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journal homepage: www.elsevier.com/puhe

Original Research

Stakeholder perspectives on public-private partnership in health service delivery in Sindh province of Pakistan: a qualitative study

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ARTICLE INFO

Article history:
Received 18 March 2018
Received in revised form
16 January 2019
Accepted 4 February 2019
Available online 16 March 2019

Keywords:
Public-private partnership
Healthcare staff
Stakeholders
People's Primary Healthcare Initiative
Barriers
Sindh
Pakistan

ABSTRACT

Objective: The objective of this study was to explore the perspectives of stakeholders on public-private partnership (PPP) in healthcare service delivery in Sindh province of Pakistan including the reasons for adopting such policies and the barriers for its implementation.

Study design: This was a qualitative primary study.

Methods: Semistructured in-depth interviews were conducted with 13 stakeholders, including officials from provincial government and district administration (legislators, district managers, deputy commissioners and assistant commissioners) and representatives from private sector organisations with direct or indirect role in implementation of PPP policy, selected using purposive sampling methods. Data were analysed using a thematic approach.

Results: Participants had very limited in-depth understanding about the concept of PPP. They considered multifaceted corruption in the health system and the success of existing PPP initiatives as the main reasons for the PPP policy adoption. Resistance from healthcare staff was perceived as the main barrier for implementation of PPP. There was a common perception that better monitoring capacity in the private sector management can be a cause of concern for public sector employees who may have become used to less efficient working. A common theme found in the narratives was the possible apprehensions from healthcare staff about the loss of their jobs.

Conclusion: Our findings indicated lack of effective engagement with key stakeholders and the resistance from healthcare staff as the key barriers for PPP implementation in Sindh, Pakistan. These findings provide useful insights for the successful implementation of such initiatives in Pakistan as well as in other similar settings.

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https://doi.org/10.1016/j.puhe.2019.02.004

Introduction

Public-private partnership (PPP) is an institutional relationship between the government and private sector, which may include for-profit or not-for-profit organisations to achieve a common goal with mutually agreed share of responsibilities.[1] Among the various arrangements of PPPs, concessional modalities or contracting are usually used for formalising the public-private relationship with the purpose of expanding services to underserved areas, introducing new services or improving the quality, cost and efficiency of existing public healthcare services.[2] Contracting is a form of PPP, in which the government delegates responsibility to a private entity for managing a health service that it owns or for developing coverage of a health service for a specified time period with predetermined performance targets.[3] Contracting in healthcare service delivery has several different approaches. For example, a service delivery contracting could include the provision of a government-owned service by a non-governmental entity that includes the provision of infrastructure, human resources, management and supplies by the non-government entity. It is usually done in the case of services that are difficult for the government departments to provide. In management contracts, the government gives the budget to a private sector organization to manage existing government healthcare services. There are hybrid arrangements as well, where attributes of two or more forms of contracting arrangements are used.[4]

PPP based on contracting arrangements emerged as a strategy on international policy agenda to improve health system performance during the mid-1990s. Contracting has since been implemented in Africa (Congo, Rwanda, South Africa and Uganda), Western Pacific (Cambodia), South Asia (Afghanistan, Bangladesh, India and Pakistan) and Latin Americas (Bolivia, Costa Rica, Haiti, Mexico and Guatemala).[3] For example, in South Africa, Netcare (a private company) partnered with the Department of Health to provide capital investment for upgrading physical infrastructure and equipment in six public hospitals. It has also introduced private facilities within two public hospitals.[5] In Afghanistan, after a complete collapse of public health services in 2001, the Ministry of Health signed an agreement with non-governmental organisations (NGOs) to provide a basic package of health services with about 80% coverage of the population.[6] However, PPP cannot be conceived as a one-size-fits-all approach, and there are considerable variations in its structure and management across settings informed by contextual factors.[7]

Despite the increased focus on PPP in health care in developing countries, only a few studies have evaluated such initiatives. Evaluation mechanisms usually include quasi-experimental designs with preintervention and post-intervention assessment.[1,8] For example, a household survey in India was conducted to assess aspects such as health care–seeking behaviour, maternal and newborn care practices in one intervention district and one control district to evaluate a PPP project before and after intervention.[9] In some countries, there are standard protocols and quantifiable targets, whereas others have lacked capacity to monitor the effectiveness of PPP.[4]

