakistan Demographic Health Survey
PPP	Public–Private Partnership
PPM	Public–Private Mix
PSI	Population Services International
PSDP	Public Sector Development Program
PRSP	Punjab Rural Support Programme
PSS	Parivar Seva Senstha
RHC	Rural Health Center
RH	Reproductive Health
SDG	Sustainable Development Goal
SIFPSA	State Innovations in Family Planning Services Project Agency
SHOPS	Strengthening Health Outcomes through the Private Sector
SRH	Sexual and Reproductive Health
SMO	Social Marketing Organization
SWOT	Strengths, Weaknesses, Opportunities and Threats
TFR	Total Fertility Rate
TNVS	Tanzania National Voucher scheme
UHC	Universal Health Coverage
UNFPA	United Nation Population Fund
USAID	United States Agency for International Development
UPTS	Uttar Pradesh Technical Support
VFM	Value for Money
WHO	World Health Organization

Introduction

Pakistan's alarming population growth rate, which was 2.4 percent between the 1998 and 2017 censuses, is now being recognized as a major impediment to the attainment of the country's development goals. The issue was highlighted in a Supreme Court Human Rights case in 2018, bringing inadequate access to family planning (FP) to the forefront as a key development challenge. A Supreme Court–appointed Task Force formulated eight key recommendations for addressing the issue, and these were endorsed by the Council of Common Interests (CCI), which is headed by the Prime Minister and comprises of all provincial Chief Ministers.

Among other important measures, the recommendations call for improving FP service delivery by increasing collaboration between the private and public sectors and adopting innovative approaches. One recommended approach is the fostering of partnerships between the public health sector and civil society as well as the business community, as the government has limited resources for achieving universal FP coverage (Recommendations 2.2 and 2.5). Joining forces with other stakeholders will help in meeting Pakistan's national and international commitments, including its FP2020 goals as well as the Sustainable Development Goals (SDGs 3.1and 3.7).

To meet SDG Targets 3.1 and 3.7, countries must, by 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births and ensure universal access to sexual and reproductive health care services, including family planning services, information and education, and integration of reproductive health into national strategies and programmes. Moreover, SDG Target 5.6, concerning women's empowerment, calls for ensuring universal access to sexual and reproductive health and reproductive rights as agreed in the Programme of Action of the International Conference on Population and Development, the Beijing Platform for Action, and the outcome documents of subsequent review conferences.

Private pharmacies, health service providers, and non-governmental organizations (NGOs) already play an important role in FP service provision in Pakistan. With the demand for services unmet, there needs to be a shift in how the public and private sectors respond jointly to achieve universal FP/reproductive health (RH) coverage. Engaging the private sector for its expertise in supply chains, information technology, data analytics, and client service will improve FP service provision more efficiently, with greater impact, and on a more sustainable basis.

The objective of this analysis is to recommend a National/Provincial Conceptual Framework for Public-Private Partnership for FP that can help provinces to weave such partnerships into their future plans, including Annual Development Program (ADP) schemes, as well as applications for federal Public Sector Development Program (PSDP) funding. Target audiences include both public and private sector stakeholders, including policy makers, planners, program implementers, legislators, academics, development partners, and civil society organizations.

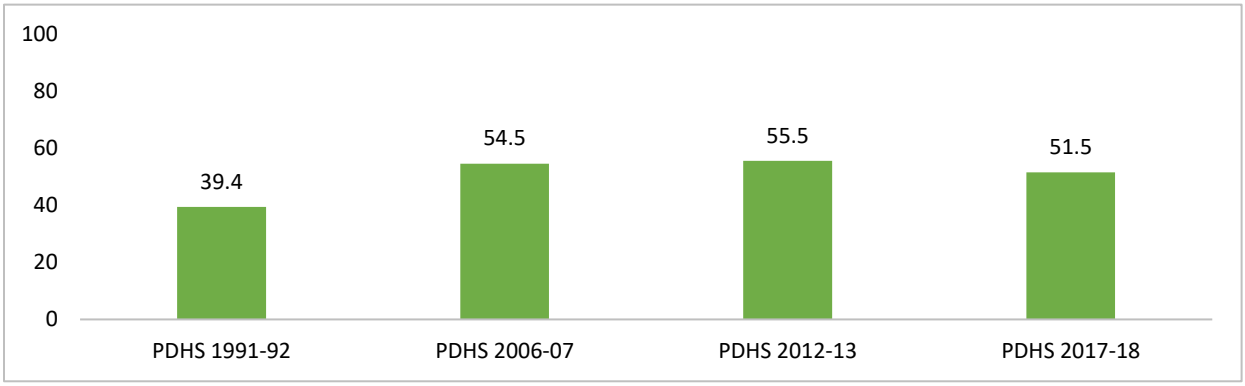
The conceptual public–private partnership (PPP) framework and guidelines presented in this report aim to provide a road map for creating the enabling environment needed to foster much-needed PPPs for family planning in the country, with a clearer definition of public and private sector roles and processes for legally binding partnerships.

Background

Pakistan's family planning program was initiated in the early 1960s and has since been a part of development planning. Yet, it has achieved only modest success as FP uptake trends show. By the end of 2012, according to the Pakistan Demographic and Health Survey (PDHS) 2012-13,[1] 55.5 percent of all married women of reproductive age (MWRA) in the country wanted to either prevent or delay their next childbirth by at least two years, but only 35.4 percent were using any method of contraception. At the London FP Summit 2012, Pakistan committed to eliminate this gap by increasing the contraceptive prevalence rate (CPR) in the country from 35.4 to 55 percent by 2020. The CPR goal was later reset to 50 percent. After the 18th Constitutional Amendment and the resulting devolution of powers, the provinces became responsible for setting their own goals and developing costed implementation plans (CIPs) to achieve them.

Findings of the latest round of PDHS (2017-18)[2] are disappointing and reflect the country's poor performance in the area of FP in the last five years, which is at odds with the significant improvement achieved in maternal, neonatal, and child health (MNCH) indicators. The PDHS 2017-18 shows that total demand for FP among MWRA has decreased by 4 percentage points from 55.5 in 2012-13 to 51.5 in 2017-18 (Figure 1).

Figure 1: Demand for family planning among MWRA from 1991 to 2018



Source: PDHS (all rounds)

Although unmet need for FP has decreased by 2.8 percentage points, from 20.1 in 2012-13 to 17.3 in 2017-18, this is not due to an increase in CPR but to a decrease in the demand for family planning, as shown in Figure 2, which shows the proportions of MWRA who:

1) Either do not want to have more children or want to wait at least two years before their next pregnancy (need for family planning),

2) Are currently using any method of contraception (met need), and

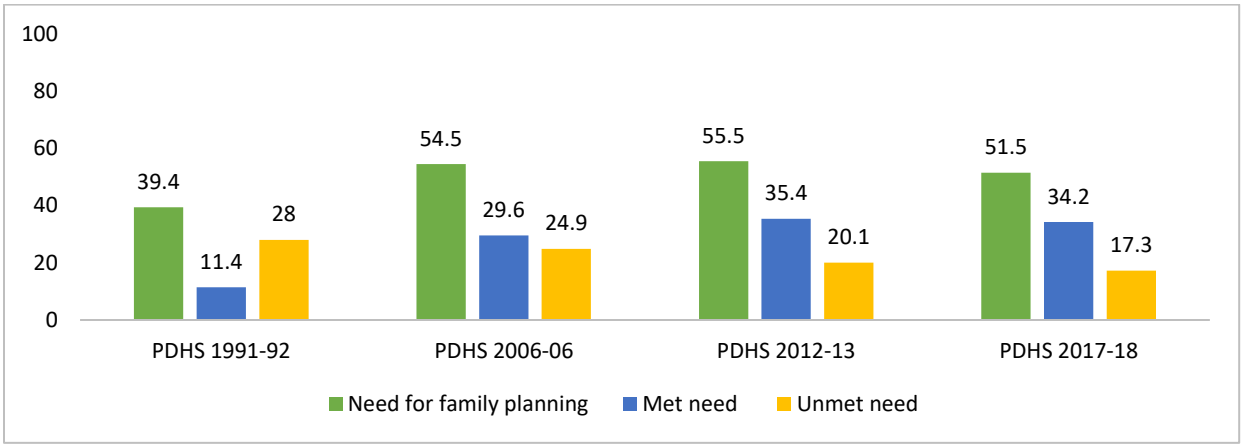
3) Are not using any method of contraception despite the need for family planning (unmet need).

The national CPR has decreased by 1.2 percentage points from 35.4 in 2012-13 to 34.2 in 2017-18.

[1] National Institute of Population Studies (2013). *Pakistan Demographic and Health Survey 2012-13*. Islamabad. Islamabad and Calverton, Maryland, USA: NIPS and ICF International.

[2] National Institute of Population Studies (NIPS) [Pakistan] and ICF. 2019. Pakistan Demographic and Health Survey 2017-18. Islamabad, Pakistan, and Rockville, Maryland, USA: NIPS and ICF.

Figure 2: Demand, met need, and unmet need for family planning in Pakistan among MWRA from 1991 to 2018



Source: PDHS (all rounds)

Table 1 shows that the method mix has not changed, and the two most popular methods remain female sterilization (8.8 percent) and condoms (9.2 percent). There is, however, a significant decrease in the use of lactational amenorrhea method (LAM) from 1.5 percent in 2012-13 to 0.2 percent in 2017-18, and this is the main reason for the 1.1 percentage point decrease in CPR in 2017-18. An encouraging finding of the survey is the emerging use of the newly introduced method of implants. Use of all other methods is almost stagnant or shows only a nominal change between 2012 and 2018.

