July 2019

Improving Access to Family Planning Services through the Private Sector in Pakistan

A Stakeholder Analysis

Improving Access to Family Planning Services through the Private Sector in Pakistan

A Stakeholder Analysis

July 2019

POPULATION COUNCIL
Ideas. Evidence. Impact.

The Population Council confronts critical health and development issues—from stopping the spread of HIV to improving reproductive health and ensuring that young people lead full and productive lives. Through biomedical, social science and public health research in 50 countries, we work with our partners to deliver solutions that lead to more effective policies, programs and technologies that improve lives around the world. Established in 1952 and headquartered in New York, the Council is a nongovernmental, nonprofit organization governed by an international board of trustees.

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

Table of Contents

List of Tables

List of Figures

Acknowledgments

This study titled “Improving Access to Family Planning Services through the Private Sector in Pakistan – A Stakeholder Analysis” was commissioned by the United Nations Population Fund (UNFPA) and carried out by the Population Council, Islamabad. Financial support for this study from the UK Government’s Department for International Development is gratefully acknowledged.

In conducting this study, we relied greatly on the leadership of Dr. Ali Mohammad Mir, Associate and Director of Programs; we are extremely grateful to Dr. Zeba A. Sathar, Country Director, Population Council for her visionary perspective and technical inputs during report writing.

We extend our warm gratitude to all of the study respondents, including interviewees and discussion participants, whose valuable perspectives and experiences provided the substance of this report.

We thank Dr. Ayesha Rasheed, Consultant, for a systematic review of literature on public and private sector family planning programming in Pakistan.

Special thanks go out to our field team for their excellent contributions and dedication. We also appreciate the efforts of our data processing team, who transcribed, translated and coded data in NVIVO against a stringent timeline. We extend our sincere thanks to Mr. Usman Ghani who managed the data.

We thank Ms. Samia Ali Shah, Project Director, for her helpful inputs, oversight and editorial support. We owe gratitude to the Administration and Financial Management team at the Population Council Islamabad office, who worked hard to facilitate the implementation of field activities. We thank Mr. Ali Ammad for formatting and laying out this report.

Authors

Iram Kamran
Rehan Niazi
Tahira Parveen
Mumraiz Khan
Kiren Khan

Acronyms

ADP	Annual Development Program
BHU	Basic Health Unit
CMW	Community Midwife
CPR	Contraceptive Prevalence Rate
CYPs	Couple-Years of Protection
DFID	Department for International Development
DKT	Deutsche Kautschuk Tagung
DoH	Department of Health
DRHR	Delivering Reproductive Health Services
FGDs	Focus Group Discussion
FP	Family Planning
FPAP	Family Planning Association Pakistan
FWW	Family Welfare Worker
GSM	Greenstar Social Marketing
HANDS	Health and Nutrition Development Society
IDIs	In-depth Interviews
His	Integrated Health Services
IUCD	Intrauterine Contraceptive Device
LAM	Lactational Amenorrhea Method
LARCs	Long-acting Reversible Contraceptive Methods
LHV	Lady Health Visitor
LHW	Lady Health Worker
MCH	Mother and Child Health
mCPR	Modern Contraceptive Prevalence Rate
MNCH	Maternal, Neonatal and Child Health
MoU	Memorandum of Understanding
MPI	Multidimensional Poverty Index
MSI	Marie Stopes International
MSS	Marie Stopes Society
MSU	Mobile Service Unit
MWRA	Married Women of Reproductive Age

NGO	Non-governmental Organization
NMNCH	National Maternal, Neonatal & Child Health Program
PDD	Department of Planning and Development
PDHS	Pakistan Demographic Health Survey
PPHI	People's Primary Healthcare Initiative
PPIF	Punjab Population Innovation Fund
PPP	Public–private Partnership
PRSP	Punjab Rural Support Programme
PSI	Population Services International
PWD	Population Welfare Department
RH	Reproductive Health
SF	Social Franchise
SHOPS	Strengthening Health Outcomes Through the Private Sector
SMO	Social Marketing Organization
TFR	Total Fertility Rate
TMA	Total Market Approach
UNFPA	United Nation Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Pakistan's population has crossed 208 million and is growing at a high rate of 2.4% (1998–2017). The contraceptive prevalence rate (CPR) regressed from 35% to 34% between 2013 and 2018, despite unmet need for family planning (FP) among 17.3% of married women of reproductive age (MWRA) (PDHS 2017–18). According to recent studies, key barriers to uptake of FP include difficulties in reaching public health facilities as well as poor care quality at these facilities, particularly, discouraging attitudes of providers, frequent stock-outs of contraceptives, and inadequate counseling. Private health facilities are often perceived by users to offer better quality of care and are far more physically accessible as they are more numerous than public facilities. However, they are less affordable and a substantial proportion do not offer FP services. There is growing realization among Pakistani policymakers, as in the wider international community, that the capacity of the private sector must also be utilized systematically through formal public–private partnerships (PPPs) to attain FP and other development goals.

This analysis of private sector stakeholders was carried out by the Population Council with support from the United Nations Population Fund (UNFPA) to assess their current role in FP service provision, the challenges they face in providing FP services, and their viewpoints about PPP to improve access to FP services, and to identify the broad avenues and modalities for cooperation and implementation of PPPs in FP. The funding for the study was provided by DFID UK. The study included secondary data analysis and a qualitative study of private sector and user perspectives, complemented by literature reviews concerning global experiences of PPPs for FP and models for increasing private participation in FP service provision in Pakistan.

The private sector stakeholders who participated in the qualitative study included 156 service providers, 29 pharmacists, 26 wholesalers and distributors, 3 importers, 1 manufacturer, 6 non-governmental organizations (NGOs) and 2 social marketing organizations (SMOs). In-depth interviews (IDIs) were conducted with these stakeholders. In addition, perspectives of consumers were also covered through 47 focus group discussions (FGDs). The FGDs and IDIs were conducted in six districts across four provinces, including Bahawalpur and Faisalabad in Punjab; Thatta and Sukkur in Sindh; Lasbela in Balochistan; and Mansehra in Khyber Pakhtunkhwa (KP).

Secondary data analysis shows that utilization of the private sector for FP services has been growing and now exceeds public sector utilization. In terms of specific sources, there are significant differences between provinces and urban and rural areas. Overall, users with greater ability to pay are relying more on the private sector than on the public sector for FP services and those with the least ability to pay are relying more on static public sector facilities. However, this division is not clear-cut: about 40% of users in the low wealth tertile are using the private sector, where they pay from their own pockets, while one third of those in the high wealth tertile use the free services of the public sector, indicating a need for implementing total market strategies.

Review of literature about global PPP experience indicates that effective partnerships are built on a sound framework with a clearly defined policy, procedures, institutions and rules. Key levers of success include high political and policy support; certainty of profit for the private sector; and underpinning of the PPP program by a legal framework. In successful cases, the private sector was contracted to provide FP services, with the government funding and regulating and an interface agency coordinating efforts.

In Pakistan, the public sector serves a relatively larger proportion of poor users but is less cost-efficient. Private facilities offer more choice of FP methods. Two of the more common models of PPPs in health/FP include contracting out of primary healthcare facilities to the private sector and capacity building of public service providers by private organizations.

Focus group discussions with men and women reveal users to be well-aware of the relative strengths and weaknesses of public and private sector FP services. The public health facilities are perceived to offer free services and better trained providers but these advantages are outweighed by impolite behavior, substandard contraceptives, shortage of staff and stocks, and long waiting periods. The private sector is expensive, but offers more client-centered attitudes, a cleaner and more peaceful environment, and perceived better quality of contraceptive commodities. Most men and women are very keen for the two sectors to work together. In their view, PPPs should ensure more client-centered services, extend service hours, and bring FP services closer to their homes. The private sector should deliver services while the public sector should lead, manage, and monitor.

In-depth interviews with private sector stakeholders find universal receptivity to PPPs. Among challenges in providing FP services, the most important and frequently cited is low demand. In addition, service providers and pharmacy staff require training to counsel clients, while importers and manufacturers are worried about new licensing requirements and possible price controls. Additional constraints for SMOs and NGOs include diminishing funding from donors, difficulties in obtaining permissions to operate, and low government interest in helping to continue or scale up their initiatives. Respondents identify the following areas for government support under PPPs:

1. Demand generation: A consistent and core demand is that the government play an active role in creating demand and awareness in the public about the need for FP and the methods, brands, and sources available. Respondents suggest general campaigns as well as promotion of specific local brands. Social media, awareness sessions, but most of all TV advertising is proposed for effective behavioral change communication; a fourth route, mentioned by consumers, is door-to-door counseling visits.

2. Training of service providers and pharmacists: Most service providers and pharmacists are interested in providing FP services and want the public sector to train them in provision of FP services/methods, especially side effect management. Private providers believe they can learn a lot from working with public sector providers. Pharmacists want basic information and information, education, and communication (IEC) materials that they can give to customers or use to guide them.

3. Supply of free/subsidized contraceptives: Service providers and pharmacists would like the government to provide them a regular supply of free contraceptives that they can provide to clients for free or at nominal charges. Wholesalers and distributors would like their networks to be used by the government to supply products to the private sector, with permission to earn nominal profits.

4. Enabling environment for manufacturing/importing contraceptives: Contraceptive manufacturers and importers are willing to invest in increased supply but very apprehensive about the government's new licensing requirements and the risk of price controls. Contraceptive pricing is a sensitive issue that should be negotiated carefully. In addition, manufacturers and importers want tax exemptions. Respondents also suggest that the government offer buyback guarantees for five years; this, coupled with export-oriented production and government promotion of local brands, will help establish local production and also help improve the trade balance.

5. Financial incentives and resources for service delivery: Until demand for FP services reaches a level that ensures profits, private service providers as well as pharmacists, wholesalers and distributors will need some incentivization from the government. Among pharmacists and suppliers, incentives can take the form of cash and gifts, as well as permission to charge nominal profit margins on free commodities supplied by the public sector. Individual private providers would like the government to invest in their clinics and permit them to work in the evenings at public facilities.

6. Task shifting to enhance performance of providers and better collaboration: Various cadres of service providers can be encouraged to play a greater role in FP service provision. The pharmacists interviewed in this study said they would like their medical staff to be permitted to administer injectables.

NGOs and SMOs and the provincial governments share a common interest in expanding provider networks and reaching underserved communities. Provincial governments should consider financially supporting SMO/NGO initiatives that have demonstrated results and can become sustainable. There is also an urgent need to address the current trust deficit between the government and NGO sector.

Contracting out is generally recognized to have worked well and there is interest in extending the model of People's Primary Healthcare Initiative (PPHI) Sindh to Balochistan. However, financial and human resource management issues will need to be addressed for the long-term sustainability of partnerships of this nature.

The study finds that partnerships for FP are not only possible but, in the view of many respondents, essential for synergizing action. All private sector stakeholders recognize that such partnerships must be adopted in which the relative strengths of each player are leveraged to serve the most appropriate segment of consumers. International experience shows that mutual trust is pivotal for successful PPPs. To be an effective steward, the government must invest, first and foremost, in its own capacity to negotiate and manage effective contracts and monitor and evaluate performance of PPPs, so it can lead in line with the five partnership commitments of the 2005 Paris Declaration on Aid Effectiveness, i.e., government ownership; alignment with government priorities and local systems; harmonization of efforts of all organizations; management for results; and mutual accountability.

1. Introduction

Pakistan's population has crossed 208 million and continues to grow at an alarmingly high rate, estimated at 2.4% between the 1998 and 2017 censuses. While it was one of the first countries in the region to introduce a family planning (FP) program and witnessed a rapid increase in FP use in the 1990s—mainly attributed to the introduction of the Lady Health Worker (LHW) Programme—the country's recent efforts to increase contraceptive uptake and lower fertility have yielded disappointing results. Over the past two decades, the decline in the country's total fertility rate (TFR) has stalled, with the TFR creeping down from 3.8 to only 3.6 between 2013 and 2018. Moreover, the latest round of the Pakistan Demographic and Health Survey (PDHS) reveals that the contraceptive prevalence rate (CPR), which the country committed to raise from 35% to 50% by 2020 at the 2012 London Summit, has actually decreased to 34.2% (PDHS 2017–18). Meanwhile, a huge proportion of total demand for FP—51.5%, according to PDHS 2017–18—remains unmet, leaving an estimated 6 million married women (17.3%) at risk of unwanted pregnancies.

FP services are delivered in Pakistan through both the public and the private sectors, with the private sector including commercial entities as well as social marketing organizations (SMOs) and non-governmental organizations (NGOs). Key Social Marketing and Greenstar Social Marketing were the two major organizations that started working in Pakistan in the early 1990s, providing reproductive health services through social franchising networks of private providers. Key Social Marketing was funded by the Department for International Development, UK (DFID) through Futures Group International, a US-based SMO, while Greenstar began as a project of Population Services International (PSI) supported by the United States Agency for International Development (USAID) (Ravindran 2010). Although both the public and private sectors have been playing their roles in FP service provision, thus far, no concerted strategy has been developed or implemented by the government to introduce a total market approach (TMA) to synergize the roles of different sources (Population Council 2016).

Recent studies indicate that main contributing factors in the low uptake of FP among men and women are difficulties in reaching public health facilities (Population Council 2015) as well as poor quality of care at these facilities, particularly, the discouraging attitudes of providers, frequent stock-outs of contraceptives, and inadequate counseling, especially regarding possible side effects of contraceptives (Rashida et al. 2015 and Population Council 2016). The private sector is often perceived by users to offer better quality of care. Furthermore, data available with the Council from censuses of facilities in 40 districts shows that it has a much denser presence on the ground, making private facilities far more physically accessible (see, for example, Haque et al. 2012, Population Council 2016, and Rashida et al. 2017). However, many users are currently unable to afford the services of the private sector and, moreover, a substantial proportion of this sector is not involved in providing FP services. For instance, collectively across Faisalabad, Peshawar and Sukkur districts, only 41% of urban providers and 29% of rural providers are offering FP services, while 69% of urban and only 53% of rural pharmacies are selling any contraceptives (Population Council 2016).

A recent landscape analysis study by the Council (Population Council 2016) found that private sector providers and suppliers would be willing to play a greater role in provision of FP services and products if it is financially viable. In interviews, commercial suppliers of condoms—the most popular contraceptive method in the country—reported that they feel crowded out of the market by sources of

subsidized products. Such issues indicate the need to not only facilitate greater participation of private actors in FP service provision but also for the various sectors—public, private for-profit, SMO, and NGO—to coordinate efforts under a total market approach so that each sector efficiently targets the right segment of consumers, with free and subsidized services offered to the poor and the commercial sector given room to serve those who can pay in order to be viable.

There is growing realization among Pakistani policymakers, as in the wider international community, that all development goals or health sector goals cannot be reached through public resources alone; the capacity of the private sector must also be utilized systematically through formal "public–private partnerships (PPPs)" (Tawab et al. 2016 and Haque et al. 2012). A Supreme Court Human Rights case in 2018 brought inadequate access to family planning to the forefront as a key development challenge in Pakistan. 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) (Government of Pakistan 2018).

PPPs based on a sound total market approach offer an opportunity to increase both market efficiency and access to FP services. However, setting up PPPs has been quite challenging in Pakistan, particularly due to limited capacity in government departments to procure and manage contracts (Sheikh et al. 2010 and Zaidi et al. 2010). Two longstanding initiatives in which the government has contracted out basic health services to the private sector are the People's Primary Healthcare Initiative (PPHI) and the Punjab Rural Support Programme (PRSP). Furthermore, in 2016, the "Punjab Population Innovation Fund" (PPIF), a public sector company proposed by the Population Council, was established by the Government of Punjab with the task of increasing access to FP services in the province by introducing innovative models for enabling the private sector to deliver quality services in underserved communities. However, for the most part, the private sector has worked independently, with donor-supported NGOs and SMOs trying out innovative models, such as social franchising, voucher schemes, social marketing, and community-based distribution systems, to increase contraceptive use (Azmat et al. 2018). Successful models are yet to be scaled up.

The federal government as well as provincial governments of Sindh, Khyber Pakhtunkhwa (KP) and Punjab have recently enacted laws and created special cells to help provide a regulatory framework for executing PPPs in various sectors. Stakeholders now need guidance in identifying the broad avenues and modalities for cooperation and implementation of mutually beneficial partnerships in FP. In this regard, the Population Council, with the support of the United Nations Population Fund (UNFPA), has conducted an extensive process of consultations with government stakeholders, as well as a qualitative study of private sector and user perspectives, to create a shared understanding on issues to be addressed, opportunities for joint action, suggested roles and responsibilities of the various players, and models that have worked and how they might be integrated in a common strategy.

This report presents our analysis of private sector stakeholders, focusing on their current role in providing FP services, the challenges they face, support they require from the public sector to be

able to extend FP services, and their perspectives about PPPs to improve access to FP services in Pakistan and proposed roles for the public and private sectors in such partnerships.[1]

Study Objectives

The objectives of this study were to:

- Take stock of the current role of the private sector, including service providers, pharmacists, wholesalers and distributors, importers, manufacturers and NGOs and SMOs, in providing FP services in Pakistan;
- Review different successful interventions for increasing private FP service provision in the country to identify those that can optimize the role of the private sector;
- Review global practices and PPP models for improving FP service provision and extract lessons applicable to Pakistan; and
- Explore views of different stakeholders, including potential clients (men and women) as well as private sector service providers, pharmacists, importers, distributors, wholesalers, NGOs, and SMOs about PPPs that could improve access to FP services in Pakistan.

Methodology

The study consisted of three components, outlined briefly below.

Secondary data analysis: Analysis was conducted to see current utilization of the public and private sector for FP services by various segments of consumers, using recent published data from Pakistan Demographic and Health Survey 2017-18, as well as earlier rounds of PDHS to identify temporal market trends.

Literature review: A systematic review was conducted based on empirical evidence and gray literature which included available evaluations and program reports to explore different PPP models implemented during the last five years in Pakistan to identify the most promising interventions for future investments. Based on stringent inclusion criteria, eight studies (listed in Appendix A) were included in the final analysis. In addition, literature was reviewed on experiences of other countries in implementing successful PPPs to increase access to FP services.

Qualitative study of private sector and user perspectives: This study was designed to probe the current role of the private sector in FP service provision in Pakistan and obtain insights and viewpoints of key stakeholders. Private sector stakeholders were stratified into three main groups—(a) providers; (b) commercial sector pharmacies, wholesalers, distributors and importers; and (c) SMOs and NGOs. Current users and potential clients of FP services comprised a fourth major category of stakeholders. The study examined stakeholder perspectives about the need and opportunities for PPPs to increase access to FP services. Data were collected through in-depth interviews (IDIs) with private sector stakeholders and focus group discussions (FGDs) with men and

[1] In a separate report, entitled "**Public–Private Partnership to Accelerate Family Planning Uptake in Pakistan: A Conceptual Framework**" (Ahmed et al. 2019), we have proposed a comprehensive framework for public-private partnership. The report is primarily based on consultations with provincial public sector officials, and lessons from literature about locally and globally implemented PPP models.

women. The FGDs and IDIs were conducted in one sub-district of six districts including Bahawalpur and Faisalabad in Punjab; Thatta and Sukkur in Sindh; Lasbela in Balochistan; and Mansehra in KP, as shown in Table 1.1. The districts were selected to capture regional variations as well as inclusion of high and low ranking districts on the Multidimensional Poverty Index (MPI)–2014-15. The study was conducted after obtaining ethical approval from the Internal Review Board based in New York.

Table 1.1: Distribution of FGDs and IDIs by district

	Demand-side Perspectives		*Supply-side Perspectives*					
Districts	*FGDs with Men (220 individual participants)*	*FGDs with Women (241 individual participants)*	*IDIs with Service Providers*	*IDIs with Pharmacies*	*IDIs with Distributors*	*IDIs with Wholesalers*	*IDIs with NGOs and SMOs*	*IDIs with Manufacturers and Importers*
Faisalabad	4	4	30	5	2	2	0	0
Bahawalpur	4	5	30	5	2	2	0	0
Thatta	4	4	27	5	3	3	0	0
Sukkur	4	4	30	5	3	1	0	0
Lasbela	4	4	26	5	0	2	0	0
Mansehra	3	3	13	4	2	2	0	0
Total	**23**	**24**	**156**	**29**	**14**	**12**	**8***	**4***

*IDIs with NGOs, SMOs, the manufacturer, and importers were conducted at their head offices in Karachi.

Focus group discussions were conducted separately with currently married men and women of reproductive age to ask which sector they preferred for procuring FP services and their opinion of how the public and private sectors could work together for their benefit. A total of 47 FGDs, including 23 with men and 24 with women, were conducted across the study districts covering both rural and urban areas. FGD participants were selected with the help of LHWs, NGOs, or community-based organizations working in the area and elders and influencers in the community, and discussions were carried out after obtaining consent from each of the participants.[2] A profile of the respondents by gender and district is provided in Table 1.2.

[2] The study protocol, including consent forms used for data collection, were approved by the Population Council's Internal Review Board in New York.

