

# **Private sector engagement to deliver maternal, newborn, child health and family planning services during COVID-19 in Pakistan**





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## Conflict of Interest

The authors certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent-licensing arrangements), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this document.

# Abbreviations & Acronyms

<b>EHS</b>	essential health services
<b>FP</b>	family planning
<b>GP</b>	general practitioner
<b>ICT</b>	information communication technology
<b>IPC</b>	infection prevention and control
<b>LMIC</b>	low- and middle-income country
<b>MNCH</b>	maternal, newborn and child health
<b>MoNHR&amp;C</b>	Ministry of National Health Services, Regulations & Coordination
<b>NCOC</b>	national command and operation centre
<b>PPP</b>	public-private-partnership
<b>SGS</b>	WHO System's governance and stewardship unit
<b>SOPs</b>	standard operating procedures
<b>UHC</b>	universal health Coverage
<b>WHO</b>	World Health Organization

# Definitions

## Private sector

The private sector includes all individuals and organisations that are neither owned nor directly controlled by governments and are involved in the provision of health-related goods and services. These consist of formal and informal healthcare providers ranging from drug shops to specialised hospitals, comprising for-profit and not-for-profit entities, both domestic and foreign. For the purposes of this brief, we focus on domestic private sector entities (1).

## Health system governance

Health system governance refers to how governments ensure that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability (2).

## Stewardship

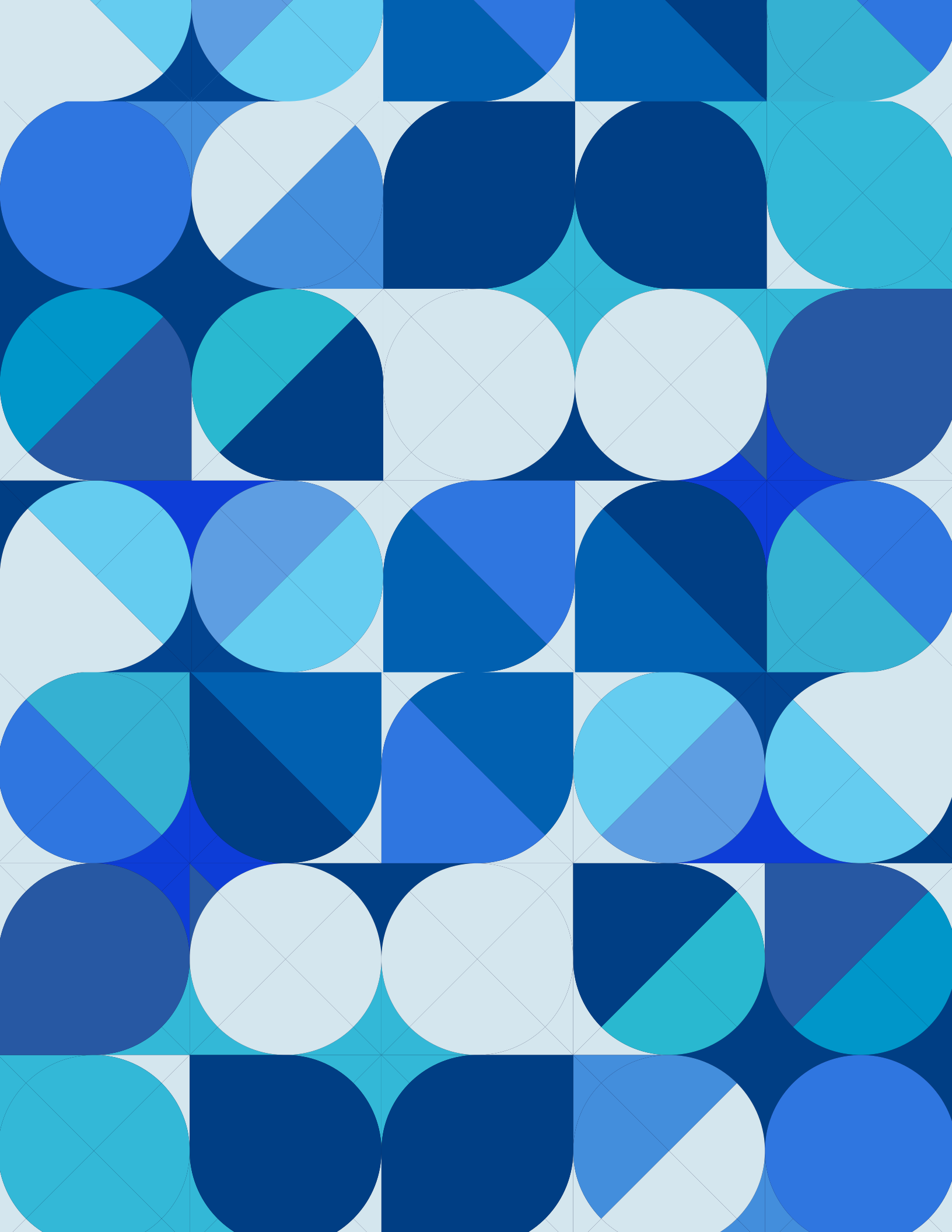
Stewardship refers to how government actors take responsibility for the health system and the well-being of the population, fulfil health system functions, assure equity, and coordinate interaction with government and society, including the private sector (3).

