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Best Bets for Accelerating Family Planning in Pakistan

The Case for Engaging Family Physicians and the For-Profit Private Sector

Total Market Approach and the For-Profit Private Sector: The International Evidence

In settings where the public sector faces resource constraints, and the non-profit private sector is able to achieve only limited success, a “total market approach” (TMA) offers a promising means to tap opportunity in the commercial private sector to expand access to family planning (FP) services and improve contraceptive security and long-term sustainability.

A Total Market Approach is widely recognized as a means of strengthening family planning markets and expanding access and provision of services. It allows multiple sectors—public, non-profit, and for-profit private—to flourish, resulting in diversification, better allocation of resources, and long-term sustainability. There is a growing recognition that, while the public sector bears the ultimate responsibility for health, governments must better harness the potential of the private sector to widen access to health services.¹

This approach requires engagement of all sectors in the roles most suitable for them in FP service provision—for example, the public and the private non-profit sectors may cater to the poor and the low wealth quintiles, while the private commercial sector provides services to consumers who have greater ability to pay.² This allows growth of service provision in the for-profit private sector

and better targeting of donor funds and government subsidies to those who need them most. Where there is a risk of donor funds or government subsidies being phased out, a TMA allows for diversification of the market.³ This approach can expand overall FP coverage and is especially useful where a range of donor or public sector-funded suppliers (such as social marketing programs and non-governmental organization [NGOs]) already exist in the market and may be displacing commercial players. Such a situation results in misalignment of resources and lack of long-term sustainability, as even those consumers who have greater ability and willingness to pay may be taking advantage of subsidies.⁴ While the profit motive of the commercial private sector may not lend itself to widespread and equitable provision of health services, creative strategies and alternative business models can make the private sector’s role compatible with public and donor interests. Financially profitable commercial models allow for sustainability and reduce the dependence on donors and changing political interests.

Given the large unmet demand, public sector delivery failures, and limited role of the private sector in the current landscape of FP service provision, there is a case for enabling the commercial private sector to play a more significant role.

This would certainly not eliminate the need for the public sector and the non-commercial private sector, but it would enable all sectors to play more complementary roles in the family planning market. Expanding the commercial private sector will free up resources of the public sector to better target those who cannot pay commercial prices or to focus on demand generation. The non-profit sector can continue to be useful in serving the FP needs of the low-income clients who have some ability to pay.⁵

Evidence shows that many women in the developing world already rely on private sector providers for various types of illnesses, as well as for family planning services, due to ease of access, shorter waiting times, and a perception of better service.^{5,6} Private physicians are also well-positioned to address unmet demand for FP services owing to their ongoing relationships and rapport with their customers.⁷ Drug shops and pharmacies are also important private sector players in improving access to and providing basic information about contraceptive products. They are already an important source of advice and treatment for patients with a variety of minor ailments. Experiences from Bangladesh show that drug

shops not only provide limited FP services but are often also the preferred option for clients seeking information and counseling.⁸

Use of pharmacies and shops is key where public sector facilities face frequent shortages and stock-outs of products. They are also good outlets for providing services to men who are less likely to visit clinics for family planning needs or for repeat purchase of temporary methods like condoms and pills.⁹ Training, quality assurance, and reliable supply of commodities are important in enabling this segment of the market.

Although the term “total market approach” is relatively new, stakeholders have been using similar concepts to transition their programs off from public and donor subsidies for many years. TMA strategies have been used with priority health products such as condoms, contraceptives, oral rehydration salts, zinc, and insecticide-treated bed nets. Strategies to improve the quality and coverage of health services by engaging the private sector can be classified as shown in Table 1.^{10,11}

Table 1: Strategies to improve the quality and coverage of private sector health services

Market-based	Contracting	Purchasing services from the private sector
	Financing	Financial incentives such as grants, subsidies and tax relief for private services and products
	Franchising and Social Marketing	Using commercial channels and communications approaches to market networks of service providers (franchises) or products (social marketing)
	Collaborating	Coordinating and creating alliances among private and public sector actors
Administrative	Regulating	Setting and enforcing standards for the private sector
	Training	Educating and supporting private sector providers
Public Empowerment	Informing	Educating consumers about healthy behaviors and the role of the private sector

In general, implementing a TMA program starts with conducting a Landscape Assessment or a Segmentation Analysis to better understand market needs so resources can be targeted where they are needed. This leads to the development of a TMA plan and strategies for moving forward and strengthening coordination and advocacy among the various partners. It is generally the government that takes on the role of actively stewarding the process.