Table 1.2: Socio-demographic profile of respondents who participated in FGDs, by gender

		Male (n= 220)	Female (n = 241)	Total
District	Bahawalpur	37	50	87
	Faisalabad	40	36	76
	Lasbela	34	39	73
	Mansehra	29	40	69
	Sukkur	43	38	81
	Thatta	37	38	75
Type of Community	Rural	107	115	222
	Urban	113	126	239
Current age	15-24	22	44	66
	25- 34	101	115	216
	35- 44	83	67	150
	45+	14	15	29
Educational attainment	No schooling	53	99	152
	Primary	53	65	118
	Middle	35	28	63
	Secondary	41	40	81
	Higher	38	9	47
Employment status	Employed	210	85	295
	Unemployed	3	156	159
Mean number of children	Mean	4	3	4

Among IDI participants, the 156 private service providers included male and female doctors, Lady Health Visitors (LHVs), nurses, midwives, dispensers, *hakims* (practitioners of alternative/herbal medicine), homeopaths, community midwives, and private hospital representatives. As indicated in Table 1.1, we interviewed representatives of two SMOs—Greenstar Social Marketing (GSM) and DKT International—and six NGOs, including Rahnuma–Family Planning Association of Pakistan (FPAP), Marie Stopes Society (MSS), Aman Foundation, PPHI, the Health and Nutrition Development Society (HANDS), and the National Maternal, Neonatal & Child Health Program (NMNCH). The four contraceptive manufacturing and import concerns whose representatives were interviewed included Zafa Pharmaceuticals, Biogenics, United Distribution Ltd., and OBS Pharmaceuticals. Together with 29 pharmacists and 26 wholesalers and distributors, these respondents were asked about the range of services/methods they provide, challenges they face in providing FP products/services, the kind of support they would like to receive from the government to improve their performance, and their viewpoint on the potential for PPPs.

All qualitative discussions were transcribed in the field while translation of data from Urdu to English and coding in NVIVO software were carried out simultaneously at the Council office. Following "grounded theory," the data was sorted based on emerging themes and sub-themes across the categories of respondents. Node reports of different thematic areas were closely analyzed. Frequencies of different responses under each of the themes were also calculated to assess the intensity of individual points across districts and respondent types.

Structure of the Report

Section 2 discusses in detail the current context of the demand for and supply of FP services in Pakistan based on findings of our secondary data analysis and literature reviews. In Section 3, we describe the findings of our qualitative study about the perspectives of men and women regarding the relative performance of the public and private sectors in FP service provision and their perception of how the sectors could best pool their strengths to improve access. Section 4 presents the findings of our interviews with various private sector stakeholders to assess their challenges in providing FP services, the support they seek from the public sector to expand their role, and their proposals for public–private partnership in FP. In Section 5, we discuss the key conclusions that emerge from the study regarding the support required by the private sector from the public sector to expand its role in provision of FP services.

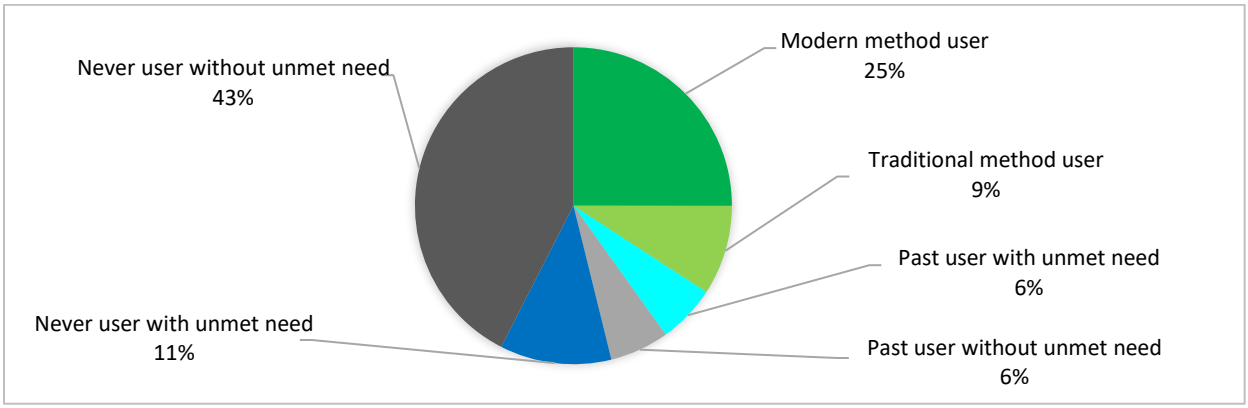
2. Current Situation: Findings from Secondary Analysis and Literature Review

This section describes the current status of FP demand and the context in which future PPPs for FP are to be developed and implemented. We begin with a brief analysis of the recently published PDHS 2017-18 data about the demand for FP in Pakistan, including overall contraceptive prevalence, method choices, unmet demand, and the barriers that cause it. This is followed by an overview of the supply of FP services in the country, including the key players and the extent to which their capacity is utilized for FP service provision and the proportions of users utilizing each sector. Based on a review of literature, models of PPP for FP are then discussed and the effectiveness of the public and private sectors compared.

Demand for Family Planning in Pakistan

Figure 2.1 provides an overview of the FP use status of the 34 million married women of reproductive age (MWRA) in Pakistan based on PDHS 2017–18 data. Only 34.2% of MWRA are currently practicing FP in Pakistan. The proportion of those using reliable modern methods is even smaller— 25% — while the rest use traditional methods which have higher risks of failure. Meanwhile, 9.5% of women have unmet need for spacing births while another 7.8% report unmet need to limit births. Among these 6 million MWRA with unmet need, 2.1 million have never used contraceptives before but 3.9 million are past users. The rate of discontinuation of contraceptive use remains very high at 30.2%. The two key reasons cited in the PDHS 2017–18 for discontinuation, after desire to become pregnant, include side effects/health concern and method failure—both suggest that couples are not receiving adequate support in continuing use of reliable methods.

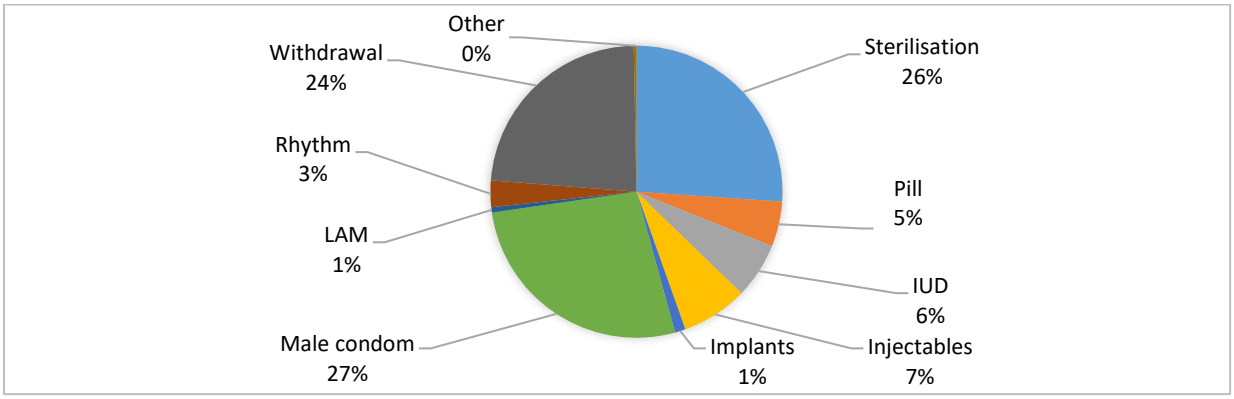
Figure 2.1: Family planning use status of married women of reproductive age in Pakistan (n=34 million)



Source: PDHS 2017–18

In the current method mix, condoms are most popular, used by 26.9% of MWRA, followed by sterilization (25.7%) and withdrawal (23.4%), with other methods comprising much smaller shares (Figure 2.2). The heavier reliance on condoms and withdrawal signifies strong ownership of FP responsibility by men but also a rejection of longer acting methods, like intrauterine contraceptive devices (IUCDs), implants, and injectables, again, raising questions about the effectiveness and regular availability of FP services.

Figure 2.2: Contraceptive method mix in Pakistan – 2017–18



Source: PDHS 2017–18

Women with unmet need and those using traditional methods represent a large potential market for modern contraceptives. Earlier qualitative research reveals that each segment of potential users of FP faces unique barriers, with implications for programming (Population Council 2016). For never users with unmet need, the primary reasons for non-use are (1) lack of information, especially among men; (2) low access to health services, especially in rural communities that are not served by LHWs; and (3) fear of side effects of modern contraceptives. Among past users with unmet need, the most entrenched barrier is (1) past experience of debilitating side effects, coupled with (2) experience of low-quality, unsupportive health services, and (3) potential high costs of managing side effects. Among users of traditional methods, (1) fear of side effects is a main barrier to modern contraceptive use, along with (2) lack of method-specific information. These barriers relate primarily to issues of access to and quality of FP services. Addressing the barriers to eradicate unmet need for FP could raise Pakistan's CPR to 51.5%.

FP Service Provision and the Untapped Private Potential

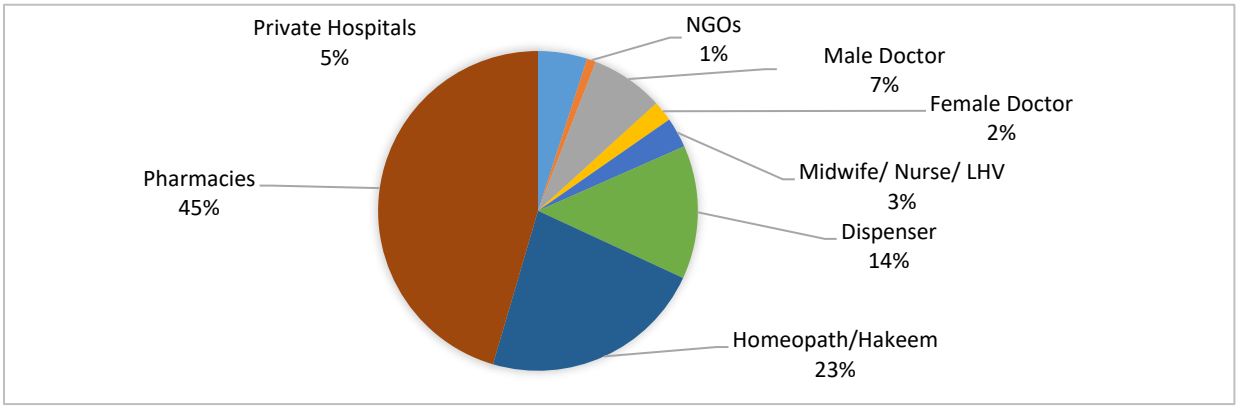
In the public sector, health and population services are a provincial responsibility. In each province, the two main departments responsible are the Population Welfare Department (PWD) and the Department of Health (DoH). Functional collaboration between these two departments is currently weak. PWD provides FP services and commodities via static facilities known as Family Welfare Centres (FWCs) as well as through Family Welfare Workers (FWWs) and Mobile Service Units (MSUs). It occasionally collaborates with the private sector to train staff and accredit service delivery outlets. Compared to other public sector outlets, this department generally offers better trained providers and has more methods available for clients to choose but its facilities are far fewer in number (about 4,000) than DoH facilities and also close early, at 2:00 p.m., making them less accessible for clients, especially in rural areas (Rashida et al. 2015).

The DoH has a larger network of static facilities (about 11,000) ranging from Basic Health Units (BHUs) providing primary healthcare services to District Headquarters Hospitals (DHQs) and other tertiary care facilities. Although this department is mandated to provide FP services as part of an essential package of care, on the ground, its facilities often do not provide FP services, or even if they offer services, very limited methods are available (Population Council 2016). Moreover, these are not offered proactively to clients visiting for other needs (Rashida et al. 2017). Notably, BHUs that have been contracted out to the private sector under PPHI and PRSP have a better record of,

both, offering FP services and having contraceptives stocks available (Population Council 2016). The Lady Health Workers of DoH are a very important source of contraceptives in the communities that they serve. Unfortunately, in recent years, LHWs' focus on FP has been adversely affected by the numerous additional tasks that have been assigned to them, especially the work of polio vaccinations (Azmat 2017, Khan et al. 2011 and UNFPA 2013), and moreover, many areas remain beyond the coverage of the LHW Programme.

In the private sector, a wide range of cadres of providers are active, serving either independently or in affiliation with commercial concerns, SMOs, or NGOs. Some idea of the diversity in this sector can be obtained from Figure 2.3, which shows the composition of private service delivery points georeferenced by the Population Council in the course of a census of health facilities and pharmacies in four districts in Sindh, Punjab, and KP.

Figure 2.3: Distribution of private sector service delivery points in four districts by type of provider (n=11,695)



Source: Population Council, Landscape Analysis of Family Planning Situation in Pakistan, Islamabad, 2016.

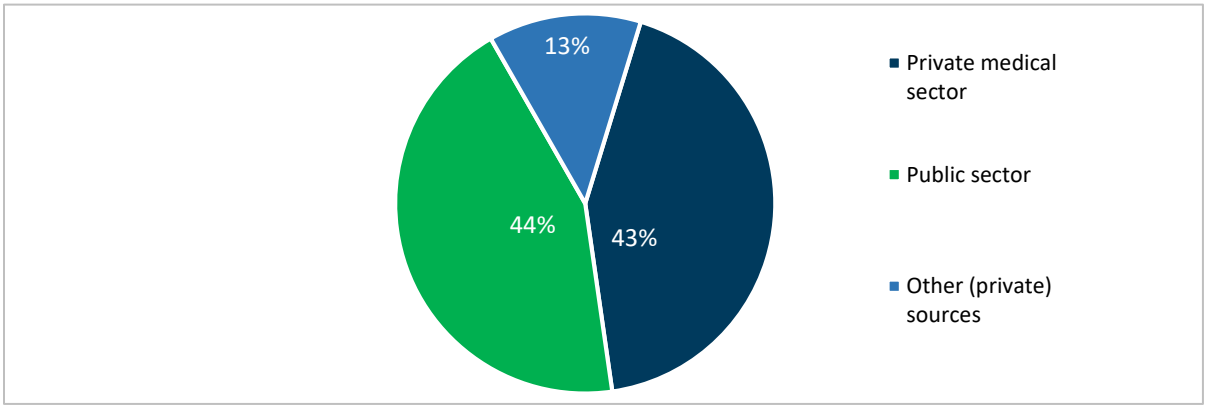
An extensive landscape study by the Population Council (2016) found that, among private providers, female midlevel providers—including LHVs, nurses and midwives—currently lead in the provision of FP services, followed by private hospitals and NGOs clinics. However, large proportions of all three channels currently do not provide services. On the other hand, the role of female doctors is limited; their clinics often do not even have the full array of contraceptives in urban areas. Male doctors are hardly providing any FP services, despite being most numerous and most well-spread out in urban and rural areas. Other underutilized cadres include dispensers, hakims and homeopaths; these mainly male providers are present in large numbers but not playing much role in provision of FP services, despite increasing use of FP methods by men.

Maps depicting the location of providers and pharmacies, developed as part of the above-mentioned study, clearly show that private health facilities are present in considerably greater numbers than public health facilities, but only a small proportion currently offer FP services (see, for example, maps of Faisalabad district in Appendix B).

Sectoral Shares in FP Service Provision

Even though its capacity is greatly underutilized, the formal private sector is playing almost an equal role to the public sector in providing FP services in the country. According to the PDHS 2017-18, the two sectors account for nearly the same shares in women's reported sources of contraceptives (Figure 2.4). In fact, private sector utilization goes up to 56 percent if we count the proportion of informal "other" sources, including shops, *dais* (traditional birth attendants), and hakims.

Figure 2.4: Proportion of women using public and private sector sources for contraceptives

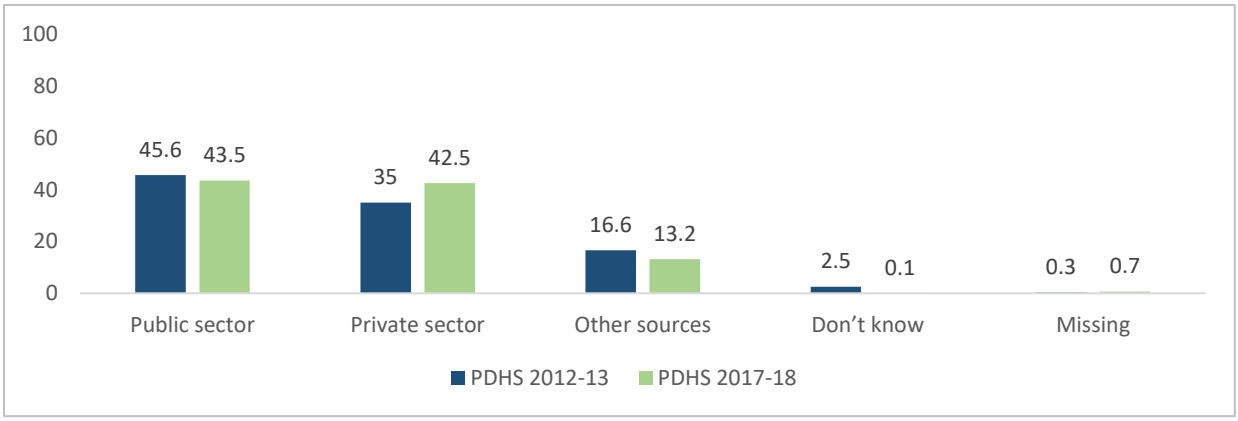


Source: PDHS 2017–18

Within the public sector, the most significant sources are government hospitals (28%) and LHWs (9.3%). In the private sector, the two major sources are private/NGO facilities (15%) and chemists and pharmacies (20%) while the major "other" private source is shops (11%), which sell condoms (data not shown).

In fact the reliance on the private sector for obtaining contraceptives has increased among users. Figure 2.5 shows that, as compared to the PDHS 2012-13, there has been an increase of 7.5 percentage points in the proportion of women using the (formal) private sector (from 35 percent to 42.5 percent in 2017-18). A corresponding decline is seen in the proportions of women reporting use of the public sector and other sources, as well as those reporting they do not know the source.

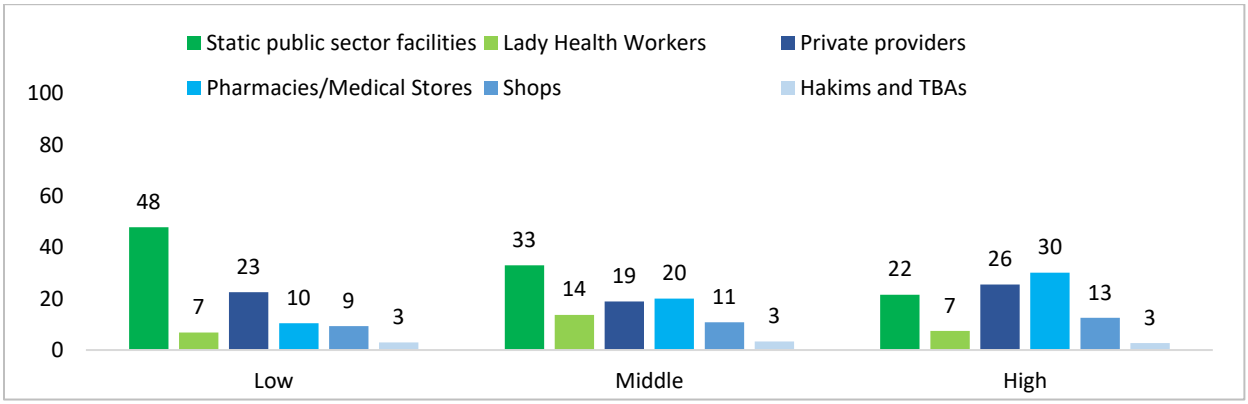
Figure 2.5: Comparison of utilization of public and private sector facilities in 2012-13 and 2017-18



Source: PDHS 2012-13 and 2017-18

Overall, users with greater ability to pay are relying more on the private sector than on the public sector for FP services and those with the least ability to pay are relying more on static public sector facilities. However, this division is far from clear-cut, as Figure 2.6 shows. About 52 percent of the couples from the low wealth tertile are using the private sector, including medical stores and shops, where they pay from their own pockets, while one third from high wealth tertile use free services of the public sector, including the LHWs. Interestingly, the same proportion (7%) of the low and high wealth tertile users are availing the services of LHWs. These observations indicate considerable need and scope for implementing total market strategies so that free and subsidized services are reserved for poor and middle-income users and better off users are directed to the private sector, which they can afford and where their concentration could improve business viability.