# Abstract

This case study documents the experience of engaging with the private sector in health to maintain the delivery and use of essential health services (EHS) with a specific focus on maternal, newborn and child health (MNCH) and family planning (FP) services during the COVID-19 pandemic in Pakistan. A case study methodology was employed, drawing on desk review and key informant interviews, which were conducted between February and April 2022. Several opportunities were raised through the case study, to seize momentum, to 'build back' and nurture trust in the health system eroded by COVID-19 pandemic, harnessing all health sectors. While these were specific to Pakistan, they can be relevant to a wider audience.



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## Introduction

In many low- and middle-income countries (LMICs), health systems comprise both public and private entities, with the private sector in health playing a large and expanding role in healthcare service delivery (4). This represents a mixture of both opportunities and threats for the provision of essential health services (EHS) and for health system governance. The way the private sector is organised and operates is significantly influenced by the organisation and behaviour of the public sector, with a well governed and competent public health system generating complementary private healthcare service delivery (4). In contrast, countries with weak governance and an unregulated private sector in health may also have an inefficient and inequitable public health system (3).

In Pakistan the private sector is diverse and spans the health pyramid. The sector provides the majority of maternal, newborn, child health (MNCH)<sup>1</sup> services (3) as well as outpatient and inpatient services in the country (5). Consequently, support for national socio-economic policies is increasingly being linked to pro-active private sector engagement (5). The impacts of these contributions however depend on appropriate governance prerequisites, including institutions, management ca-

pacities, a culture to collaborate, amongst others, to allow effective partnerships and delivery designs that target the needy and underprivileged. A change in mindset across the healthcare value chain is thus needed to position the private sector as a co-investor and partner in healthcare systems. This has been particularly important during the COVID-19 pandemic. The pandemic highlighted the need for whole-of-government and whole-of-society approaches to respond to health crises and achieve Universal Health Coverage (UHC) (6). This has been seen in many LMICs, where the private sector played a crucial role in supporting governments in the fight against the pandemic, bringing resources, skills and capacities to maximize the national response, and maintain EHS.

Building on the existing work of the WHO System's Governance and Stewardship unit (SGS) and the department of Maternal, Newborn, Child and Adolescent Health and Ageing (MNCH), this case study documents engagement with the private sector in health to maintain the delivery and use of EHS, with a specific focus on MNCH, to protect UHC outcomes (quality, access, financial protection) during the COVID-19 pandemic in Pakistan.

1: MNCH services are understood as including family planning and reproductive health services.

# Methodology

## Design

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A case study methodology was employed using key informant interviews, as it allows exploration of the “richness of actual cases” (7) and reinforces adaptive and shared learning. A desk review of background articles relevant to the context have been referenced as part of the case study. A specific focus of the case studies was on the delivery and use of EHS with a specific focus on MNCH services during the COVID-19 pandemic.

## Ethics and consent

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Written consent was sought for the interviews. Respondents’ information was anonymised as part of data analysis and presentation of findings. Quotations are referenced as international, private sector, academic, government and umbrella organisation respondent. Because the case study involved data collection only from persons working in their official capacity on issues in the public domain, the protocol [ID: CERC.0147] was exempted from further ethical review.

