SERVICE PROVISION AND PRIVATE SECTOR FAMILY PLANNING MODELS IN PAKISTAN

Background

Both the public and private sectors provide family planning services in Pakistan. As was discussed in a previous brief, the public sector services are availed by around 35% of current users, whereas the private sector services are responsible for the remaining 65%. Nearly all FP commodities in Pakistan come from a central warehouse and therefore their supplies are recorded and all providers, public or provided report the services they provide against these commodities thus allowing tracking of provision of family planning services in Pakistan. These records have been published annually by the Ministry of Population Welfare until it was devolved in 2010. Thereafter, these records have been published by the Federal Bureau of Statistics.

Public Sector

Services via Public Sector are supplied by the Ministry of Health and Ministry of Population Welfare. While the provinces have always provided the services, since devolution of health and population in July 2011, the provincial departments have also assumed the role of planning and will assume financial responsibilities in 2014.

Private Sector

Private Sector is currently providing more than 40% of the FP services in Pakistan and its contribution towards FP services and products is increasing. A major part of the private sector contribution includes independent procurement of services by clients from stores and pharmacies (of pills and condoms) or services provided by independent healthcare providers. These supplies are largely supplied by the Greenstar Social Marketing (below). In Pakistan, where per-capita GNP is low and 70-80% seek care in the private sector, affordability and access to quality health products and services are key challenges particularly given the fact that many couples view family planning as a discretionary expense and may not be as willing to pay for it as they would for something they view as essential. However some prominent NGOs have been making an important contribution to healthcare in general and to reproductive health and family planning in specific.

Contraceptive Performance Report 2010-11

The table below shows the number of women served with FP services in the public or the private sector. The number of women served is calculated from the commodities moved in the annual reporting period of 2010-11. Sterilizations conducted are also shown for completeness. Private sector is the prominent contributor in providing short term methods such as condoms, pills, IUCDS and injections, where as sterilization is still mostly provided by the public sector.

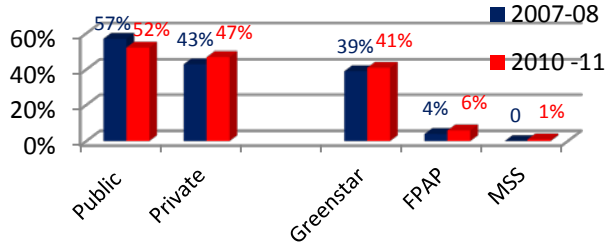
Persons Served from Provider Data in 2010-11 (in millions)

	Condom	Oral Pill	IUCD	Injec-tion	Sterili-zation	Total
Public	0.5	0.1	0.8	0.4	0.1	**1.9**
Private	0.9	0.1	0.4	0.3	0.02	**1.72**
Total	1.4	0.2	1.2	0.7	0.12	**3.62**

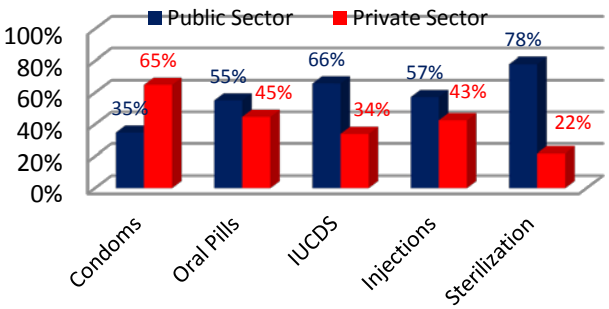
SALIENT POINTS

- Private Sector is providing more than 47% of FP services
- In the same time, the role of NGOs and private sector has expanded suggesting that the role of government has shrunk.
- A large component of private sector products are self procured
- Majority of private sector services are for short term methods
- A number of efficient and viable private sector/ NGO models now exist that can be utilized to scale up services.
- Main lessons from the private sector are: 1) quality of services, 2) asking clients about their needs, 3) involving communities in service provision and 4) ensuring supplies

Share in Contribution to FP Services



Method Mix Contribution by Sectors



Based on this table it is seen that short term contraceptives are more commonly served by the private sector. One thing must be remembered that a considerable proportion of this contribution is **self procurement** of condoms and pills by couples (made available via the private sector) but is not "services" per se, in that these "clients" do not meet a

provider or are counseled in the use and management of side effects, all of which are essential components of quality family planning services.

MAJOR PRIVATE SECTOR SERVICE PROVIDERS

Listed below are some of the major service providers in the private sector.

Greenstar Social Marketing (GSM) is a nonprofit organization that pioneered the "sabz sitara" portfolio in the social franchising of private sector health services. It's the Pakistan affiliate of the Population Services International, an international NGO. Their core mission is to enhance the quality of life among people by improving their access to health care products, information and services particularly among the lower socio- economic population groups in Pakistan.

After the Government of Pakistan, Greenstar is the second-largest contributor to family planning in Pakistan. They are mainly responsible for FP commodities sold in shops in addition to the models described below. Their implementing partners include GOP, Population Council, PAHVNA, and Save the Children.

Franchising Model: Greenstar uses a **franchising model** where they train, license and supply private providers (usually doctors) for FP services. Since 1995 Greenstar has trained 19,000 private healthcare providers and operates/ supplies 80,000 retail outlets providing up to 19 products and services through their Greenstar network of providers. Greenstar reaches out to approximately 100 districts of Pakistan and continue to scale up.