Table 1: Contraceptive prevalence rate and method mix in Pakistan, 1991-2018

Use of Contraception	PDHS 1991-92[3]	PDHS 2006-07[4]	PDHS 2012-13	PDHS 2017-18
Any Modern method (mCPR)	**10.7**	**21.7**	**26.1**	**25.0**
Female sterilization	4.2	8.2	8.7	8.8
Condom	3.3	6.8	8.8	9.2
Pills	1.1	2.1	1.6	1.7
Injectables	0.9	2.3	2.8	2.5
IUD	1.2	2.3	2.3	2.1
Implant	-	-	-	0.4
LAM	-	-	1.5	0.2
Other modern methods	0.0	0.0	0.4	0.1
Any traditional method	**0.7**	**7.9**	**9.3**	**9.2**
Withdrawal	0.5	4.1	8.5	8.1
Rhythm	0.2	3.6	0.7	1.0
Other tradition methods	0.0	0.2	0.1	0.1
Any method (CPR)	**11.4**	**29.6**	**35.4**	**34.2**

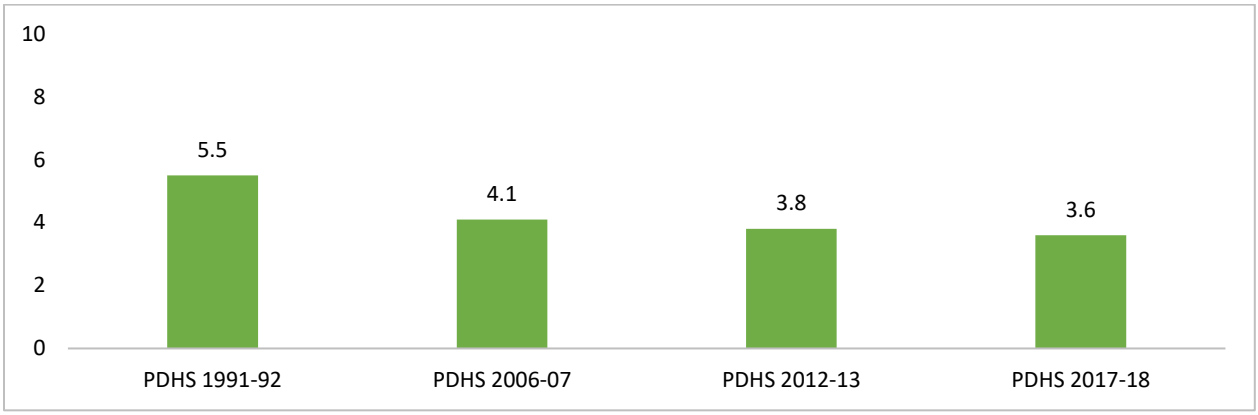
Source: PDHS (all rounds)

[3] National Institute of Population Studies (NIPS) [Pakistan] and IRD/Macro International Inc. (1992). Pakistan Demographic and Health Survey (PDHS) 1990-91. Columbia, Maryland: NIPS and IRD/Macro International Inc.

[4] National Institute of Population Studies (NIPS) and Macro International Inc. (2008). Pakistan Demographic and Health Survey 2006-07. Islamabad, Pakistan: National Institute of Population Studies and Macro International Inc.

Successive rounds of the PDHS also show a steady decline in fertility rates over time, from 5.4 births per woman as reported in the 1990-91 PDHS to 3.6 births per woman in the 2017-18 PDHS—a drop of about two births per woman in almost three decades (Figure 3). However, this decline in fertility level has stalled in the last five years.

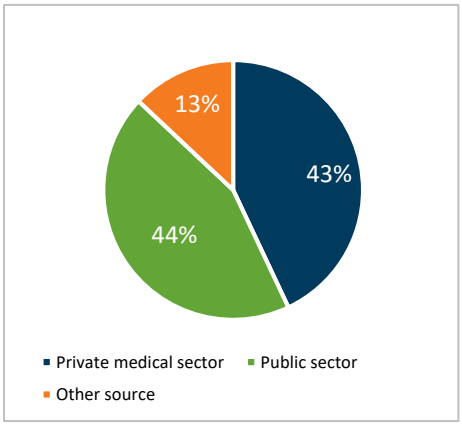
Figure 3: Trends in total fertility rate from 1991 to 2018



Source: PDHS (all rounds)

Among women's reported sources of contraceptives in PDHS 2017-18, the public and private sectors have almost the same share. However, private sector utilization goes up to 56 percent if the proportion of 'other sources,' which include *dais* (traditional birth attendants) and *hakims* (practitioners of alternative medicine), is included, since both are private providers (Figure 4).

Figure 4: Sources of modern contraceptive methods



Source: PDHS 2017-18

PDHS data indicates a decrease in mCPR from 26.1 in 2012-13 to 25.0 in 2017-18. On the other hand, a comparison of the contraceptive performance reports of the Pakistan Bureau of Statistics for 2012-13[5] and 2016-17[6] indicates a significant increase in the distribution of contraceptives by the public sector. One reason for this could be that the 2012-13 report focused only on distribution by Population Welfare Department (PWD) facilities and Lady Health Workers (LHWs) and did not include the contribution of Department of Health (DoH) facilities, which are included in the 2017-18 report.

Meanwhile, the above-mentioned reports indicate that there has been no significant change in the sale of contraceptives by the private sector (Table 2). But notwithstanding this stagnancy during the last five years, the private sector is making a significant contribution to the promotion of contraceptive use in Pakistan. It provides access to millions of MWRA by selling established brands of contraceptives (condoms, pills, and injectables) at substantially subsidized prices through private service providers, pharmaceutical outlets, and shops carrying fast-moving consumer goods. The *Sathi* and *Touch* brands

[5] Pakistan Bureau of Statistics. 2014. Contraceptive Performance Report 2012-2013. Government of Pakistan, Statistics Division, Pakistan Bureau of Statistics, Islamabad.

[6] Pakistan Bureau of Statistics. 2019. Contraceptive Performance Report 2016-2017. Government of Pakistan, Statistics Division, Pakistan Bureau of Statistics, Islamabad.

of condoms and *Nova* brand of pills marketed by Greenstar Social Marketing are the most popular contraceptive products in the country (PDHS 2017-18). They are available for a nominal price at more than 70,000 pharmaceutical and retail outlets across the country.

Table 2: Distribution of contraceptives to clients as reported by the public and private sectors, 2012 to 2017

Family planning commodities	Public sector			Private sector		
	2012-13	2016-17	Increase, %	2012-13	2016-17	Increase, %
Condoms (units)	73,742,775	160,319,484	117.40	114,708,689	113,690,918	-0.89
Pills (cycles)	3,366,476	15,353,073	356.06	3,206,626	1,065,019	-66.79
Injections (vials)	1,359,796	7,865,084	478.40	1,627,193	839,892	-48.38
IUDs (units)	777,663	946,524	21.71	642,801	754,820	17.43

Source: Pakistan Bureau of Statistics (PBS), Contraceptive Performance Reports for 2012–13 and 2016-2017

For private sector providers , family planning is a low-revenue service and therefore not a priority. However, a Landscape study conducted by the Population Council in 2016 found that private providers are interested in offering FP services, provided they receive refresher trainings to manage side effects as well as a supply of contraceptive products.[7]

Rationale for Public–Private Partnerships

The global community acknowledges that the private sector is critical in the provision of FP as well as other basic health care services in low– and middle–income countries (LMIC) and that the public sector should leverage it for its capabilities as part of a total market approach. At the 63rd World Health Assembly, it was resolved that it is incumbent to "strengthen the capacity of the governments to constructively engage the private sector in providing essential health care." This resolution acknowledged that the private sector is a major source of health care in most countries and has been effectively regulated and financed by governments in high-income countries, and that LMIC can effectively engage and regulate this sector through formal PPPs to expand access to health care.

There is considerable scope for reducing the population growth rate through fast-track implementation of PPPs for FP by all provinces. This potential arises, on the one hand, from the immense unmet need for contraceptive services—17.3%, which translates into about six million potential users—and on the other hand, from the large proportion of private sector providers who are not currently providing FP services.

The public health sector does not currently have sufficient capacity to achieve universal coverage in basic health care, which is a fundamental human right. A study to assess availability and motivation of public sector providers found that public sector facilities are understaffed because vacant positions are not being filled and staff motivation is low, negatively impacting quality of care.[8] The public sector budget is not increasing in real time and a large proportion of it is being consumed by non-development expenditures, especially salary support. Developmental activities, including service expansion, are therefore compromised. While PWD and the People's Primary Healthcare Initiative (PPHI) are actively

[7] Population Council. 2016. "Landscape Analysis of Family Planning in Pakistan." Report and Brief. Population Council, Islamabad.

[8] Mir, Ali M., Gul Rashida, Saleem Shaikh, Neha Mankani, Anushe Hassan, and Maqsood Sadiq. 2013. "Assessing retention and motivation of public health-care providers (particularly female providers) in rural Pakistan." Islamabad: Population Council.

providing FP services, as are LHWs of the DoH, findings from a 2017 study show that the numerous static facilities of DoH are not fully on board, with several opportunities for offering FP services being missed.[9]

The private sector has the advantage of much larger numbers of service delivery points than the public sector and is generally perceived to provide more client-centered care, but its services are less affordable, especially for poorer segments of the population. Private practitioners in Pakistan are engaged in managing a variety of health issues, providing both preventive and curative care, largely due to relatively low capital requirements and high demand. This pattern involves them directly in core "public health" activities such as treating patients with malaria, tuberculosis, and other communicable diseases, as well as treating sick children and pregnant women. Despite widespread concern about cost and clinical quality, patients often bypass public facilities to use private providers, frequently citing reasons of convenience and responsiveness.

Unfortunately, many private health facilities do not offer FP services at present. A recent study found only 41 percent of private providers in urban areas and 29 percent in rural areas were providing FP services.[10] Pharmacies were performing better, with 69 percent offering FP products in urban areas and 53 percent in rural areas, but they were mostly selling condoms.

For optimizing the full potential of existing providers, there is a need for all sectors to play a role in increasing demand for FP through provision of correct information, education and communication, with the entire health sector leading in service provision. It is imperative for the government to initiate tailored PPP schemes to achieve public health care goals utilizing the private sector, without deviating from the general objective of fostering a publicly dispensed basic health system. Public-private partnerships that capitalize upon the strengths of the two sectors and overcome their inherent weaknesses can lead to accelerated uptake of FP services. A key challenge the private sector faces in offering family planning as a stand-alone service is that it does not generate high enough revenue. Therefore, PPPs should integrate FP in other revenue generating services such as maternal, child, and primary health care.

By positioning family planning as a continuation of maternal and child health, and offering reasonable monetary and non-monetary incentives, private providers—including doctors as well as mid-level providers like Lady Health Visitors (LHVs) and community midwives (CMWs)—can be engaged in delivery of family planning services all over the country. This will have several advantages. Firstly, incentives from the public sector will make it sustainable for private providers to start providing FP services or to increase the range of methods they offer. From the government's perspective, the main advantage will be a rapid increase in human resource availability and expanded outreach of FP services. Secondly, private sector interest in FP service provision will also increase competition, improving both efficiency and quality of care. This will improve client experiences of FP services and could eventually reduce contraceptive discontinuation rates and also generate additional demand for family planning through diffusion of information. Finally, PPP schemes will require the government to collect more complete data about private health facilities, which will contribute to improving regulation of the private sector, leading towards a more robust health system.

[9] Rashida G., Kamran I., Khalil M., Khan M., Tasneem Z., Niazi R., Parveen T. 2017. "Increasing Access to Reproductive Health Care through Improved Services Delivery." Population Council, Islamabad.

[10] Population Council. 2016. "Landscape Analysis of Family Planning in Pakistan." Report and Brief. Population Council, Islamabad.

Public-private partnerships can make the preventive and promotive aspects of health common goals for private and public providers, with both sectors accountable for strengthening national policies and programs, and the government leading in providing citizens their fundamental rights.