If poorly managed, PPP can pose risks to health systems, potentially causing cost escalation, poor quality of care, less focus on preventive services by contractors and discoordinated health systems.[10,11] Evidence has indicated wide variability in terms of PPP effectiveness in health care between countries. In some countries, such as Bangladesh, Cambodia, India and Pakistan, PPP has been regarded as successful, whereas in some others, such as Tunisia, Jordan, Lebanon and Lesotho, results indicated the failure of such initiatives in producing expected outcomes.[11,12]

In Pakistan, there is an extensive network of primary healthcare facilities, the basic health units (BHUs), each covering a population of 25,000. However, it is largely underutilised due to poor quality of services, and about three-quarters of the population is accessing the private sector for health care. Owing to the poor performance of the government-funded primary healthcare system, the government, in 2003, considered PPP as a way to improve the management of BHUs. The provincial government of Punjab signed an agreement with an intergovernmental organization Punjab Rural Support Program to manage all BHUs in Rahim Yar Khan District.[13,14] This form of contracting has been described as hybrid of intergovernmental and management contracting by Loevinsohn and Harding.[4] Later, in 2004, the government commissioned an external third-party evaluation of the PPP to assess utilisation, community satisfaction, quality of services and cost. Based on the initial reports of improvement in BHUs functioning after the PPP arrangement, the Rahim Yar Khan experiment was considered a success, and therefore, the contracting was expanded to 82 other districts in all four provinces of Pakistan under the People's Primary Healthcare initiative (PPHI).[15]

Sindh, situated in the southeastern part of Pakistan, is the second largest province in the country. The social and health indicators in Sindh fall below the average national estimates (Table 1).[16] As a signatory to the international health targets of Millennium Development Goals (2000–2015) and now in progress towards Sustainable Development Goal 3 of Health for All by 2030, the provincial Government of Sindh (GoS) requires creative policy options. The GoS signed a contract with an NGO, Sindh Rural Support Organization, now known as PPHI giving control over

Table 1 – A comparison of key health indicators in Sindh province with Pakistan.

Indicator	Sindh	Pakistan
Infant mortality rate (per 1000)	81	78
Maternal mortality ratio (per 100,000)	314	276
Female education	46%	46%
Institutional deliveries	42%	41%
Measles coverage	77%	82%
Child anaemia	73%	62%
Maternal anaemia	62%	51%
Food insecurity	72%	58%
Public sector utilisation	22%	29%

Source: Health Sector Strategy Sindh 2012–2020.[16]

(i) administration and management of all BHUs, (ii) existing staff and their transfer on request to district government, (iii) BHUs infrastructure, (iv) procurement of drugs and supplies, (v) a budget equal to precontracting arrangement and (vi) salaries of existing staff, which were the responsibility of the government, but the PPHI paid the doctors who they hired. The management of community health programs and vaccinations were not given to the PPHI. The PPHI uses the government's health management information system for reporting and provides a quarterly progress report on the main BHU functions[17] (Fig. 1). Encouraged by the improved service delivery at BHUs under PPHI, the provincial government has entered into contracts with five private sector organisations for the management of 50 secondary hospitals in March, 2015. Under this management contracting agreement, the private sector organisations were envisaged to be responsible for the management and provision of services, ensuring availability of equipment and upgrading of facility infrastructure and funding and overseeing were with the government.[18] However, there was a delay in implementing the proposed initiative with dearth of evidence on the challenges faced by the government in its implementation.[19–21]

The objective of this study was to explore the perspectives of stakeholders on PPP in healthcare service delivery in Sindh including the reasons for adopting such policies and the barriers for the implementation of PPP.

Methods

The data presented in this article were derived from qualitative, in-depth, semistructured interviews conducted with 13 participants including individuals with key roles at provincial government and district administration level (legislators, district managers, deputy commissioners and assistant commissioners) and representatives from private sector organisations. The participants were approached through email and telephone. All people who were invited to participate accepted. Interviews were scheduled according to the participants' availability and convenience. Purposive sampling technique was used for participant recruitment, and the sample size was decided based both on data saturation and practical considerations such as resources and feasibility. The inclusion criteria for participation were that they should have had a minimum of 3 years of experience of working in the Department of Health or private sector organization in Sindh with direct or indirect roles in implementation of PPP policy. The participants had roles in public and private sector organisations as presented in Table 2.

