WORLD BANK GROUP

Policy Note- Pakistan
"For Better Quality and More Integrated PHC Services through Harnessing the Private Sector in Sindh Province: Options Paper"

Introduction

Achieving Universal Health Coverage (UHC) in Pakistan, as in most countries, will require strengthened collaboration between the public and private sectors, as the public sector often does not have the flexibility nor the fiscal space to grow service delivery capacity at sufficient pace and quality. However, successful partnering with the private sector through various forms of contracting and service agreements including Public-Private Partnerships (PPPs), requires the appropriate analysis and identification of the gaps in service provision. To that end, this study aims to assist the GoS in identifying opportunities to engage the private health sector more effectively, to help provide affordable, quality PHC services to the urban poor whilst also creating evidence for the better integration of the private health sector in health service delivery.

As part of the initial phase of this advisory work, and operating within a limited timeframe and funding environment, this policy note presents the initial set of observations and recommendations, based on the information collected via questionnaires and informant interviews, as well as secondary data/existing studies. Information on alternative health service providers, the regulation of personnel and training institutions, and pharmaceutical regulation, was beyond the scope of this assessment. In addition, no analysis of the fiscal space, or business investment climate was conducted.

The intent is to continue working in close collaboration with the government counterparts and key private sector stakeholders, to explore various options for engaging the health private sector to improve primary healthcare service delivery, through measures operating on both the supply side and the demand side, and in line with achieving Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs).

Target Audience

The target audience for this work includes the Government of Pakistan and more specifically Sindh Province policymakers; private sector stakeholders, particularly those interested in partnerships with the public sector; domestic and international investors with an interest in the private health sector; development partners; and the World Bank country teams involved in current and future operations in Pakistan.

Background: Challenges and Opportunities

*5th as of the 1st July, 2019 U.S. Census Bureau (210 million)
https://www.census.gov/popclock/print.php?component=counter

According to the Sustainable Development Goals Index and Dashboards report, Pakistan ranked 126 out of 156 countries, with an overall score of 54.9 for progress towards the United Nations Sustainable Development Goals (SDGs),[1] and received a Universal Health Coverage Tracer Index (0-100) score of 43.8.[1] In the Global Burden of Disease Study (2016), based on a scale from 0 to 100, Pakistan scored 38 together with Bangladesh and Mauritania.[2] Pakistan also had a gross ranking of 150 out of 187 in the UNDP Human Development Index in 2018,[3] and Pakistan's World Bank Human Capital Index (2018) score of 0.39 (134 out of 157 countries) is lower than the average for the South Asia Region and its respective income group.[4]

Pakistan is the world's sixth* most populous country based on the results of the recent 2017 national census, which estimated an increase in its population size to 207.7 million.[5] It is classified as a lower-middle-income country, with a per capita gross national income of US$1,473 (2016).[6] Pakistan's population is expected to reach an estimated 350 million people by 2030, with more than half of the population living in urban areas.[7] Pakistan has made significant strides towards establishing macroeconomic stability in recent years. However, Pakistan continues to face challenges in progress towards achieving appropriate Human Development and the SDG targets.[8]

The Government of Pakistan has also shown a high level of commitment towards improving the performance of the health sector. Despite these efforts, challenges in the health sector remain, as reflected by the relatively lower health performance outcomes. Public health expenditure comprises 36% of the total health expenditure, and the current health expenditure (%GDP) is 3 percent (2016)[26] (WHO benchmark is at least 6 percent of GDP required to provide basic and life-saving services).[2] The country's total fertility rate remains high at 3.6 (regional average 2.5).[8] The country has the third-highest proportion of stunted children in the world, with more than 9.6 million Pakistani children facing chronic malnutrition.[9] Pakistan's infant mortality rate, at 64.2 per 1000 live births in 2016, ranks the highest relative to its regional neighbors, whilst modeled estimates of maternal mortality, at 178 deaths per 100,000 live births in 2015, ranks Pakistan the third highest in the region (behind Afghanistan and Nepal).[6] More positive reports (DHS 2017-18) indicate that 86% of pregnant women received antenatal care (up from 73%, 2012-13 DHS), whilst 69% of deliveries were assisted by a skilled provider (up from 52% , 2012-13 DHS), and 62% of women received a postnatal check-up within two days of delivery.[10] It has been reported that only 23.7% of the general population (sick or injured) availed themselves for services provided by the public sector (urban 20%; rural 26%)[10]. Pakistan is also one of the countries with the highest utilization of the private sector (71%) in the Eastern Mediterranean Region.[11]

Sindh Province

The Government of Sindh (GoS) has shown a high level of commitment towards improving the performance of the health sector and has already initiated several strategic policies/guidance post-devolution (18th Amendment to the Constitution of Pakistan) including the Sindh Health Sector Strategy 2012-2020. This long-term strategic plan, accompanied by an M&E and financial framework, provides guidance on eight priority areas including: (i) strengthening the district health systems; (ii) strengthening urban primary health care; and (iii) regulating the private sector.[6] This strategy is aligned with Pakistan's broader National Health Vision (2016-2025)[12] and associated reforms, which emphasize the importance of the private sector as a partner in healthcare delivery that could potentially contribute towards achieving the SDG targets and UHC. Thus far, the implementation of the strategy has proved challenging with some components showing minimal progress.[13]