Tapping Existing Opportunities

The policy environment in Pakistan is already moving towards public-private partnerships in provision of health services, including family planning. As mentioned earlier, taking cognizance of the alarming population growth in Pakistan, the former Honorable Chief Justice of Pakistan took suo moto notice in Human Rights case 17599 of 2018 and constituted a Task Force to formulate a mechanism to curb population growth rate in the country. The Task Force's recommendations[11] and action plan specify clear priorities, activities, roles and responsibilities, and timelines for actions. They were placed before the Council of Common Interests and approved in principle on November 18, 2018. The recommendations relevant to the private sector, along with corresponding activities in the action plan, are provided in Table 3.

Table 3: Private Sector–related Recommendations and Actions Proposed by Task Force for Curbing Population Growth Rate

Recommendation	Broad Actions to Implement the Recommendations
2. Ensure Universal Access to FP/RH Services	
ii. All general registered private sector practitioners and hospitals to provide FP counseling, information and services to male & female clients.	2. Enlisting and signing Letter of Understanding (LoU) 4. Conduct Training of Trainers (ToT) 5. Step down training 6. Monthly performance report to PWDs [linked to Recommendation 1 (C)]
v. NGOs and Civil Society Organizations to work in close coordination with provincial DOHs & PWDs to extend FP/RH services to underserved and unserved areas.	2. Partnership mechanism / MoUs between PWDs and CSOs 3. Provision of counseling and/or services by NGOs in underserved and unserved areas. 4. Coordination / Periodic Performance Review
3. Finances	
iii. Donor financing to NGOs and private sector organizations involved in FP/RH to be streamlined through an effective coordination mechanism.	1. Federal Government (MoFA and EAD) to mobilize external resources through bi-lateral, multi-lateral and international community arrangements for NGOs and private sector under different modalities including social / commercial marketing and social franchising 2. EAD to establish a donor consortium for supporting the advancing family planning agenda 3. Consultative meeting under the chair of Secretary EAD to finalize protocols / mechanism for supporting Civil Society Organizations 4. Circulation of Instructions from EAD to the concerned quarters

[11] Government of Pakistan. 2018. Investing in Sustainable Population Growth: National Symposium on Alarming Population Growth in Pakistan: Call to Action (Dec 5, 2018). The Ministry of National Health Services, Regulations and Coordination and LAW AND Justice Commission of Pakistan.

Recommendation	Broad Actions to Implement the Recommendations
iv. Corporate Sector to allocate CSR funds for FP services and advocacy.	1. Hold meetings with M/o Finance, FBR and SECP to require compulsory allocation of substantial part of CSR funds for family planning. 2. Jointly review and work out modalities of utilization of CSR by the corporate sector bodies for FP services & advocacy 3. Devise review system and ensure its implementation and reporting on annual basis
4. Legislation	
i. Family Planning & Reproductive Health (FP&RH) Rights Bill ensuring mandatory FP/RH services by all general health care facilities in public and private sector.	1. Drafting the FP&RH Rights Bill in consultation with relevant stakeholders and departments including DOH and getting it vetted from Law Division / Department
6. Curriculum and Training	
vi. Training to be provided to all public & private health care providers on all modern contraceptive methods.	1. Updating National / Provincial Standards and training material on FP&RH to include infusion of a rights-based approach 2. Training of Trainers of RTIs, RHS-A master training centers and Public Health Schools of DOH 3. Step down training of the services providers (public & private)
7. Contraceptive Commodity Security	
ii. Pooled Procurement model to be adopted by the Federal & Provincial Governments (subject to their consent) to garner the benefits of economy of scale.	1. Holding meeting of Inter-Ministerial Strategic Forum on Health & Population to develop consensus on pooled procurement 2. Taking up the matter at respective Provincial Task Forces for endorsement 3. Finalization of operational modalities
iii. Supply Chain Management System to be strengthened to ensure availability of all contraceptives at Service Delivery Points.	1. Develop/improve dashboard at the district / sub-district level showing method wise availability of contraceptives at all service delivery points of public & private sectors including CSOs 2. Develop Android app for real time reporting on performance and availability of contraceptives at sub-district offices and SDPs 3. Provide Android tablets at all sub-district offices and service delivery points including private sector 4. Design & conduct training of supervisors and service providers of public & private sectors including CSOs;

Source: Government of Pakistan. 2018. Investing in Sustainable Population Growth: National Symposium on Alarming Population Growth in Pakistan: Call to Action (Dec 5, 2018).

Note: Recommendations and actions are numbered as in the original document.

At the National Symposium on "Alarming Population Growth in Pakistan," organized on December 5, 2018 under the aegis of the Supreme Court to emphasize the need for swift action on the Task Force's recommendations, it was recommended that NGOs and civil society organizations (CSOs) should work in close coordination with the provincial departments of health and population welfare to extend FP services to underserved and unserved areas and ensure universal access to FP services. Federal and provincial governments are responsible for this coordination.

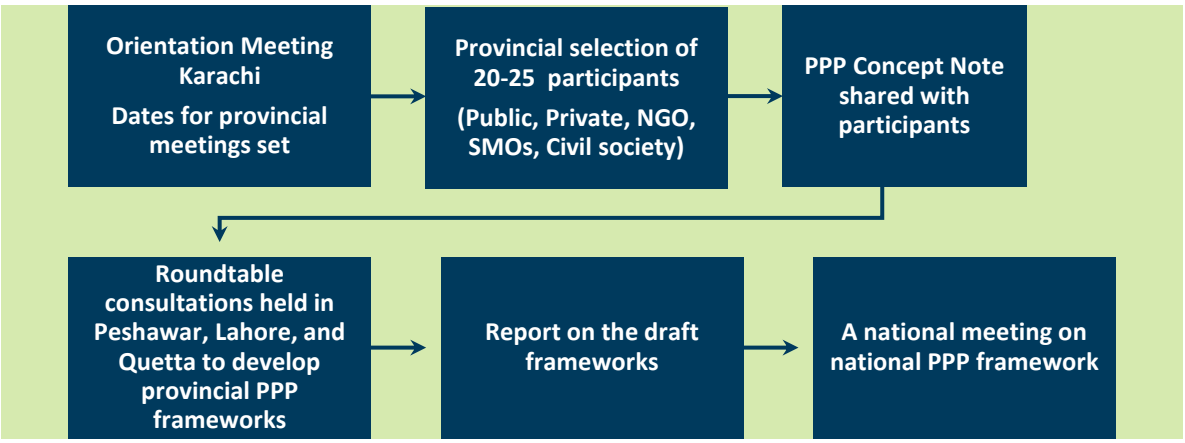
Moreover, all the provincial CIPs, population policies, and strategic health roadmaps acknowledge the need for forming PPPs. Currently, regardless of the approval status of their CIPs, and in consonance with their provincial population policies, all provinces are committed to scaling up partnerships in health through contracting mechanisms. In Sindh, the PWD and DoH have identified linkages for public-private partnerships to reach vulnerable segments of the population, including the poor and youth, as a specific strategic area.[12] Three provinces, including Sindh, Punjab, and Khyber Pakhtunkhwa (KP), have also passed legislation to support the creation of PPPs under which administrative units to spearhead PPPs have been established. Collectively, these elements have created an enabling environment for the government to move in the direction of PPPs.

Approach

The United Nations Population Fund (UNFPA) supported/commissioned the Population Council to work with a national consultant and federal and provincial governments for developing a framework to guide PPPs for family planning in the country. The major activities to ensure a full consultation of stakeholders is outlined below.

- **A literature review** of relevant best practices in PPPs was conducted. Projects with partnership mechanisms for FP provision in the country were also studied.
- **An orientation meeting** was held in Karachi (on October 10, 2018), attended by the Director General, Population Program Wing, Ministry of National Health Services, Regulations & Coordination and provincial Secretaries of the Health and Population Welfare departments of the Punjab, Sindh, Balochistan and Khyber Pakhtunkhwa provinces, as well as representatives of the Population Council and UNFPA, to develop a plan of action and inception report.
- **Provincial and national roundtable consultations** were conducted in Peshawar (on November 16, 2018), Lahore (on November 24, 2018), and Quetta (on December 12, 2018), and a final national consultative meeting was held in Gwadar (on December 18, 2018). Participants included experts from the public and private sectors, donors, and civil society. More than 25 experts were present in each of the provincial consultations. The first draft of the framework components was circulated for comments to all the participants. Their feedback and inputs are incorporated in the current document.

[12] http://pwdsindh.gov.pk/Publications/e-books/CIP%20Sindh-03%2015%2016-final.pdf



- **Qualitative research:** A qualitative study was conducted to obtain insights of private sector service providers, suppliers, and end-users of FP services about potential public-private partnerships to improve access to FP services in Pakistan. The study also looked into the proposed roles of the two sectors and benefits of PPPs to end-users. The findings of this study, which are documented in this companion report entitled "***Improving Access to Family Planning Services through the Private Sector in Pakistan – A Stakeholder Analysis***", have also been used in developing the framework.[13]

Findings from Existing Literature on PPP

A wide literature search was undertaken to better understand the concept and definition of public-private partnership and identify models relevant to the Pakistan context. Another key objective was to help in identifying the key levers for success of PPPs and the pitfalls to be avoided.

Definitions – What is a Public-Private Partnership?

In recent years, both the public and private sectors have found mutual benefits in engaging in partnerships as there is potential for addressing complex problems by leveraging the strengths of each sector. To begin with, it is important to clarify what we are defining as "public" and "private."

- The public sector refers to all sectors of the government at different levels, i.e., federal, provincial, district, municipal, local government and other inter–governmental agencies which deliver public goods.
- The private sector is much broader: it includes for-profit, commercial or business entities in both the informal and formal sectors, ranging from small business and micro-enterprises, to cooperatives and large national and multinational companies, and it also means professional associations and corporate philanthropic foundations directly funded and/or governed by business.[14] Civil society is also part of the private sector. It includes NGOs, social marketing organizations (SMOs), faith-based organizations (FBOs), and philanthropic entities.

[13] Kamran I., Parveen t., Niazi R., Khan M. and Khan K. 2019. Improving Access to Family Planning Services through the Private Sector in Pakistan – A Stakeholder Analysis. Islamabad. Population Council.

[14] Martens, J. 2007. Multisectoral Partnerships - Future Models of Multilateralism? Dialogue on Globalization and Friedrich Ebert Stiftung . No. 29, 1-78. Berlin.

- There is no single, internationally accepted definition of what constitutes a public-private partnership. A broad view taken globally is that a PPP is a long-term contract between a private party and a government entity for providing a public asset or service in which the private party bears significant risk and management responsibility, and remuneration is linked to performance.

The United Nations defines partnerships as voluntary and collaborative relationships between various groups, state and non-state actors, in which all participants agree to work together to achieve a common purpose or undertake a specific task and to share risks and responsibilities and resources.[15]

The Initiative on Public–Private Partnerships for Health (IPPPH)[16] points out that the term "partnership" has been used loosely to include communication, consultation, coordination, and collaboration, and cautions that simply calling a venture a partnership does not mean that there is joint decision-making. The terminology is further expounded to describe PPPs as "a continuum of loose to tight arrangements that combine different skills and resources from institutions in the public and private sectors with the aim of effectively tackling socio-economic problems like education and health that persist in the face of independent actors." [17]

The World Health Organization (WHO) describes public–private partnerships for health as: "public sector programmes with private sector participation"—a vague definition that allows for many shapes and sizes of PPPs, and implies that a government partner sits at one end of the table, setting the priorities and rules under which private organizations operate.