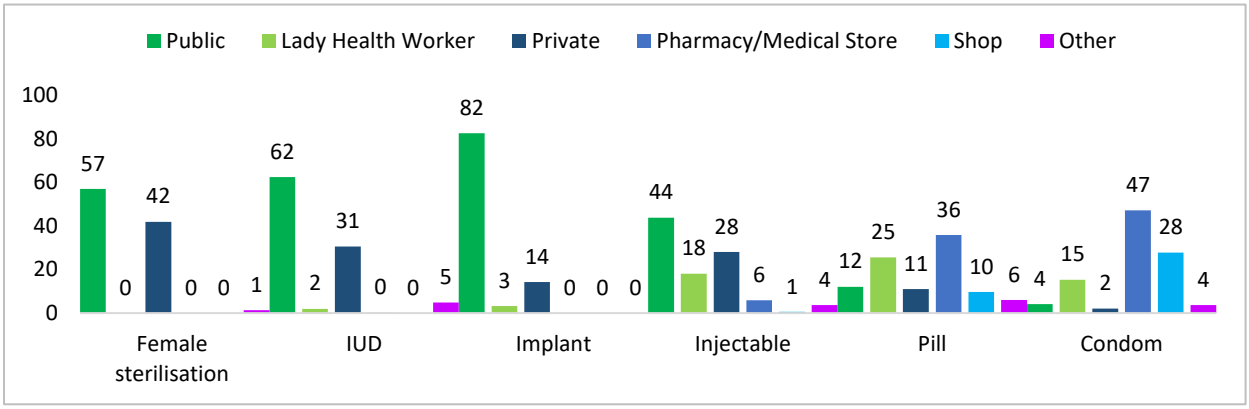
Figure 2.6: Percent distribution of users of modern contraceptive methods, by low, middle and high wealth tertile and by source of supply



Source: PDHS 2017–18

Method-specific provision of contraceptives varies considerably across sources, with ample room for both the public and private sector sources to increase provision (Figure 2.7). Long-acting reversible contraceptives (LARCs) are provided primarily by public static facilities, while sterilization services are provided by both sectors (albeit at a much higher cost in the private sector). In the case of short acting methods, injectables are mainly provided by the public sector (when LHWs are included), while condoms and pills are supplied mainly by the private medical sector and shops. Figure 3.1 also shows that LHWs are involved in provision of IUCDs and implants; this is worrying as they are neither mandated nor trained to provide these methods.

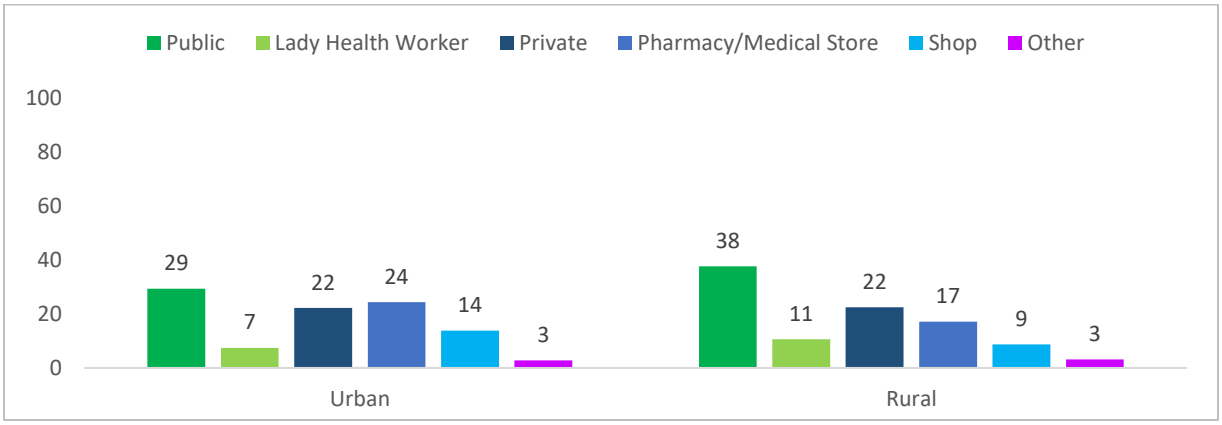
Figure 2.7: Source of supply for current modern method users, by method



Source: PDHS 2017-18

There are some urban/rural differences in utilization of sources, shown in Figure 2.8. As in previous years, the public sector, including LHWs, remains the main source in rural areas. In urban areas, there is far greater utilization of medical stores and shops. However, private health facilities are used by the same proportion of urban and rural users.

Figure 2.8: Source of supply for current modern method users, by residence



Source: PDHS 2017-18

The most interesting differences in sources of contraceptives are observed across regions (Figure 2.9), in part reflecting the differences in the method mix across provinces and also between urban and rural areas within provinces. While clients in Punjab and Sindh report getting most of their contraceptives from the public sector, clients in KP and Balochistan rely mostly on the private sector for commodities and services. In general, Punjab and KP show more of a spread across service delivery types in both urban and rural areas, whereas in Sindh, the role of pharmacies and shops diminishes sharply in rural areas. The share of services provided by LHWs is higher in Punjab and KP and very negligible in Sindh and Balochistan; KP is the only province where LHWs are catering to a higher proportion of women in urban than rural areas. Shops play a dominant role as sources of contraceptives in KP and are also significant sources in urban areas of Balochistan. These striking patterns reaffirm the importance of addressing the program needs of each province individually.

Figure 2.9: Source of supply for current modern method users, by residence and province

Source: PDHS 2017-18

Finally, in terms of the efficiency of the FP markets, PDHS data (not shown) indicate that the public sector, including static facilities and LHWs, cater to considerable proportions of users from the low wealth tertile in Punjab (61%), Sindh (55%), KP (40%), and Balochistan (47%). However, their free services and commodities are also availed by large proportions of users from the high wealth tertile in each province, i.e., 31% in Punjab, 29% in Sindh, 34% in KP, and 19% in Balochistan. On the other hand, pharmacies, shops, and "other" sources, such as traditional birth attendants, to whom users pay out of pocket, serve 19% of the low wealth tertile in Punjab, 20% in Sindh, and—surprisingly—38% and 39% of the users in KP and Balochistan, respectively, clearly denoting a need to expand access to free or subsidized services. Across Pakistan, the proportions of the low, middle and high tertiles that obtain FP services from private service providers are 23%, 19% and 26% respectively; however, it is difficult to infer market efficiency for this category because data for commercial providers and subsidized/non-governmental facilities are combined in the PDHS.

Models for Increasing Private Participation

While commercial service providers in Pakistan typically offer FP services only when asked by clients and on a for-profit basis, a number of NGOs and SMOs in the country are dedicated to the objective of increasing use of FP through subsidized services. These organizations undertake a variety of activities, such as social marketing and franchising and demand creation to increase both demand for and access to FP services. For the most part, the work of these organizations has been carried out with the support of bilateral and multilateral aid agencies, with the government sometimes

playing a supporting role, such as supply of subsidized contraceptives or registration of SMOs' brands of contraceptives. With the exception of PPHI and PRSP, limited public–private partnerships exist in the health sector in Pakistan.

Globally, the literature offers many examples of PPPs playing a significant role in increasing 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. Demand for FP was particularly generated through promoting small family size by Indonesia's national population and FP board, known as the *Badan Kependudukan dan Keluarga Berencana* Nasional (BKKBN). Providers played an important role in motivating potential users to make informed decisions. NGOs' outreach workers were used for interpersonal communications with potential users to clear myths and misperceptions about contraceptive use. The successes achieved by four notable PPPs in this manner and the role of partners in the partnerships are summarized in Table 2.1.

Table 2.1: Selected global examples of public-private partnerships for family planning

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 IUCDs 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 by BKKBN • Engagement of religious leaders by BKKBN	• 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 28% • Decline in TFR from 4% to 2.5%

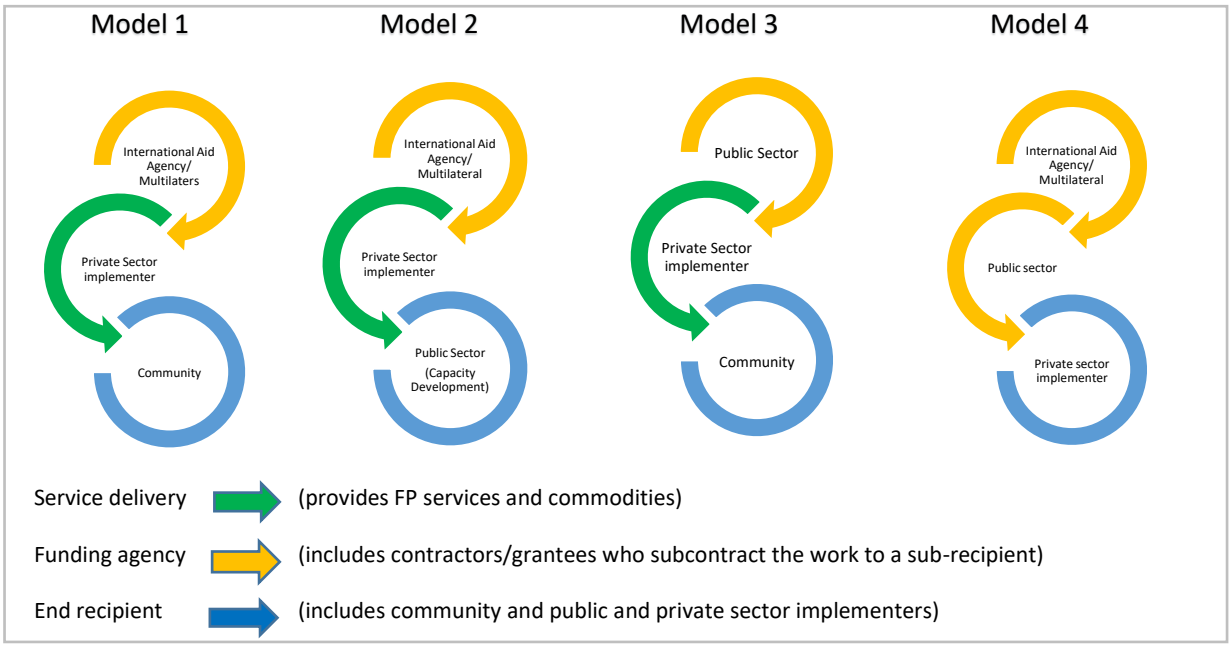
One of the lessons that can be learnt from PPP programs that have had a national impact is that that they are built on a sound PPP framework which defines the policy, procedures, institutions, and rules that together direct how the PPP will be implemented. The key levers of global PPP success include high level of political and policy support; certainty of profit 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 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 for five partnership commitments in 2005,[3] presents the following five important principles for 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. **Managing for Results** – There is a focus on producing—and measuring—results; and
5. **Mutual Accountability** – All parties are accountable for results.

In the case of Pakistan, based on a review of literature, four broad types or models of PPPs can be observed in the health and population sectors. These are depicted in Figure 2.10 and discussed briefly below.

Figure 2.10: Models of PPPs observed in health and population sectors in Pakistan



Model 1 – Aid agency/Donor funds private sector for service delivery to community: Among PPPs for FP in Pakistan, a recent example of this model is the Delivering Reproductive Health Results Project (DRHR) being implemented by Marie Stopes Society (MSS) with the support of DFID. Although the public sector does not participate in this model as a core partner, its role is mimicked in the arrangement by a donor agency.

This model is the basis for **social franchising** initiatives in which a central organization (the franchisor) develops networks of individual private health providers linked to it by providing initial training; supplies for improving quality standards of the outlet/clinic (usually one-time); ongoing quality assurance; and ongoing contraceptive commodities' supplies. Franchisees generally deliver

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

FP methods that require the involvement of a skilled provider and a clinical setting, such as IUCDs and implants. Social franchises typically offer formal quality assurance mechanisms. Several organizations have adopted this mechanism in Pakistan, including MSS, Greenstar Social Marketing, Rahnuma–FPAP and DKT International. There is a role in social franchising for increased public sector involvement so as to bring private providers franchise networks to scale up the level of effort for broader health impact.

Social franchising programs are often linked with **social marketing**, in which marketing principles are applied to a social cause—in the current case, FP. SMOs have introduced a business model of selling subsidized FP products through private sector outlets such as pharmacies and drug shops while also using commercial marketing techniques to promote behavior change.

In both social marketing and social franchising models, products and services are subsidized to a price that is affordable for the target populations. SMOs typically act as 'franchisors' as well as managing social marketing programs. Mainly GSM and DKT follow this model in Pakistan.

Voucher schemes have also been tried on a pilot basis with donor funding, e.g., by MSS and GSM (Boddam et al. 2016) and these helped increase uptake of LARCs, but again, resources are needed to continue or scale up these schemes.

Model 2 – Aid agency/Donor funds private sector to develop capacity of public sector: This is the second most commonly implemented PPP model in Pakistan. Private partners have been contracted by aid agencies to provide technical assistance for enhancing government capacity in contraceptive security—most notably the USAID DELIVER project as well as budgeting, procurement and financial management through general Technical Assistance programs in health and FP. With the support of the Bill and Melinda Gates Foundation, Aman Foundation, under its Sukh initiative, has also piloted some PPP programs in peri-urban areas of Karachi. Most relevant is the training and subsidization of 200 LHWs to enable them to administer the first dose of injectable contraceptives (Najmi et al. 2018).

Model 3: Public sector contracts out services to the private sector for delivery to communities: Examples of this model are mostly found in the health sector, where the government has contracted out the operation of some of its health facilities to the private sector. In the People's Primary Healthcare Initiative, for example, the Government of Sindh has contracted out primary healthcare facilities to the Pakistan Rural Support Programme and higher level facilities to the Poverty Eradication Initiative. Currently, 1,176 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.

Third-party evaluation of the PPHI shows higher utilization of the contracted BHUs in terms of volume of outpatient attendance (TRF 2011). There has also been improved cleanliness and maintenance, higher staff presence, and higher patient satisfaction. In the last five years, FP use has increased, with the mCPR in rural Sindh rising by more than 3 percentage points, from 17.4% in 2012-13 to 20.4% in 2017-18—including an increase in use of LARCs from 1% to 2.8% (PDHS 2012–13 and 2017–18). These improvements could be attributed in part at least to PPHI, which has a focus on providing LARCs.

After the success of the PPHI collaboration with the DoH, Sindh, a similar relationship is being developed in Balochistan whereby PPHI will also work with the PWD. In addition, in the health sector, the government is also trying to 'contract in' at public health facilities, but only for support services such as cleaning, security, etc.

Integrated Health Services (IHS) is another NGO to which DoH Sindh contracted out operation of 111 facilities (6 Taluka hospitals and 104 Rural Health Centers) in 21 districts in 2016. Increased turnover of patients is reported in these revamped 24/7 facilities where services are free.

Similarly, the Sindh and KP governments have signed memoranda of understanding (MoUs) with HANDS for free provision of contraceptives in Sindh and in district Mansehra, KP, respectively.

Model 4: Aid agency/Donor funds public sector to support private sector implementer: An example of this model is the Punjab Population Innovation Fund (PPIF) a public sector company, which has been established by the Government of Punjab with donor funding to support innovative private sector initiatives to increase FP use.

Review of existing PPPs in the health sector suggests that the province of Sindh is at a far more advanced stage than other provinces as it has introduced a number of PPPs. However, thus far, all PPP initiatives of the Sindh government have originated from the Department of Health and not from the Population Welfare Department. Therefore, these are designed to deliver integrated services, with a relatively limited focus on FP services. While Punjab and KP have also passed similar legislation and have PPP units in place, these have not been used to launch any major health-related PPP initiatives in these provinces.

Sectoral Effectiveness in FP Service Delivery

The original design of this study included a systematic review of evaluations and program reports concerning different models for PPP in health/FP services implemented during the last five years in Pakistan to assess which models have worked best in terms of achieving results, cost-effectiveness and sustainability and to identify the most promising interventions for future investments. Unfortunately, there is very low availability of updated and centralized data and at the same time, a great deal of variation in the ways SMOs and NGOs engage with provider clinics as well as high levels of attrition within these partnerships in Pakistan. Evaluations and systematic analyses are lacking, particularly for PPP programs implemented on a large scale in recent years.

In particular, limited to no data are available on the performance of the private sector as a contractor for the public sector in the area of FP. Research on this specific aspect is available for general health service delivery but the output and outcome measures are vastly different from FP which is generally not a priority indicator for health service contracts. Most of the available studies are based on non-experimental designs and there is no evidence of a randomized control trial. Available studies do not compare easily in terms of their indicators, indicator definitions, results and data collection tools. Moreover, the paucity of raw data leaves limited space for unpacking data and looking into individual associations.

With these limitations, we selected a total of eight studies for review, which are listed along with their key findings in Appendix A. Some of these studies are based on primary data and others on secondary data analyses; a number of them are cross-sectional studies. Only one evaluation,

conducted for DFID's DRHR project, includes baseline and endline studies to allow for comparison. During the review, these core studies were supplemented with gray literature identified from references provided in the published literature.

Based on the scope of the available literature, the following criteria were selected for assessing the performance of various FP-related interventions in Pakistan:

- Cost per client for providing FP services within the program (total costs divided by total number of clients);
- Percentage of clients reached who are poor (% poor among clients of the service);
- Quality of services, i.e., condition of clinic, availability of equipment, standards and hygiene (while quality criteria vary across the studies, there is enough overlap to allow comparison);
- Client satisfaction based on exit interviews (considered part of quality of care in some assessments);
- Range of FP services provided (in terms of types of methods);
- Cost of providing the service per couple-year of protection (CYP);
- Change in CPR in the intervention catchment population; and
- Robustness—methodology of case control studies.

While most of the studies did not address all of the above criteria, each presents a useful perspective on some of them. An overview of the parameters addressed by each reviewed study is provided in Appendix C.

Key findings of the review are outlined below.

The private sector delivers services more cost-effectively

In the studies reviewed, only two mentioned costs per client, which were estimated by dividing the cost to deliver (facility level operational plus some capital costs[4]) by the number of clients. Shah, Wang and Bishai (2011) compared the cost of clinics across a number of providers, including government clinics, social franchise (SF) clinics, and private (individual) non-franchise clinics. The study found that government services were most expensive, at $39 per client served, compared to SF services ($31 per client) and private providers ($30 per client).

In a separate estimation, Khan and Khan (2012) based costs per client on overall annual budget and number of clients served over the years. Their estimate of the cost per client in the public sector was $55 per woman served per year, mainly due to the high inefficiencies in the sector and low numbers of clients.

The public sector targets the poor better than the private sector

In terms of FP programs' ability to reach or be accessible to the lowest quintile in the community, it appears that government services perform better than any private sector intervention (Shah, Wang and Bishai 2011 and Whitter et al. 2016) while franchised clinics perform least effectively. Some

[4] Facilities were identified and costs included facility costs plus salaries of staff that were employed in the facilities; the same was done for government owned facilities.

targeting of the poor is achieved by private SF programs through the introduction of voucher schemes but this seems to reach the third and fourth income quintile better than the lowest quintile and is directed towards promoting the use of LARCs. The lack of targeting of the poorest quintile in SF programs is attributed to the fact that, in addition to poverty ranking, vouchers are distributed to clients on the basis of their capacity to benefit—meaning that a woman is given a voucher if she reports financial difficulties as the reason why she cannot access services, irrespective of her poverty ranking score and household income (Shah et al. 2011).

In the DFID-funded DRHR program, however, pro-poor targeting seemed to be slightly better in the group that was primarily delivering services through social marketing interventions, which included a small percent of franchised clinics as well (Whitter et al. 2016).

In the public sector, poor households are targeted mainly through LHWs, but these workers are only permitted to provide a limited range of methods and their clients are therefore more likely to use reversible short-term methods. There are also examples of government mechanisms that can guide the development and expansion of franchises, for instance, the pilot tested by PWD Punjab (2016-18) in DG Khan, Jhang, Layyah, Rahim Yar Khan and Khushab districts. It was anticipated that if every service provider partnering with PWD provides FP services to 10-12 new clients per month, approximately 45,000-55,000 new FP clients would 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 (Population Welfare Department, n.d.). The public sector remains the main provider for the needs of the poor.

Quality scores are similar but client satisfaction is higher with private facilities

Overall quality of care is about the same at public and private facilities, with clients generally more satisfied with franchised private facilities. When looking at quality of services, most studies develop a composite score that is based on a number of provider-based criteria, such as training, skills and range of services provided and facility-based criteria, such as physical infrastructure, availability and condition of equipment, availability of medicines, inventory, signage and client satisfaction scores. Overall, both government and private sector clinics score similarly on quality scores (Javed et al. 2015 and Shah, Wang and Bishai 2011). However, clients seem more satisfied with private providers and, among these, franchised clinics score better than individual private providers and NGO-run clinics. Among private franchised clinics, those affiliated with PSI/GSM performed better than those run by MSS, although the latter offered a larger range of services (Azmat et al. 2018).

The one exception to this general view comes from a study based on secondary analysis of PDHS 2012-13 data from Sindh, which finds that, overall, clients are less satisfied with the private sector than the public sector for FP services, particularly with regard to sterilization services; however, in other areas of quality of care, such as follow-up care, counselling services, infection control, timely treatment and attitude of staff, clients are more satisfied with private clinics than with the public sector (Javed et al. 2015).