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Large scale contracting-in & contracting-out of services has already been initiated in Sindh, including the contracting of primary, secondary and tertiary health care facilities. Some accompanying regulatory reforms have also been carried out. However, despite the government's efforts to improve the performance of the health sector, some challenges remain, as reflected by relatively lower health performance outcomes in Sindh. Sindh Province's total fertility rate remains high at 3.6 (national average 3.6) [14], and the prevalence of contraceptive use (all methods) among married women remains relatively low at 31% (national average 34%).[10] Sindh Province's infant mortality rate (per 1,000 live births) stands at 60 (national average 65;for ten years preceding the study)[10] , and the under-five mortality rate is 77 deaths per 1,000 live births. The Sindh population predominantly chooses to use private health providers in both urban and rural areas (i.e.78%)[6], including for promotive services, although public goods (i.e. immunization, malaria, and polio prevention services) are predominantly delivered by the public sector. In addition, public health sector utilization is lower than the rest of the country (22 percent vs 29 percent) as the users show a preference towards the private sector. [6]

In addition, a recent World Bank report, *Leveraging Urbanization in South Asia,* described Pakistan's urbanization as 'messy and hidden', reflecting the challenges faced in Pakistan and the South Asian region regarding people living in slums; characterized by poor quality housing, often in hazardous areas, with a lack of access to basic health services.[15] As described in the report, the proportion of urban populations in countries in the South East Asian region living below the national poverty-line range from one-eighth in Pakistan, to a quarter in Afghanistan. Similarly, under five-mortality rates in the urban poor are higher in urban rather than rural areas in Bangladesh, India, Nepal, and Pakistan.[15] The population in Sindh has also seen the equilibrium shifting towards rapid urbanization, largely due to internal migration from the rural and other conflict-affected areas in Pakistan. The Pakistan Demographic and Health Survey (2017-18 PDHS) reports that most in-migration in Sindh was into urban areas, with 48% from rural to urban areas, and 35% from urban to other urban areas.[10] This directly affects Sindh's health system in terms of balancing resource needs and administrative requirements.

Sindh Healthcare Delivery System: Current Status

Demographic Challenges

Sindh Province has a total population of 47.9 million of which 48% is rural, whilst 52% reside in urban areas, and the poverty headcount stands at 32.8%.[5] Sindh Province's capital, Karachi, the most populous city in Pakistan, also has a relatively high population growth rate in Pakistan, at 2.4% per year [27], driven mainly by the constant influx of poor rural migrants.[14] Although the wealthy households living in urban areas have sufficient access, the urban poor, living in slums where there is a higher concentration of health risks and negative outcomes, need additional support to enable better access to primary health care services. The increasing urbanization (and burgeoning urban slums) coupled with insufficient infrastructure and social services, results in more people being exposed to health problems than in the general population.

Demographic and epidemiological transitions also pose new challenges in health service provision. With the increasing levels of non-communicable diseases (NCDs) accounting for 56% of disease burden, there

has been a resultant increased pressure on the health system, which will require new innovative ways of offering health services and financial protection.[6]

Health Expenditure

In Pakistan, approximately 64% of health expenditure is funded through non-public funding, of which 89% is out of pocket (OOP) health spending from private households.[16] The annual per capita health expenditure in Pakistan (NHA 2015-16)[16] was USD 45.0 increasing from USD39.0 (NHA 2013-14), and lower in comparison to the regional context including Sri Lanka, India at USD127.0, USD 75.0, respectively.[16] The Sindh Government's expenditure on health accounted for 24% (NHA 2015-16)[16] of overall expenditure, with inputs provided on a line-item basis. Private households contribute approximately 60% of OOP in Pakistan, and 29% of this OOP expenditure is spent on outpatient care for their illness, whilst approximately 47% of OOP is spent on medicines.[16]

Health spending is also regressively distributed, with the lowest income quintile spending 7% of monthly household income.[6] Whilst the Bait-ul-Mal and Zakat funds contribute to improving the welfare of vulnerable and poor populations, non-availability of disaggregated data makes the assessment of their effectiveness in providing financial protection difficult. However, Zakat fund religious charity tax as well as philanthropic contributions from private corporations and citizens, are the main source of funds for the local NGO sector. Micro-insurance schemes have also been explored as an option and have shown good potential, however, they require substantial initial support to ensure adequate utilization, as evidenced by the experience of the Punjab Rural Support Program, and the complexity of putting in place a micro-insurance that benefits the poor.[17] The Benazir Income Support Program (BISP) has a component for complementary social assistance, designed to cover vulnerable populations in private health sector facilities that are registered with the insurance companies, to enable to access critical health services. A recent ILO Actuarial Analysis of the Federal Sehat Sahulat Program was favorable; however, the program is in its initial phase, with limited coverage for families below the poverty line (based on the Nationwide Poverty Scorecard Survey) across Pakistan, and it currently only covers in-patient (IP) care.[17]

Innovative subsidized user charges and co-payment models are also being piloted by the Dow University of Health Sciences (DUHS)[6] and SINA Healthcare amongst others. These PHC services are often funded through large scale philanthropy or at subsidized cost through private investments. The alignment of private philanthropy and investments with public sector financing of PHC services is essential for supporting sustainable PHC service provision and financial protection.