Strengthening Health Outcomes through the Private Sector (SHOPS), a flagship initiative of the United States Agency for International Development (USAID), defines a PPP in health as any formal collaboration between the public sector at any level (national/local governments, international donor agencies, bilateral government donors) and the non-public sector (commercial, nonprofit, service providers) in order to jointly regulate, finance, or implement the delivery of health services, products, equipment, research, communication, or education.[18]

According to yet another definition in global health programing, PPPs represent a public–private mixed (PPM) approach to health care delivery which involves an integrated system of public health care providers and for-profit, not-for-profit, and/or informal providers.[19]

Although definitions vary, the objective is assumed to be use of private sector advantages to meet public health goals through implementation of policies that can increase coverage and improve quality and cost effectiveness of basic health services. For this to happen, it is essential for public policy to define the division of labor and identify the sector responsible for specific segments of the population. To make such a division possible, the public sector should avoid provision of free or heavily subsidized services to clients who can pay, so that the private sector does not have to compete against it for these clients.

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[15] Ibid.

[16] www. Ippph.org

[17] Nantulya, V.M. (2008) Getting diagnostics into countries. Bringing products to markets. Health partnerships review. Global Forum for Health Research 68-72.

[18] Jeffrey Barnes. 2011. *Designing Public-Private Partnership in Health.* Bethesda, MD: SHOPS Project, Abt Associates.

[19] Kaboru, B. B. (2012). Uncovering the potential of private providers' involvement in health to strengthen comprehensive health systems: A discussion paper. Perspectives in Public Health 132(5), 245–252.

The two main categories representing service provision are, first, service delivery and, second, facility management. The private sector can be engaged in either through a contract. Contracts can then balance out the efficiency and equity considerations.

Existing PPP Models in Pakistan

In Pakistan, the government has some experience—more so in the recent past—of partnering with the private sector for expansion of infrastructure and public services in sectors other than RH, such as energy, transport, roads, and more recently, urban waste management. However, no formal framework currently exists to guide Pakistan's mixed and fragmented health system in engaging the private sector for much-needed participation in FP service provision.

There are, on the other hand, many examples of the government supporting private sector institutions in their efforts to promote FP in Pakistan. For example, through registration of **GSM's** condom brand *Sathi*, and subsequent renewals of its trademark, the earlier entity of the Ministry of Population Welfare enabled GSM to promote use of condoms, which are now the most popular method of family planning in Pakistan and constitutes 37 percent (9.2 out of 25.0 percentage points) of mCPR in the country.

Moreover, there are some prominently known primary health care initiatives that are based on the PPM approach. Most notable among these is the **People's Primary Health Initiative (PPHI)**, a successful PPP management contracting experience that began as the President's Initiative in 2007, when management contracts for basic health units (BHUs) were given to Pakistan Rural Support Program (PRSP) in 69 districts across the country, starting with Rahim Yar Khan. Memoranda of Understanding (MoUs) were signed between district governments and the PRSP.[20] The initiative was registered as a nonprofit company under section 42 of the Companies Ordinance 1984 and a supervisory Board of Directors was established to take the initiative forward.[21]

In Sindh, **the PPHI collaboration** is functioning smoothly and now a similar relationship is being developed in Balochistan whereby PPHI will work with the PWD. The budget is given as a one-line item to PPHI. Currently, 1,140 out of 1,192 primary health care facilities are being managed across Sindh (except in Karachi and Nawabshah) through this publicly financed model. Thus far, 311 BHUs have been upgraded into "BHU Plus" units, which remain open round-the-clock.[22]

Third-party evaluation of the PPHI shows higher utilization of the contracted BHUs in terms of volume of outpatient attendance as compared to pre-partnership performance. There has also been improved cleanliness and maintenance, higher staff presence, and higher patient satisfaction.[23]

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[20] Ravindran, T. K. S. 2010. Privatization in reproductive health services in Pakistan: Three case studies. Reproductive Health Matters 18(36):13-24.

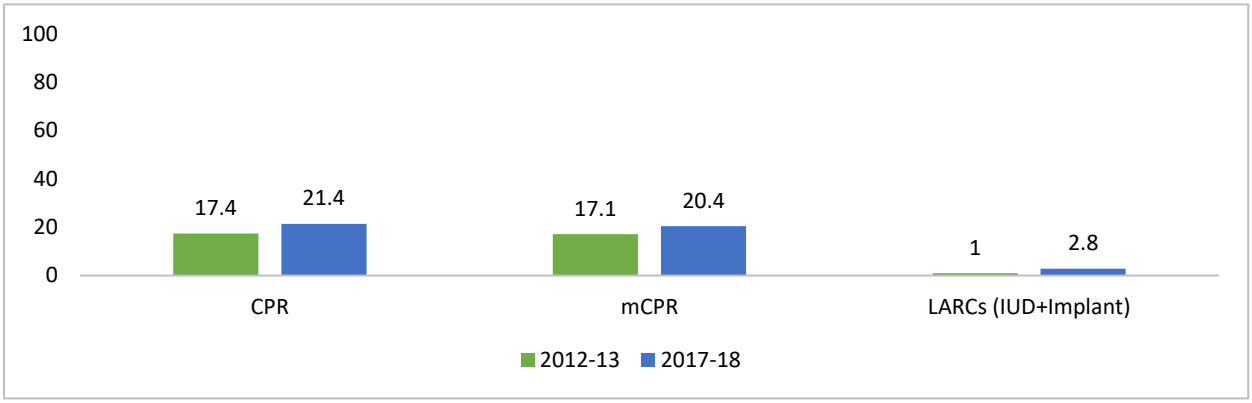
[21] https://www.healthynewbornnetwork.org/partner/peoples-primary-healthcare-initiative-pphi-sindh/

[22] ibid

[23] Martinez, J., Pearson, M., England, R., Donoghue, M., Lucas, H., Khan, M.S., Haq, B., Hayat, M., Moinuddin Q. H., Rehman, A. and Jogezai, M. 2010. Third-party evaluation of the PPHI in Pakistan. DFID-HLSP, Technical Resource Facility and SOSEC: Islamabad.

As shown in Figure 5, in the last five years, family planning use has increased with the mCPR among MWRA in rural Sindh rising by more than 3 percentage points (from 17.4 percent in 2012-13 to 20.4 percent in 2017-18), which seems to be the result of the public-private partnership programs.

Figure 5: Increase in contraceptive use in rural Sindh among MWRA



Source: PDHS 2012-13 and 2017-18

Another private organization that has partnered with the public sector is **HANDS**, which has evolved in 37 years as one of the larger non-profit organizations of the country with an integrated development model and disaster management expertise. Under its "Adopt a Hospital" initiative, HANDS has executed management contracts with the Department of Health. Under its Marvi Programme, supported by the Bill and Melinda Gates Foundation (BMGF), the organization has shown that access to health services can be improved in the most remote communities that are not served by LHWs by training local uneducated women to provide basic family planning materials and services, and enabling them to provide this service on a commercial yet affordable basis, provided there is a back-up organization (NGO or private entity) to ensure contraceptive supply and resolve other issues. Each community health worker ("Marvi") covers 100 to 150 households. By 2016, there were 945 Marvis in 21 districts across Pakistan. In target areas of the program in Sindh, CPR has increased from 9 percent to 27 percent in three years; while not a PPP, the program has demonstrated that the CPR can be raised quickly when the private sector replicates successful approaches of the public sector. Recently, the Sindh and KP governments have also signed MoUs with the HANDS for free provision of contraceptives in Sindh and in district Mansehra, KP, respectively.

Similarly, **Aman Foundation**, under its Sukh initiative, has also piloted some public-private partnership programs in peri-urban and rural Sindh. Most relevant is the training and subsidization of 200 LHWs to enable them to administer the first dose of injectable contraceptives.[24]

Integrated Health Services (IHS) is another NGO working to increase access by integrating health services. IHS has a contract with DoH Sindh since 2016 to operate 111 facilities (6 Taluka hospitals and 104 Rural Health Centers) in 21 districts of Sindh. Increased turnover of patients is reported in these revamped 24/7 facilities where services are free.

The **Employees Social Security Institutions (ESSI)** is another PPP model in Pakistan. It shares the service provision and financing role with the private sector but as the management is quasi-governmental, it could be considered a subsidiary body of the government.

[24] Najmi, H., Ahmed, H., Halepota, G.M., Fatima, R., Yaqoob, A., Latif, A., Ahmad, W. and Khursheed, A. 2018. Community-based integrated approach to changing women's family planning behaviour in Pakistan, 2014–2016. Public Health Action, 8(2), pp.85-90.

Social franchising initiatives have helped to build a network of facilities providing FP services and following consistent standards to ensure quality of care. The facilities are branded so that they are easily identifiable. Among the largest SMOs, Greenstar Social Marketing and Franchising is present in the country since 1995 and works on both the supply and demand side by strengthening private providers and creating demand through behavior change communications through all media. There is scope for increased public sector involvement in social franchising so as to bring networks of franchised private providers to scale for a broader health impact.

Clinical Franchising There are examples of government mechanisms that can guide the development and expansion of franchises, for instance, a pilot tested by PWD Punjab (2016-18) in DG Khan, Jhang, Layyah, Rahim Yar Khan, and Khushab districts.[25] It was anticipated that if every service provider partnering with PWD provides family planning services to 10-12 new clients per month, approximately 45,000-55,000 new family planning clients will be served in two years in these districts. The pilot test was executed with the assistance of NGOs having well-established linkages with private practitioners and service providers in their respective districts.

Voucher schemes have also been tested as small projects by NGOs such as Marie Stopes Society (MSS) and GSM with donor funding and these helped increase uptake of LARCs. However, implementing organizations have not had resources to continue or scale up. A study of the cost-effectiveness of implementation of Marie Stopes' *Suraj* social franchise in 29 districts in Sindh and 3 districts in Punjab between October 2013 and June 2016 found the cost per additional CYP to be $4.27 compared to business-as-usual from the perspective of the funder.[26] This compares the results to other interventions with similar objectives and it found that the voucher scheme was cost-effective and affordable, having the potential to be scaled up provided certain structured changes were incorporated.[27]

Table 5: Major Contributors of Couple Years Protection (CYP) – Reported in PBS 2016-17

Outlet	% of Total CYPs
PWD (Family Welfare Centers)	20.3
DoH (Lady Health Workers)	17.0
DoH (Health Facilities)	15.6
Greenstar Social Marketing	13.3
Marie Stopes Society	11.1
Rahnuma-Family Planning Association of Pakistan	10.7
RHS (Reproductive Health Services – PWD)	8.6
Others	3.4
National	100

Source: Pakistan Bureau of Statistics 2016-17

[25] https://pwd.punjab.gov.pk/system/files/Initiatives_0.pdf

[26] Broughton, E. I., Hameed, W., Gul, X., Sarfraz, S., Baig, I. Y., & Villanueva, M. (2017). Cost-Effectiveness of a Family Planning Voucher Program in Rural Pakistan. Front. Public Health 5:227. doi: 10.3389/fpubh.2017.00227.