GoodLife: In 2005 Greenstar launched a broader network of private family healthcare providers under the name GoodLife. With this network they have managed to expand to providing ANC, PNC and natal services with their voucher schemes. About 75% of GSM outlets are located in very low income neighborhoods

Marie Stopes Society (MSS) is a social enterprise that caters to providing family planning and reproductive health services to the people of Pakistan. MSS is a subsidiary of Marie Stopes International (an international NGO) that has affiliates with 43 countries. Their core mission is to improve the reproductive health of people in Pakistan by adopting a client centered approach and filling in gaps in the unmet need for services as well as reproductive health information in Pakistan. MSS adopts an integrated approach towards improved reproductive health by combining comprehensive reproductive health services, social marketing, capacity building, advocacy, and networking and information dissemination. MSS implements its projects through continuous support from local communities and invests in their development by building their capacity through intensive trainings. MSS strategizes a **business approach** to their community programs in which a local district team develops monthly targets for their MSS Behtar Zindagi centers (clinics providing family planning services) and outreach workers and follows up closely to ensure that these targets are met. As of 2009 MSS has increased its presence via its 100 Behtar Zindagi Centers in 73 districts of Pakistan and caters to over 300,000 FP clients annually via its service delivery models and centers.

The ***Community Based Distribution (CBD) Model*** is a community based doorstep model whereby CBD workers took reproductive health information and short term contraceptives to clients door step. A total of 490 CBD workers registered 1000 couples each and followed up with them for short term contraceptive services, referrals and counseling sessions. By 2010 the project had reached out to over half a million women with FP services in 49 districts of Pakistan and increased CPR in service delivery areas from 36% to 51%.

Suraj (Private Providers Partnerships) : As part of its national expansion programme MSS initiated partnerships through their Suraj programme with private providers across Pakistan . These providers provide FP services under the Suraj Logo. Suraj means sun and the analogy refers to a distribution network of outreach workers that reach out into the community and refer to a "Suraj provider at its center. Since its operation Suraj Model has 100 partners in 18 districts of Pakistan and provided birth spacing services to more than 40,000 clients.

Rahnuma - Family Planning Association of Pakistan (FPAP) is a nonprofit social development organization focusing on the marginalized and urban slum population that was established in 1953 and pioneered the family planning movement in Pakistan. Currently FPAP is the largest reproductive health services provider in the NGO sector in the country by virtue of having one of the largest networks for FP services nationwide with 130 facilities and over 50,000 employees. They collate their own information about services rendered and commodities used. Their commodity usage information is also shared with the UNFPA as the latter acts as supply intermediary for FPAP.

The NGO works on Advocacy, Social Development and Service Delivery for FP. The cornerstone of FPAP's work has been its community participatory approach coupled with its focus on improving management capacity according to the highest standard. Its parent organization, International Planned Parenthood Federation (IPPF) is its largest single donor that annually provides core funds for program needs including its infrastructure. FPAP works with a wide range of public and private sector and has implemented projects with Pakistan Armed Forces, Government of Azad Jammu Kashmir, Northern Areas Health Department etc. Its currently providing FP services on behalf of the Population Welfare Department of AJK. The overall cost of FPAP services is less than USD 10 per CYP.

Family Health Clinics (FHC) are the basic building block of RAHNUMA - FPAP's services delivery program and were started in 1969 to cater to the needs of marginalized and underserved communities of rural communities and urban slum. An FHC is a community-based centre managed by a Lady Health Visitor who is assisted by Motivators and supported by FPAPs mobile teams. The volunteers generate public support for family planning and reproductive health services through a network of trained birth attendants, community based distribution workers and satisfied clients. The FHC acts as the first referral base of service delivery system and further refers clients to Family Health Hospitals (FPAP established hospitals providing RH services in 7 major cities). As of 2007 FPAP had a network of 34 FHCs spread over five regions that are providing services to masses at their doorsteps.

The ***Private Practitioners Project*** was initiated by RAHNUMA - FPAP in 1972 to involve the private practitioners in promotion of family planning. Private practitioners are qualified medical professionals who are respected and trusted by the community. They are service providers with their own clinical and surgical facilities An FPAP identified representative visits them daily to replenish their stocks and to generate a daily progress report. As of 2007 there were 2357 private medical practitioners who collaborated and partnered with FPAP projects.

Conclusion

In Pakistan public and private sectors contribute to service delivery for family planning with the private sector gaining ground on the public sector. In concept, private sector models are very similar to those of employed in the public sector in that both employ various combinations of fixed centers and outreach. However, operationally there are many differences in details of how these are implemented. In nearly all cases, NGOs set and seek to meet certain targets of quality and in case of MSS of the number of clients they will serve. The important learning point in target setting by MSS is that the target is for the number of clients and not for specific methods as a large array of choices are available at each of their outlets. In all NGO programs attention is paid to maintaining provider skills, of engaging communities and clients and ensuring that supplies are available.

These models must be contrasted with the outreach that the government provides with lady health workers. LHWs supposedly reach 110 million individuals or around 60% of MWRA and yet contribute only 5-10% of all family planning services. In part this is due to the fact that LHWs seldom ask women about their FP needs, don't counsel about side effects and often run out of supplies. Government fixed clinics, particularly those in with the Health Departments also don't ask about FP needs and seldom carry FP supplies.

In a country where women with an unmet need for family planning outnumber those availing FP services 2 to 1 and where government supplies a third to half of all FP services, a number of lessons may be learnt from what the NGOs are doing well. These include attention to quality of services provided including inquiring clients about their FP needs, addressing side effects and ensuring supplies are available. Another lesson from NGOs is that contrary to the debate on cost recovery, many of the NGOs have charged full or subsidized prices to clients without restricting the uptake of these services. Thus while costs may be an issue for the extremely poor, for the majority some cost recovery may be an option that promotes sustainability.

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