Voucher programs have a positive impact and should be scaled up

Voucher programs, which are delivered almost entirely through the private sector providers/ franchises, seem to have an overall positive impact on the uptake of LARCs and permanent methods. This could be because most of the vouchers solely promote the use of LARCs. The main issue with voucher programs remains their limited reach; greater efficiencies and more coverage could be attained if the programs were implemented on a wider scale, which is unlikely if

dependence remains on donor funding. Government-funded voucher programs for FP have not been widely implemented in Pakistan. However, the Sehat Sahulat Card voucher program, implemented in Kasur and Rawalpindi, offers an example of a district government PPP for integrated reproductive, maternal, newborn and child health services, including FP counseling (Mangone and Gitonga 2017).

Private facilities offer a wider range of services, with fewer stock-outs

Generally, private sector interventions offer better method choice and range of services, as well as better availability of contraceptives, with fewer stock-outs (Shah, Wang and Bishai 2011 and Javed et al. 2015). Compared to the public sector, there is more counseling of clients on alternative methods but counseling for side effects of contraceptives remains low even here.

Impact: There is evidence of small-scale private sector programs raising CPR

The literature reviewed did not provide evidence of a significant rise in CPR through recent large-scale programs delivered through the private sector,[5] although increase in user and provider knowledge on FP products and services is documented. However, a rise in CPR has been found in small-scale interventions where trials for voucher schemes were conducted (Boddam-Whetham et al. 2016). Moreover, an evaluation of the Marvi program of HANDS, in which community women in rural Sindh were provided basic health promotion training along with reproductive health (RH) and nutrition commodities to provide services on the pattern of the LHW Programme, found the program to be quite successful in improving the contraceptive use among MWRA (HANDS 2014). The CPR increased from a baseline of 9% to 27%, with women crediting the Marvi workers with their higher demand for and use of FP services.

While there is some variation in the literature reviewed, the general verdict is that franchised private clinics offer better quality services and a wider range of FP products than non-franchised private clinics but do not reach the very poor. There is still some deficiency in private sector capacities to fully address the barriers to FP use, which are related less to cost and more to availability (Whitter et al. 2016). Moreover, most franchised clinics are part of donor–supported programs, which puts their FP services at high risk of being discontinued when donor funding dries up due to lack of funds or change in donor policies and priorities. In terms of outreach to the poor, the public sector is performing better, though not by a very wide margin. However this sector's efficiency in terms of cost per client and numbers of clients served is low.

[5] However, strong evidence of increased CPR emerged from an evaluation of the Family Advancement for Life and Health (FALAH) Project, which is not formally included in this review because it was published more than five years ago. Under FALAH, a consortium of private sector organizations led by the Population Council enhanced the capacity of public health facilities to deliver FP services, alongside demand-side interventions. In the project's target districts, the CPR increased from 29.4 percent, as reported in the baseline survey (2008–09), to 37.9 percent in the end line survey (2011–12).

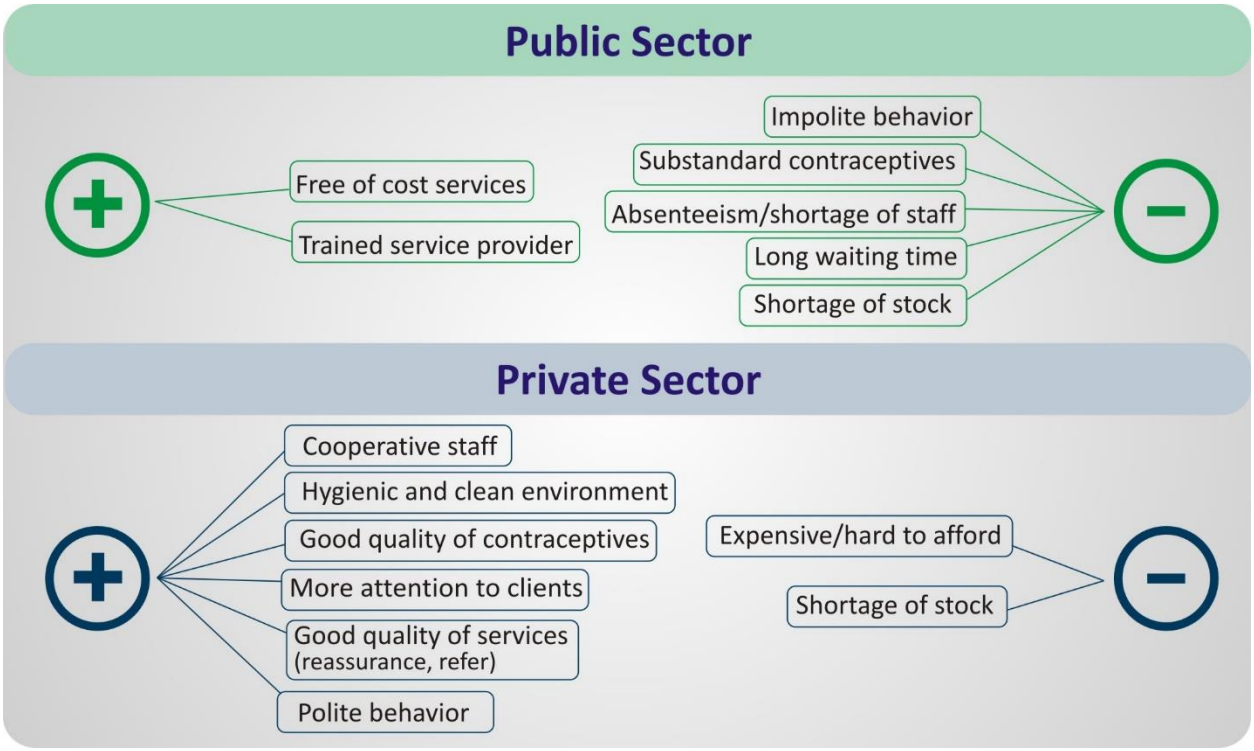
3. Perspectives of Clients

This section explores the perspective of current and potential clients of FP services, i.e., married men and women, regarding public and private sector service provision and the potential for partnership, based on our qualitative study. Respondents were asked about the FP methods and sources available in their vicinity; their assessment of services provided by the public and private sectors; and their views on whether PPP would be beneficial for their communities and what roles they thought the two sectors should play in such a partnership.

Perceived Differences between Public and Private Sector Services

Men and women were asked about differences between the public and private sector with regard to the provision of FP services. In response, they listed a number of strengths and weaknesses for both the public and the private sector, which are summarized in Figure 3.1. (It is important to mention that, at times, these responses were not only based on the respondents' experience of FP services but also drew from their experience of general health services.) As is evident from the figure, respondents linked more weaknesses and relatively few strengths with the public sector, while they perceived the private sector to offer more strengths and fewer weaknesses. In general, the strengths mentioned for each sector were also the reasons for obtaining services from that sector.

Figure 3.1: Positive and negative characteristics of service provision in the public and private sector, according to clients



The majority of respondents, both men and women, mentioned that FP services are free at public health facilities, which is a great relief for the poor. Moreover, service providers are well trained and experienced. However, the weaknesses in service delivery outweigh these benefits, pushing clients towards the private sector. All women across all the FGDs pointed out differences in the behavior of public and private sector service providers. They said government providers exhibit very

unpredictable behavior, do not do proper clinical examinations, do not listen to the patient attentively, and ask patients to visit their private clinics, where they provide better treatment. Patients are often humiliated at public facilities, not just by doctors but also by paramedical staff. Doctors and staff are at times so rude and aggressive that patients return home without getting any treatment.

I don't think anybody would be crazy enough to visit a government hospital if he/she could afford to get treated from a private hospital. In government centers, no one bothers whether you live or die. For a simple service, getting an injection, one has to suffer and wait. If we had the money, we would go to the private hospitals to avoid all the hassle and insulting behavior. FFGD[6]- Rural -Faisalabad

Government hospitals are not good. They don't treat properly. Doctors' behavior is also not good. They behave as if they were running their home, not a hospital. The compounder sees the patient even in the presence of the doctor. MFGD[7]- Rural-Thatta

Men and women complained that public hospitals are overcrowded and going there is a waste of time, with the entire day spent in queues or running from one place to another, which wears the patient out. In their view, government hospitals do not have sufficient facilities. To avoid the tiring wait, hustle, and rush women prefer to visit private facilities, even if they charge for care.

A visit to a government hospital is time consuming. One has to wait in a queue in such a big crowd. They get angry a lot and don't give medicines either. You have to wait long hours for your turn. FFGD - Rural -Lasbela

Most of the people go to private facilities because the public sector is too crowded and there isn't any chance of getting treatment quickly. Patients keep on suffering in public facilities. That's why they choose to go to the private sector. MFGD- Urban-Sukkur

A great concern for both women and men across the districts was the quality of contraceptives, which was *perceived* by them to be substandard at public health facilities. Women are scared to go to the public sector because they do not have information about methods. They believe public sector contraceptives sometimes cause heavy bleeding and other problems can also occur because the provider does not consider the client's overall health condition while prescribing methods. They claim that, at times, an IUCD is not inserted properly and then the patient is blamed for complications. Men particularly mentioned that although LHWs go door to door and fulfill their duties, the methods they provide are not that effective and also choice is limited. This is why people would rather pay a fee and get any method of their own choice from private facilities. Men also mentioned that public sector staff are not well trained and have neither all the necessary facilities nor quality medicines.

Information is not provided by public hospitals about different methods and the provider doesn't check properly (but) just injects the medicine. It causes bleeding so we get worried and they don't provide treatment. On the other hand, private providers ask every detail before treatment. FFGD- Rural-Thatta

[6] FFGD – Female Focus Group Discussion
[7] MFGD – Male Focus Group Discussion

During FGDs, women also mentioned that government hospitals staff are often not present, or busy in personal conversations, not caring that someone needs a checkup. A woman might even be in pain but no one attends to her, especially at night.

At government hospitals we don't get services. If we are given a birth spacing injection in the day time and experience bleeding at night, we have to go to a private facility because the doctor won't be available in government facilities. FFGD- Rural-Sukkur

Although there is huge dissatisfaction with static public health facilities, men and women generally consider LHWs the best source for FP services since they provide doorstep services. Respondents also suggested steps for improving provision of FP services through these community-based workers, such as more training and greater focus on FP.

For family planning we don't go to anywhere else because there is an LHW in our village. If we want any family planning method or advice, we can get it easily from her. We can even get medicine for coughs and fever, etc. MFGD- Rural-Bahawalpur

The majority of men and women express satisfaction with the quality of FP services being provided by the private sector. Aspects of good quality mentioned by respondents include polite behavior, due attention to clients' problems, proper guidance, positive attitude with clients, and according of respect as well as sufficient time. However, private hospitals are very expensive, which is a barrier for poor people.

Private sector facilities give information regarding side effects. After giving a birth spacing method, they suggest follow-ups in the next week or within next 15 days or a month, but in the government there is no such system and people don't go for follow-ups. In the private sector, they guide us properly. FFGD-Rural -Sukkur

Men emphasized that since private sector services are paid for, service providers are motivated and provide client-centered services. They give proper time, conduct examinations, and pay attention to every detail. They counsel the patients to adopt FP. In private hospitals, there are fewer patients so they charge more fees but they do their work well. Men also said that private sector facilities offer a large variety of contraceptives while public service providers only have a few methods.

They get good health care there and get free in no time. Although they charge fees, they check you properly whereas in government hospitals it takes so much time. In private hospitals they do a thorough checkup and also provide good medicines whereas in the government they do not care about anything. They do not check properly because they know whether they work or not they will get paid in the end. FFGD- Rural-Faisalabad

In private facilities a person can speak because he pays money and he speaks for his rights. Regarding family planning, they give us medicine and injections for 6 months and guide us about producing fewer kids. MFGD- Urban -Sukkur

There is a clear preference for the private sector among users. However, affordability issues prevent many clients, especially the poorer men and women, from availing private services and they are left with no choice except public health facilities, where the above-mentioned array of issues confronts them. Where present, NGOs help address this dilemma by offering services with a quality advantage similar to the private sector at a low cost comparable to the public sector. NGOs providing FP

services were mainly mentioned by respondents from Sindh, who shared that service providers at NGO clinics guide them properly and provide them methods free of cost or at nominal charges. However, this third option is currently present only on a limited scale.

There are Marvi workers. They guide us about child spacing and condoms. Marvis provide treatment free of cost. In case there is any reaction, they also deal with that. MFGD-Urban-Thatta

Viewpoints about PPP

When asked whether they thought the public and private sector should work together to provide services, the response of both men and women was overwhelmingly positive.

The majority of women (222/241) and men (208/220) supported the idea of public-private partnership and felt it was the only way to improve FP service provision, especially for the poor.

However, 18 women, mainly from Punjab (during three different FGDs) and 12 men expressed apprehensions about the possibility of such a partnership. They felt the agendas of the two sectors were too different and it would be difficult to offer a sufficiently profitable arrangement to the private sector. The women particularly pointed out that it was more profitable for the private sector to conduct deliveries than to help prevent pregnancies.

Private providers make as much money as possible. If they guide people about family planning, how will they make money from delivery cases? The government wants less population, so they work a lot for family planning while the private sector wants to maximize earnings by deliveries. FFGD-Rural -Faisalabad

When supporters of PPPs were probed further about why they felt a need for such partnerships in their areas, they pointed to gaps in each sector, which they perceived could be addressed by the other sector. Most of the gaps and issues mentioned by women related to the public health sector. The problem identified most frequently across the districts, by men as well as women, was shortage of staff which respondents felt leads to many allied issues, such as crowded facilities, insufficient time and attention to clients and rude behavior of providers, despite their experience.

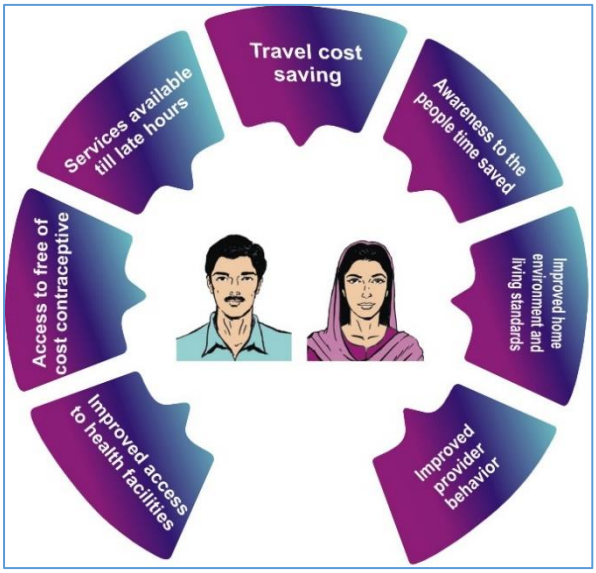
In government hospitals, there is a crowd of people and there are less staff due to which their behavior gets harsh. If the private sector works with them, they will distribute the work among themselves and their behaviors will improve. FFGD-Urban -Bahawalpur

A few women mentioned that most of the time contraceptives are out of stock at public facilities. This causes interruptions in women's use of methods. Respondents felt this is an area where the private sector could fill the gap if there was a partnership between the two sectors.

When the government gets out of stock, at that time, a private organization should provide stocks to the government at a minimum price. MFGD- Urban -Mansehra

Men and women were asked about possible benefits of PPP in FP for their communities. Their responses are summarized in Figure 3.2. Interestingly, women were more articulate than men on this subject, probably because they have more experience of visiting health facilities for FP services and facing challenges there. One of the major benefits they mentioned was improved access to health facilities providing FP services, especially for women, because facilities would be closer and they would be able to visit facilities unaccompanied. At present, they usually have to wait until their husbands can take them.

Figure 3.2: Potential benefits of PPP according to clients



When FP facilities are available close by, a woman does not have to invest money on transport and medicines. Whenever she gets free from household work, she can go and get family planning services easily. Poor women can't go anywhere. They just produce children and while doing that they lose their lives. If they (the two sectors) work together, there will be a facility for such women, who don't know from where to get family planning methods or medicines. FFGD- Urban-Mansehra

The other main benefit identified by respondents was saving of time and resources, including travel costs, as well as time for work. Respondents felt their access issues would be resolved and living standards improved if there were health facilities nearby offering free services. They felt the government should increase staff by adding private providers to its team so that they can offer 24/7 services by working in shifts and dividing responsibilities. Users hope that this measure—which happens to be similar to existing PPPs involving contracting out of public health services—can reduce the burden on doctors, enabling them to deal more peacefully with their patients.

If we have this facility then time, money and energies for labor will be saved. If a laborer goes to the city for treatment, he wastes his time, money and energy. And also we would be getting proper treatment at our doorstep. MFGD- Rural-Sukkur

There should be a 24-hour service. Contraceptives and medicines should be available all the time. We don't want a situation where they have to say that such and such medicine isn't available. This (PPP) will be a good step and people's lives will be improved. FFGD- Urban–Sukkur

We will support the government and private sector if they will provide facilities to us. Over here, we have to go to other areas for deliveries. The government should bring some improvement in this situation because the mother loses her life during the journey. If the hospital is nearby, her life will be safe. MFGD-Rural-Lasbela

Proposed Roles of Public and Private Sectors in PPP

While the majority of men and women strongly supported the idea of public–private partnerships and were able to explain their potential benefits, they had relatively limited ideas to offer regarding what the role of each sector might be. Men mostly talked about management and monitoring perspectives whereas women talked more about service delivery in a partnered model. While they did mention some common roles, the respondents generally distinguished the roles of the two sectors quite clearly and expected the public sector to assume the major responsibilities. Their suggestions are summarized in Figure 3.3.

Figure 3.3: Public and private sector roles proposed by clients for public-private partnership in FP service provision

The main role proposed for the public sector related to leadership, management, and administration. Respondents suggested that the government should initiate the partnership, contact private providers to engage them, and ensure support for them. Some of the men felt the public sector needed to prioritize this initiative as much as its polio and dengue eradication efforts.

In addition, respondents proposed that the public sector should invest the financial resources required to implement the partnership. They also proposed strongly that the public sector should provide free contraceptives to private service providers to expand services, reasoning that the availability of sufficient stocks of contraceptives at both private and public facilities would also result in less hassle at public hospitals and optimal services for clients. It was also emphasized by rural respondents that the public sector should involve private providers, especially dispensers, through monetary incentives so that they can be motivated to provide FP services. Moreover, men and women recognized resource sharing opportunities, suggesting that the government provide space in public buildings to private providers to extend service hours so that clients could access services at times that suited them. By sharing responsibilities in such ways, men and women felt PPP in FP would ultimately prove beneficial in increasing access for their communities.

The government should invest money and make small hospitals in which private staff should also be appointed and provide free family planning methods so people can get free contraceptives from everywhere. Bahawalpur-Rural-Women

The government should provide all the family planning facilities and methods to private and government organizations so people can get all the facilities related to family planning. FFGD- Urban-Mansehra

Respondents across the districts, particularly men, proposed that there should be a monitoring mechanism and the public sector should conduct monitoring and reporting to ensure that private providers are providing appropriate FP services.

Government should be responsible for monitoring; the private sector can't do that. There should be a proper entry system for patients. MFGD-Urban-Sukkur

With regard to the role of the private sector in partnerships, respondents mainly stressed delivery of services. Both men and women suggested that private service providers receiving a supply of free contraceptives from the public sector should provide them to clients free of cost or at a subsidized rate. If people could get free medicines from private facilities, they would surely visit them and this would be especially useful for people with financial constraints. The other responsibility respondents proposed for the private sector was keeping records of clients, which could be shared for monitoring by the public sector.

The private sector should reduce its fees. If the private sector would reduce its charges to Rs. 200, all of us would go there. Marie Stopes is near us but we can't go there because we don't have that much money. If they reduce their charges, all of us would go there. Believe me, if we get facilities over here—if they provide good facilities at minimum charge—we won't go to the government hospitals. FFGD-Urban-Bahawalpur

If the government provides free FP products to private providers and then they provide them to people at low cost, then this is good. If they work together, there is also benefit for the private sector because they will get contraceptives for free. MFGD- Rural-Bahawalpur

Respondents proposed that both sectors could share the responsibility of creating awareness at community level about FP services and sources. They suggested that service providers go door to door to make people aware of public and private facilities present in their area and motivate them to visit them.

They should work in the field and give awareness to people regarding family planning and they should tell them the real meaning of family planning. They should provide treatment for side effects. The government should work on side effects. FFGD-Rural-Sukkur

4. Perspectives of Private Sector Stakeholders

In this chapter, we present the findings from in-depth interviews with service providers, pharmacists, distributors and wholesalers, SMOs and NGOs and manufacturers and importers regarding their current role in provision of FP services/methods, the constraints they face in this regard, the support they require from the public sector to play or increase their role in FP service provision and their views on what type of PPPs might expand access to FP services and what roles the private and public sectors should have therein. The first part of the chapter focuses on the challenges of various private sector stakeholders and the support they say they require, while the second part discusses their suggestions for PPPs for FP.

Current Role, Challenges, and Support Required

Service Providers

A total of 156 service providers were interviewed from the study districts, including 93 from rural areas and 63 from urban communities. These providers were identified in the field using a snowball technique. They included professionals at private hospitals; male and female MBBS doctors; midlevel providers, i.e., LHVs, nurses and midwives; dispensers; and also hakims and homeopaths. In-depth interviews were conducted with these health care providers after obtaining their informed consent.