## Key informant interviews

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Semi-structured, in-depth interviews (see Annex) were conducted with 18 respondents from international (3), private sector (4), academia (5); government (4) and umbrella organisations (2)<sup>2</sup>. Among the 18 respondents, 11 were women and seven were men. Some respondents worked across respondent categories, for example respondents working both in the public and the private sectors. Designation is therefore based on how respondents self-identified and were recruited into the study. Interviews were conducted over the period February-April 2022. Targeted sampling was employed

where respondents were selected by the Ministry of National Health Services, Regulations & Coordination (MoNHSR&C) and WHO Pakistan Country Office. Geographically, respondents were located or supported operations in the Islamabad Capital Territory and Pakistan’s four provinces and two territories. Interviews were conducted in English and led by the primary and second authors accompanied by the fourth author. All interviews were conducted remotely using an online meeting application. Interviews were audio recorded to facilitate note taking and transcription.

## Analysis

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A coding frame was developed for data extraction, based on the semi-structured interview guides. A framework matrix was developed by the primary author for the analysis using Microsoft Excel 2016. The matrix was constructed horizontally with the key themes and vertically by respondent. Interview notes were condensed, with information arising from data sources inserted into the matrix. Quotes from the transcripts were inserted as part of data extraction. Where needed, the authors compared notes and understandings to ensure completeness of information and consistency of interpretation. The completed framework matrix was reviewed by the primary, secondary and fourth authors. The primary author drafted the paper, and the other authors reviewed the drafts and final manuscript.

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2: Umbrella organisations were professional in nature.

# Framework

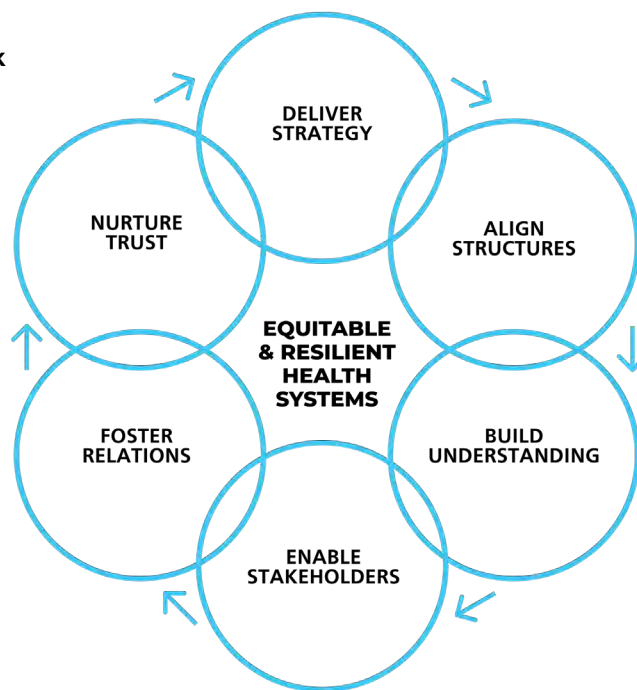
Findings have been structured using the WHO governance behaviours, a framework adopted in the WHO strategy report, "[Engaging the private health service delivery sector through governance in mixed health systems](#)"(8). Behaviours have been operationalized for essential MNCH services as follows:

**Nurture trust:** recognition and management of competing and conflictive interests for continuation of essential MNCH services during the COVID-19 emergency.

**Deliver strategy:** organisational learning to improve engagement of the private sector for the delivery of essential MNCH services to support the COVID-19 response.

**Align structures:** alignment of public and private structures for the continuation of essential MNCH services during the COVID-19 emergency.