Landscape of (PHC) Service Delivery

Pakistan has a mixed health system with various stakeholders including public and private health providers. [12] The Sindh public health sector comprises four tiers of service delivery and related ancillary institutions, and this study will focus on the third tier of primary healthcare institutions, which includes rural and urban health centers/basic health units and maternal and child-care health centers. The availability of PHC facilities in the urban areas has been described as insufficient, with current showing a PHC facility to population ratio of 1 to 82,000 population in Karachi, Sindh.[11] PHC is mainly delivered through static facilities and mobile outreach activities, governed by the Sindh Provincial Government

through the Department of Health (DOH). The Health Department (HD) follows a centralized administrative structure, with many subordinate/attached offices directly reporting to the Secretary of Health.[6]

The private sector health facility operations can be classified under (i) for-profit hospitals and self-employed practitioners; and (ii) not-for-profit and non-governmental providers, including faith-based organizations, and civil society. The private sector at the PHC level includes general practitioners ranging from doctors, hakeems (3%), homeopathy practitioners (1%) and ayurvedic clinics, to maternity homes and traditional birth attendants.[6] A study by Aleemi et al in urban Sindh found that 32% of participants relied on a Daii (midwife) for obstetric care; a spiritual healer (32.6%), and a Hakeem (practitioners of traditional medicines most often distributing potions; 11.4%), mostly for general treatments. [18] An outreach primary service package is also delivered through the Lady Health Workers from the public sector, whilst some private sector organizations have outreach models operating on voluntary, community workforce, franchise, and home-based care models. [18]

Although the private sector is the dominant provider of basic health care in urban areas, these services vary in quality and with often limited preventive and health promotion services, and access for the poor. The Pakistan Social and Living Standards Measurement Survey (2014-15) observed that in the majority of districts of Punjab and Sindh, women seek consultations for antenatal care and postnatal care from private hospital/clinics. [8] In Sindh, of all the obstetric deliveries in a health facility, 44% took place in private facilities, and only 22% took place in government facilities.[10] However, whilst private providers are the predominant providers of primary, secondary, diagnostic, pharmaceutical and ambulance services, the public sector dominates in the provision of tertiary care for the low-income groups.[19] The private sector is also the predominant source of outpatient consultations and maternal and child health services.[20] There are multiple vertical programs in Sindh and Pakistan such as the Family Planning and Primary Health Care (FP&PHC), Expanded Program on Immunization (EPI), disease-specific programs, and Maternal & Child Health programs. [2]

Figure 1: PSLM 2014-15 Percent Distribution of Health Consultations in the past 2 weeks by type of health provider consulted

PROVINCE & DISTRICT		HEALTH PROVIDER / CONSULTED							
		PRIVATE DISP/HOSP	PUBLIC DISP/HOSP	RHC/ BHU	HAKEEM/ HERBALIST	HOMEO PATH	CHEMIST/ PHARMACY	SAINA/ SAINI	OTHER
Sindh	Total	75.59	19.94	1.80	0.85	0.80	0.40	0.40	0.21
	Urban	84.05	13.51	0.23	0.57	1.07	0.49	0.05	0.04
	Rural	59.86	31.90	4.74	1.38	0.29	0.24	1.07	0.52

Health Seeking Behavior

As confirmed in the findings of this study, the utilization of the private sector primary health services by the population of Sindh is largely due to several factors, including (i) the convenient opening hours of private sector facilities; (ii) the ease of access and transport constraints; (iii) frequent staff and drug shortages at government health facilities; and (iv) diversion of patients to private clinics by dual-practice practitioners. A 2009 UNICEF report also found that other factors driving patients to the private sector to include better equipped facilities in terms of laboratory, diagnostic and support services, as well as friendlier staff and client appreciation. [32] In addition, for Sindh Province, receiving permission to go for treatment from spouses, money for treatment, and distance to the health facility, were all contributing factors according to the Pakistan Demographic and Health Survey (2017-18 PDHS). [10] Similarly, Aleemi et al found that reasons for not seeking health care were mostly related to the lack of awareness of available

resources, with 14% of study participants incorrectly reporting the unavailability of such services. Upon further investigation into the reasons for not utilizing formal health care facilities, Aleemi et al found that easy access (29%); lower costs (24%); and waiting timings, (13.7%), were the main reasons for seeking care from the formal and informal private sector. [18]

Currently, there is a need to increase consumer awareness and, whilst a consumer protection policy exists in Sindh, this needs to be reinforced. Institutions such as the Agha Khan University (Urban Health Programme) and franchises including Greenstar, conduct social and behavior change communication activities within their private network clinics. However, there is a need for improved coordination with the Lady Health Workers (LHWs), as well as greater community engagement. A USAID baseline study found the LHW program's coverage to be only between 20 and 43 percent in six districts, indicating the need for further community outreach activities. [13]

Quality of Health Services

The findings of this study suggest that some private sector providers follow the International Organization for Standardization (ISO) regimens and quality assurance standards. Also encouraging is that other providers have self-developed standards that are Joint Commission International (JCI) approved, whilst others follow quality standards provided by parent international organizations such as Marie Stopes International (MSI) and Jhpiego. The Pakistan Medical and Dental Council (PMDC) and the Pakistan Pharmacy Council are responsible for licensing medical and pharmacy schools and practitioners.