[27] Azmat, S. K., Ali, M., Hameed, W. and Awan, M. A. 2018. Assessing family planning service quality and user experiences in social franchising programme–case studies from two rural districts in Pakistan. Journal of Ayub Medical College Abbottabad, 30(2), 187-197.

Findings from Provincial Consultations

Interest in Forging PPPs for FP

During the consultative meetings, all provincial participants confirmed that the challenge of reaching the FP2020 target of 6.7 million additional users of contraception will require enhanced resources, raising the per capita expenditure to the FP2020 commitment of $2.50, and a programmatic refocus to address the service needs of couples by introducing long-acting reversible methods, and policy reforms such as task sharing. They also agreed that the government alone cannot deliver fully on this commitment.

Participants agreed that the root cause of Pakistan's poor health indicators is an underfunded health system, with annual expenditure of only $12-13 per capita. The resulting considerable out-of-pocket spending on health has encouraged the private health sector to flourish, mostly providing curative services. If public finances can be used as an incentive to harness this sector for essential services to low-income populations, then chances of improving health indicators can be raised. Participants shared that there is a growing realization in the government of the significance of the private sector in contributing towards delivery of infrastructure and social services. This is manifested in recent legislative, policy, and institutional measures that provinces have undertaken in this respect.

There was a consensus across the provinces on the need for having PPPs to increase access to FP services, and to integrate these services with RH services and the MNCH program. Representatives from Punjab, KP and Balochistan emphasized the dearth of manpower in the public health sector and recommended that partnerships be forged to outsource facilities to private sector partners. They felt that PPPs could enable provision of evening services at PWD centers and in the MNCH departments of public sector hospitals. In Balochistan, the biggest issue is absenteeism and how to motivate government employees. Private partners may be involved to help resolve this issue. KP and Punjab expressed an interest in expanding provider networks for family planning services by increasing the number of family planning clinics and reaching out to underserved communities through private sector community-based distribution systems and SMOs.

During the consultative meeting in Punjab, representatives of the PPP Unit/cell said they were willing to support health sector projects with PPP contracts and mechanisms and they already have some experience in giving management contracts for government hospitals to the private sector, as in the case of Pakpattan Hospital. However, during an in-depth interview in Sindh, the government representative was of the view that the province has a functioning model for PPPs in rural areas in the shape of PPHI, and that post-18th Amendment, federal technical assistance is not required. The representative pointed out that PPHI already offers integrated services in Sindh, including MNCH, FP, immunization, nutrition, and general outpatient clinics for eye and dental care, as well as vaccination for dog bites, snake bites, etc.

Institutional Readiness for PPPs

Punjab, Sindh and KP have passed legislation to govern public-private partnerships, known in each province as the Public Private Partnership Act 2014, and each province has also established a PPP Cell under this legislation. The PPP cells/units in Punjab and KP are embedded in the Planning & Development Department while Sindh's PPP unit is housed within the Finance Division. The PPP cell is responsible for identifying partnership projects, carrying out initial screening and feasibility studies, and monitoring and coordination throughout the project life.

Since the 18th Amendment, which resulted in the devolution of social and infrastructural sectors, the provincial governments have developed PPP projects with wider application, for example in the transport, waste management, and energy sectors. However, there are very few examples of formal PPPs in the health sector, and those that exist mostly have a narrow focus on delivering infrastructural services. As mentioned earlier, the People Primary Health Initiative is deemed to be working well in Sindh, as are some other hospital management contracts, but these are yet to be evaluated externally.

Suggested Contours of PPPs for FP

Six partnership areas were identified, including service delivery and integration of services; governance; planning; implementation; human resource and government capacity building; and finances and commodity security. These blocks are described in Table 6.

There was agreement on the following:

- It is important for provinces to be clear about the specific issues that the partnerships would address, where and why investment is needed, how partnerships would be implemented, and by what means the performance would be monitored.
- Intermediary partners should be identified to act as an interface between the public and private sectors. These intermediaries could be NGOs, SMOs, academic groups, or professional associations.
- With regard to governance, government must be the lead organization advancing PPP efforts for FP, with technical, financial, and operational management assigned to both the public and private sectors. Contractual mechanisms should be established to help define the roles and responsibilities of each sector.
- Contractual arrangements should be duly notified and implementing committees formed, such as management and quality assurance committees. Management committees would monitor projects from the beginning, keeping track of all aspects agreed in the PPP contract. A regular monitoring mechanism should be put in place while periodic evaluation of the implementation work should be carried out in compliance with regulations through third-party audits.

Overall planning should be carried out as a joint effort by the government and private partners, with a need-based approach and a focus on the requirements of each region. The process should be based on solicited proposals. All PPPs should be initially tested as pilots, with potential future formalization and upscale.

Table 6: Partnership Building Blocks and Common Elements Identified in Provincial Consultations

Partnership Building Block	*Description*
Service delivery & services integration	Family planning service expansion by engaging private sector to offer services under the umbrella of mother and child health from all public and private sector facilities.
Governance	Public sector leadership; utilize the PPP Act and Units for awarding contracts and managing public finances; govern through committees with public and private sector representation. Establish regulations and enforce standards.
Planning	PPP to be set up through solicited projects, i.e., identified by government with support from a civil society or private sector consulting firm, which serves as an interface partner. Unsolicited proposals from private sector to be submitted to government for approval. Participation of different stakeholder groups, as intermediaries with defined roles, responsibilities and capacities, to assist in PPP management.
Implementation	Establish an Implementation Committee for strategic oversight and overall monitoring. Current *ad hoc* models in use can be scaled up. E.g., private sector can be engaged to introduce evening FP services at PWD centers MCH centers of public sector hospitals can be outsourced to private parties through management contracts and they can work for FP promotion and service delivery In Punjab, there is interest in the "Build, Upgrade and Transfer" or "Build-on-operate" model, under which private parties can build model MCH hospitals with initial support from the government (grant of land for construction of facility)
Human resource skills and government capacity	Hiring contractual employees from private sector
Finances and commodity security	Private pharmaceutical companies to lower profit margins on contraceptive products for bulk purchase by government

Conceptual Framework for PPPs for Family Planning

In this section, we present a conceptual approach that can help guide PPP planning and implementation. The framework we are proposing is generic and can be refined according to provincial requirements. The framework is also modular and can be modified in response to specific challenges. In the early stages of setting up partnerships, emphasis should be on creating an enabling environment for PPPs to flourish, and creating and promoting opportunities for partnerships. In some provinces, PPPs in health have already been implemented on an *ad hoc* basis; these too can be strengthened through use of this framework.

Step 1: A SWOT Analysis – What the Public and Private Sectors Can Offer

The main basis on which the public and private sectors can forge strong partnerships is the recognition that both sectors offer complementary strengths as well as limitations. Working together, the two sectors can address issues by utilizing their respective strengths, avoiding or compensating for one another's weaknesses, and capturing opportunities available to them. To identify what the public and private sector can offer in Pakistan's context, we conducted a SWOT (strengths, weaknesses, opportunities and threats) analysis, which is summarized in Figure 6.

Figure 6: Public-Private Partnership - Illustration of SWOT Analysis

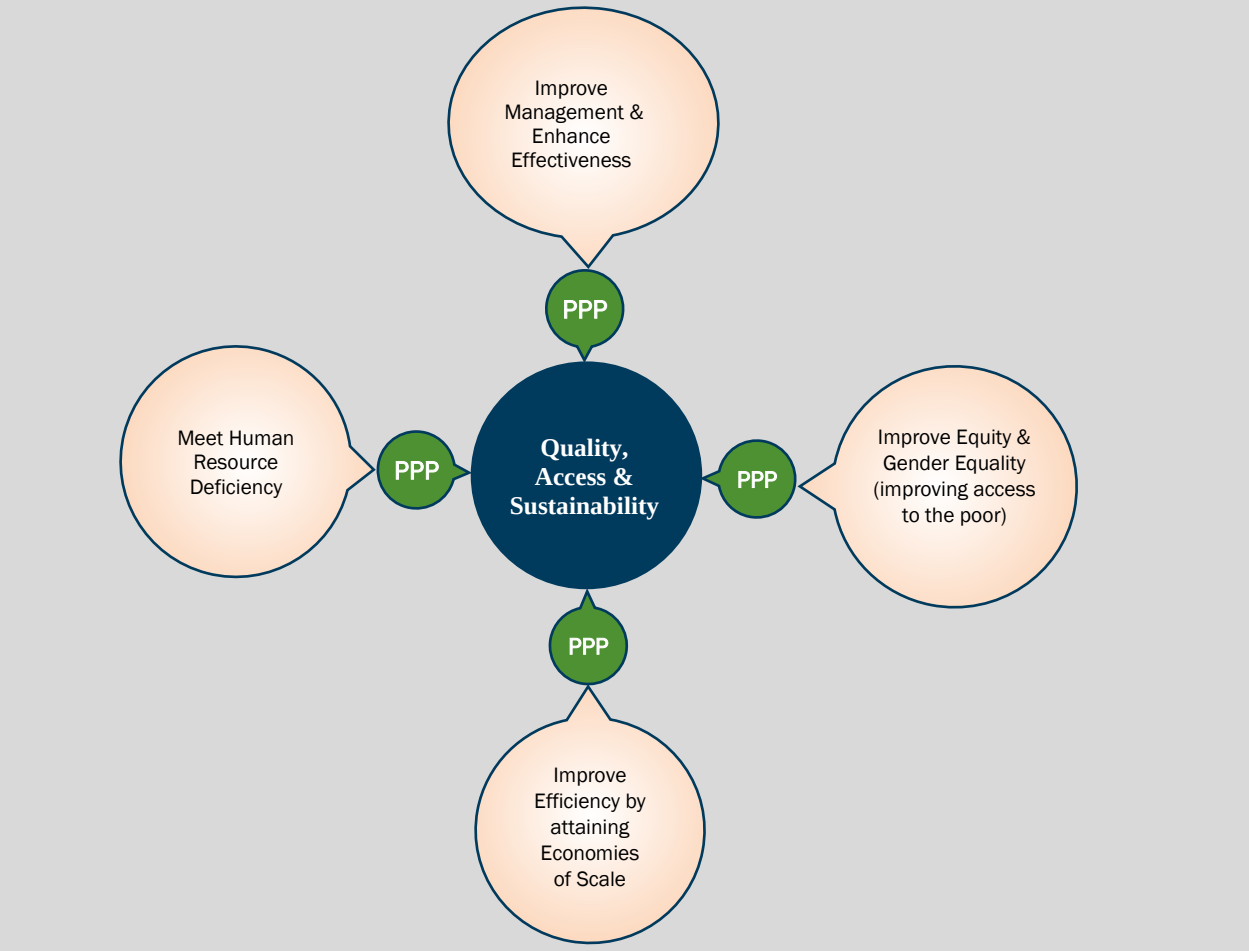
Strengths	**Public Sector** • Affordable services • Widespread physical infrastructure at various levels—primary, secondary, and tertiary • Training capacity • Technical competency	**Weaknesses**	**Public Sector** • Irregular supplies • Poor quality of services • Overcrowded, especially at large facilities • Deficiency of female providers • Inflexible rules and regulations • Ban on recruitment • Demotivated staff • Non-functional equipment
	Private Sector • Flexible • Hiring/firing is easier • Based on efficient business models Higher number of providers • Deeper penetration makes for greater efficiency and effectiveness		**Private Sector** • Poorly regulated fee for services • Focus on profit • Varying standard of services • Less focus on preventive, promotive, and non-lucrative services
Opportunities	**Public Sector** • Legal cover through PPP Act passed by the provinces • Chief Justice judgment encouraging PPP	**Threats**	**Public Sector** • Weak understanding of PPP • Possibility of abdication of responsibility by public sector • Mistrust of private sector
	Private Sector • Willingness to work with public sector • Realize the potential growth of their market as unmet need for FP is high (a market that can be easily tapped)		**Private Sector** • No maintenance of standards • Not respecting the ethics of voluntary FP service provision • Pushing for single "lucrative methods" • Overemphasis on profit