It is important to note that the service providers were selected on the basis of their cadre and residence and not their FP provision status. Therefore, perspectives of providers that were and were not providing FP services are included in this analysis.

A total of 103 service providers, including 22 males and 81 females, were providing some type of FP services at their facilities. Almost all midlevel female providers (i.e., nurses, LHVs and midwives) were providing FP services in both urban and rural areas; a few of them were franchisees of MSS, GSM, or DKT, especially in Sindh. Sixty-six of the service providers who were providing FP services had received training on FP while the remaining 37 providers had no such training.

Current Role in FP Service Provision

Notably, all providers, especially those who are not currently providing FP services, see FP as an important and needed service for men and women and are willing to provide these services if the obstacles they face (described in Figure 4.1) could be addressed.

Of the **156** interviewed service providers, **103** are providing family planning services, but **37** of these have never attended any training in family planning.

It is important to explain to those people who don't consider family planning acceptable what family planning really is…It is necessary to make people understand that family planning does not mean limiting childbirth; it means birth spacing. It will take time to make people understand this. IDI[8]-Dispenser clinic-Urban-Bahawalpur

[8] IDI- In-depth interview

The numbers of specific types of providers who mentioned that they were providing a specific method are shown in Table 4.1. All 103 providers were providing some FP service, particularly counseling and referral, but the range of specific methods they were providing was generally very limited. Most of the female midlevel providers interviewed said that they provide mainly injections, pills, condoms, and IUCDs and refer clients elsewhere for implants, including to rural health centers, tehsil or district headquarter hospitals or to camps arranged by an NGO (This was confirmed by the study team to be Marie Stopes). The only homeopath who does provide FP services provides only one modern method to clients, i.e., injectable, and prefers to provide his own traditional medicines for birth spacing. Male MBBS doctors mainly provide counseling and refer clients to female service providers nearby if they ask for services.

Table 4.1: Number of service providers who mentioned providing specific methods, by type of facility (n=103)

	Family Planning Methods				
Type of service provider/facility	Condom	Oral pills	Injection	IUCD	Implant
Private hospital	6	8	8	8	0
Maternity home	4	8	15	12	4
Female doctor clinic	4	6	8	7	1
Male doctor clinic	0	3	4	2*	NA
Nurse clinic	5	11	8	8	NA
LHV clinic	3	10	14	11	2
Midwife/CMW clinic	7	8	10	8	NA
Dispenser clinic	5	3	4	1**	NA
Hakim clinic	0	0	0	NA	NA
Homeopath clinic	0	0	1	NA	NA
Total SPs providing method	**34**	**57**	**72**	**57**	**7**

NA=Not applicable (Cadre is not permitted to provide this method.)
* In both cases, the IUCD is provided by the providers' wives, who are also MBBS doctors. These cases have not been counted in the female doctor category because the facility was a male doctor's clinic.
** The IUCD is provided by an LHV appointed at the provider's clinic.

The 53 service providers who were not providing FP services are mainly males (39), particularly hakims, homeopaths, and MBBS doctors across the districts. The majority of these service providers reside in rural areas. While they are not providing FP methods or counseling, they do refer clients to other facilities or write prescriptions for methods at their request. This indicates that there is no opposition or reluctance on their part to provide FP services and they can be mobilized to participate if the concerns and issues they mention are addressed.

I only advise people or give a written prescription to purchase a contraceptive from outside or tell them a place to go to because we don't have any methods now—that is why we don't provide them. And not that many people come here to seek family planning. Mostly women used to go to the government hospital for family planning methods. IDI-MBBS Male clinic- Rural-Bahawalpur

No, I don't provide any services because I don't have any Lady Health Visitor with me. Even in cities, LHVs or ladies provide services like this. In villages, it's impossible without a lady. IDI-Dispenser clinic-Rural-Faisalabad

Challenges in Providing FP Services

The 103 providers who do offer FP services were asked about any challenges they have to face while providing FP services. Twenty-five providers responded that they do not face any challenges, while the rest mentioned a number of issues, which are shown in Figure 4.1. The area of each segment reflects the frequency with which a particular challenge was reported.

Figure 4.1: Major challenges service providers face in providing FP services

The challenge mentioned most frequently (by 29/110 providers) was that clients are affected by myths and misconceptions about certain FP methods, particularly about long acting methods. Service providers see this as a root issue that leads to another major challenge—difficulty in removing negative perceptions and convincing people to try FP methods. They believe it is harder to convince rural men and women and attribute the difficulty to clients being uneducated or less educated.

Mostly people do not agree to tubal ligation or copper T or to multiload due to misperceptions being spread in the community. I have to convince them to try it (IUCD) at least once. They worry about whether it would suit them and that it might affect their husbands too. Then I have to show it to them and explain that it is just a thread which will be placed inside and it will not harm either of them and when they intend to take it out, then it's just a matter of pulling the thread slowly and it is out. So how can this get stuck? It's just the fear that has been generated over time against it. IDI-Maternity Home-Town-Lasbela

The other major and important challenge service providers mentioned was their own lack of training and the resulting limited knowledge about methods, especially about management of side effects. The majority of the 37 providers who have never attended any training related to FP but are providing FP services are male and, not surprisingly, this gap was mainly identified by male

providers. However, this challenge was also mentioned by service providers who *have* attended some training but who feel they are not equipped with the latest knowledge or skills.

From doctor to midwife, there is no guideline. They only have a diploma and that's it. They don't have any of the latest training in methods. IDI-Maternity home-Rural- Bahawalpur

As mentioned earlier, almost all providers are in favor of providing FP services. However, having no female staff is perceived to be a challenge among male providers since women usually prefer to go to female providers for FP services. The male providers therefore limit their services to providing them information or referring them to other facilities, which are not necessarily easily accessible.

Mostly women go to the nearest hospital for such cases. There is a lady doctor nearby who is offering FP methods. People prefer going to her. IDI-Hakeem clinic-Town-Lasbela

While a number of recent studies conducted directly with women show that the factor of opposition of mothers-in-law and husbands has diminished as a barrier in FP use (Rashida et al. 2015 and Rashida et al. 2017), a few of the service providers from Bahawalpur, Sukkur and Faisalabad perceive that it remains a problem in their area.

Sometimes she has a problem of permission from her husband or mother-in-law. So I have to talk to her family for this. Mostly the client says that I will ask my family first. IDI-LHV clinic-Urban-Sukkur

In addition to these highlighted issues, service providers also mentioned other challenges such as unavailability of contraceptives and people's lack of trust in alternative medicines offered by hakims and homeopaths. But the frequency with which these issues were mentioned was low.

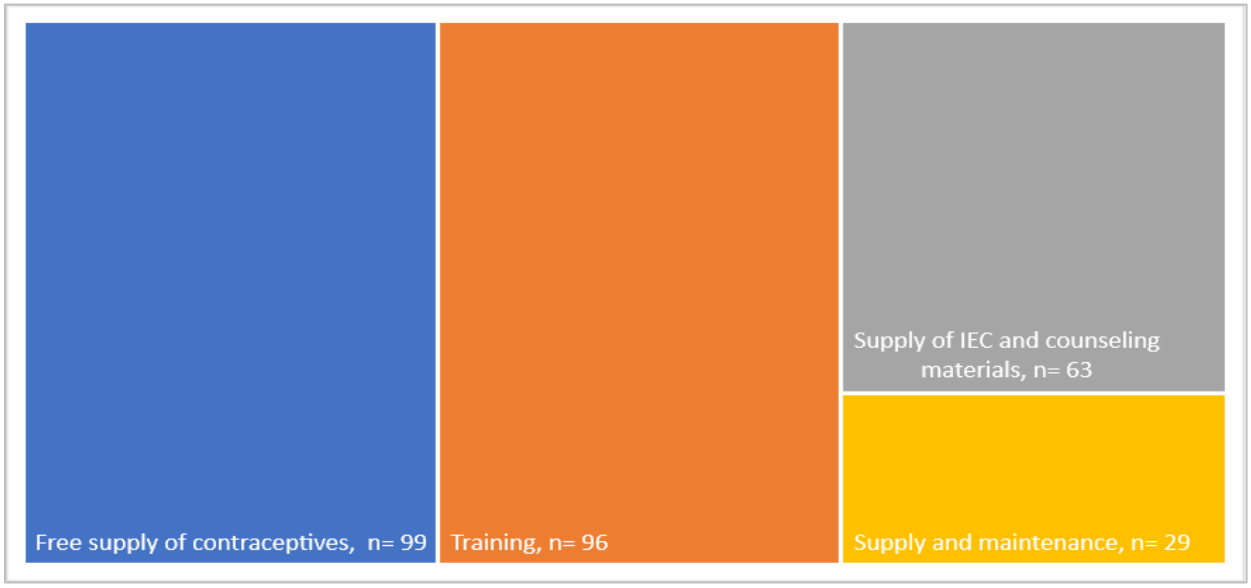
The 53 service providers who were not providing any FP services included mainly hakims, homeopaths, dispensers, and male MBBS doctors, along with a few female MBBS doctors and nurses. When they were asked about their reasons for not providing FP services, they cited challenges that were very similar to those mentioned by current providers of FP services (outlined above), including non-availability of a female provider at their facility; lack of training in FP service provision, especially management of side effects; lack of contraceptives and material to aid in counseling; and disapproval of FP in their areas. In most of these cases, the service providers would be willing to provide FP services if provided training, contraceptives, and information, education and communication (IEC) materials. Male providers can be trained to identify potential FP needs of clients and to provide condoms, pills and injectables, or at the very least, counseling and guidance about FP.

It is interesting that most of the challenges mentioned by those who are providing FP services and those who are not providing FP services are common. While some providers try to overcome these issues and provide FP services others do not. Those who are providing FP services try to counsel women against fear of side effects. Similarly, the providers who lack training refer clients to nearby facilities, and male providers seek services from female providers so that their clinics can provide female methods, such as IUCD.

Support Required from Public Sector

All the service providers interviewed were asked what kind of support they would like from the government to be able to provide FP services. The types of support and the number of respondents who mentioned each type are shown in Figure 4.2.

Figure 4.2: Support service providers require from the public sector



Free supply of contraceptives (99/156): The majority of the SPs (99) mentioned that they would like to receive a free supply of contraceptives and a few also wanted incentives as support from the government so that they could provide free or affordable contraceptives and charge affordable fees to clients.

If the government provides us free methods, then we will be able to provide them for free. This will improve family planning services. There are many women who are not allowed to leave the village and they come to me. If I have better services then I will be in a better position to help them in family planning. Also, it will be good if they give us some incentive. IDI-CMW clinic-Rural -Thatta

Trainings (96/156): A substantial number of service providers (96) across the districts asked strongly for trainings and refreshers to close their knowledge gaps and to increase their capacities in providing FP services. LHVs, nurses, and midwives who are already providing FP services are particularly interested in trainings in FP methods as well as management of side effects. Hakims and homeopaths are also keen to attend training on contraceptives so they can start providing services.

The government should arrange trainings and I am interested because when I know how to provide good services, my prestige will improve in the area. I am going to leave for 3 months and I have planned that I will attend training in a government organization. I will go wherever they provide it. IDI-Nurse clinic-Urban-Sukkur

Supply of IEC material for counseling (63/156): Service providers, particularly from Sindh and Balochistan, asked for pamphlets and other IEC material for counseling clients. According to them, pamphlets should be available with all methods' details along with information about the dates of free camps for tubal ligation in their respective communities.

The public sector should send us messages and pamphlets, etc., through their facilitators, counselors and service providers. Those pamphlets should have everything mentioned along with dates and numbers of free tubal ligation camps and also all the information about what methods they can avail. They can read all the details and, if not, then their husbands can read the materials to them. IDI-Female MBBS Doctor-Urban-Lasbela

Supplies and maintenance (29/156): Service providers, especially from Faisalabad, Sukkur and Thatta, mentioned that the government should allot private providers a separate corner within their facilities to provide FP services and provide maintenance support for private clinics. They also mentioned that they require furniture for waiting and procedure rooms, as well as refrigerators to store medicines safely.

They should update this room and give me a proper setup for a clinic. They should give all the facilities which a family planning center has like furniture, tiles, etc. IDI-Maternity home-Rural-Sukkur

Apart from the above demands, four homeopaths also expressed an interest in becoming franchised by the government so that people in their community would know they are also providing FP services and visit them. Since dispensers are not currently allowed to provide FP services by the Health Care Commissions, a few of them also demanded that they be granted official permission to provide FP services so they could contribute without any fear.

Pharmacies

In-depth interviews were conducted at 29 pharmacies across the six study districts in both urban and rural areas. All of them were selling at least one FP method.

Respondents from both urban and rural settings reported that they were selling condoms, oral pills, emergency contraceptive pills (ECP), and injectables of various varieties and brands. IUCDs and injectables were available only at a few pharmacies, mostly in urban settings and these were mostly sold on the prescription of private doctors.

Urban pharmacies offered a greater range of methods and brands than those in rural areas. At district level, pharmacies in Faisalabad, Sukkur and Thatta offered a wider range than those in Bahawalpur, Lasbela, and Mansehra. (Appendix D provides details of the methods and brands available, by district and location, at pharmacies).

Some of the pharmacies were receiving supplies through the social marketing programs of GSM and MSS. These were mostly situated in urban areas. A few respondents mentioned that they purchase contraceptives at subsidized rates and these are affordable for clients. However, they also mentioned that on non-subsidized varieties of condoms (specifically, *Happy Life*, *Josh*, *Touch* and *Climax*), they earn a large profit.

Pharmacists reported that condoms and pills are the most frequently sold FP methods. Condoms are the highest selling method in both urban and rural areas and there are a variety of brands to meet the needs of different economic segments of consumers. Among oral pills, the second highest selling method, the main brands include *Famila*, *Progyluton Tab*, *Daen Tab*, and *Yaz*. Injectables are the least sold method, provided only on doctors' prescriptions. Available brands include *Depo-Provera*, *Nova-ject*, and *Femi-ject*.

Among long-acting methods, the copper-T is the only method sold because it is the only long-acting method with which customers are familiar. Only a few urban pharmacies were selling this method and they did so mostly on the prescription of private service providers. Although there is no formal referral mechanism between pharmacies and the public sector, pharmacies informally refer clients in need of long-acting methods to PWD and PPHI facilities.

Challenges in Providing Contraceptives

Limited sales of contraceptives: When asked about any challenges they face in selling contraceptives, all respondents from pharmacies mentioned that sale of contraceptives is limited. This is a key issue that seems to be a result of the other problems mentioned by the respondents.

Limited knowledge about contraceptives among pharmacy staff: It was reported by the pharmacies that their staff have limited knowledge about the varieties of contraceptives, their efficacy, side effects, the duration of their effect, etc. The majority of the respondents said that they simply provide methods on demand, when a customer asks through a prescription or by name. But if someone wants further details about the methods, pharmacy staff are not able to help, which can be a hindrance in selling products. This genuine gap needs to be addressed to expand access to FP methods.

Pharmacists should be given training every 15 days or monthly in order to make them aware of the products and injections. They should know what the time limit of a particular product is and when it should be given. IDI-Pharmacy-Bahawalpur

We are not providing those products because we don't have enough information. Secondly, we don't have information about the usage of these products and we can't guide our clients, so we don't keep them. IDI-Pharmacy-Sukkur

Limited awareness and demand among customers: Nine out of 29 respondents reported that there is no hurdle in selling contraceptives except low demand for products due to people's lack of awareness or information about FP. The majority said that if there was collaboration among all actors working for FP, demand for contraceptives at pharmacies would also increase, which would motivate pharmacists to contribute in FP programs.

Difficulty in buying and selling long-acting methods: Respondents said that the biggest issue was that LARCs are expensive and people cannot afford to buy them, which greatly limits demand for these methods at pharmacies. This is why most pharmacies hesitate to stock IUCDs and implants.

Actually, other methods are a little expensive and if these methods were free then we would guide people that these are methods and there are such benefits with no side effects. Then people will demand these other methods as well because the biggest issue is that they are expensive so people don't buy them and we also don't keep those products. IDI-Pharmacy-Bahawalpur

Support Required from Public Sector

In terms of the support they desired from the public sector to enhance their role in provision of FP methods, the respondents mentioned the following:

Train pharmacy staff: To address their lack of knowledge about contraceptives, most respondents emphasized that they should be provided training on the different varieties of contraceptives so that they could guide customers properly. They would then be willing to keep more stocks of contraceptives.

We are advising according to our knowledge and if we will get training, then we will provide all possible services. IDI-Pharmacy-Bahawalpur

Build community awareness: A few respondents suggested that awareness should be created among local communities about the availability of contraceptives at pharmacies. This would

enhance linkages among communities and pharmacies and would also serve to link the public and private sectors.

Let me reiterate: if there is awareness, then people will demand more FP methods and then we will keep more things at the store. We don't have any issue in that. IDI-Pharmacy-Bahawalpur

Provide IEC materials to pharmacies: A few respondents from Punjab and Sindh said the government should provide IEC materials to all pharmacies to be handed out to customers because people need information about FP. There should be printed brochures containing all contraceptive details. They further suggested that the government display signboards at their pharmacies to inform people that the pharmacy provides contraceptives.

Provide free and regular supply of contraceptives: Respondents suggested that the government provide pharmacies a regular supply of free contraceptives which they could provide to clients for free or at a nominal charge. This would benefit communities in the vicinity by providing them easy access to affordable contraceptives. This would save time and money for people and improve sales of pharmacies.

There will be benefit because the sale of family planning products will be improved, the knowledge of people will increase. Besides this, there are more benefits … the more knowledge people get, the better decisions they make. The agenda of family planning can be pushed strongly. We don't need any benefit from them. We don't have greed in this; the government should provide awareness to people. IDI-Pharmacy-Sukkur

Books, brochures, and IEC material should be provided along with incentives to us. Incentives should be given in the form of cash payments. All methods should be given free of cost to pharmacies by the government. Then we can provide them to clients for free. The supply of FP methods should be regular. IDI-Pharmacy-Bahawalpur

Refer public sector clients to pharmacies: A few respondents (6 out of 29) also mentioned that they refer clients to government facilities such as those of the PWD, DoH and PPHI for long-acting methods, even though they are not part of any formal referral chain. However, this favor is not returned by public facilities. Since pharmacies offer a wider variety of brands of short-acting contraceptives compared to the public sector facilities, they suggested that the public sector should at least refer its clients to local pharmacies after assessing clients' choice and ability to pay. Sales could improve with such a mechanism in place.

Yes, whenever such customers come to us who are looking to limit child births, we refer them to the government hospital. We prefer to send them to any (private sector) gynecologist but if we think a government hospital is more suitable for them then we send them there. The rest is entirely up to them. IDI-Pharmacy-Bahawalpur

Population Welfare (facilities should be instructed) that if they don't have any FP method then they should refer clients to us or they should tell them that they can get items from our medical store at a low price. IDI-Pharmacy-Faisalabad

Give incentives to pharmacists: It was suggested by a majority of respondents that they should be given incentives in the form of cash or gifts for selling contraceptives. In a few interviews, respondents also mentioned that the government should allow pharmacies to administer injectables to clients. In their view, this permission could also increase access to FP services.

If we are appreciated for selling FP products then sales will increase as well. Another important thing is that we don't have permission to provide injections. We can only give products

according to the prescriptions; we can give neither medicines nor any advice on our own. The government should give us permission to provide the Famila injection; it will help expand FP services. The Department of Health announced that (users should) get the injection from MBBS doctors and not from medical stores. IDI-Pharmacy-Faisalabad

Distributors and Wholesalers

Across the six study districts, 14 distributors and 12 wholesalers were interviewed to assess their current role in contraceptive supply. Most of the interviews were carried out in the urban centers of the study districts, where these stakeholders are generally based.[9]

Most of the respondents reported that they were currently supplying various brands of FP methods, including condoms, oral pills, ECP, and injectables. IUCDs and implants were available with only a few distributors who were part of the distribution network of social marketing organizations, importers, or manufacturers. (Details of the methods and brands they were supplying are provided in Appendix D.) Like the pharmacists, distributors and wholesalers reported that condoms are the most frequently sold methods of FP.

Wholesalers reported that there is demand in the market for various condom brands, especially *Sathi, Touch, Josh, Climax*, and *Happy Life*. The next highest demand is for pills: *Famila-28*, *EmKit* and *Progyluton Tab* and *Daen-35* are frequently sold products. The lowest demand is for injectables, for which the brands available are mostly *Depo-Provera*, *Nova-ject*, and *Femi-ject*.

None of the respondents had ever had any detailing meetings with the Population Welfare Department or been visited by a medical information officer. However, a few did have linkages with social marketing organizations like GSM. These respondents reported that SMOs arrange seminars from time to time where they invite wholesalers and distributors for their awareness and knowledge.

Challenges in Supplying Contraceptives

Limited demand for contraceptives: The distributors and wholesalers emphasized that they supply all products, including contraceptives, on the basis of market demand. The challenge for them in increasing supply of contraceptives is the perception of limited demand.

The respondents perceived three main reasons for limited demand: lack of awareness in the public about the benefits of FP; fear of harmful effects of contraceptive use on health; and lack of awareness of different brands of contraceptives available in the private sector.