Figure 1. Analytical Framework



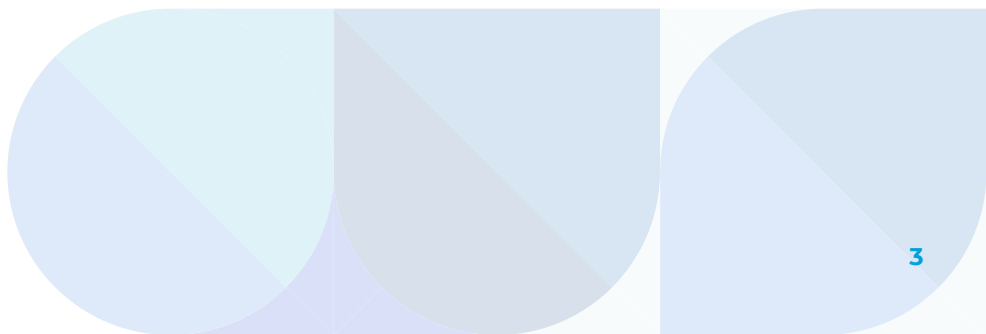
**Foster relations:** coordination arrangements and sectoral engagement for the continuation of essential MNCH services during the COVID-19 emergency.

**Enable stakeholders:** the development and implementation of financing mechanisms and regulations, to authorize and incentivize health system stakeholders for the continuation of essential MNCH services during the COVID-19 emergency.

**Build understanding:** private sector data captured and information exchange for the continuation of essential MNCH services during the COVID-19 emergency.

# Findings

Key findings have been framed for consideration by a Pakistani audience and for wider cross-country learning.



# Align Structures



A national command and operation centre (NCOC) provided the apex body for the COVID-19 response with similar command and operation centres established at provincial level. These provided a multisectoral platform for health and non-health stakeholders. At federal level, the centre was led by the senior federal minister and the military with representation of the Minister for Health, Federal Secretary for Health, the Director General of Health and the National Institute for Health (NIH). The National Disaster Management Agency, and counterparts in provinces oversaw rapid response units, which were supported by some international partners. These worked closely with the major hospitals at provincial and district level. Focus on this level was more on COVID-19 care rather than the continuation of EHS, including MNCH services, with services closed or disrupted (9, 10).

The health structure was not prepared for rapid response to the pandemic, despite Pakistan being prone to emergencies. The early phase of the pandemic was described as “a tornado”, “you watch it, and then you say, now what to do with it, it was initially chaos” (umbrella organisation respondent). Provincial response varied with some of the larger provinces exhibiting more complacency, “[they] did not utilize the structures and advantages of public-private engagement in the health sector, its full capacity” (academic respondent). This was attributed to a coordination “tug-of-war” between the federal level and provinces, in which the private sector “plugged holes” in the COVID-19 response “but at a very high cost” which was passed on to healthcare consumers (11).

Based on respondent feedback, in all provinces, the private sector played a role in service delivery during the pandemic. This was mainly at the secondary and tertiary level and concentrated in large cities. Initially, private hospitals were hesitant to engage in the COVID-19 response due to the stigma associated with the virus. However, over time, some public and private hospitals were designated COVID-19 treatment centres. Reportedly, those that chose not to “take on COVID-19” due to capacity constraints, suffered financially with some closing during the initial phase of the pandemic. In contrast, private general practitioners (GPs), “the service backbone of the health system, were not involved in a very organised manner” (academic respondent) in the response or the continuation of EHS.

Based on respondent feedback, private for-profit entities did not play a significant role in rural settings or

in the provision of preventive services. Within these settings, international non-governmental organisations provided critical, though “patchy”, support to the response given uneven coverage, particularly in provinces with less developed health infrastructure, such as Baluchistan and Gilgit Baltistan. Community-based health workers delivered COVID-19 awareness and prevention activities, at the expense of primary health care (PHC) services. Immunization programmes were also affected, “home visits stopped, the vaccinators were diverted towards home-to-home contact tracing of the COVID patients” (private sector respondent).

***“It’s a 210 million population, and we have 70% in rural remote locations that are actually not being provided by the private sector...and for private sector in the remote and rural locations, there’s probably an absence of very little coverage, because it’s not profitable”  
(academic respondent).***

Digital health, already in practice in Pakistan, played an organic role in the provision of COVID-19 services and in maintaining EHS: “quick experimentation was done, and that experimentation has been translated into policy and programmatic work” (government respondent). Experimentation varied in its sophistication, from simple telephone consultations between patients and providers to more bespoke telemedicine and decision support applications. This work was supported by the private sector in collaboration with the federal and some provincial health departments. Digital health was recognised by most respondents as an important adaptation that “became routine”, however, there were also concerns voiced that applications were not uniformly available, particularly in the public sector and in areas with less developed information communication technology (ICT) infrastructure.