All the interviews were conducted by the first author (N.N.K) who has a background in public health. Informed consent was obtained before the start of the interview. The qualitative methodology enabled the researcher to view the individuals within their context in a holistic manner.[22] The

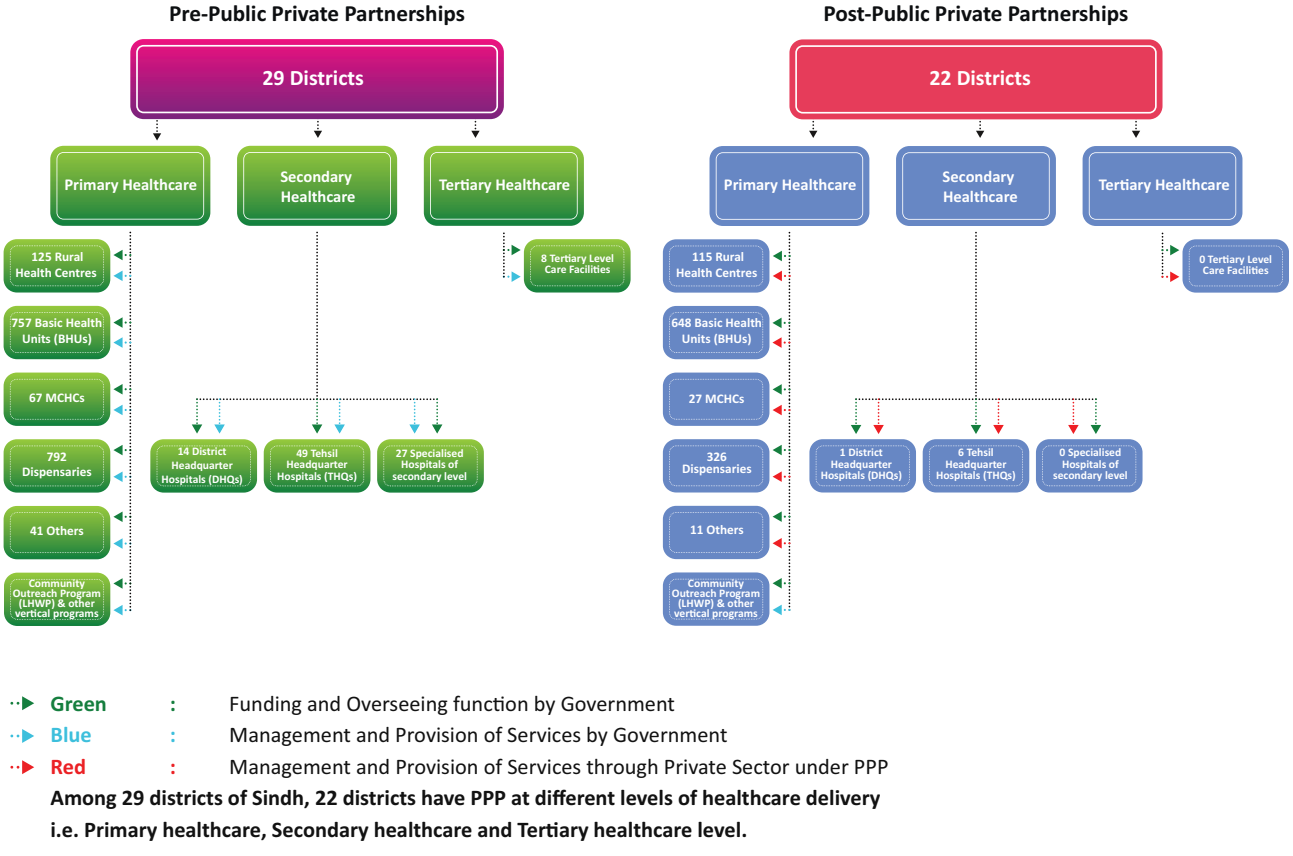

Fig. 1 – A comparison of before and after public-private partnerships in healthcare service delivery in Sindh, Pakistan. PPP, public-private partnership; MCHCs, Maternal and Child Health Centers; LHWP, Lady Health Worker Programme.