The main thing is that people are not aware of the benefits of family planning. People have a fear that using these products will be harmful for their health and it will damage their internal system and they will lose strength. It's not like that. They don't understand that it's just for delaying births and keeping some spacing and it doesn't have side effects. IDI-Distributor-Sukkur

Notably, recent rounds of the PDHS and various studies suggest that public awareness about FP and its benefits is quite high. Moreover, fears of side effects of hormonal methods of contraception are not entirely unfounded, since service providers usually report not knowing how to manage these effects. Therefore some of the reasons for low demand cited by the respondents suggest that distributors and wholesalers are not completely in touch with demand-side realities.

[9] Interviews with distributors for Lasbela were conducted in Karachi since contraceptives are supplied from this city to the district.

Support Required from Public Sector

Permission to supply public sector products in private sector: Respondents were of the view that private sector distribution networks could be tapped by the government to supply contraceptives in the private sector. For this, the government would have to give official permission to individual distributors to supply its products. Moreover, in order to avoid shortages, the government could facilitate inventory management by helping to coordinate orders for contraceptives from service delivery points/pharmacies.

The government should arrange a family planning order (from companies) and they should tell us how much stock we should have so we don't face problems of shortage. They should give us a letter of permission allowing us to sell medicines and products of the government so that when we sell government medicines in the private sector, if any problem arises, we can show the permission letter. IDI-Distributor-Mansehra

Provision of free or subsidized products: Furthermore, respondents were of the view that the government should incentivize supply of contraceptives by providing products to distributors for free or at subsidized rates and permitting them, as well as wholesalers and retailers, to earn nominal profit margins. They also suggested that contraceptive products be exempt from general sales tax (GST) so that the prices remain low, and products are affordable.

The government should provide free medicines to the distributors. Then they will add some margin in it and supply them onward and then store owners will charge a 1- to 2-rupee margin. In this way, people will get cheaper methods and the business of medical stores and distributors will also increase. IDI-Distributor-Mansehra

There shouldn't be any GST on such products. Instead they should give subsidies on it because population is the biggest issue. So they should remove GST. IDI- Distributor-Faisalabad

Outreach to suppliers and retailers: Finally, the respondents suggested that, in order to sell contraceptives in the private sector, the government needed to adopt an intensive marketing strategy to encourage suppliers and retailers to sell FP products, train them to guide customers and alleviate their concerns, and also support them in sales tactics such as shop front displays to make products as accessible to customers as possible.

Condoms and other over-the-counter methods should be displayed in shops where they are easily visible and customers don't feel any difficulty in purchasing them. People should be given awareness. Every organization has its teams and there should also be a team of the government. They should give awareness individually. Workshops should also be conducted. IDI-Distributor-Sukkur

If we were trained then we could guide our customers properly…Due to low prices, people would come to the private sector because the public sector is overcrowded. People also have a hesitation about family planning products. If they would come to us, we would guide them individually. In this way, services would be improved. IDI-Wholesaler-Faisalabad

SMOs and NGOs

Social marketing and non-governmental organizations since the decade when they started working, made a significant contribution in increasing access to FP services in Pakistan. They have a focus on addressing the needs of underserved communities and poorer segments of the population through interventions based on a variety of models and approaches, as outlined in Section 2. However, most

of these projects rely on donor funding, which limits their scale, scope, and duration, and there is no system of plowing back profits into long-term sustainability.

Representatives of eight SMOs and NGOs were interviewed for this study. The organizations and their current major projects are outlined in Table 4.2.

Table 4.2: NGOs and SMOs represented in interviews and their major current projects

Organization	Current Products and Projects
Social Marketing Organizations	
Greenstar Social Marketing	**Products**: Condoms: *Sathi,* Touch Injectables: Femi-ject, Novadol, Nova-ject, Depo-Provera ECP: Levonorgestrel 0.75mg **Projects**: *Sabz Sitara* clinics; 7,000 franchised service providers (including LHVs and male and female general practitioners); provision of small clinics housed in containers; community-based workers – *Baji*
DKT International	**Products**: Condoms: *Josh* and *Prudence* **Projects**: *Dhanak* clinics (staffed by community midwives and LHVs)
Non-governmental Organizations	
Rahnuma–Family Planning Association of Pakistan	10 hospitals and 110 clinics; mobilizers; helpline; 200 private practitioners – provide training and contraceptive supplies at government rates; train LHVs to provide implants (Faisalabad, Umerkot and Lasbela)
People's Primary Healthcare Initiative	Operate public health facilities contracted out by government; renovate BHUs and provide services (mostly 24/7), including FP
Aman Foundation	Community interventions: Service delivery (200 community workers in unserved areas, following model of LHWs) Policy Interventions: Task shifting - 200 LHWs to give first dose of injectables; LHVs trained for insertion and removal of implants
HANDS	FP service delivery through Marvi workers in unserved areas, based on model of LHWs
Marie Stopes Society	*Behter Zindagi* centers (clinics); *Suraj* social franchise network of LHVs; demand-side financing through voucher scheme; *Roshni* mobile outreach vans, which also provide IUCD, FP counseling, and general medicine (local government teams mobilized to make announcements)
National Maternal, Neonatal & Child Health Program	Post-delivery IUCD provision at public teaching hospitals through free services with 24-hour female counselors

Challenges in Providing FP Products and Services

Lack of trust and cooperation from government: Almost all interviewed NGOs and SMOs representatives except one mentioned about limited support received from government officials for their initiatives. According to them, despite a longstanding presence and contributions in the country, it is hard for them to convince heads of public sector facilities to upscale their interventions. The prevailing environment of distrust poses a challenge for SMOs and NGOs because the success of every initiative or project ultimately relies on government support.

There is an issue of political will. If the CM can call a meeting about dengue at 6:00 a.m., then why not for population? If, in any area, the LHW finds a polio case, everyone becomes active about it, but if a woman dies during delivery, it is no issue for anyone. We are getting funds because of international pressure; otherwise, there is no political will. IDI- NGO

Lack of government interest in scaling up successful models: There are several examples where NGOs and SMOs have successfully tested, with limited funding and short duration of time, different models for expansion of FP services and meeting the needs of people, coupled with an agenda of advocacy so that successful models can be up scaled up and replicated in other areas by the government. However, the government, particularly departments of Health and Population Welfare, have little interest mainly due to limited funds in upscaling the tested models. This is why different small-scale models of interventions have been implemented from time to time but hardly any model has been scaled up in its entirety on the national level. The PPHI is a proven model but, again, it is limited to Sindh and to some extent to Balochistan.

One of the organizations especially mentioned that NGOs and SMOs have trained public sector staff to enhance their capacities and productivity using resources provided to them by donors. However, afterwards, the results do not last and the investments of NGOs/SMOs are wasted.

Collaborative initiatives are not monitored or evaluated: Some respondents complained that despite repeated demands, no third-party monitoring and evaluation mechanism has been initiated by the government to evaluate the performance of each partner in collaborative initiatives. In the specific case of contracting out, a major challenge for PPHI is managing staff (of vertical programs) who report to the DoH and not to PPHI management.

Lack of mass media campaigns: NGOs are of the view that, to increase demand for and access to FP services, mass media campaigns are crucial. However, such campaigns are too expensive for NGOs to implement and the government is not providing support in this regard either.

Diminishing funding from donors: A challenge especially mentioned by SMOs and NGOs is that donor funding for FP is now declining, which is shrinking the portfolios of international NGOs (INGOs). As a result, organizations are compelled to squeeze the scope and scale of their operations, particularly in terms of geographic coverage and work has to be increasingly limited to urban areas. One of the SMOs particularly mentioned that their long-term project of franchising has been compromised by cuts in funding. This issue compelled a large pool of previously supported service providers to discontinue provision of subsidized FP services in underserved areas. One of the NGO representatives also shared that donors now demand substantial results in a short time span, which is not always feasible and creates problems in meeting their requirements.

We are getting 6% of the health budget. At first we were saving from this but now we can no longer save. In fact, we are using our additional budget for BHU Plus. There is a problem of electricity, so we have installed solar panels on which we are relying for lights and fans. IDI- NGO/ Company

Restricted functioning environment: Due to recent restrictions and issues of registration, NGOs are facing difficulties in conducting field operations. At times, NGOs have had to close health outlets that were providing FP services; in one case, an NGO had to scale down its operations from 140 to 70 districts. In addition, public sector stakeholders avoid collaboration if there is any issue in

registration. One of the NGOs has had to shift its focus from scaling up to simply preserving its existing system due to such restrictions.

In the current scenario, due to the restriction of registration, the NGO sector is facing difficulties in conducting field operations. IDI- NGO

When we signed an MoU with the Population Welfare Department, that was the time when this issue of NGOs began. We asked the PWD to review that MOU. They said "No, we can't work with you because you're not registered. You should get registered first, then we will sign it again." When such things happen, partnership doesn't work. IDI-NGO

It is very important to ponder on the reservations voiced by NGOs and SMO sectors. They indicate the major potential issues that must be resolved and preempted for the success of future efforts to formally engage the private sector in expanding access to FP services.

Support Required from Public Sector

Finance sustained implementation of successful initiatives: With donor funding on the decline, a key requirement of NGOs and SMOs is that the public sector should step in to help finance the continued operation of their successful initiatives.

In the franchise model, the private sector is leading. But you can't say that it was donor-funded and now there is no funding so everything must stop. There are things running—the government should continue them. IDI-SMO

Regulate prices of contraceptives: Moreover, an SMO representative suggested that the government should control prices of contraceptives and should also collect subsidies from the local companies from which it is procuring contraceptives, so that the gap in prices between public sector and social marketing products could be reduced. However, as outlined in the next section, representatives of manufacturing say price controls would spell "collapse" for the industry.

The government should control prices and should collect subsidy on contraceptives. For instance, we are getting an IUCD worth 120 rupees and giving it for 50 rupees. We will keep doing this as long as the donor supports it. But the donor is not going to keep doing this till the end of time! The government should see that its cost is 35 rupees and it is selling it for 120 rupees and we are selling it in the market for 50 rupees. IDI- SMO

Create demand for family planning: Respondents were also of the view that the government should conduct mass media campaigns to encourage the public to adopt FP and to make it aware of the different products and brands available in the market.

The government can run a campaign to promote FP. They can give people awareness about brands like Sathi, along with other brands. The government should hire some boys (for marketing), just like we began with working staff given to us by Key Social Marketing. That gave us a financial boost at that time. IDI- SMO

Importers and Manufacturers

Representatives of three importers and one manufacturer of contraceptives were interviewed for this study. The names of the organizations and the FP products they are currently providing are listed in Table 4.3.

Table 4.3: Importers and manufacturer represented in interviews and their major products

Organization Type	Organization Name	Products
Importers	United Distribution Ltd.	*Happy Life* and *Intense* condoms (imported from Malayasia) Import, distribute and market
	OBS Pharmaceuticals	Import *Implanon* (implant) for government for bulk consumption in Sindh
	Biogenics Pharma	*Hamdam* condoms
Manufacturer	ZAFA Pharmaceutical	*Famila-28* (combined oral contraceptive pills), *EmKit (EC pills)* and *Norifam* (Injectables)

Challenges in Supplying Contraceptives

Low demand: Like NGOs and SMOs, importers felt that demand for contraceptives is low and increasing it through mass media campaigns in support of FP is crucial. While private organizations do not have the resources to launch such campaigns, the public sector does, but is not taking sufficient measures.

New licensing requirements and price controls: A serious challenge mentioned was that the Ministry of National Health Services, Regulations & Coordination has recently placed condoms and implants under the purview of the Drugs Regulatory Authority of Pakistan (DRAP), which means that new rules and regulations are applicable to their import, manufacture and supply. Manufacturers and importers will now have to obtain licenses for supplying contraceptives and furthermore, may confront price controls. With the market for contraceptives already limited, respondents say price controls could well mean "collapse" of the industry.

There is another regulatory side, which is the Ministry of Health. They used to concentrate on pharmaceutical products, mostly on drugs. Basically there weren't many restrictions or conditions on these contraceptives (condoms and implants). Now, the Ministry of Health has included these contraceptives under drugs which are regulated by the Drug Regulatory Authority of Pakistan. They have their rules and regulations and the first and foremost is that you have to get a license to do anything, which is an establishment license. If you are a manufacturer or an importer of any product, you have to apply for the license. Now just like in pharmaceuticals, if the contraceptives get regulated in the prices, then the industry will collapse. This is a serious concern and a challenge. IDI-Importer

Support Required from Public Sector

Eliminate taxes on imports: A few importers desire that the government should eliminate taxes on imports to facilitate them.

Cooperate and give buyback guarantee to encourage investment in local manufacturing of condoms: When asked about their interest in manufacturing condoms, the manufacturer and importers were of the view that it would be difficult to make the undertaking feasible because raw material, particularly rubber, has to be imported, which is expensive and hard to afford. Despite availability of cheap labor, indigenous manufacturing of condoms would be more costly than importing products. However, some respondents said they would be willing to manufacture condoms provided the government supported them. In this regard, their most common demand was cooperation and a buyback guarantee from the government. They also suggested that no more than one manufacturing plant should be set up initially, to ensure an adequate market for the investor. Without such support, the respondents said they would not be able to invest in local condom manufacturing.

In addition, respondents said the government should support promotion of locally manufactured products to help establish the new manufacturing company and the industry in general. One respondent suggested that this would also improve perceptions about the quality of contraceptives supplied through the public sector.

For condoms, if the government eliminates the duty on import of contraceptives then it would be fine. The other option is that the government gives a guarantee that it will purchase his (the local manufacturer's) products for 5 years. Then he will come and establish a factory; otherwise, he will refuse to invest. And until you have local products, you will have to spend dollars, which is not right. IDI-SMO

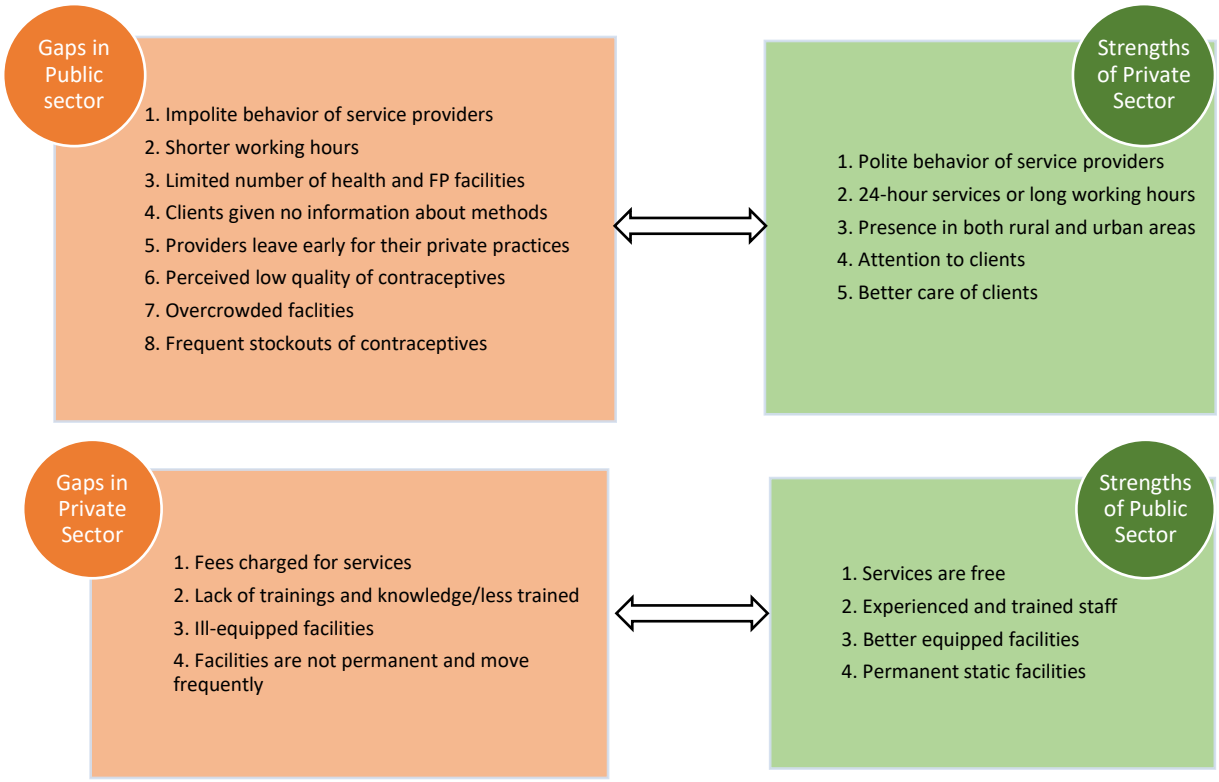
The government does heavy purchasing. If the government buys products from the private sector and promotes those, it would be great. Because, at the end of the day, we are helping out. We are promoting a social cause but at the same time, from a business point of view, we are establishing a brand. IDI- SMO

DKT and Greenstar are considered superior brands as compared to the government and when, on the media, people will see private products with the name of the government, their acceptability will increase. When PWD will show the name of Greenstar on the media, people will think that they don't get any subsidized brand; they are getting the same thing which my wife or my sister is using. Their wives will be using it; this will increase their acceptability. IDI- Manufacturer

Views on Potential for Public–Private Partnership

All of the interviewed private sector stakeholders, including service providers, pharmacists, distributors, representatives of NGOs and SMOs, importers and manufacturers, strongly supported the idea of PPP to bring about improvement in access to FP services. Nearly all respondents were of the view that while the public sector is providing FP services, partnership with the private sector could achieve better results. They recognized that the two sectors have unique gaps as well as strengths to offer and joining forces could mean that the gaps of one are addressed by the other's strength. Figure 4.3 summarizes the strengths and gaps of the public and private sectors identified by respondents, which they felt could be taken into account in partnerships between the two sectors.

Figure 4.3: Views of private sector respondents about private and public sector gaps and strengths



In general, the most detailed responses came from service providers themselves, who represent multiple cadres. Dispensers, hakims, and midwives from Lasbela, Sukkur, Bahawalpur and Faisalabad acknowledged that the public sector provides free FP services, which attracts people. However, public facilities are overcrowded and there are no proper arrangements for waiting and the behavior of service providers is often impolite, leaving clients disappointed. They attributed the disrespectful behavior of public sector providers to the constant pressure of clients at public facilities and felt this was a problem the private sector could help address, by offering less crowded facilities and more polite service providers, albeit in return for additional financial returns.

In government hospitals, the behavior of the doctors is not good with the patients generally. They do not give importance to the patients. The patients suffer there while carrying around a token number or the prescriptions in their hands. They don't even get a proper place to sit there. When they come to us,

we are conscious that these are the people from whom we earn our living; we show care to them and listen to them. IDI-Dispenser clinic-Rural-Sukkur

Service providers and a few pharmacy staff shared that stock-outs of commodities can last for up to six months at government facilities and nobody considers it important. In a partnership, the two sectors could support each other by sharing stocks in time of need.

If the public and private (sectors) work together, it will be beneficial for people in the sense that if there is any method or any other service which is not available with the private doctor, he or she can refer the patient to a government hospital or to the government doctor and vice versa. In this way, ultimately the patient will benefit. IDI-Pharmacy-Mansehra

The lack of information on contraceptive methods and counseling provided at government facilities was frequently mentioned as another area where private providers could help improve FP services

Government institutions don't do their work well. Hospital or government dispensaries don't provide much information regarding family planning. IDI-Dispenser clinic-Urban-Bahawalpur

If the government does not consider improving its performance, it will not succeed. If it starts dealing with clients properly, then there is no doubt that the clients will prefer its facilities. If the doctor will not listen to the patient, what he has to say, then how can he provide treatment? The main cause of failure of FP methods over there is precisely this, that the clients are not given proper explanations. Due to the mistreatment, they get discouraged about family planning as a whole. IDI-Homeopath clinic-Urban-Sukkur

On the other hand, midlevel service providers said that there are trained and experienced staff in government facilities, who can guide and share their knowledge with private sector providers.

About 90 out of 156 service providers said that the private sector is responding well to the needs of clients and that is why a greater concentration of people is turning to this sector. Even if private facilities are sometimes less adequate, clients are attracted by providers' better behavior, including their efforts to listen, understand problems, and provide services for extended hours. Although clients are charged money, they at least receive quality services. When both sectors work together, the workload between the two sectors will be better divided and services will improve.

Private providers are doing hard work. They are providing family planning services to people. If they work with the government, it would be better. The government's name would be included in this work. IDI-LHV-clinic-Rural Faisalabad

Private organizations work better, for 24 hours. On the other hand, the government hospital staff go home at 2:00 p.m. IDI-Nurse clinic-Rural-Faisalabad

A total of 32 out of 156 service providers mentioned the positive contribution of NGOs and SMOs working to improve FP services, expressing an interest in being affiliated with such programs. Mostly GSM, DKT and MSS were mentioned in this context by the interviewed service providers. A few of them were currently or had in the past been franchisees of these NGOs or SMOs, attended their trainings, and received contraceptives at subsidized rates as well as free IEC material from them. They also appreciated these organizations' community mobilization activities and the seminars they conducted in different areas to educate people and rectify various method-specific misperceptions.