***“Funding agencies would like to invest in technology to prove that it works... and certainly it worked but it only happened in those communities where we have those funding available”  
(umbrella organisation respondent).***

# Foster Relations



Alignment and coordination of international entities for the COVID-19 response created a “kind of bond and urgency” (international respondent). These entities directed attention to the continuation of MNCH services and advocated at a ministerial taskforce level specifically for FP services to reopen. However, given the devolved health structure, this did not mean an even response nor the availability of MNCH services in practice. Commodity shortages, particularly of contraceptives, also curtailed service delivery, with some respondents reporting that they resorted to “personal connections” to provide women with post-partum FP and post-abortion care services.

***“Everybody was using their own personal connections, their own agency, their own way of ensuring if a woman needs post abortion care, how do we make sure that she is able to access a provider? And then how do we make sure that providers are safe?”  
(International respondent).***

There was respondent consensus that Pakistan’s network of professional associations played a coordinating role during the COVID-19 response. This was mainly in relation to the development of standard operating procedures (SOPs) and their dissemination through their membership at federal and provincial level. In total 60-70 SOPs were developed, led by a technical unit within the MoNHSR&C supported by the National Health Support Project and by technical experts. Aga Khan University also provided training to health cadres; through this “more than 100,000 healthcare providers were trained on infection prevention and control (IPC) including the private sector” (government respondent). This form of support gave facilities the tools to resume EHS, which had come to a standstill. As part of this, nurses and administrative personnel were considered “agents of change” particularly in hospital settings as they led

readiness and IPC efforts. Some respondents reflected that while training cut across cadres and sectors, resources flows were mainly directed to the public sector and delivered in professional silos.

***“If anything positive came out of this whole thing [the pandemic] is that Pakistani health professionals learned infection prevention. This is now ingrained”  
(private sector respondent).***

During the COVID-19 response, there were concerted efforts to coordinate across sectors, although efforts varied by province and entities. This was seen as an improvement over past engagement, “private sector engagement was good, compared to how Pakistan was performing in past, but there are still a lot of areas where improvement is required” (government respondent). Key personnel working in existing public-private-partnerships (PPPs) were engaged on a daily basis in the initial phase of the response, in provinces where these arrangements were in place. Respondents working at a clinical level also reported close coordination around patient care, particularly in the larger cities. Despite these efforts and given the size and diversity of the private sector, there were still gaps in coordination with the view that both sectors tended to work independently.

***“We haven’t seen any coordination, any meetings, any workshops, any conferences. Private sector has its own policy and its own structure...they’re not seeking any help from government and government is not seeking any help from the private sector”  
(academic respondent).***

# Build Understanding



The inclusion of the private sector in COVID-19 data collection was seen as a major departure from past practice, “the private sector data doesn’t come to public sector, they don’t share anything” (international respondent). Use of information and information exchange was also not an established practice, given weak health information systems within the public and private sectors and the tendency to use data on an ad hoc basis.

***“They [government] are having a meeting for fistula patients, then they will call me and ask please send us the data for fistula patients. When they are talking about vaccination in the assembly, then they will just text me a letter and ask me all the vaccination data” (umbrella organisation respondent).***

This changed with COVID-19 pandemic, where prominence was given to the availability of “real time” data to monitor the response. The technical unit within the MoNHSR&C supported these efforts with public and private sector entities. This however did not focus on MNCH services.

During COVID-19 there were several “rapid” studies conducted on specific MNCH services and populations (9, 12-14). Studies cited a large reduction in skilled delivery, with the assumption that some women opted to deliver at home (12). Many MNCH services, including FP, antenatal and postnatal care, PAC and child immunization services were also highlighted as impacted by COVID-19. There was some evidence that government was responsive to such studies, resulting in easing of service restrictions alongside improved facility and health worker readiness to resume in-person services. It was also noted by one respondent from an international organisation, that poor performance in some service areas, such as FP, pre-existed COVID-19 and were systemic “governance” issues.