Table 2 – Participant characteristics.

Participants	Occupation	Years of experience	Role
Participant 1	Member of Sindh Provincial Assembly	12 years	Policy formulation and legislation process
Participant 2	Project manager of a PPP programme in Sindh	7 years	Implementing the PPP project at the district level
Participant 3	Senior official of a private insurance company	11 years	Lead role in a company that provides insurance for various purposes, one of which is health care
Participant 4	Assistant commissioner of a district in Sindh	6 years	Responsible for governing the government departments at the subdivision level; public hospitals come under his administration
Participant 5	Assistant commissioner of a district in Sindh	6 years	Administrative role with responsibilities in policy implementation
Participant 6	Assistant commissioner of a district in Sindh	4 years	Administrative role with responsibilities in policy implementation
Participant 7	Deputy project manager for government projects	9 years	Deputy project manager for government projects
Participant 8	Judicial Magistrate	16 years	Administration and responsibilities for overseeing the government functionaries of district
Participant 9	Public health consultant	11 years	Consultant for preventive measures to improve health indicators
Participant 10	District Health Officer in Sindh (retired)	35 years	Key person in implementing health policies and dealing with front-line issues in health sector
Participant 11	Assistant director in a government department	4 years	Deals with corruption issues and cases of corruption, for example, procurement of healthcare equipment and medicines
Participant 12	Assistant commissioner of a district in Sindh	8 years	Administrative role and involvement in implementation of policy
Participant 13	Assistant commissioner of a district in Sindh	4 years	Administrative role and involvement in implementation of policy

PPP. public-private partnership.

interviews were conducted in an unobstructed natural way by putting the interview questions in a conversation style contrary to a formal question-and-answer session.

A semistructured interview guide was developed based on a tool that sought to explore the views of stakeholders regarding PPP in an earlier study.[23] The flexible interview guide covered aspects such as participants' understanding and awareness of PPP; the sources where they received the information from; their perspectives about the reasons for the provincial government to adopt the PPP policy and the delays in implementation; and the perspectives about the barriers in implementing the policy. The interviews were conducted in English. The average duration of the interview was 45 min. All the interviews were audio recorded with permission from the participants and were later transcribed as verbatim notes. The transcripts were shared with the participants for validation. Furthermore, interview notes were shared with the second author (S.P.) to check validity of transcription and translation.

The analysis was based on a thematic approach developed by Braun and Clarke.[24] Two researchers conducted the analysis manually. Although the use of software was considered, we resorted to a manual analysis as the time frame of the study and other resources did not permit the use of an analytical software program. Each interview was coded with a set of within-case themes based on a meaningful segment of text in the transcript. The themes were subsequently categorized using a simple framework based on the study objectives. Discussions between the researchers took place at regular intervals throughout the study. The researchers undertook a cross-case analysis, based on comparing, collating and contrasting the transcripts for 13 participants. The methodology was consistent with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.[25] The ethical approval for the study was gained from the Institute for Health Research Ethics Committee, University of Bedfordshire. The study was conducted from March to August 2016.

Results

The accounts reflected three key themes and subthemes as presented in Table 3. The key themes included understanding of PPP, perceived reasons for adopting PPP approach for healthcare service delivery in Sindh and barriers for PPP implementation in Sindh.

Understanding of PPP

The participants in our study demonstrated different levels of understanding in relation to the concept of PPP. Most of them (six out of thirteen) defined it as a 'contract' agreed between government and private entity where 'infrastructure', 'subsidies' and 'employees' are provided by the government and management is run by the private sector. They emphasized that 'inefficiency' of government-led institutions was the main reason for the public sector choosing to partner with the private sector.

Table 3 – Key themes and subthemes.