Step 2: Potential Areas for Developing PPPs for Family Planning

The overarching outcome of the proposed framework for PPPs for FP is to improve the quality of existing services and enhance access, efficiency, and future sustainability. Based on a SWOT analysis, outlined above, we have identified four areas where partnerships can be developed, which are shown in Figure 7.

Given the private sector's vast coverage of services and large number of providers, often extending to areas where public sector facilities are not present, PPP schemes can help reduce human resource deficiencies and help reach out to the marginalized. Joint procurement of equipment and supplies can reduce procurement and logistic costs, helping to enhance economies of scale. Private sector management is based on efficiency and introducing a similar culture in public sector entities can reduce inefficiency and wastage.

Figure 7: Potential areas of Public-Private Partnership Framework



Step 3: Creating the Enabling Environment for PPP

The following specific measures are needed to create an enabling environment for private sector participation in improving FP outcomes:

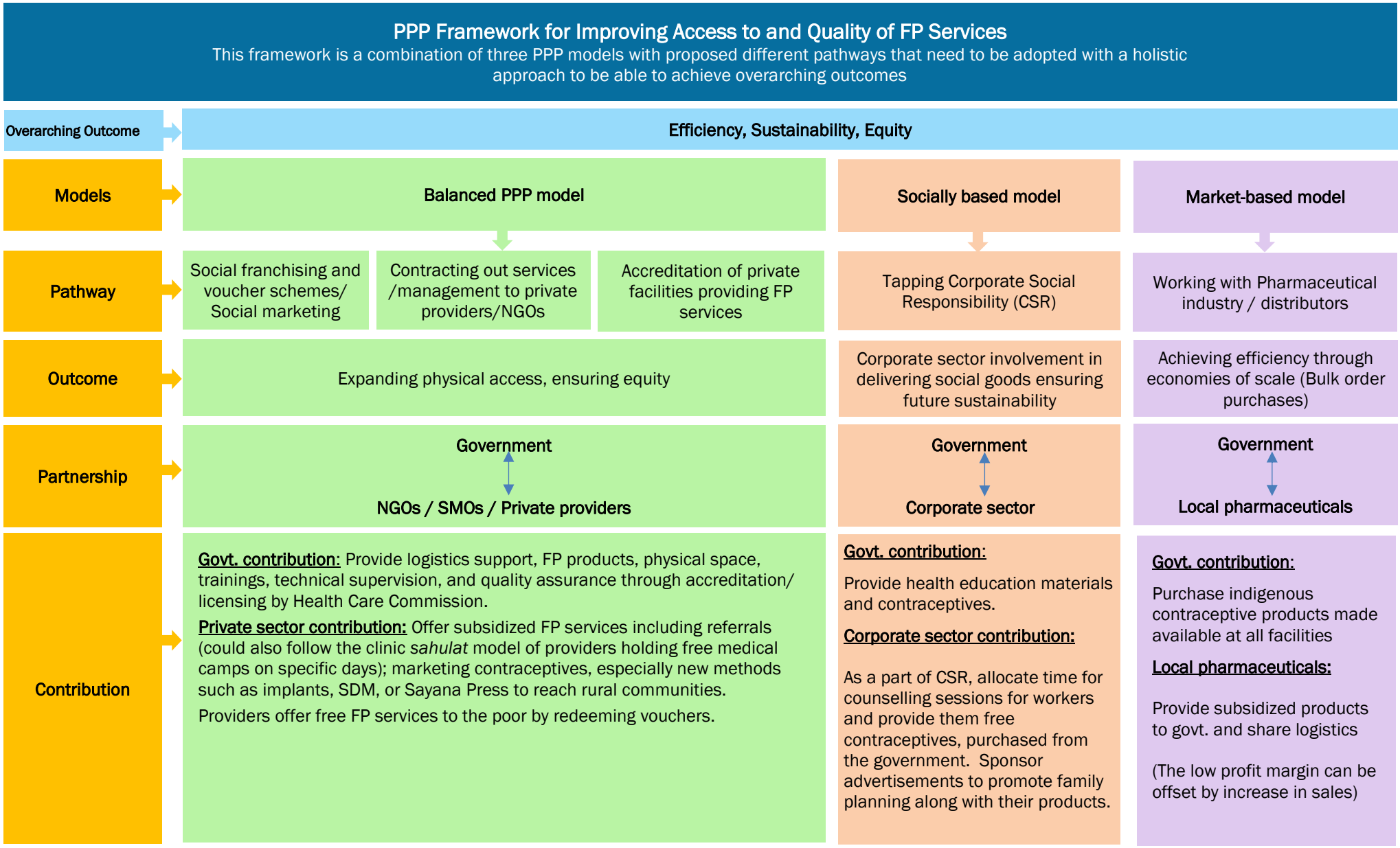
1. Create a broad-based consensus on the framework through provincial consensus building workshops.
2. Establish supportive policy and legislative frameworks to encourage private sector participation. This is the first and foremost step that will ensure that partnership are not established on an *ad hoc* basis.
3. Create institutional mechanisms for effective interaction and coordination with the private sector. The literature points to the utility of creating specialized PPP cell or nodes in the public sector to help foster partnership.
4. Identify an institutional funding mechanism, i.e., provision of funds through provincial ADP schemes, or soliciting PSD funding, and also explore donor interests.
5. Ensure that agreements between public and private sector entities take the form of formal written contracts rather than informal or nonbinding agreements such as MoUs. The contracts should lay out specific deliverables to be contributed by each partner and also clearly spell out penalties and rewards for each partner.
6. Accommodate the profit motive of the private for-profit sector in partnerships.
7. Increase capacity and skills required by public and private sectors for undertaking partnership initiatives in health. Staff capacity in the PPP cell/node/units must be developed through trainings to deal with legal, operational, and managerial requirements for successfully implementing the partnership. The PPP unit should have the commercial and legal skills needed to be a key source of support for the public sector in developing and financing projects.
8. Work closely with potential private sector partners to build their trust and willingness to be involved in partnership initiatives for improving outcomes, aiming for a win-win scenario for both partners.
9. Establish implementation oversight committees.
10. Develop consensus on a third-party evaluation mechanism. The generic components of such a mechanism are shown in Figure 9.

Proposed Public-Private Partnership Framework

Our proposed framework for PPPs for FP as based on the above concepts and responsive to the needs of Pakistan as expressed by our stakeholders is summarized in Figure 8 and described on the following pages. It incorporates three distinct models that have been individually tested in Pakistan and globally, and found to be feasible in our setting. However, the scale of their implementation has been generally limited or they have been executed as isolated initiatives addressing one issue or one segment of the population. The proposed framework advocates execution of a combination of the three models described in the literature as the balanced model, socially based model, and market based model[28] as a comprehensive initiative by the government to address the needs of all segments of users. The three models bring together the private (commercial) and social sectors together.

[28] Jeffrey Barnes. 2011. Designing Public-Private Partnership in Health. Bethesda, MD: SHOPS Project, Abt Associates.

Figure 8: Proposed Public-Private Partnership Framework



1. The **balanced model** brings together the social and commercial sectors. It is dependent upon commercial profits and social investments. The first aspect we propose under balanced PPP model is **Social Franchising**. The social franchiser (intermediary agency) utilizes public or donor funds to provide trainings; distribute commodities or products; and offer quality services through agreements with franchisees (commercial health providers) in a prescribed manner over a specified period. This type of partnership is effective for immediate improvement for quality of and access to services and for facility development.

   In the framework, we propose a model of social franchising in which the public sector supports interested private providers in far-flung areas in FP service provision by providing trainings as well as FP products and technical supervision, while the private providers offer subsidized services. The public sector can train private doctors and LHVs in a range of family planning services, including FP counseling; insertion of intrauterine device (IUDs), postpartum intrauterine contraceptive device (PPIUCDs), and implants; and manual vacuum aspiration (MVA) services. Providers meeting quality standards can be branded and allowed to use a predefined franchise logo. Similarly, private sector MNCH providers can be recruited to provide postpartum FP services. This approach was tried on a limited scale in Punjab in DG Khan, Jhang, Layyah, Rahim Yar Khan, and Khushab districts.

2. We also propose adding to the franchising model a **Voucher Scheme** for beneficiaries of the Benazir Income Support Program (BISP). Access to the franchised providers can be enhanced through the voucher scheme in selected areas where there is higher concentration of BISP beneficiaries. The government can issue vouchers to the poor to avail private sector services managed by a private sector voucher management agency. The voucher will cover the cost of travel to public sector facilities as well as private providers' fees, which will be predetermined.

3. We recommend expanding the outreach of existing **SMOs** to penetrate to the rural areas and provide contraceptives, especially newer products, at shops, pharmacies, and clinics of private providers. SMOs will also work with the government to launch behavior change communication programs leveraging their strong marketing capabilities.

4. Another aspect of balanced model is "**Contracting Out**" whereby the private sector offers a defined set of health care services in return for a pre-negotiated remuneration. In order to enhance the capacity of the existing public sector facilities, especially those that are understaffed, we propose in the framework that, applying the balanced model, the government contract out services to private providers, for example, unemployed Lady Health Visitors or Family Welfare Workers (FWWs), who can set up their clinics within the government facilities and provide subsidized services to FP clients in the evening hours, when the facilities are otherwise closed. This concept was suggested by senior government officials from KP during the provincial meetings. In addition, in order to reach underserved areas, the government should contract out to an NGO to provide FP services through community workers on the lines of the Marvi worker model practiced in Sindh, or outsource its Mobile Service Units to serve marginalized populations in hard-to-reach areas.