A male doctor in Thatta mentioned receiving incentives through MSS's *Suraj* voucher scheme while another mentioned PAIMAN's support in renovating operation theaters. Service providers showed their keen interest in being engaged to receive support from such programs.

Private (NGOs) are good at gathering people, motivating them, listening to their problems, and referring them to centers when they become ready for FP services. IDI-Dispenser clinic-Town-Lasbela

Greenstar set up their stalls outside medical stores to provide advice for family planning. People used to come there and ask about methods whether they eventually used them or not. They provided us literature, so we gave that to people that this is the method. These are good doctors. IDI-Dispenser clinic-Urban-Bahawalpur

Additionally, pharmacists and distributors emphasized that people often have to travel from remote areas to obtain FP methods and services and public-private collaboration could bring affordable services closer to them, making access easier.

People come to government hospitals from far-flung areas. If they can get facilities and free things at medical stores and private clinics (closer to their homes), it will be easier for them. Then people will avail this partnership-based FP program. IDI-Pharmacy - Mansehra

Roles Proposed for Public and Private Sectors in Partnership

Almost all private sector stakeholders across the districts were strongly of the view that PPPs would improve FP service provision. When asked to propose what role the public and private sectors could play in a successful partnership there was a broad consensus that the public sector should play a leadership role and also take the initiative of involving all private sector providers, as it has the responsibility to provide FP services. While proposing a division of roles between the public and private sectors, generally all stakeholders assigned more responsibilities to the public sector than to the private sector. The broad responses are summarized in Figure 4.4 and the following description identifies variances in responses across stakeholders, where applicable.

Figure 4.4: Public and private sector roles proposed by private sector stakeholders for partnership in FP service provision

Public Sector

Financial and commodities support: Across all districts, most of the private sector stakeholders, particularly service providers, pharmacies, NGO and SMOs, felt that the public sector has greater human and financial resources, which could be leveraged to address current gaps in the private sector and enable it to provide FP services. Another mentioned area for support included supply of free contraceptives and provision of equipment and IEC material to private providers. A primary suggestion was that the government could provide all FP methods to the private sector which could then be responsible for providing them to poor people free of cost or for nominal charges.

Government institutions should have connections or contacts with private doctors and they (government) should provide free family planning methods and supplies and they should support private organizations and doctors so they can provide these facilities. IDI-Homeopath clinic -Rural-Thatta

The government should give free contraceptives to private service providers and pharmacies so they can provide these further to the poor people. It will be beneficial for common people. Then results will be better. While providing family planning products, the prices should also be fixed. IDI-Pharmacy-Mansehra

Representatives from NGOs and SMOs proposed allocation of appropriate budgets from the government for activities to be carried out under the partnership, including their field operations and various strategies that formed part of their project activities.

The government should also provide us funds. Right now, the government is not paying the money; instead, the donor is paying. IDI-SMO

Our target should be behavioral change. Funding should be allocated by the government for this. IDI-NGO

Importers also mainly pointed out that the government should invest in indigenous manufacturing of contraceptives and should purchase products from the private sector and distribute them through its program. They suggested that the local manufacturer should also be export-oriented, so it would have a larger market for its products. Such an arrangement would not only be beneficial locally, but could also eventually enable the country to capture a part of the international market for contraceptives, provided the initiative was established on a strong footing through a joint venture.

Someone from the government should approach them for a joint venture and through this there will be a local plant in future. If the supplier is a local manufacturer and their target is export marketing and serving the region, then everything is possible. IDI-Importer

Human resource sharing and development: Respondents, especially service providers, also felt that the government could easily offer and share staff, buildings, and operation theaters with the private sector for provision of FP services. A few service providers particularly mentioned that at government health facilities that close by 2:00 p.m., space could be utilized in the evening by private sector providers for FP service provision.

During the day, government employees are providing family planning services. Private institutes or providers should utilize the same government hospitals to provide family planning services in the evening. IDI-Dispenser clinic- Urban- Faisalabad

The majority of service providers, particularly male providers, and pharmacy personnel felt hindered in FP service provision by their own lack of training and knowledge about FP methods, especially side effects management. Most of them strongly proposed that government service providers should provide free training on all birth spacing methods to transfer knowledge to private sector providers. They also suggested that certification be provided after trainings to keep providers motivated and to gain clients' trust. They proposed that such trainings be arranged in government buildings.

Training is also very important. They should give us training once or twice a week and call us there and give us awareness and information. We would attend it happily. I don't want to take money from the government. We only want to provide all the facilities to people for free. IDI-Male MBBS Doctor- Urban-Bahawalpur

The government should provide them (private providers) training so they become aware of all methods, have knowledge, and do not give spurious advice to people. Each and every person who is providing family planning services should have a training certificate. If she (the provider) visits a client at her house, they should not listen to her if she does not have the certificate. (Only) if they know she has it, then they should trust her. IDI-Hakeem clinic- Rural- Faisalabad

The public sector should give us trainings on modern contraceptives, so we have updated knowledge and the trainings should be conducted at a time that is suitable for us. IDI- Nurse clinic-Rural-Bahawalpur

Pharmacists also suggested that the public sector train their staff so they could counsel customers.

It should provide training to my medical staff, who are available at my medical store. When a person at the medical store advises a customer about any medicine, they spread that message to others. IDI-Pharmacy-Mansehra

Awareness raising and demand generation: Another role strongly proposed for the public sector was awareness raising for demand generation, rectifying end-users' misconceptions about various methods, and also informing the public of private sector sources. It was stressed by every stakeholder that the government should invest resources or conduct media campaigns for demand generation. Interestingly, stakeholders elaborated this potential role with reference to their own perspectives: service providers said it would increase their clientele; pharmacies saw it as a way to increase their sales; import and manufacturing concerns wanted to see an increase in their products' advertisement and sales. The gist of these responses was that increased demand would make it commercially feasible for the private sector to play a greater role.

While respondents proposed different strategies that the government could adopt for awareness raising, the general consensus was that TV programs would have the most influence on people. In addition, the government could develop materials for social media and also arrange seminars.

More and more material should be in audio and video form as it will be more beneficial for those who are uneducated because they use social media. IDI -NGO

The government should keep campaigning for family planning services, not specifically promoting any particular brand, like Hamdam, but promoting condoms instead. This will ultimately benefit the people. IDI-Importers

Our government should show all brands of contraceptives available in the market through TV and other media sources. IDI-Manufacturer

Incentives should be given by the government and it can do it in collaboration with the private sector. The government has the whole coverage of Pakistan. It can cover every corner and is also responsible for making laws. Awareness should be given through camps and people should be guided about these products and methods of family planning. If the government and private sector would work in collaboration, things would improve and they can achieve this target together. IDI-NGO

Monitoring and evaluation: The role of monitoring and evaluation (M&E) was generally assigned to the public sector by all stakeholders except for a few service providers and pharmacists who suggested that the private sector monitor joint efforts. Respondents proposed that the public sector appoint dedicated staff for monitoring. To evaluate the partnership programs, a committee with representation of both the public and private sectors should also be formed, with the responsibility of sharing a monthly report that identifies areas for improvement. They believed this would result in enhanced effectiveness of FP programs and in improved provision of FP services in their communities.

I think the public sector should do monitoring. It's their responsibility to keep a check but they don't do it. IDI-NGO

If both are held responsible for monitoring, that could be even better. The partnership will bring improvement in FP services in the community. IDI- Midwife clinic- Urban- Sukkur

If they would work together it could improve a lot of things and they could both enjoy working together. The private sector should take responsibility for monitoring the projects. IDI-Pharmacy-Thatta

The government knows that it should work with the private sector. If they work together, there will be improvement; I think the government has its own role. It's not like it can take over everything; it has other priorities too, like education. So the role of the government should be to develop programs, run them, and keep an eye on funds. The government should play the role that donors play. Implementation should be completely carried out by the private sector. The government will then be much more effective in holding the NGOs and (for-profit) private sector accountable. IDI-Importer

Private Sector

Respondents had far less to say about the role of the private sector in PPPs. Essentially, they felt the private sector should focus on providing FP services and contraceptives, while the public sector ought to play an enabling and monitoring role.

Mandatary provision of FP services: Respondents proposed that the government should make it mandatory for all private sector providers to provide FP services under PPP and provide them supplies and materials and then it should be the responsibility of private sector providers to devote sufficient time to FP service provision and ensure that they are available for extended hours to be more accessible to clients.

Private staff should offer more time when the government provides them extra pay and material for family planning. They should manage their time so people can get 24-hour services. IDI- Hakim clinic-Rural-Faisalabad

Local manufacturing of contraceptives: It was proposed by importers that the private sector should take the initiative in establishing contraceptive manufacturing units, with a buyback guarantee from the government. In this way, contraceptives could be produced locally, meeting national demand while also offering potential additional profits and other economic benefits through exports.

Manufacturing is not the duty of the government. There should be a programmatic approach and there should be a third party for monitoring. Without this, it's impossible. Partnership is so important. We can export our things and the (economic) growth rate will increase. IDI- Importers

Client record keeping: A few service providers and pharmacists said it should be the responsibility of private providers and organizations to provide quality FP services and they should maintain records, including the number of clients served with FP methods, referral cases, contraceptive stocks with consumption data, etc. These records should be shared with the public sector for monitoring of the partnership.

Awareness raising: A few service providers and NGO representatives also suggested that, alongside the public sector, the private sector should play an equal role in raising awareness about FP, by distributing pamphlets in the areas it serves and giving lectures at local gatherings. Both sectors could motivate and counsel people at the community level by working together.

Private organizations or clinics like us will try convincing clients to use family planning methods. We will spare half an hour or an hour to do the counseling of clients. This way we will play a role in making it a success. IDI- Homeopath clinic- Rural-Faisalabad

The private organizations should send their staff to villages to talk to people there about family planning. Women and men should work separately. IDI-Nurse clinic- Rural-Thatta

People don't know about these things and they have no one to explain things to them so the private sector should reach out to them and convince them to use products through promotions and awareness sessions. IDI-NGO

Respondents proposed that both sectors should initiate partnership with mutual acceptance of the other's presence and role. They felt that "when they start sitting together, they will start looking for solutions," and each sector would start showing its full capability in providing FP services. Under a PPP, facilities providing FP services would be more accessible to clients and the pool of providers offering FP services would increase, resulting in greater time to clients and ultimately, greater access to FP services.

5. Conclusions

The slight decline in Pakistan's CPR between 2013 and 2018 is a deeply worrying sign given the persistence of unmet need for FP among couples and also the wider national need to slow down population growth. The method choices of current users of FP are telling too: three quarters of couples are using condoms, withdrawal and female sterilization, indicating very low preference for hormonal methods or long-acting methods even though they are more reliable reversible options for preventing pregnancy and can greatly reduce the frequency of resupply visits and attendant problems of access.

The current study provides important perspectives and insights from the private sector about the obstacles in improving access to FP services, as well as the willingness and suggestions of private sector stakeholders, including both for-profit entities and SMOs and NGOs, to work with the government to resolve issues. Partnerships for FP are not only possible but, in the view of many respondents, essential for synergizing action; all stakeholders recognize that such partnerships must be adopted to implement a total market approach in which the relative strengths of each player are leveraged to serve the most appropriate segment of consumers.

Existing studies and recent PDHS data both confirm that the public sector, while less cost-effective than the private sector, is performing better in terms of reaching the poor. However, this apparently positive attribute comes across in an entirely different light in our qualitative findings: almost universally, men and women see public health facilities—despite being free, better equipped and offering more qualified providers—as the last resort of the poor and desperate. They say public facilities are overcrowded, stressful, waste their time, and provide substandard contraceptives with only limited choice of methods. But the issue that most decisively pushes them to the private sector is the poor quality of provider-client interactions: providers are accused of being aggressive and rude, not giving enough time to clients, not conducting proper examinations, and not even providing sufficient information or counseling about the FP methods they provide. The latter issue can ultimately lead to method failure and/or health concerns, both of which are major reasons for the high rate of contraceptive discontinuation in the country. Notably, however, men and women are largely satisfied with LHWs, although they feel these workers need better training and products.

From the perspective of potential FP clients, a main advantage of public–private partnership could be that private sector providers—who have a much better record of client interactions—start serving them as part of publicly funded initiatives. Ideally, PPPs would ensure more client-centered services, extend the hours of services, and bring FP services closer to their homes. Some respondents even feel such partnerships should be launched on an emergency footing akin to polio and dengue eradication efforts.

The good news is that all stakeholders are in favor of PPPs in FP and see potential for collaborations along roughly the same lines that users envisage. Our parallel examination of public sector perspectives, documented separately (Ahmed et al. 2019), found that the experience of provincial governments in terms of implementing such partnerships varies, from considerable in Sindh to relatively limited in Balochistan, but all government stakeholders are interested in engaging the private sector to meet human resource gaps in the public sector and to extend networks of FP service sources, mainly to target poor communities, especially urban slums and rural areas. In developing their individual frameworks for PPPs for FP, provincial governments will need to keep in

view the local method and source preferences, which the data show to vary considerably across regions. For their part, all the private sector representatives we interviewed—service providers of various cadres, pharmacists, wholesalers and distributors, SMOs and NGOs, a manufacturer and importers—support the idea of partnering with the public sector and are willing to play a larger role in FP, including subsidized services/products for the poor. They would expect the government to lead such a partnership and are also prepared to support its monitoring and evaluation.

However, in order to enhance their role, private sector stakeholders require support from the public sector. Outlined below are the specific areas they mention where they need support, which also correspond broadly to the domains proposed by them as part of the role of the public sector in PPPs:

1. Demand generation

A key recommendation from all private sector stakeholders was that they want the government to play an active role in creating demand and awareness in the public about the need for FP and the methods, brands, and sources available. For service providers, such a campaign would increase demand for FP services among clients and make it easier for them to dispel couples' misperceptions about contraceptives. Increased sales would send pharmacists, wholesalers, distributors, importers, and manufacturers the signal to increase supply. Respondents suggest general campaigns as well as promotion of specific locally available brands. Social media, awareness sessions, but most of all TV advertising is proposed for effective behavioral change communication; a fourth route, mentioned by consumers, are door-to-door counseling visits. Private providers are willing to play a role in increasing awareness among the clients who visit them. At the same time, respondents suggest that the government launch a marketing strategy to encourage pharmacists, wholesalers and distributors to increase supply.

2. Training of service providers and pharmacists

Most service providers and pharmacists want the public sector to train them in provision of FP services/methods, especially side effect management. Private providers believe they can learn a lot from working with public sector providers. They also want training in the latest methods, along with certification if possible so that clients will trust them, as well as IEC materials to help them counsel clients. Pharmacists too want basic information and IEC materials that they can give to customers or use to guide them. They believe if they are better able to guide customers about usage of specific methods, their sales will increase. This opinion is shared by wholesalers and distributors.

3. Supply of free/subsidized contraceptives

One of the most common requests across the private sector, especially among service providers and pharmacists, is that the government provide them a regular supply of free contraceptives that they can provide to clients for free or at nominal charges. Wholesalers and distributors would like their networks to be used by the government to supply products to the private sector, provided they and the retailers they supply are permitted to charge a nominal profit margin.

4. Enabling environment for manufacturing/importing contraceptives

Contraceptive manufacturers and importers are willing to keep up with any increase in demand, but they are apprehensive of the government's new licensing requirements, imposed recently with the shifting of contraceptives to the purview of DRAP. They moreover fear that if the government imposes price controls, as it does for medicines, the local contraceptive business will "collapse." On the other hand, a representative of an SMO suggested that price regulation is needed. Among provincial governments, Punjab's is interested in bulk purchase of contraceptives at lower prices from private pharmaceutical companies (Ahmed et al. 2019). The pricing of contraceptives is a potentially sensitive issue that will test the stewardship capabilities of the provincial governments; it should be negotiated carefully, keeping in view the long-term objective of making commercial supply of contraceptives viable and therefore sustainable.

In order to increase supply, manufacturers and importers say they will need tax exemptions—an incentive already being mulled by the Punjab government (Ahmed et al. 2019). Further, to invest in manufacturing contraceptives, respondents suggest the government offer buyback guarantees for five years. Respondents say that this, coupled with an export-oriented production plan and promotion of local brands by the government, will help establish local production of contraceptives and also contribute towards an improved balance of trade.

5. Financial incentives and resources for service delivery

Until demand for FP services reaches a level that ensures profits, private service providers as well as pharmacists, wholesalers and distributors will need some incentivization from the government. Among pharmacists and suppliers, incentives can take the form of cash and gifts, as well as permission to charge nominal profit margins on free commodities supplied by the public sector.

Individual private providers would like the government to invest in their clinics, for example, by supplying equipment. Alternatively, they can be permitted to work in the evenings at public facilities that usually close in the afternoon, such as facilities of the Population Welfare Department. The latter proposal, also recommended by consumers, is being considered by provincial governments (Ahmed et al. 2019).

Contracting out is generally recognized to have worked well and there is interest in extending the model of PPHI Sindh to Balochistan (Ahmed et al. 2019). However, interviews with representatives of the program suggest that their fiscal space in shrinking due to limited contribution from the public sector and there are challenges in managing public sector employees, as they do not report to PPHI. Such issues will need to be addressed for the long-term sustainability of partnerships of this nature.

The governments of KP and Punjab are interested in expanding provider networks and also in reaching underserved communities through private community-based provider networks on the pattern of the LHW Programme (Ahmed et al. 2019). NGOs and SMOs have good experience of conducting both social franchising programs and community-based worker programs and they would like the government to consider investing in their upscale. This is particularly important since donor support for such programs is declining. However, it is also critical that the potential for such programs to reach the poor and to eventually become self-sustaining be examined beforehand; in the long run, social franchising programs should be able to achieve both. If

required, provincial governments could first pilot test the available models in accordance with their current plans.

6. Task shifting to enhance performance of providers and better collaboration

Various cadres of service providers need special encouragement to start playing a greater role in FP service provision. In this regard, male doctors could be enabled with minimal training to counsel on and provide all methods, except IUCDs, and be provided a regular supply of contraceptives. Our past research shows that the largest potential for expansion lies in increasing the role of pharmacies and dispensers to include more trained providers and a larger range of contraceptive products. Hakims and homeopaths have the potential to provide FP counseling and some methods, including condoms, ECP, oral pills and injectables, following training (Population Council 2016). The pharmacists interviewed in this study said they would like their medical staff to be permitted to administer injectables. They would also like government providers to refer clients to their pharmacies/stores if they run out of contraceptive stocks.

There is also an urgent need to address the current trust deficit between the government and NGO sector. In recent months, the latter's ability to work in the field has been restricted by new registration requirements and lack of permissions and support. In some cases, prior MoUs have not been renewed. This situation contradicts the government's aims of increasing private participation, expanding provider networks, testing and scaling up innovative initiatives, and doing so in collaboration with an experienced private sector intermediary (Ahmed et al. 2019).

International experience shows that mutual trust is pivotal for successful PPPs. If it is to be an effective steward, the government must adopt a more positive mindset and focus, first and foremost, on its own capacity to select good private partners and to lead them in line with the five partnership commitments of the 2005 Paris Declaration on Aid Effectiveness, i.e., government ownership; alignment with government priorities and local systems; harmonization of efforts of all organizations; management for results; and mutual accountability. As recognized in some provinces (Ahmed et al. 2019), the government must invest in its capacity to negotiate and manage effective contracts and also to monitor and evaluate the performance of partnerships.

7. Synergized efforts of private sector players for a collective push

In addition to the measures recommended by private sector stakeholders, our findings suggest a need for all private sector stakeholders to partner also with each other so that a unified voice of the sector can push the PPP agenda, which is a key challenge. There is a strong need for the whole private sector, including service providers, to work together and establish a private sector coalition to engage in joint advocacy efforts for highlighting the problems faced by the sector and the support that they need from the public sector.

References

Abdel-Tawab, N., Oraby, D. and Bellows, B. 2016. "Situational Analysis of the Private Sector in the Delivery of Family Planning Services in Egypt: Current Status and Potential for Increased Involvement," Research Report. The Evidence Project. Washington, DC: Population Council.

Ahmed, R. Mir, A. M., Kamran, I. and Niazi, R. 2019. "Public-Private Partnership to Accelerate Family Planning Uptake in Pakistan: A Conceptual Framework." Population Council: Islamabad.

Ahmed, T. 2013. The State of Family Planning in Pakistan: Targeting the Missing Links to Achieve Development Goals. Pathfinder International, Pakistan Office.

Al-Attar, G.S., Bishai, D. and El-Gibaly, O. 2017. Cost-effectiveness analysis of family planning services offered by mobile clinics versus static clinics in Assiut, Egypt. African journal of reproductive health, 21(1), pp.30-38.

Ayesha, K. and Adnan, K. 2016.Understanding MARVI – Assessment of the outreach community workers intervention in Umerkot 2014. HANDS, Pakistan.

Azmat, S. K. (2017). Models to accelerate modern family planning/contraceptive services access and uptake among married women in rural Pakistan. Ghent: Ghent University

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.