Theme	Subtheme
1. Understanding of PPP	1) Government-owned services are contracted out to private sector due to poor governance
	2) Government and private sector agree on certain terms and conditions in the form of a contract
	3) Outsourcing of government services for limited period
	4) Government provides resources, whereas management is done by private organisations
2. Perceived reasons for adopting PPP approach for healthcare service delivery in Sindh	1) Existing corruption in public hospitals
	2) Lack of accountability in government services
	3) Poor monitoring results in inefficiency among staff
	4) Existing PPP arrangements have improved service delivery in BHUs
3. Barriers for PPP implementation in Sindh	1) The staff at public facilities resist PPP initiatives
	2) There is fear among staff about increased accountability under PPP
	3) Involvement in malpractices lead public sector staff to oppose any third-party intervention
	4) Staff perceptions about loss of jobs under new management structure

BHUs, basic health units; PPP, public-private partnership.

"The meaning of PPP would be, the entities which are owned by government but when the government is not able to administer effectively, they hand it over to NGOs on contract basis" (senior official of a private insurance company)

"Government and the private partner agree on certain terms and conditions in the form of a contract. For example, in health sector of Sindh, the Government takes responsibility for providing the employees, funding for their wages and running affairs of hospital whereas, the management is done by the private sector" (Assistant Commissioner of a district in Sindh)

One participant, nevertheless, had limited knowledge of what PPP is. He perceived PPP as equivalent to privatisation.

"Some shares of a public institution are sold to private party …in order to improve the service delivery and capacity of public institutions" (Assistant Director in a Government Department)

Perceived reasons for adopting PPP approach for healthcare service delivery in Sindh

Based on their experiences, respondents perceived several reasons for the GoS to adopt PPP for healthcare service delivery.

Those involved in implementation of PPP policy in healthcare service delivery viewed lack of accountability in public sector hospitals as a major reason for provincial GoS to outsource the management of health facilities. Most of the participants described lack of efficiency and 'malpractices' such as 'theft of medicines' among public sector employees. They also expressed dissatisfaction with job recruitment processes adopted in the public sector hospitals.

"Corruption in medicines is a problem for example, cartons of Augmentin are procured in excess more than written by Medical Officer and after 8–10 days there is medicine theft from the store, and the only medicine stolen is Augmentin. So you understand that how people working inside these institutions are involved in these practices" (Assistant Commissioner in Sindh)

"…if such privatisations and PPP would come, they are in government led system from decades and have developed habit of not working, how they can afford that? That's why they do protests and create hue and cry" (Member of Sindh Provincial Assembly)

"…posting of Medical Superintendent is done on the basis of corruption for example if he pays a hundred thousand US dollars, he would get posted to his place of choice. So naturally, if he has paid a huge amount, he will then not give relief to people, rather will try to make money…different groups who blackmail him… include paramedical staff, they tell him that you got money for a particular number of drugs but you didn't procure it…So he gives undue leverage to them, they are not punctual on job…. It's a vicious cycle" (Deputy Project manager for Government projects)

Almost all of the respondents mentioned existing PPP arrangements in Sindh. The PPHI, in which the management of BHUs is outsourced to an NGO, was cited as an example of 'success' and was mentioned by eight participants as a reason why they believe the government is opting for PPP.

"PPHI is a successful project" (Assistant Commissioner of a district in Sindh)

"I don't know much about PPHI but I know one thing that all BHUs in my sub division which are led by PPHI are doing a very good job" (Assistant Commissioner of a district in Sindh)

It appeared from the accounts that participants perceived substantial improvements in the environment and quality of services in BHUs after PPHI introduction. These improvements were attributed to the program's efficiency in providing better salary for the staff and increased accountability, along with administration and management by qualified personnel. To support arguments about improvements following PPP, participants came up with direct comparative accounts between BHUs led by the PPHI with government-run health facilities.

"PPHI for example…is delivering, I visit them, everyone's present there with no absenteeism. They have good monitoring; a separate monitoring team is there with executive monitoring officer responsible for example to see supply of medicines, attendance of

doctors and paramedics. Because of strong monitoring and good leadership, it is performing" (Member of Sindh Provincial Assembly)

"Officers working in PPHI are from management background, they are not medical doctors; these are from civil services, energetic, young officers…are taken on deputation basis on higher salaries" (Project manager for a PPP program in Sindh)

Two participants, however, expressed that the PPHI could not be considered a successful project altogether because there are many deficiencies. They also stated that performance of the PPHI was not well matched with the amount of government funding and resources it received.