Of concern, is that a previous *Centro de Investigación de Enfermedades Tropicales* (CIET) social audit of the delivery of public services found that, among households that are current users of services, only 27% of all households were satisfied with the government health services. Quality and satisfaction with government health services is low, especially among the vulnerable groups.[21] The service utilization is worse in the urban areas and with the urban poor. There is also limited information available on the quality of health care services at private sector establishments in the absence of an enforced minimum standards package, as well as quality measurement and accountability mechanisms. Although private practitioners are reported to have good availability of basic equipment, the standard of care is uneven and, often drug prescription protocols (World Health Organization) are not always followed.[10] A 2018 study by Transparency International (Citizen Report Card (CRC) study) in Sindh Province (Kashmore and Shikarpur Districts), in which respondents were asked to compare their experience of treatment by doctors in government-managed facilities as compared to private clinics and whether they found it equal in quality of service, found that 27 percent responded 'Yes' while 41 percent responded, 'To some extent'.[2]

Innovations in PHC Service Delivery

In Sindh Province, the private health sector is making great strides in terms of promoting the integration of innovation and technology in primary healthcare service provision. Programs utilizing healthcare technology, developed by or in partnership with the private sector are already in place. However, they would need additional support in order to be scaled-up strategically. This includes established initiatives such as the Aman Foundation (Aman Telehealth service), the Indus Health Network (paperless hospitals and primary care centers), and Easypaisa (a subsidiary of the Telenor Health Group). The Integrated Health Services (IHS) recently launched an online platform for patient consultation 'Ring-a-Doctor'. Similarly, the SINA Health, Education and Welfare Trust, a privately funded not-for-profit organization network of 27

clinic locations in Karachi, is the first primary healthcare organization with digital data management systems (Android-based Electronic Medical Reports (EMR) streamlining the existing healthcare protocols); these are examples of innovations that could be potentially scaled-up to help improve PHC in Sindh. [32, 33,34,35,36,37]

Ongoing Contracting

Sindh has a thriving private sector with the highest concentration and levels of utilization (78% of households) of private sector health facilities in Pakistan. However, the private health care services provided are largely unregulated, whilst holding over 80% of the province's health service infrastructure.[19] Purchasing of a variety of private health services by the Sindh Government has increased post-devolution, however, their effectiveness in improving the quality of and access to health services has not been adequately monitored or evaluated.

Table 1: Primary Healthcare Facilities: Health Department of Sindh (2019)

No.	Category	Total No. of Health Facilities	No. of HFs with PPP Node	No. of HFs with PPHI	No. of HFs with Health Dept.
1	Rural Health Centers	125	114	1	10
2	Basic Health Units	757	0	648	109
3	Dispensaries	792	0	326	466
4	Mother & Child Health Centre (MCH Centers)	67	0	27	40
5	Sub Health Centers/ Clinics	3	0	2	1
6	Homeopathic Dispensaries	1	0	0	1
7	Urban Health Centers	1	0	0	1
8	Unani Shifa Khana	36	0	9	27
	TOTAL	1782	114	1013	65

Over 60% of public PHC facilities in Sindh are currently contracted-in (24 of the 27 districts) to PPHI which currently manages over 1,013 PHC facilities, as shown in Table 1. PPHI was developed in Pakistan to improve the delivery of PHC services in public health facilities that were understaffed, poorly resourced and/or ineffectively managed.[38]A 2011 Third-Party Evaluation of PPHI provided evidence for the improvements in staffing, the availability of drugs and equipment and physical condition of facilities, including the rehabilitation of dysfunctional BHUs that the PPHI had been operating since 2007.[22] Surprisingly, of the over 90 secondary healthcare facilities in Sindh, only 7 are currently contracted-out through Private-Public Partnerships.[2] There are also existing plans to scale-up the Ambulance services in Sindh. Aman Foundation (AF), launched in 2009, has a fleet of 100 state-of-the-art ambulances and an ambulance service in Pakistan staffed with trained doctors and paramedics that meet international

standards.[32] Other contracted entities in Sindh include the Indus Healthc Network; SINA; Aman Foundation; Integrated Health Services (IHS) and Health and Nutrition Development Society (HANDS). Please see Annex 1 for further details.