5. Another component proposed within this model is for the government to bring on board the private sector by making provision of affordable FP services a mandatory requirement for **accreditation** and licensing by the provincial health care commissions.

6. The **socially balanced model** aims to improve public health through engagement of the corporate sector. A typical example of the model is **corporate social responsibility** (CSR), in which the commercial sector helps to expand social welfare activities led by the government. The organized corporate sector

and other business and industry associations can play an increasingly significant role in such efforts as advocacy, funding of NGOs for innovative interventions, and allowing workplace FP service provision.

We propose that the government work with large corporate sector establishments requisitioning them to make family planning provision mandatory through all their health care facilities. Corporate sector entities may also be requested to allocate time for their employees to attend special FP counselling sessions and participate in clinics organized by the PWD/Health department at the workplace. Public corporations and other government departments should be involved in such initiatives as well, e.g., Pakistan International Airlines (PIA), Oil and Gas Development Company Limited (OGDCL), Pakistan Railways, Pakistan Steel, Pakistan State Oil (PSO), etc.

The cost of the clinic, including price of contraceptives provided during the clinic, may be borne by the commercial enterprise. Furthermore, the corporate sector can be engaged to air public service messages about family planning on the electronic media as well as the print media. These activities can be funded by corporate concerns from their CSR budgets; while they will not earn them profits, they will accrue social returns, i.e., a better public image as a responsible corporate body. In addition, having employees who are able to plan families could, in the long run, contribute to better health among their staff, reduced staff health expenses, and fewer maternity/paternity leaves, thereby improving worker productivity and lowering costs per worker.

7. In the **market-based model**, the commercial sector is encouraged to accept a tradeoff of lower profit on sale of contraceptives at the start of the initiative in exchange for greater growth and profit in the future. The commercial for-profit entity partners with the public sector with the objective of enhancing social impact. The model is sustained through profit generation. In this framework, we propose bringing on board the local pharmaceutical industry, such as ZAFA, Bayer, and others, to lower the profit margins on their contraceptive products, allowing bulk purchase of their products by the government for all its departments. The shortfall in price can be offset by the expansion of the market so the pharmaceutical concerns still make profits. New products such as implants and Sayana Press can in this way be introduced into the public sector.

Operationalizing the PPP Framework

Step 1 – Legislation: Many countries introduce PPP legislation as a more binding form of commitment to a PPP framework. National policies control and describe what should be done for approval, procurement and regulation of commodities, their promotion in the mass media, their sales and distribution or delivery of services. Policies also determine the amount of government financial resources that go to FP provision.

In Pakistan, three provinces have a dedicated PPP law which is a component of broader public financial management law. Specific details with regard to PPP for FP need to be elaborated. A clear policy, legal and regulatory framework should be established as PPPs depend heavily on contracts that are effective and enforceable. Where possible, legal terms and approaches familiar to the private sector should be employed. Moreover, laws and regulations as well as policy directives should be put in place to facilitate the partnership process as part of a total market approach.

Step 2 – PPP Forums: This should be followed by creation of joint PPP forums to facilitate the development of strategic operational plans by the PPP units/cells and roadmaps for implementation. The strategic plan identifies the roadmap that guides implementation. Importantly, a PPP cell or unit in the planning and development department should develop the operational plan that includes guidelines, staffing and capacity strengthening requirements.

It should notify a PPP Task Force with membership from public and private sectors including NGOs, development partners, and academic and professional societies' representatives, which should have quarterly meetings to support the work of promoting PPPs, overcoming bottlenecks, and increasing transparency and accountability. The task force can also develop joint proposals for receiving funding from global financial facilities.

Step 3 – New Financial arrangements: Financial plans should be drawn up to demonstrate high-level political support, to indicate the potential flow of future projects, and to explain how projects fit together within the context of provincial and national plans.

Step 4 – Manual development: To ensure discipline in all these processes, a detailed PPP Manual must be developed that clearly outlines the standards that ensure that clients obtaining services from the private sector are making fully free and informed decisions.

Step 5 – Supply supporting materials: Guidance materials, such as manuals, and other tools to formalize PPP procedures should be developed to supplement policy statements or legislation, as a codification of good practice.

Timelines for Implementation of the Framework

The timelines are broken down into four logical phases of inception, development, implementation, and mainstreaming and review, as follows:

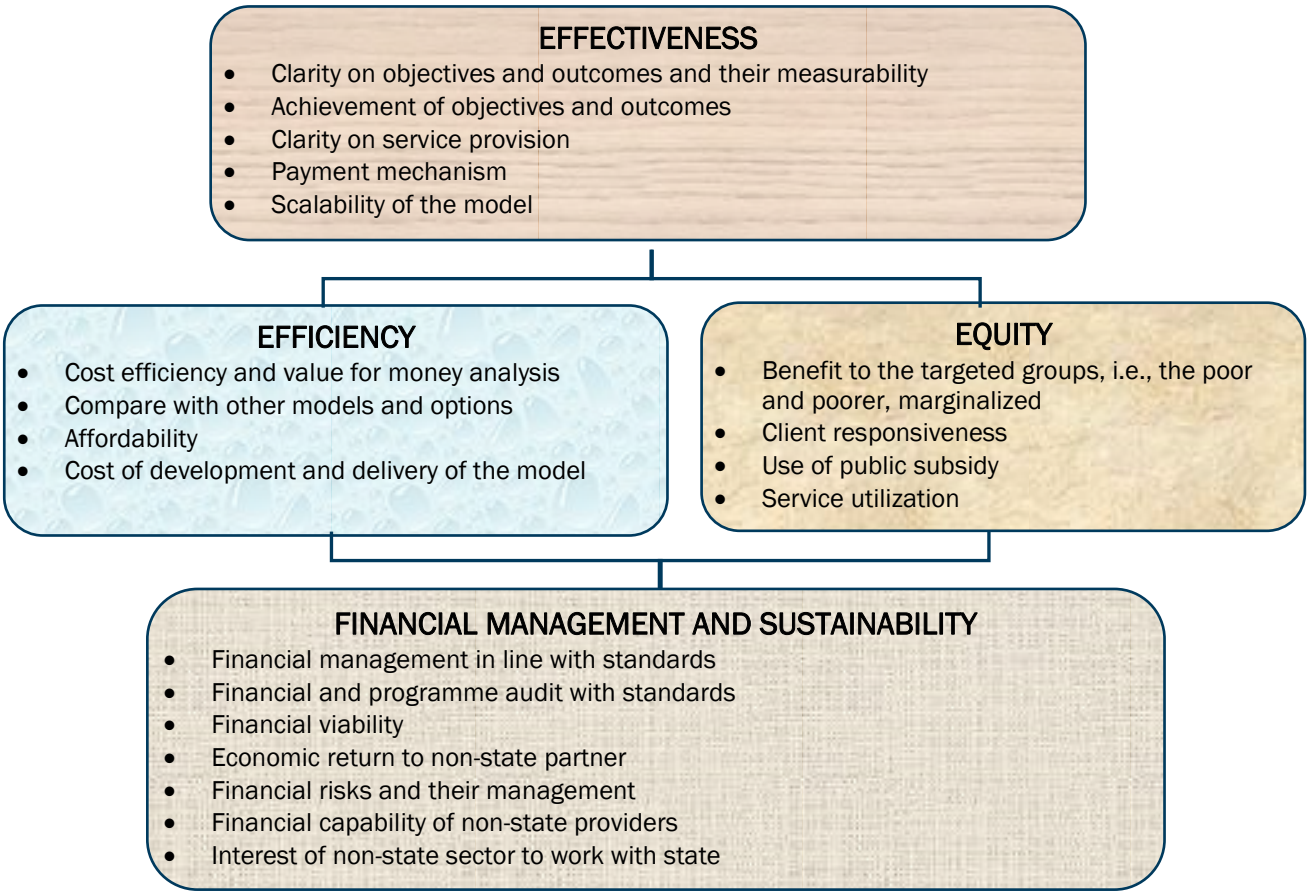
- Inception Phase – within 6 months
- Development Phase – within one year
- Implementing Phase – within 2-3 years
- Mainstreaming & Review Phase – 3rd year onwards.

- The development phase will entail finalization and approval of all proposed instruments necessary for creating supportive policy and legislative frameworks for engaging the private sector. In the implementation phase, proposed activities will be carried out as per the roadmap, having stipulated timelines and targets.
- An evaluation is proposed at the end to take stock of implementation. This will help in understanding challenges faced, documenting lessons for further improvement, and proposing a set of recommendations for a revised strategy. In essence, the strategy will seek to sustain an enabling environment for private sector contribution and engagement in improving FP outcomes in each province.
- The importance of having a competent PPP unit that is staffed with highly qualified individuals able to work across government departments cannot be overemphasized. If a successful PPP program is to be delivered, both project management and rapid monitoring mechanisms are critical.

PPP Framework Evaluation Model

Once the PPP framework has been implemented, a strong and robust evaluation should be designed, broadly following the steps shown in Figure 9.

Figure 9: PPP Framework Evaluation Model



Source: Adapted and modified from KPMG. The Emerging Role of PPP in the Indian Health Sector. Policy Paper

Conclusions

As the Supreme Court recommendations (2.2 & 2.5) state the inclusion of expanding private sector involvement with earmarked funds, the provincial governments must take the leap and make the private sector a key partner to support them in achieving universal health coverage, the FP2020 goals, the SDGs, and other public health commitments made by Pakistan for improving the wellbeing of people.

The time is ripe for taking forward the conceptual framework and roadmap presented in this report, and for the provincial governments to develop a blueprint for strong, sustainable, and effective PPPs. Legally binding alliances between the public, private, commercial, and NGO sectors can help address the unmet need for FP and basic health services. This could make access more equitable by reaching populations that are vulnerable and underserved, both geographically and from a demographic perspective. A quick win strategy proposed here is to adapt existing examples of PPPs in the country and in neighboring countries, with formulation of relevant guidelines to ensure discipline in the partnership projects.

Given the public-private market shares (existing and potential) for health services and products, and consumer preferences, there are various roles and responsibilities for both sectors. PPPs provide opportunities to capitalize on strengths, maximize the use of existing capacity, create competition, achieve economies of scale, extend service delivery networks, reach the poor, and mobilize additional resources. All endeavors need the support of favorable policies, open dialogue, and resources.