***“Deliveries still happened, somehow women found their way, but other MNCH services suffered” (umbrella organisation).***

Other studies looked at how budgets were diverted to COVID-19 “at the cost of women’s health”; this also prompted reaction with development partners stepping in to support COVID-19, enabling government to focus more on the continuation of EHS (international respondent). The media, both social and mainstream, also reportedly played a role in monitoring the response including availability and pricing of health services. Based on respondents feedback, the private sector was considered particularly sensitive to media attention, and reportedly adjusted its operations in response to this.

Technical working groups, which typically have very minimal representation from the private sector in health, were activated for the COVID-19 response and facilitated some information exchange. However, there were concerns voiced that data was not being used as part of information exchange nor did it provide adequate insight at operational level for the purposes of course correction for MNCH.

***“I don’t know what the use of that data is, but it is being submitted in the administration at all hospital levels, whether primary, secondary or tertiary care, the data is there” (umbrella respondent).***

***“The guidelines were put in place, but she asked, how do we know it’s working? What is the data we are collecting? How do we know we are making progress? And I did not find a satisfying answer.” (International respondent)***

# Enable Stakeholders



The private sector has traditionally operated on its own terms, “they’re not restricted to follow or collaborate with the government policies” (academic respondent). While regulation of the private sector in health has traditionally been weak, there is an evolving regulatory framework and infrastructure. This includes formulation of a National Digital Health Strategic Framework at federal level to streamline the use of technology for supporting the healthcare delivery system. Health care commissions are in place, to varying degrees of functionality, at provincial level. An essential health care package has been designed as have standards for primary and secondary health care. These are to inform licensing and registration requirements, which have been digitized “in the spirit of transparency and accountability” (government respondent).

A UHC scheme has also been introduced in some provinces, through which public and some private hospitals have been empanelled. This is undergoing a formative evaluation. The federal and selected provincial governments have also demonstrated openness to partnering with the private sector in health. For example, there is PPP legislation and capacity in Sindh and Punjab provinces and experience managing PPP contracts. According to respondents, some of these existing arrangements were utilised for the COVID-19 response.

Some experimentation was done to finance telemedicine services, using systems such as EZ Pass or through government and development partner subsidy. For example, the [Sehat Kahani](#) application was introduced under an initiative called Digital Pakistan, through which COVID-19 telemedicine and other health consultations were reimbursed by the federal government. Telemedicine consultations were previously a health governance “grey area”, but COVID-19 changed that, “people became used to the idea of having virtual doctors, governments saw this as an opportunity to provide more doctors in low-income communities and bridge the gap between doctors and patients” (private sector respondent).

The COVID-19 experience prompted the development of a national telemedicine policy, launched as a Presidential Initiative. The government also developed a national health care framework to regulate digital health, which is done at a different pace in every province, “the process of other provinces adapting to the policy and creating the regulation will be much faster than where we were two years before” (private sector respondent).

# Nurture Trust



Prior to COVID-19, prices in the private sector were considered high and a barrier to population access (11). Prices for EHS, including MNCH services, increased during COVID-19 in the private-for-profit sector (e.g., linked to the costs of personal protective equipment and IP). In the non-profit sector, pricing was reportedly adjusted to ensure that no one was denied services. Price increases were not typically viewed as opportunistic by case study respondents but were considered an area for reform.

***"Private health care is expensive anywhere in the world. At the peak of this pandemic, drugs were hard to procure, stuff was hard to get. And if a patient went into special care, or intensive care, I mean, that is really expensive"***  
***(private sector respondent).***

It was further suggested that the private-for-profit sector exercised some self-control over pricing to protect their "brand" reputation.

***"The for-profit sector...there is an accountability, because if your behavior is not good, your market is going to be affected. So, most of the time they are well mannered."***  
***(Private sector respondent)***

Populations, particularly the urban poor, were left to navigate access to EHS during COVID-19 on their own. Within large metropolitan areas, there was a "widening schism" in coverage of some EHS, given spatial het-

erogeneity in access.(15) Physical access barriers were further compounded for poorer population segments by increased cost of healthcare, reduced household income, and fear of infection and stigmatisation (16).

In addition to navigation of lockdowns and EHS closure, workload also shifted, from public to private facilities.

***"Public sector MNCH services, these suffered a lot, almost for one year. That provided a niche to private sector, because people had to go somewhere"***  
***(international respondent).***

There was substantial decline in service utilisation during this period.