Greenstar has created a social marketing value-chain that is largely self-sustaining. It starts with a social mobilizer who is at the center of a series of value chain referrals. This social mobilizer has commodities to offer households at their convenience, advisory services for the healthcare needs, and effective referral linkages. Community Health Solutions (CHS), is a social enterprise that links individual private providers to TB and other public health programs through its 30 health center locations. Health and Nutrition Development Society (HANDS) has also developed an innovative cadre of outreach providers through its Marvi Workers program. HOPE and HELP focus on Primary Health Care (PHC), whilst the Women and Child Health division of Aga Khan University is working on Maternal and Child Health. Marie Stopes Society is also working on improving reproductive health and family planning.[22]

Regulatory and Contract Management Capacity

Contract Management

Overall, the Sindh PPP Unit, in collaboration with DOH, has actively embraced the contracting of health services. Promulgation of the Sindh Public-Private Partnerships Act 2010, coupled with legislative guidelines and financing and procurement rules, was largely a result of the urgency to improve service delivery post-devolution, and to help reduce the infrastructure and service delivery gaps within the limited resources available. Along with these reforms came the establishment of the PPP unit in the Sindh Finance Department (SFD). The Sindh PPP Unit, in recognition of the commercial nature of PPPs, has also established a Viability Gap Fund (VGF) to provide assurances to private sector partners that negotiated subsidies or payments over the life of a PPP project will be met according to contractual obligations. Complimentary to this, the Sindh PPP Act 2010 (Chapter V) defines financing options for all PPP projects inclusive of construction/infrastructure and equipment. However, some gaps remain in contract design - the overarching Sindh outsourcing strategy needs further refinement, including more detailed operational procedures for performance monitoring and payments-schedules; performance-based penalties are not completely developed; and finally, the issue of the assessment and regulation of technology and related ethical concerns needs to be addressed.

In addition, in order to develop and implement a sound contracting and institutional framework, there is a need to incorporate gold-standard practices of contracting including pre-contract feasibility studies; pricing analyses; competitive tendering and pre-qualification of bidders; adequate costing and Terms of Reference preparation of the contracts; as well as putting feedback mechanisms in place. There is also no overarching strategy that fosters the growth and development of the private health sector, nor a framework/platform for developing a sound working relationship between the public and private health care sectors. Other concerns are that in a form of self-evaluation, and a weakness in monitoring and evaluation, each contractor is required to hire their own independent evaluator. Baseline assessments of the contract which utilize DHIS data have limited information available for initial inputs, leading to difficulties in assessing performance. Another challenge is that the process for the awarding of contracts is vulnerable to political interference, and taxation levels are inhibitory for some private sector entities'

entry into PHC service delivery, coupled with lower profit margins in the sector. Diagnostic and laboratory service fees are the main component of fees charged in contracted-out facilities.

The PPP Node is housed under the DOH and currently has staffing organizational structure of up to 4 people. The study findings suggest challenges including delays in receipt of payments for contracted entities, with biannual payment mechanisms using a single line budget transfer facility. Payment delays have been attributed to difficulties in bifurcations of the budget. There is also a need for more contracting in preventative programs, and unclear referral mechanisms between the public and private sectors hamper PHC service delivery. To help meet the infrastructure needs, the GoS is also being supported by the Asian Development Bank (ADB) in the development of policies for sustainable infrastructure development and private sector engagement, and as part of this ongoing work the ADB aims to develop a Private Sector Support Facility. This World Bank Group analytical work and the subsequent potential technical assistance, will provide additional tailored health-specific support to build the capacity of Sindh DoH and related government institutions as well as the health private and public stakeholders, to support the achievement of SDG and UHC targets.

Regulatory

The 18th Amendment to the Constitution of Pakistan resulted in the devolution of the sector services (including health) to the provinces (with some Federal co-responsibility). Mandated by the Sindh Healthcare Commission Act No. VII of 2014 [23], the Sindh Healthcare Commission (SHCC) was tasked with strengthening the government's regulatory function through licensing and quality assurance and banning quackery in all its forms. [23] The SHCC is also preparing to conduct a mapping of the public and private sector providers, and to set out a baseline for the standards of and access to quality care. To date, the SHCC has already developed the Minimal Service Delivery Standards; Sindh Service Delivery Standards; and Primary Health Care & Clinics Standards. Although the progress made thus far is positive, this institution, and the related Sindh Provincial Health departments require additional capacity building in terms of their organizational structure, and human and financial resources, in order to implement their essential core stewardship and regulatory functions.[19]

A shift in approach is also needed to move away from a traditional punitive government-dominated approach to regulation, and towards a mix of incentives and legislation implemented and developed in collaboration with multiple stakeholders, i.e. SMART regulations - which include strategies such as tax breaks, subsidies, branding, accreditation, consumer awareness and penalties, to bring compliance and encourage private providers to self-regulate. [33] The Aga Khan University, in partnership with the London School of Hygiene and Tropical Medicine and SHCC have designed a research project to test the response to innovative health care regulations in Sindh through a participatory multi-stakeholder approach.

Key Findings: Challenges and Opportunities in PHC and Private Sector health service provision

- **Population Growth and Urbanization:** Sindh is experiencing high rates of population growth. The increasing rate of urbanization and resultant disparities further reduces the access to quality

health services for the urban poor. This will also put further strain on the health system in terms of infrastructure resource needs and administrative requirements.