Annexures

Annex - 1 Feedback from provincial consultative meetings for developing PPP framework

Balochistan

public-private Partnership for FP through a provincial PPP Law and process	• PPP for FP is a new concept in Balochistan. • The partnership will be established through a legal contract between public and private sector partners with clearly defined roles and responsibilities of each sector. • There is no current PPP Act or system in the province. This will be rectified with advocacy.
Objectives of PPP	The PP partnership will aim to contribute towards achieving Balochistan FP 2020 goals of: universal access to safe and quality reproductive health/family planning services by 2020, increase CPR and in mCPR
Service delivery & Integration	The PPP will allow private sector including pharmacies and NGOs & SMOs through a 'pay for performance' contract for: • investment in family health services MNCH and family planning targeting urban slums and rural communities; • expansion of networks for family planning service delivery points by reaching out to unreached communities with community based distribution and social marketing systems;
Governance	• The Population Welfare Department will be the focal organization advancing family planning efforts in Balochistan and overall leadership will be with the Government • Technical, financial, implementation and operational leadership will be assigned to both public and private sectors. • Sector leaders will be responsible for deliverables of their areas
Planning	• The planning will be done by the government and the partners jointly, keeping in view the need-based approach and requirement of that area. • Contract will be signed between public and private partners and roles and responsibilities of each partner will be clearly defined • The management committee should monitor projects from start, keeping track of all aspects agreed in the PPP contract.
Implementation	• Each partner will participate in the implementation according to the roles and responsibilities agreed in the contract • A mechanism will be developed for regular monitoring and periodic evaluation of the implementation work by implementing partners • Compliance of laws and regulations will be checked by a third-party audit
Human Resource	• Policies for task shifting will be formulated and providers will be trained accordingly to ensure quality • Private sector will be assigned to fill the gap where facilities and structures are available but the government is not able to provide qualified and capable persons for service delivery
Finances & Commodities	• The provincial government will allocate budgets for each year • Other sources of finances including donors and development partners; UN agency contribution • Soft loans from international financial institutions and tax exemption from government for the commodities can also be tried to arrange needed resources.

Khyber Paktunkhwa

public-private Partnership for FP through the current PPP Law and process	• The partnership will be established through a legal contract between public and private sector partners with clearly defined roles and responsibilities of each sector using the existing PPP system in the province, which has thus far been used for other sectors such as roads e.g.: Chitral expressway • No request has yet been put forward by PWD for PPP to the legal PPP unit or node for assistance.
Objectives of PPP	The PP partnership will aim to contribute towards achieving KP goals of : • universal access to safe and quality reproductive health/family planning services by 2020. • increase Contraceptive Prevalence Rate (CPR) to 42percent by 2020. • raise modern CPR from existing level to 28percent by 2020. • reduce unmet need for family planning to 15 percent by 2020.
Service delivery & areas of service Integration	The PP partnership will allow private sector and NGOs (Social franchising and social marketing organizations and pharmacies) through a 'pay for performance' contract for • investment in family health and family planning targeting urban slums and rural communities; • expansion of networks for family planning services by increasing the number of family planning clinics and reaching out to unreached communities with community based distribution and social marketing systems; • undertaking operations research activities in search of proven innovative methodologies for service delivery; and • Introduction of gender specific career counseling within the framework of existing counseling services.
Governance	• The KP Population Welfare Department will be the focal organization advancing family planning efforts in KP and overall leadership will be with the Government • Technical, financial, implementation and operational leadership will be assigned to both public and private sectors. • Sector leaders will be responsible for deliverables of their areas • Governance will be informed through two notified committees, for example: Management and Quality assurance committees
Planning	• The planning will be done by the government and the partners jointly, keeping in view the need-based approach and requirement of that area. • Contract will be signed between public and private partners and roles and responsibilities of responsibility of each partner will be clearly defined • The management committee should monitor projects from start, keeping track of all aspects agreed in the PPP contract.
Implementation	• Each partner will participate in the implementation according to the roles and responsibilities agreed in the contract • A mechanism will be developed for regular monitoring and periodic evaluation of the implementation work by implementing partners • Compliance of laws and regulations will be checked by a third-party audit
Human Resource	• Policies for task shifting will be formulated and providers will be trained accordingly to ensure quality • Private sector will be assigned to fill the gap where facilities and structures are available but the government is not able to provide qualified and capable persons for service delivery • Capacity building: Contracts are critical to the success of the PPP initiative: both for infrastructure and for service contracts. There is a critical need for adequate contract management knowledge and thus capacity building essential for government institutional development so that PPP is delivered properly. Current PPP unit is in place and can lead on this.
Finances & commodities	• The provincial government will allocate budgets for each year • The programmes, projects and schemes premised on the goals and objectives of the Policy 2015, covering all out efforts at reaching population replacement level by 2032 and advancing towards

	stabilization by 2045, will be adequately resourced and sustained in view of their critical importance and linkage with provincial development endeavor • Other sources of finances including the annual development program finances (ADP) , donors and development partners; UN agency contribution and INGOs can also be tapped • Soft loans from international financial institutions and tax exemption from government for the commodities can also be tried to arrange needed resources.

Punjab

public-private Partnership Government of Punjab	• The Punjab public-private Partnership Act 1X of 2014 exists. There is a PPP cell within Planning & Development Department , Government of Punjab • A public –private partnership for health sector projects thus far has taken the form of management contracts with hospitals. • FP projects can also be explored with assistance from the PPP department.
Objectives of PPP	The PPP will aim to promote • use of contraceptive to increase the CPR • discourage abortions to prevent the birth of unplanned child
Service delivery and services Integration	• Area of collaboration will be the mother and child health and under this umbrella FP services can be provided by private sector providers. (This implies the linking of FP with MNCH)
Governance	• Government can outsource the project to private parties and both parties are to abide by the terms of the contract
Planning	• Under the existing PPP in Punjab, there are 2 types of PPP projects, one is solicited PPP project and other is un-solicited PPP project. Solicited project means that government agency will identify and conceive the project, they can have any consulting firm involved in PPP transactions for them, and develop a whole PPP project. • Unsolicited projects are planned by private sector parties and submitted to the government for acceptance
Implementation	• There could be 3 models for implementation of FP projects under existing PPP: • Evening service in PWD centers can be outsourced to private sector to provide FP services • Mother and child health care centers of public sector hospitals can be outsourced to private parties through a management contract and they can work for promotion and service delivery of FP • 'Built on upgrade transfer' or 'built on operating model'. Under this model private parties can build model mother and child heath care hospitals with initial support from the government (grant of land for construction of facility) under a contract regarding their future ownership and operations
Human Resource	• Since government will outsource the facilities, human resource needed to run these facilities will naturally will be the responsibility of private sector
Finances & commodities	• The government will provide the facilities (in other words cost of infrastructure) or soft loans to build MCH facilities to private sector and private sector will be responsible for their operating expenses.

Annex - 2 Global PPP Experiences

The literature has many examples of public-private partnerships playing a significant role in increasing the use of contraception and reducing population growth rates. In many developing countries, including South Korea, Thailand, Indonesia, and Morocco, governments encouraged PPPs by introducing policies that enabled private providers to deliver FP services as well as supplies.

Providers played an important role in motivating potential users to make informed decisions about achieving a small family size. NGOs' outreach workers were used for interpersonal communications with potential users to clear myths and misperceptions about contraceptive use. The successes achieved by various public-private partnerships and the role of both partners in the partnerships are summarized in Table 4.

Table 4: Global examples of public-private partnerships

Country	Role of public sector	Role of private sector	Impact
South Korea	• Strong leadership endorsement • Intensive outreach and education effort	• Private physicians trained and engaged • Service voucher program for long-acting reversible methods (LARMs)	• Increase in CPR from 18% in 1964 to over 80% in 2001 • Decline in TFR to below replacement level
Thailand	• Provision of pills and IUDs by midwives	• Popularization of FP in communities through Population and Community Development Association	• Increase in CPR from 14% in 1970 to 70% by 1993 • Decrease in TFR from 6.3 in 1963 to 1.7 by 2003
Indonesia	• Promotion of small family norm • Engagement of religious leaders	• Pioneering of private provider networks	• Increase in mCPR from 5% to 57% • Decrease in TFR from 6 to 2.6
Morocco	Authorization of Direct-To-Consumer (DTC) marketing and advertising	• Pharmacists trained • Lowering of oral contraceptive prices by manufacturers	• Increase in pill use from 16% to 21% • Increase in mCPR from 20% to 289% • Decline in TFR from 4% to 2.5%

Notably, among the examples listed above, Indonesia's PPP is of special relevance to Pakistan. In 1995, a public and private sector team supported by PSI visited Indonesia on a study tour to learn about the private provider network model there. This was then replicated by Greenstar Social Marketing (GSM) in Pakistan as the "*Sabz Sitara*" franchise network which became the largest private sector family planning/reproductive health network in the world. This franchise model has not only been replicated in Pakistan but also in several other countries in Asia and Africa.

One of the lessons that can be learnt from PPP programs that have had a national impact is that that they are built on a sound PPP framework which defines the policy, procedures, institutions, and rules that together direct how the PPP will be implemented. The key levers of global PPP success examples include high level of political and policy support; certainty of payment for the private sector; and underpinning of the PPP program by a legal framework. In addition, in successful cases, the government was the funder providing grant, capital, or asset support to the private sector, which was engaged in provision of FP services on a contractual basis, and the role of regulator also remained with the government while the role of coordination was assigned to an interface agency, such as an NGO, SMO, or professional association.

The Paris Declaration on Aid Effectiveness, signed by over 100 developed and developing countries in 2005,[29] presents the following five important principles for PPPs, which we recommend should be used as the driving force in Pakistan's PPPs:

1. **OWNERSHIP** – PPPs are owned by the government, which identifies its own strategies, and improves its institutions;
2. **ALIGNMENT** – All organizations bring their support in line with the government's strategies and use local systems;
3. **HARMONIZATION** – Organizations coordinate their actions, simplify procedures, and share information to avoid duplication;
4. **RESULTS** – There is a focus on producing—and measuring—results; and
5. **MUTUAL ACCOUNTABILITY** – All parties are accountable for results.

Tanzania Policy: Public- Private Partnership

Since the mid-1990s, the Tanzanian government has followed a policy of public-private partnerships. According to the Tanzanian Ministry of Health's 2006 annual report, private service providers now account for 40 percent of health care provision in Tanzania. The remaining 60 percent is covered by the state. In order to reach the ambitious targets of the Tanzanian health programme, both parties cooperate with one another, share resources, and coordinate their services.

The development of a service agreement between state and private health care providers has been approved by the Ministry of Health and the authorities for regional administration and community policy.

The Tanzania NGO Alliance Against Malaria (TANAM), a national level NGO consortium, used the PPP approach to address malaria control. This PPP demonstrated that relationships between the public and private sectors may begin from very humble and loose beginnings. However, with perseverance from committed individuals, vision, and trust, the partnership relation may become powerful advocates for meeting prescribed health agendas.

Source: TANAM (2008) Tanzania National Malaria Movement (TANAM) - First breath fresh air conference - November 18-20, 2008. AMREF and European Union.

[29]https://www.oecd.org/development/effectiveness/parisdeclarationandaccraagendaforaction.htm

Annex - 3 Glimpses from provincial consultative meetings for developing PPP framework

Peshawar - November 16, 2018

Lahore - November 24, 2018

Quetta - December 12, 2018

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