***"[Women] are self-managing or they are approaching those providers who are not trained to give them adequate correct dosage or information"***  
***(international respondent). Reportedly rural areas and populations were less affected as "service delivery continued much like before"***  
***(government respondent).***

***"We feel that a lot of women never came to hospital, they delivered at home, without any services, many would have died. I think we have no documentation of that"***  
***(private sector respondent).***



# Deliver Strategy



A key learning from the COVID-19 pandemic was that change can be made quickly, “when it’s needed and when it’s urgent” (private sector respondent). The pandemic provided a “policy window” to push through health reform, to better govern and engage the private sector in health.

***“Practitioners, providers, health administrators, who felt that no, we can’t make change instantly, then you have the COVID pandemic to prove that they can”  
(private sector respondent).***

In Pakistan, this was considered more an issue of implementation rather than a lack of vision or policy. Seizing the policy window and building from good practices established during the COVID-19 response was considered critical. As part of this, reevaluation of the role of nurses and PHC providers was considered as deserving of more attention to improve quality and pathways to care.

To this end, there was recognition of the need to reflect, consolidate, and share organisational learning. This extends beyond publication of manuscripts (and case studies such as this one) to application in the health system, “if we keep our learnings to ourselves, it would be very difficult to say that our healthcare systems are

strengthened now, to respond to crisis again” (umbrella organisation respondent). In Pakistan, organisational learning has been initiated through a task force to identify what worked and didn’t work during COVID-19 for some MNCH services, spearheaded by a senior Director in the MoNHSR&C. Efforts such as these need to be developed with an understanding that “change is possible in the short run...and continued learning should be part of our ethic” (academic respondent).

***“This pandemic provided an opportunity to reflect where we are heading... what are our values? Because once it’s over, you know, that intensity reduces. And once the intensity reduces, there are so many other things to look after. And then we tend to forget”  
(umbrella organisation respondent).***

***“This pandemic was a game changer. I cannot imagine talking to you on the Zoom two years ago. That we can communicate across oceans across you know, continents, and we are connected. And we are communicating, this is the best part of whatever we have learned”  
(private sector respondent).***

# Discussion

The study sought to examine how the private sector was engaged to support the delivery of MNCH services in Pakistan during the COVID-19 emergency, using the WHO governance behaviours framework. The findings of the study suggest that Pakistan has an opportunity to 'build back' and nurture trust in the health system eroded by COVID-19 pandemic, by harnessing all health sectors to maximize efforts in providing MNCH services for all.

Based on the responses of the 18 respondents, the following have emerged as key opportunities for Pakistan to leverage private sector capacities for public health goals and to strengthen health system's responsiveness and resilience:

- **Leverage the role of professional associations and improve the consistency of engagement.** This could focus on quality of care using tools such as self-regulation and continuous medical education, building from collaborative experience during COVID-19.
- **Strengthen and extend COVID-19 coordination structures and surveillance/information systems.** These mechanisms can be broadened to address other health system issues with a similar level of leadership under COVID-19. The findings of the study suggest that MNCH should receive more prominent attention in all provinces within information and surveillance systems. At sub-national level, the role of the liaison officers could support other coordination requirements. Information and data should be converted into a "palatable form" to guide policy.
- **Strengthen the implementation of regulatory and financing mechanisms.** This can be done through the development of the role and capacity of the healthcare commissions to regulate price and quality of private (and public) practice, across entities and levels of care. Strengthen contracting modalities and related capacities was also a key issue that emerged based on respondent feedback.

- **Improve the consistency of the engagement and collaboration with the private sector in health in reform.** The study findings identified that there is commitment, but this needs to be coupled with a mindset shift and a foundation of trust between sectors and entities. While the initiative and incentives need to come from the public sector, equally private sector representation needs to be better organised.
- **Incentivise private sector engagement at the PHC level to improve the availability and quality of care.** This could leverage EPHS pilot plans and evolve to engage both for-profit and not-for-profit entities. It was also noted by some respondents that across sectors, there is need to revalue the role of nurses and PHC providers.
- **Secure the role of digital health and ICT more broadly within the health system.** This is a key opportunity that was highlighted by many respondents with opportunity to build from the recently developed policy and regulatory framework and supportive legislation at provincial level.