- **Governance and stewardship functions have limited capacity**: Although the progress made thus far by SHCC and the related Sindh Provincial Health Departments is positive, there is room for improvement in human, financial, and technical resources to carry out their core stewardship functions, including regulation and accreditation, strategic planning, and monitoring & evaluation, whilst ensuring adequate clinical governance and the integration of parallel vertical programs at the provincial, district, and service delivery levels.
- **Capacity for Contracting-out of PHC services:** The Sindh PPP Unit, in collaboration with the DOH, has actively embraced the contracting of services; however, the DOH & PPP Node have limited in-house capacity in the core technical areas, legal or financial aspects of contract management and tendering systems. A platform for continuous dialogue between the private and public health sectors is also absent in the Sindh health system.
- **Quality of PHC:** The information available on the quality of private health service provision is limited. This study findings identified the need for a standard model of quality assurance in the health sector in Sindh.
- **Health Seeking Behavior:** Access to quality health services is further limited by barriers to health-seeking behavior, including a lack of consumer awareness, and factors such as transport costs amongst others.

Discussion and Progress

The urban poor have limited financial resources, and sound health is essential for generating their daily income and subsistence. Investments in pro-poor basic health services and public health promotion are critical to reducing urban poverty and achieving UHC and the related SDG targets.

In collaboration with the GoS, the World Bank Group held a workshop "Maximizing Impact through Public-Private Collaboration in the Health Sector" in December 2018 in Karachi, Sindh. With a focus on the primary healthcare needs of the population, the workshop aimed to: (i) facilitate public and private sector discussions on the potential areas of engagement and collaboration, and identify options and opportunities for deepening collaboration and partnership; and (ii) co-develop a framework for a regular consultative process with a joint agenda.

Outcomes of the workshop included reaching a consensus on supporting initiatives aligned with:

- On-going local and regional activities that could inform a strategy to increase access to health services for the urban poor
- Fostering bottom-up solutions from those who understand the conditions on the ground
- Incorporating technology as part of the solutions (helping to lower costs through scalable interventions; standardization to improve quality; and in-process data collection for better management), whilst including innovators in the discussion

The need for establishing a platform for continuous dialogue and fostering partnerships between public and private sectors was put forward and the World Bank's facilitation role was welcomed. Previous examples of similar Public-Private Dialogue Platforms can be found in Box 1. A regular consultative process with joint agenda setting would be useful for deepening the collaboration between the public and private

sectors; with well-defined monitoring & evaluation and quality assurance mechanisms. The interactive platform will allow GoS and various stakeholders to critically appraise options and consider the implementation and policy requirements, share regional and global health experiences and policy frameworks that could be applied to enhance value for money in health service delivery, and inform the capacity requirements to manage PPPs and contracting-out of services. The continuous dialogue will also be necessary to address the challenges of delivering PHC services to the urban poor.

It is equally essential to support the development of a regulatory mechanism that is transparent and at arm's length from political influence, with the ability to address grievances and provide continuous community engagement. Regulators should work hand in hand with the innovators to ensure that barriers to innovation are addressed, and policy and legal frameworks nurture innovation, and encourage contracting out of services and Public Private Partnerships.

Box 1: Public-Private Dialogue Platform Examples

a. **USAID *SHOPS Project.*** *Strengthening Health Outcomes through the Private Sector Project: Final Report 2009–2016 Caribbean*
In Antigua and Barbuda, SHOPS strengthened coordination by designing and facilitating the Public and Private Health Sector Task Force, a forum for open dialogue and regular, constructive communication. SHOPS also helped create two multisectoral working groups based on stakeholder priorities: one focused on regulating private health facilities, and the other focused on health information systems and improved data collection and sharing. In response, SHOPS piloted a mobile platform to enable public and private providers to report critical health data. In Dominica, the mobile reporting pilot included bi-directional data sharing: providers shared relevant data, and the MOH shared national statistics.[24]

b. **Afghanistan Public-Private Dialogue.** Over the past decade, the MoPH has sponsored periodic working groups and task forces involving public, private, and international participants, but these have mostly been called to work on specific strategies and policies. This changed in 2012 when the MoPH established a permanent Public-Private Dialogue Forum chaired quarterly by the Minister. Attended by regulatory staff from MoPH departments and private sector representatives, the Forum deals with a range of legislative, regulatory and operational issues. The meetings have resulted in greater trust and collaboration between the MoPH and private providers, a consistent flow of information and the resolution of a number of regulatory issues affecting the private health sector. [25]

Recommendations

- Although Sindh has a vibrant private sector, with the highest concentration and utilization of private sector health facilities in Pakistan [5], their participation in PHC service provision needs to be fostered with adequate and innovative regulatory and financing mechanisms. Similarly, GoS needs to build its capacity to oversee the technical, legal, and financial, aspects of contracting-out of health services and conduct active market management. This could further help in leveraging public financing with private capital, improving governance and financing mechanisms, and minimize fiscal risks related to PPPs financial management, whilst ensuring value for money, with transparent procurement and competitive, strategic selection of contractors, and sound regular monitoring and evaluation mechanisms. Collaborating with the private sector would also help to

identify creative options and ideas, utilizing a bottom-up and context-specific approach to enhance Human Capital development.