"It can be called better rather a success. There is monopoly, one person controls everything. The services which are delivered by PPHI are over rated in comparison to the financial grant given by government of Sindh" (senior official of a private health insurance company)

Barriers for PPP implementation in Sindh

Resistance from healthcare staff was considered the main barrier for implementation of PPP by most participants. Six participants perceived that the healthcare staff from public sector facilities oppose PPP due to the fear of increased accountability under private sector management.

"Private sector intervention will be associated with more monitoring and accountability, more check and balance whereas the employees are used to lethargic working conditions of public sector hospitals" (Assistant Commissioner of a district in Sindh)

Two respondents associated the resistance of staff as an act to protect corrupt practices including involvement in malpractices such as theft of medicines and stated that staff may be well aware that with third-party intervention in management, they would not be able to continue malpractices in their roles.

"Paramedics and store managers of these hospitals are concerned…Whenever medicines are procured; these store keepers steal those medicines and sell them to private medical stores. Additionally, patients are pressurised to buy medicines from those private store" (Judicial Magistrate)

Four participants viewed lack of punctuality among staff members to be an important factor for resistance to any initiative that involved effective monitoring such as PPP. Among them, one participant highlighted the common phrase 'visa employees' that is used locally to refer to employees who don't turn up for job.

"Some employees don't attend to their duties, they are called visa employees, a doctor settled in Karachi but he gets posted to Sukkur and he doesn't want to work in Sukkur so he pays little amount from his salary to somebody like a clerk or Medical Superintendent and gets his attendance done" (Deputy project manager for Government projects)

A common theme found among the narratives of participants (8 out of 13) was the realisation that because healthcare staff were not taken into confidence while this policy was decided, they have apprehensions such as loss of jobs. They explained that people opted to work for the government sector because of job security, but with PPP, healthcare staff fear losing their jobs.

"Security of job is an essential point of government employment, which has various incentives and terms of retirement, pensions, allowances etc. Another reason is that when you are switching a government set up to private sector there are various apprehensions regarding hiring and firing and more work load" (District health officer in Sindh)

"There is a fear of getting fired by private sector" (Public Health Consultant)

Discussion

This article is based on a qualitative study carried out to explore stakeholder perspectives on PPP in healthcare service delivery in Sindh province of Pakistan, including the reasons for adopting such policies and the barriers for its implementation. Previous studies conducted in Pakistan have compared performance of government-administered health facilities with those run by PPP.[12,26,27] Studies have also identified the challenges in the wider policy context for PPP implementation in the healthcare sector in Pakistan.[28,29] However, there is a dearth of research about stakeholder perspectives on factors that act as barriers in implementation of PPP in healthcare service delivery.

Although the PPHI has successfully been established in Sindh, it would appear that the systems for administration of PPP are weak with little emphasis placed on setting up and monitoring of actual performance targets or objectively verifiable outcomes.[15] As per the management contracting agreements of secondary hospitals with private organisations adopted by the Sindh provincial government, private sector organisations will be responsible for management and provision of services, ensuring availability of medicines, equipment and upgrading of facility infrastructure as per requirement.[18] Management contracts with NGOs for the provision of primary healthcare services have been reported in other low- and middle-income countries also. However, the contract arrangements have some variations, e.g., in Cambodia's contracting-in agreements for primary healthcare services, NGOs controlled management of health facilities, but the supply of medicines was done using government channels.[30,31]

Findings from our study highlighted that although most participants thought they had a fairly good understanding of the concept of PPP, the accounts indicated limited conceptual or practical understanding about PPP. They felt

introduction of PPP policy was only in response to bad governance in government hospitals which is not in line with the essence of the process as outlined by the World Health Organization.[32] While improving the quality of services is one of the goals of PPP, the participants perceived that it is a process that comes only as a consequence of poor performance from the government. This perception among participants could be attributed to the fact that in Pakistan, existing PPP initiatives started only as a result of poor performance of the government sector. Other researchers have found that overall understanding of PPP is good among public and private sector health workers.[23]

The participants in our study viewed the issue of corruption as a main reason for the provincial government to introduce PPP in healthcare service delivery. Malpractices in the public sector such as sale of medicines from hospitals to private pharmacies for individual financial gains by government employees were repeatedly emphasized. Such malpractices have been reported from other countries.[33]