The findings from the present study need to be considered in light of certain limitations, several of which point to important directions for future research. First and foremost, this was a qualitative study that relied on a non-probabilistic limited sampling size. Like any qualitative study, the transferability of results must therefore be considered in light of the sample at hand. Moreover, the sample was predominantly from the middle and southern provinces and from participants working and residing in major cities. We tried to have a "symbolic representation" that illustrates the diversity within the population boundaries, though we did not receive answers from all the respondents identified and this reduced the sample size to 18 informants. The study would have benefited from exploring the perspectives of those working in more remote areas, where it may be more difficult to create a sense of trust and collaboration between private and public actors. Thus, the findings in the present study may be limited in its scope because participants not selected or who opted not to participate may have differing experiences that were not reflected in the data presented in this study.

# Conclusion

How accountable a country's health system is to its population depends to a large extent on the degree of accountability between the public and private health sectors (17). Where there is inadequate accountability, a culture of mistrust and 'blame shifting' may exist. This has been the experience in Pakistan. Learning from this experience and impetus to reform should be seized.

As a follow-up to the present study, the authors propose to convene a Pakistan multi-stakeholder workshop to validate findings from the literature review and case study, to further distil insights and policy recommendations. The output of the workshop may result in the formulation of a policy brief to improve engagement of the private sector for the delivery of MNCH services in Pakistan.



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# Annex: Interview Guide

1. Can you provide a brief summary of your role (optional: and that of your organisation)?
2. **[foster relations, deliver strategy]** How was coordination of the COVID-19 response undertaken?
  - Was the private sector involved? Were all critical voices represented? Were any left out? [probe: primary health care]
  - Did the pillar structure provide for adequate attention to the continuation of essential MNCH services?
  - In general, how do you think coordination structures have functioned? Have they facilitated communication and collaboration?
3. **[align structures]** How has the private health sector been involved in the provision of essential MNCH services as part of the COVID-19 response in your country?
  - How has MNCH service capacity been addressed? (In the public and private sectors, including services and supply chains)
  - How have MNCH services been adapted? What prompted adaptations? (In the public and private sectors)
  - How were service trends affected by new waves of transmission?
4. **[nurture trust, enable stakeholders]** Were adverse practices displayed by some segments of the health sector during the COVID-19 response in relation to essential MNCH services? [probe for specific examples]
  - Did these emerge over time, in response to emergency peaks in demand?
  - What were the root causes? What were the consequences?
  - Were there public channels available for reporting adverse behaviours and opportunistic practices? [probe examples]
  - How did government act upon such information?
5. **[build understanding]** How were essential MNCH service data and trends communicated across sectors and levels of the health system during the COVID-19 response?
  - How did data and information inform decisions in relation to the provision of essential MNCH services?
  - What other data and information sources were available/used during COVID-19 to inform the provision of essential MNCH services? [probe: the use of studies and assessments]
6. **[enable stakeholders]** What measures (regulations, financing reforms) were introduced by government to address access to essential MNCH services? [probe: if any inputs or subsidies were directed towards the private sector]
  - How was the private sector involved in the development and implementation of such measures? [probe: role of intermediaries, ability to shape regulation, etc]
7. **[nurture trust]** How was equity considered as part of the response/access to MNCH essential services?
  - How were the needs of specific populations catered for as part of the response?
  - How was affordability addressed/monitored?
  - How were consumer concerns communicated?
  - How did government act upon such information/concerns?
  - Were perspectives of frontline service providers (public and private) considered as part of the COVID-19 response?
  - Overall, do you think the response instilled trust in the health system?
8. **[deliver strategy]** As part of emergency preparedness and response, how could the organization of essential MNCH services be improved going forward?
  - What learning emerged from the response?
  - What policy changes are needed, if any?
  - What regulatory and financing changes are needed, if any?
  - What role should the academia/the private sector play?
  - What role should the public/consumers play?
9. Do you have any other recommendations and lessons for private sector engagement in essential services for other countries/regions?
10. Do you have any final comments or questions?



**World Health Organization**  
**20, Avenue Appia**  
**CH-1211 Geneva 27**  
**Switzerland**  
**[www.who.int](http://www.who.int)**