- A platform for continuous dialogue between the private and public health sectors is currently absent in the Sindh health system and establishing one could provide a useful entry-point for discussions and more stable partnerships, while supporting the development of well-defined monitoring & evaluation and quality assurance mechanisms for PPPs. This could also provide an opportunity to exchange information regarding good practices, on-going innovations and lessons learned, engage in dialogue to identify creative solutions, and serve as an idea testing platform.
- In order to improve on the progress made on health indicators in Sindh, it would be equally important to develop multisectoral policies & strategies, including targeting the social determinants of health, that would address the effects of the high population growth and rapid urbanization in urban Sindh. This includes harnessing the private health sector in basic health services to play an active role in strengthening the capacity and readiness for better quality service delivery.
- The GoS, SHCC, and related health stewardship departments, require further support to enhance their stewardship and oversight functions, ensuring increased transparency and accountability. Further assessments of the SHCC and related Sindh Provincial departments human, financial, and technical capacity to carry out core stewardship functions, including regulation and accreditation; strategic planning; monitoring & evaluation; and assessing and managing the market and operational risks; should be carried out.
- Greater information/evidence on the access to and the quality of public and private PHC health service provision needs to be generated, as well as supporting the SHCC in developing a standard model of quality assurance available in the health sector in Sindh. This could be achieved through improved information sharing and data reporting between the public and private health sectors, as well as operational research and evidence generation for the effectiveness of private sector contracting, utilizing public sector comparators to benchmark PPPs including estimated operational efficiency gains provided by the private sector. Improved data could prove useful in facilitating the private and public-sector development of solutions exploring ways to use technology (for example mobile-enabled transactions) to improve the efficiency of health-financing and financial protection.
- Efforts should also be made to better understand, monitor and improve the population's health-seeking behavior pattern. Working together with civil society, community- based organizations as well as the private providers and to promote consumer awareness and health promotion.

Proposed World Bank Group areas of support

Assuming additional resources are secured, this World Bank Group program of work intends to help strengthen the GoS's strategic framework for addressing urban primary healthcare through support to relevant institutional arrangements, policies, and guidelines whilst establishing links to the broader World Bank Sindh Human Capital project; and stimulate advocacy for mechanisms to mobilize the private sector integration in delivering urban PHC services. Part of the support of the World Bank Group could take the following form:

Short term

- A review of existing procedures and terms and conditions of existing health contracts and the undertaking of rigorous analyses to ensure value for money (VFM) for the GoS and population of Sindh. This would be followed by developing standard contracting procedures and protocols, including financial reporting mechanisms, based on well-known good practices (such as feasibility studies; adequate pricing analysis; contract templates pre-qualification of bidders; and performance-based payment guidelines) for better management of PPPs and contracts.
- With support from the World Bank Group, the GoS could develop a platform for dialogue with various public and private sector stakeholders to critically appraise options and consider the implementation and policy requirements, share regional and global health experiences and policy frameworks that could be applied to enhance value for money in health service delivery, and inform the capacity requirements to manage PPPs and contracting-out of services. This platform should incorporate a Public-Private Partnership Technical Working Group, with regularly scheduled meetings to review progress/status of implementation of PPP strategies and policies, improving private sector reporting, quality standards, sensitize providers about SMART Regulations that re-align incentives for better outcome regulations, and explore collaborative opportunities.

Medium Term

- The World Bank Group could support the preparation of an overarching Sindh Health Capacity Development Plan which would provide an assessment and guidance on enhancing the capacity of the GoS in policy making for contracting-out of services and the alignment of PPPs in health service provision, and the identification of much needed services in newly urban areas particularly within the domain of PHC services. This should help improve the capacity of the GoS, DOH, PPP Unit and PPP Node to (i) design and evaluate contract proposals; (ii) conduct feasibility analysis and negotiate agreements; and (iii) monitor performance and manage contracts; and (iv) develop technical and legal frameworks for data sharing/reporting across the public and private facilities. A long list of recommendations will be prepared, leading a prioritization process.

- In collaboration with the GoS and private sector stakeholders, the World Bank Group could develop a set of metrics and tools to collect data, conduct operational research and evidence generation, and evaluate the impact of the innovations and technology that will improve the efficiency, quality of primary health services, and financial protection.

Annex 1: Examples of Innovations by Private Health Service Providers

Aman Foundation	• Aman TeleHealth is a 24-hour healthcare helpline which provides access to diagnostic services, basic medical advice, mental health and family planning counselling over the phone. Aman TeleHealth has over nearly 20,000 health providers nationally mapped out on its system enabling callers to access information about the relevant facilities in their vicinity. • Aman Ambulance, Aman Health's flagship initiative, is the first state-of-the-art ambulatory vehicle network providing round-the-clock emergency care in the province of Sindh. The service provides a tiered emergency response system with Basic Life Support Ambulances and Advanced Life Support Ambulances, operating through a Command and Control Centre powered with real-time tracking and a wireless communications network. • The Aman Foundation Sukh Initiative is a Family Planning program. The goal of Sukh is to increase modern contraceptive use by 15 percentage points amongst married women in four towns of peri-urban Karachi, covering a population of 1 million.
SINA	• SINA Health, Education and Welfare Trust is a privately funded not-for-profit organization, founded in 1998. They have a network of 27 clinic locations of which 2 are referral clinics and 3 are mobile clinic locations. • SINA is the first primary healthcare organization with digital data management systems (android-based Electronic Medical Reports (EMR) streamlining the existing healthcare protocols); an innovation that could be potentially scaled-up to help improve PHC in Sindh. More than 80% of patients treated at the SINA clinics are Zakat eligible. • SINA's in-house diagnostic service provides free and highly subsidized investigations including laboratory tests and ultrasounds. Patients are examined by qualified physicians whose performance is monitored by a quality management system. • SINA has developed a unique referral system whereby every patient who requires specialist opinion or secondary and tertiary care gets the opportunity to have access to qualified consultants in Karachi free of charge or at highly subsidized rates
HANDS	• HANDS has a network of 33 branches across the country and has access to more than 22.2 million population more than 17,000 villages/settlement in 48 districts of Pakistan. They have a Public Private Partnership Management contract with the Government of Sindh for 34 health facilities for Performance improvement in Malir District Health from Nov. 2016 to October 2021. • HANDS is for improving health, promoting education, alleviating poverty and developing social institutions for community empowerment. HANDS Social Mobilization Program philosophy has been to develop Community Based Organization (CBO) as its partner in community development. • Marvi Social Franchise Project- Marvi workers are a cadre of community-based outreach health workers in areas where there is no LHW. Marvis provide services related to reproductive health, family planning, nutrition, WASH, MCH etc. Marvi worker also sells social marketing products including safe delivery kit,