Participants in our study also perceived the success of existing PPP initiatives as an important facilitator for the provincial government to be interested in adopting the PPP policy. Previous studies have indicated that BHUs under the PPHI management perform better than government-run BHUs.[12,15,26] For example, Tanzil et al.[12] compared functioning of two BHUs in Sindh, one administered by the PPHI and the other led by the government. They found that the performance between the former and latter varied in terms of availability of medicines, infrastructure and the availability of staff. BHUs administered by the PPHI performed better in all aspects than those run by the government.

Our findings suggested that resistance from healthcare staff of public sector is a major barrier to the implementation of PPP. Participants explicitly mentioned that staff consistently opposed initiatives such as PPP because of their involvement in malpractices including undue political favour that they receive for job postings and rampant absenteeism at work. Other studies have highlighted the issue of bad governance and inefficiency in public sector hospitals in Pakistan.[34,35] Shah et al.[36] argued that working in the public sector was preferred among people due to the job security that it offers rather than the motivation to do the job. Resistance against government initiatives that allow an increased role of private sector in healthcare provision has been reported in Pakistan[15] and other settings. For example, around 50% of public sector health workers opposed the idea of PPP in delivery of healthcare services in Enugu State of Nigeria.[23]

Findings from this study provide several insights for the implementation of PPP for the provincial government of Sindh. Although the accounts from key stakeholders did not explicitly point out existing facilitators for the implementation of PPP, the participants considered PPP with good prospects in healthcare delivery overall.

Our study has limitations. As it is a relatively small qualitative study with a small sample size comprizing mostly of decision-makers, the findings from this research and the narratives presented may not represent the views of all the stakeholders involved in PPP in Sindh province. However, this is likely to be minimal as the inclusion criteria for participation were that they should have had at least three years of experience of working in the Department of Health or private organization with direct or indirect involvement in implementation of PPP project. The focus of the project was limited to perspectives relating to the overall implementation of PPP rather than the implementation of PPP with respect to the specific elements of the health system.

Conclusion

This research explored the perspectives of 13 stakeholders on PPP in healthcare service delivery including the potential reasons for adopting such policies and the barriers for its implementation in Sindh province in Pakistan. Overall, participants had limited in-depth knowledge of the PPP concept. Participants perceived multifaceted corruption in the health system as the main reason for the provincial government to adopt PPP policy. They used the example of the success of an existing PPP initiative as a reason for the provincial government to adopt PPP policy. In addition, participants perceived great resistance among healthcare staff potentially due to staff involvement in malpractices. These findings provide useful insights into the policy and practice of PPP in Pakistan and other similar settings internationally.

Nationally, the Department of Health should restrategize on its current effort, taking adequate measures to create awareness about the PPP policy, its meaning and its potential to improve service delivery. Support and cooperation of public sector healthcare staff is key to the success of the implementation of PPP, and the staff should be invited to participate in the policy dialogue, their concerns should be addressed and the process should be revised in discussion with them. Moreover, there should be a thorough evaluation of the existing PPP initiatives using well-defined indicators complimented by qualitative evidence of provider and user perspectives.

Author statements

Acknowledgements

The authors would like to thank the Commonwealth Commission UK and the University of Bedfordshire for the logistic support. The authors also thank all the participants in this study for their time and participation, without which this study would not have been possible.

Ethical approval

The ethical approval for the study was gained from the Institute for Health Research Ethics Committee, University of Bedfordshire.

Funding

The first author was supported by a fellowship by the Commonwealth Commission UK and the University of Bedfordshire. The views presented in the article are solely those of the authors.

Competing interests

The authors declare that they have no competing interests.

Consent for publication

Informed consent was sought from each participant.

Availability of data and material

The data sets used and/or analysed during the present study are available from the corresponding author on reasonable request.

Authors' contributions

N.N.K. conceived the study with S.P.'s input to the protocol. N.N.K. conducted all the interviews and took the lead in managing and analysing data with support from S.P. N.N.K. drafted the initial version of the manuscript, which was revised by S.P. Both the authors have read, reviewed and approved the final manuscript.

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