Barnes, J. 2011. Designing Public-Private Partnerships in Health. Abt Associates.

Berg, R. and Mitchell, S. 2013. Social marketing: Leveraging the private sector to improve contraceptive access choice and use. New York, Futures Group.

Boddam-Whetham, L., Gul, X., Al-Kobati, E. and Gorter, A. C. 2016. Vouchers in fragile states: reducing barriers to long-acting reversible contraception in Yemen and Pakistan. Global Health: Science and Practice, S94-S108

Gheorghe, A., Zaman, R.U., Scott, M. and Witter, S. 2018. Delivering reproductive health services through non-state providers in Pakistan: understanding the value for money of different approaches. *Global health research and policy*, 3(1), p.33.

Government of Pakistan. 2018. Investing in Sustainable Population Growth: National Symposium on Alarming Population Growth in Pakistan: Call to Action, Islamabad, December 5, 2018, Ministry of National Health Services, Regulations and Coordination and Law and Justice Commission of Pakistan.

Haque, M.U., Miller, P.C., and Kamran, I. 2012. Role of private sector in delivering birth spacing services in FALAH districts. Islamabad: Population Council.

Kamran, I., Tasneem, Z., Parveen, T., and Zaidi, Y. 2015. Investigating the low patterns of modern contraceptive use in Pakistan. Islamabad: Population Council.

Khan, A. 2011. Lady health workers and social change in Pakistan. Economic and Political Weekly, 28-31.

Mangone, E. and Gitonga, N. 2017. Public-private partnerships for family planning: Case studies on local participation. Primer.

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.

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.

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

National Institute of Population Studies (NIPS) and ICF International. 2018. Pakistan Demographic and Health Survey (PDHS) 2017-18. Islamabad, Pakistan, and Calverton, Maryland, USA: NIPS and ICF International.

Population Council. 2014. Evaluation Report. 2014 Pakistan: End of Project Evaluation for Norway-Pakistan Partnership Initiative (NPPI). Population Council: Islamabad

Population Council. 2016. Landscape Analysis of Family Planning in Pakistan. Report submitted to Bill and Malinda Gates Foundation. Population Council: Islamabad.

Population Welfare Department. N.d. “Key Initiatives.” Lahore: Government of the Punjab. Available at <https://pwd.punjab.gov.pk/system/files/Initiatives_0.pdf> (accessed June 17, 2019).

Rashida G., Kamran I., Khalil M., Khan M., Tasneem Z., Niazi R. and Parveen T. 2017. “Increasing Access to Reproductive Health Care through Improved Services Delivery.” Population Council: Islamabad.

Rashida G., Kamran, I., Muhammad, K., Niazi, R. and Parveen, T. 2015. The Availability and Quality of FP Services across Eight Districts in Pakistan: The Potential and the Constraints. Islamabad: Population Council.

Shah, N.M., Wang, W. and Bishai, D.M. 2011. Comparing private sector family planning services to government and NGO services in Ethiopia and Pakistan: how do social franchises compare across quality, equity and cost? *Health policy and planning*, 26, pp.i63-i71.

Shaikh, B., Rabbani, F., Safi, N. and Dawar, Z. 2010. Contracting of primary health care services in Pakistan: is up-scaling a pragmatic thinking. *Journal of the Pakistan Medical Association*, 60(5), p.387

Sophie, W., Rashid, Z., Molly, S. and Rozina, Mistry. 2016. Delivering reproductive health results (DRHR) through non-state providers in Pakistan. MSI/PSI, Pakistan.

Appendix A. Studies Included in Systematic Review

Table A.1: Key Studies Included in Systematic Review and Their Key Findings

Study title	Author/Year	Design/population	Outcome	Main findings
Comparing private sector family planning services to government and NGO services in Ethiopia and Pakistan - How do social franchises compare across quality, equity and cost?	Nirali M Shah, Wenjuan Wang and David M Bishai, 2011 (Ethiopia and Pakistan)	Secondary Analysis of cross-sectional data collected in 2001 and 2004; FP outlets, their staff and their clients	Cost per client, access to poor and quality of services	In Pakistan, Government clinics provide the highest quality, followed by franchise clinics; NGO run clinics are the most efficient and Government and NGO run clinics are the most equitable with greater percentages of their clients being drawn from the poor
Impact evaluation of the Delivering Reproductive Health Results Through Non-State Providers	Sophie Whitter et al. 2016 (Pakistan)	Cross sectional survey comparing intervention and control areas; cluster sampling for Household survey at baseline (7888) and at end line (6336); health facilities at baseline (219) and end line (188) and outlets at baseline (735) and end line (620)	Assess impact on increasing (a) access to RH services (b) utilization of RH services (c) equity in terms of targeting the poor (d) quality of RH services compared across three arms PSI/GSM+MSS, PSI/GSM only and control	**Access:** no change in time and cost required to reach nearest provider; decrease in mean number of RH providers known to community, decrease in awareness of government providers, increase in MWRA awareness that nearest RH provider was non-state **Utilization:** in terms of current use and unmet need, no significant change across three arms, awareness of modern methods increasing for all three arms; costs increased hugely across all groups, average costs increased more in the PSI only group **Equity:** A pro-poor pattern was found only in the PSI-only group, control group also showed a pro-poor increase in ever use of contraception. Substantial reduction in mean transport spend among poor in the MSI/PSI group. **Quality:** significant reduction in stock outs in all arms, increase in display of quality standards at facilities in intervention areas, increase in 'good' ratings by clients in PSI group. No change in counseling for side effects but significant increase in counseling for alternative methods Impact: No significant impact for the two intervention groups compared to control (after propensity scoring)
Cost effectiveness of a family planning voucher programme in rural Pakistan	Edward Ivor Broughton et al. 2017 (Pakistan)	Cross sectional; empirical data from 168,206 voucher recipients; costs calculated from programme data	Cost of providing FP services through a targeted voucher programme; costs per CYP	Average cost per woman who received FP services is $19.50; average effectiveness of the programme in terms of additional CYP per voucher recipient is 1.66 CYP and an incremental cost of $4.28 per CYP as compared to not having the programme. This compares favorably internationally to a range of $2-$13

Study title	Author/Year	Design/population	Outcome	Main findings
Engaging with community based public and private mid-level provider for promoting the use of modern contraceptive methods in rural Pakistan, result from two innovative birth spacing interventions	Syed Khurram Azmat, Waqas Hameed et al. 2016 (Pakistan)	Quasi experimental cross-sectional survey (pre-post intervention with control arm conducted 24 months apart) comparing two models (1) Suraj SF including vouchers and (2) community midwife Interviewed 5566 and 6316 MWRA	Increase in FP awareness and contraceptive use and effectiveness of a private SF model with control gp Confounders adjusted for: age, education, province, number of children and socio-economic status	Overall greater increase in FP knowledge in CMW areas compared to Suraj areas (from baseline); highest increase in knowledge about IUCDs Net CPR in Suraj areas increased by 5% and 13.7 % increase in modern methods; in CMW areas 7.5% increase in CPR and 5.1% in modern methods; a net decrease in withdrawal methods 1% in Suraj areas and 4% in CMW areas
Assessing family planning service quality and user experiences in social franchising programme– Case studies from two rural districts in Pakistan	Syed Khurram Azmat, Moazzam Ali, Waqas Hameed and Muhamad Ali Awan 2018 (Pakistan)	Cross sectional; 20 randomly selected private providers and 39 clients interviewed	Quality of clinical services and user experiences between GSM/PSI clinics and MSS clinics	High quality of services for both MSS and GSM/PSI clinics, PSI clinics offered greater range of FP services whereas MSS clinics had better clinical governance and were more user focused; exit interviews yielded high client satisfaction
Vouchers in fragile states: Reducing barriers to Long Acting Reversible Contraception in Yemen and Pakistan	Luke Boddam-Whetham, Xaher Gul, Eman Al-Kobati, Anna C Gorter 2016 (Yemen and Pakistan-three provinces	Cross sectional; 1,557 family planning clients interviewed at 151 MSS social Franchise centres in Pakistan	Increase in voluntary uptake of LARCs and PMs	Vouchers enabled 10 times more women to choose LARCs and PMs in Franchise areas and are a flexible financing approach that enable expansion of contraceptive choice and the inclusion of private sector in service delivery to the poor.
Community-based integrated approach to changing women's family planning behaviour in Pakistan 2014-2016	H Najmi et al 2018 (Pakistan)	Comparative cross sectional, retrospective pre-post intervention data of 5140 and 3810 MWRA at a 24 month interval	Change in women's behaviour with regards to Family Planning as a result of the 'Sukh' community based initiative, weighted analysis formed	Overall a 10% increase in contraceptive use, use of modern methods increased by 9%, largely increase seen in use of LARCs 22% increase in exposure to FP and 13.6 % increase in inter-spousal communication and a 13.7% increase in use of government facilities for FP from baseline
Increasing contraceptive use in rural Pakistan: an evaluation of the Lady Health Worker Programme	Megan Douthwaite and Patrick Ward 2005 (Pakistan)	Cross sectional survey of 4277 MWRA of which 3346 were living in LHW covered areas.	Effect of the LHW programme on the knowledge about and uptake of FP in rural women controlled for household and individual characteristics	Women served by LHWs are significantly more likely to use a modern reversible method (OR 1.5); Overall CPR in LHW areas was 30% (control 21%) and modern method use was 20% (control 14%)
Client Satisfaction: Does Private or Public Health Sector Make a Difference? Results from Secondary Data Analysis in Sindh, Pakistan	Wajiha Javed et al 2015 (Pakistan - Sindh)	Cross sectional survey, secondary analysis of PDHS 2012-13 data on 3133 MWRA	Client satisfaction with FP services through public or private sector controlled for age, residence, education, wealth and current contraceptive use	In terms of contraceptive provision, clients were more satisfied with government services, but results were non-significant. Clients were more satisfied with private clinics in terms of quality of care and follow up

Appendix B. Presence and Status of Service Delivery Points in Faisalabad

Figure B.1: Location of public and private health facilities and pharmacies in Faisalabad district

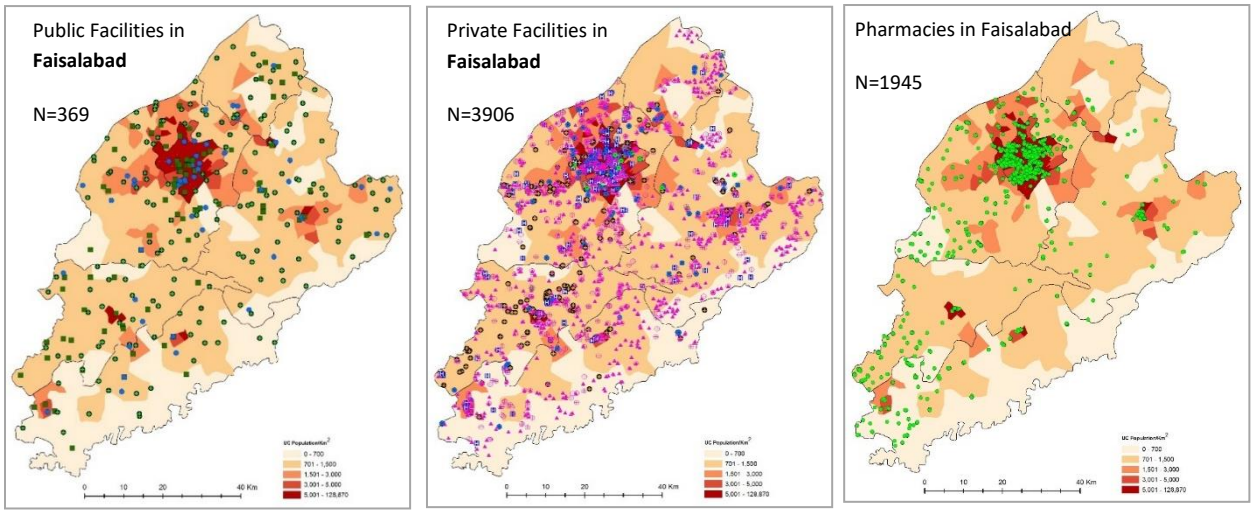
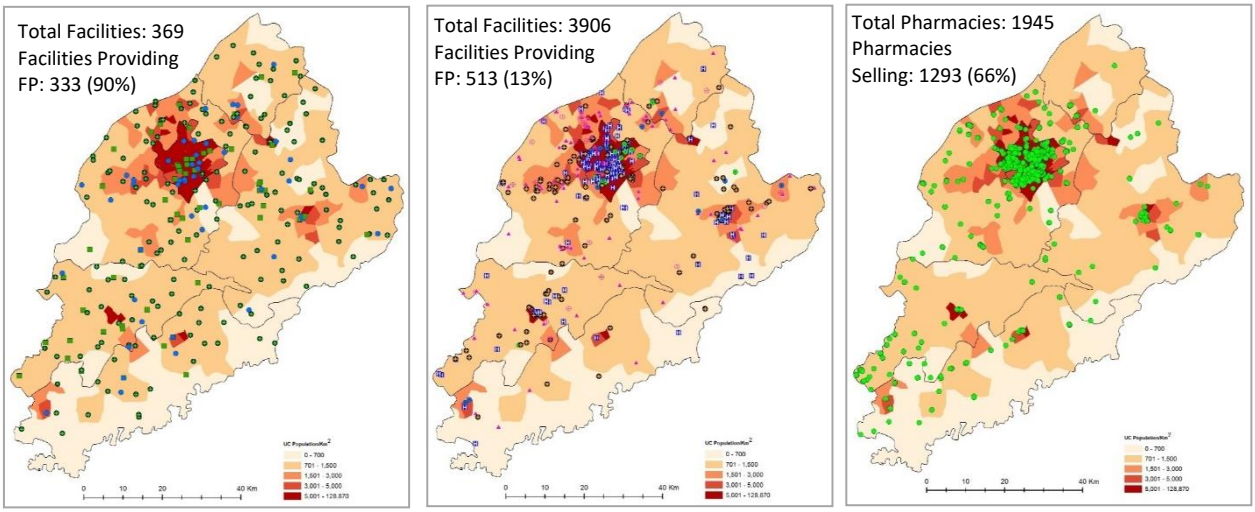


Figure B.2: Location and proportion of public and private health facilities and pharmacies providing any FP services



Source: Population Council, Landscape Analysis of Family Planning Situation in Pakistan, Islamabad, 2016

Appendix C. Parameters Assessed in Systematic Review

Table C.1: Parameters Assessed in Studies Included in the Systematic Review

Study	Year of publication	Cost per client	Access to the poor	Quality of services	Client satisfaction	Cost per CYP	Increased range of services	Use of FP (CPR)
Comparing private sector family planning services to government and NGO services in Ethiopia and Pakistan - How do social franchises compare across quality, equity and cost? Niralil M Shah	2011 (data collection in 2001 and 2004)	Yes	yes	Yes	Included in the quality score	Not assessed	Included in the quality score	Not assessed
Impact evaluation of the Delivering Reproductive Health Results though Non-State Providers – HEART	2016	Not assessed	yes	Yes	Not assessed	Not assessed	Yes	Yes
Cost effectiveness of a family planning voucher programme in rural Pakistan	2017	yes	yes	Not assessed	Not assessed	Yes	Only for LARCs	Not assessed
Engaging with community based public and private mid-level provider for promoting the use of modern contraceptive methods in rural Pakistan, result from two innovative birth spacing interventions	2016	Not assessed	Not assessed	Not assessed	Not assessed	Not assessed	Yes	Yes
Assessing family planning service quality and user experiences in social franchising programme- case studies from two rural districts in Pakistan	2018	Not assessed	yes	Yes	Included in quality scores	Not assessed	yes	Not assessed
Vouchers in fragile states: Reducing barriers to Long Acting Reversible Contraception (LARC) in Yemen and Pakistan	2016	Not assessed	Yes	Not assessed	Not assessed	Not assessed	Yes but Only LARCs	Not assessed
Community-based integrated approach to changing women's family planning behaviour in Pakistan 2014-2016	2018	Not assessed	Not assessed	Not assessed	Not assessed	Not assessed	yes	yes
Increasing contraceptive use in rural Pakistan: an evaluation of the Lady Health Worker Programme	2005	Not assessed	Yes	Not assessed	Not assessed	Not assessed	yes	Yes
Client Satisfaction: Does Private or Public Health Sector Make a Difference? Results from Secondary Data Analysis in Sindh, Pakistan	2015	Not assessed	Not assessed	Somewhat	Yes	Not assessed	Not assessed	Not assessed

Appendix D. Contraceptive Brands Available with Pharmacies, Wholesalers, and Distributors

Table D.1: Range of contraceptives available at pharmacies, by district and by location

District	Urban	Rural
Faisalabad	**Condoms:** Touch, Climax, *Sathi*, Happylife, *Josh* **ECP:** Emkit **Pills:** Prebrova, Probligation, Famila-28 **Injectable:** Depo-Provera **Rings**	**Condoms:** *Sathi*, Happylife **ECP:** EmKit **Pills:** Famila-28 **Injectable:** Nova-ject
Bahawalpur	**Condoms:** *Sathi*, Touch **ECP:** EmKit **Pills:** Famila-28 **Injectable:** Famila injection	**Condoms:** *Sathi*, Touch **ECP:** EmKit **Pills:** Famila-28, Contrave tab
Sukkur	**Condoms:** Touch, Desire, *Sathi*, Happy life, *Josh* **ECP:** EmKit **Pills:** Famila-28, Yaz **Injectable:** Depo-Provera, Femi-ject	**Condoms:** *Sathi*, Climax, *Josh* **ECP:** EmKit **Pills:** Famila-28, Novodol, Gynaecosid **Injectable:** Depo-Provera, Femi-ject
Lasbella	**Pills:** Famila-28 **ECP:** EmKit **Injectable:** Nor ject, Depo-Provera, Femi-ject **IUCDs and Rings**	**Condoms:** Touch, Knight Rider, *Sathi*, *Josh* **ECP:** EmKit **Pills:** Famila-28, Novador **Injectable:** Famila ject, Nova-ject, Depo-Provera
Thatta	**Condom:** *Sathi*, Touch, Happy life, *Josh* **ECP:** EmKit **Pills:** Navadol, Famila-28, Yaz, Daen Tab, Progilotan Tab **Injectable:** Depo-Provera, Femi-ject, Nova-ject **Copper-T**	**Condom:** *Sathi*, Touch, Happy life, *Josh* **ECP:** EmKit **Pills:** Navadol, Famila-28, Yaz, Daen Tab, Progilotan Tab **Injectable:** Depo-Provera, Femi-ject, Nova-ject **Copper-T**
Mansehra	**Condom:** Happy life, *Sathi* **ECP:** EmKit **Pills:** Famila-28 **Injectable:** Famila injection, Depo-Provera **Copper-T**	**Condoms:** Happy life, *Sathi* **ECP:** EmKit **Pills:** Famila-28 **Injectable:** Famila injection, Depo-Provera **Copper-T**

Table D.2: Range of contraceptives available with distributors and wholesalers, by district and method

	Condom	ECP	Pills	Injectable	IUCD
Faisalabad					
Distributors	Josh	EmKit 75mg, EmKit DS	Famila-28	Famila injection, Depo-Provera, Femi-ject, Nova-ject	IUCD, Safe load
Wholesalers	Climax, Delay, *Sathi*, Humdam, Happy life, Josh, Pleasuremax durex	Gynaecosid, EmKit, Misoprostol, Mosctol	Famila-28, Salt ethinage, Estradiol, Ecstasy, Veprona	Famila injection, Depo-Provera, Gyno ject, Femi-ject, Nova-ject	
Bahawalpur					
Distributors		EmKit Heer (IUCD)			
Wholesalers		EmKit			
Sukkur					
Distributors	Josh delay, Josh dotted, Josh Strawberry, Paradise	EmKit	Famila-28, Navadol	Famila injection, Norifam, Depo-Provera, Femi-ject, Nova-ject, Safe-load, IUCD, Jadelle	
Wholesalers	Touch, *Sathi*		Claric, Famila-28, Navadol, Diane-35, Progyluton	Femi-ject	
Lasbela					
Distributors	*Sathi*, Touch	EmKit	Famila-28	Famila injection	IUCD
Wholesalers	*Sathi*, Touch, Hamdam		Famila-28, Ecstasy	Nova-ject, Depo-Provera, Femi-ject	
Thatta					
Distributors		EmKit, Gynaecosid	Navadol	Famila injection, Depo-Provera	Copper-T
Wholesalers	*Sathi*, Touch, Knight Rider			Depo-Provera, Nova-ject Multiload	
Mansehra					
Distributors	*Sathi*, Touch, Durex	EmKit	Famila-28	Famila injection	IUCD
Wholesalers	Touch, *Sathi*	Gynaecosid	Famila-28	Famila injection, Depo-Provera, Nova-ject	

Disclaimer
This report has been funded by UKaid from the UK government; however the views expressed herein do not necessarily reflect the UK government's official policies.

UKaid
from the British people

POPULATION COUNCIL
Ideas. Evidence. Impact.

UNFPA