	sanitary pad, iodized salt and Oral Rehydration Salt (ORS) and some essential drug. • For behavior change different strategies are being used including an Information Communication Technology (ICT) based mobile applications with recorded health education messages.
Integrated Health Services (IHS)	• Integrated Health Services (IHS) is a national healthcare group with operations spreading from Islamabad to KPK, Sindh, Gilgit to Baltistan and Balochistan, IHS is involved in provision of a wide range of curative and preventive health services along with interests in research, consultancies, public health trainings and health infrastructure development. • Under the Sindh Public Private Partnership Act 2010, a performance-based partnership agreement was signed between Department of Health, Sindh, and Integrated Health Services in March 2015. Under this agreement 111 Health Facilities, including 105 RHCs and 06 THQs in 20 districts of Sindh, were contracted out to Integrated Health Services.
Indus Health Network	• Pakistan's first paperless hospital and primary care network where patient records are maintained electronically on a secure server. • Manages GoS public hospitals and primary care clinics (under Public-Private Partnership Model) as well as Indus' own hospitals and primary care clinics financed through private philanthropy. Free of charge services are provided across all healthcare facilities under the umbrella of Indus Health Network. • Indus Health Network has also set up regional blood centers under the public private partnership agreement in order to facilitate blood transfusions and blood management at Government owned facilities.
Greenstar Social Marketing Pakistan (not currently contracted by GoS)	• An affiliate of PSI and a nonprofit, nongovernmental organization. • Greenstar has 3,850 social franchised clinics in Punjab and extensive community mobilization. Greenstar's primary goal is to increase quality reproductive health (family planning) services and reduce maternal mortality in all Greenstar regions including Karachi. • Greenstar`s Service Delivery Network comprises of 7,000 Service Providers Referrals of VSC cases to Family Health Clinics (FHCs) in DHQs and THQs • Signature Clinics, Rural Clinics, Korangi Model Clinic, Portable Container Clinics provide LHW referral opportunities. Mobile Service Units are for service delivery in Hard to Reach Rural Areas. • Greenstar TB Project – Collaborating with National TB Control Program since 2005. Round 3, Round 8, Round 9 projects under Global Fund Grants. Initiators of Public Private Mix TB interventions through implementation of effective GP Model.
Community Health Solutions (not currently financed by GoS)	• A Pakistani social enterprise seeded by Global Fund and UNITAID to provide free access to diagnostics and treatment for TB (and other diseases of public health priorities) by linking to individual private providers in low-income neighborhoods. • CHS operates over 50 Sehatmand Zindagi Centers (30 locations in Sindh) that have digital X-rays, ultra-sound, and full laboratory diagnostics available. • Each Sehatmand Zindagi Center hosts clinics for primary care doctors and counselors

	• CHS have received over USD 15m of seed funds from Global Fund, UNITAID and the Stop TB Partnership to provide access to standardized diagnostics and treatment to patients who access care in the low-cost private sector.
PPHI	• The PPHI Sindh is a Public Private Partnership Programme of Government of Sindh. It was initially started under the umbrella of Sindh Rural Support Organisation (SRSO), Pakistan • A section 42 Company organized by independent private citizens as a Board of Directors. From 2014, PPHI became a registered not for profit company. The objective of the organization is to revitalize delivery of health services in the rural areas of Sindh. • PPHI Sindh manages 1140 primary healthcare facilities through funding provided by Government of Sindh. The organization's main focus is improving health care in the area of maternal, newborn and child health which includes antenatal care, labour & delivery, postnatal care, family planning, immunization, nutrition, BEmONC, CEmONC, laboratories, ambulance services.

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2. SINA Health, Education & Welfare Trust https://www.sina.pk/
3. HANDS http://www.hands.org.pk/
4. Integrated Health Services (I.H.S.) https://www.ihspakistan.com/src/#/publichealth
5. Indus Health Network https://indushospital.org.pk/about/ihn/
6. Greenstar Marketing https://www.greenstar.org.pk/health_pakistan
7. PPHI http://pphisindh.org/pphiweb/index.php/what-is-the-pphi/

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