Experience from Mali, Uganda, and Kenya suggests that introducing a TMA framework strengthens stewardship of reproductive health (RH)/FP markets, most notably by generating data to help understand market strengths and weaknesses, and by forging improved multisectoral relationships that recognize the strategic role of the private sector. In Mali, a number of activities, such as generating intelligence through a Market Segmentation Study, establishing a TMA sub-committee led by the

Directorate of Pharmacy and Medicine (DPM) under the Ministry of Health, and identification of pricing restrictions as a barrier for commercial brands, helped implement the TMA program.³ In Uganda, TMA implementation led to a strengthened role of the Ministry of Health in building coalitions and partnerships and in understanding policies and regulations that were inhibiting increased access to RH/FP products through the private sector.³ In Kenya, the Ministry of Health has made important progress in strengthening key stewardship functions for its RH/FP market. It has generated a substantial amount of intelligence through diagnostic studies, segmentation analysis, and quantification of the for-profit private sector role in the FP market; established a TMA working group that holds quarterly meetings; and allows private providers to access free FP commodities through public sector sourcing.³

Pakistan's Experience with Social Marketing and the Private Sector

In Pakistan, Greenstar Social Marketing (GSM) was set up as an affiliate of Population Services International in 1991 with the primary objective of marketing FP products and services through private sector outlets. GSM implements a social franchise model under which it provides contraceptive pills, intrauterine devices (IUD), injectables, condoms, and implants to clients through selected private sector clinics branded as *Sabz Sitara* (or Greenstar), and knowledge and skill-based training to the clinic-based providers. GSM has trained 7,000 Sabz Sitara providers since its formation. In addition, under its social marketing program, GSM supplies its brands of combined oral contraceptive pills, emergency contraceptive pills, and condoms to over 30,000 pharmacies and medical shops, and condoms to over 70,000 retail shops across the country. GSM-marketed contraceptives are mostly received free of cost from donors and sold at various price points to earn revenues that help to recover the cost of operations. In the process, GSM also caters to customers from higher wealth quintiles who can pay commercial prices for brands from the for-profit private sector.

The Marie Stopes Society (MSS) is a local NGO registered under the Societies Act, 1860. It provides a wide range of comprehensive RH and FP services through clinics located in 34 districts across Pakistan. MSS operates 32 static centers branded as *Behtar Zindagi* (Better Life) clinics in urban and peri-urban areas. In addition, it implements a social franchise model, branded as *Suraj* clinics, through a network of around 400 private sector practitioners across the country. Many of its clinics offer free or subsidized services to the poor through a redeemable voucher scheme.

Between 1997 and 2007, the Futures Group, now Palladium, implemented a social marketing program in Pakistan known as Key Social Marketing (KSM) to expand the contraceptive market for private sector manufacturers and suppliers using the principles of the "Manufacturers Model." The Project was funded by the

Department for International Development (DFID) until 2003, and then by the United States Agency for International Development (USAID) until it ended in 2007. It provided technical assistance to ZAFSA, a local pharmaceutical partner, to improve the quality of its hormonal pills and injectables. KSM also provided marketing and communications support to increase sales of ZAFSA's brands of contraceptives as well as the condom brands marketed by its local distribution partners.

The project helped create an enabling environment for the commercial private sector to grow in a market where the contraceptive prevalence rate (CPR) was stagnating and competition from donor-funded contraceptives was fierce. During its second phase, the project saved USAID over \$3.5 million in commodity cost by leveraging the resources of private sector partners.

The KSM experience demonstrated that, if given adequate support, the for-profit private sector in Pakistan can play a bigger role in the FP program by bringing in new users and creating a more sustainable market that is not dependent on donor commodity assistance. In 2006, full-priced condoms, pills, and injectables supported by KSM were used by over 430,000 couples who would otherwise have availed public sector or other subsidized sources.

The impact of social marketing programs would be far greater if their product subsidies were targeted at the less wealthy consumers who need them most, leaving the urban, better-off customers to be served by the commercial private sector. In addition, if IUDs and injections could be sold to family physicians outside the franchised clinics supported by effective training programs, the payoff would be much higher in terms of increased CPR. Availability of provider dependent methods through private physicians would also attract more investment from pharmaceutical companies.

The Argument for Enabling the For-Profit Private Sector to Enhance Access to Family Planning in Pakistan in the Current Scenario

According to the Pakistan Demographic and Health Survey (PDHS) 2017-18, the total demand for family planning, i.e., the percentage of married women of reproductive age who express a desire to either prevent or delay childbirth, is 51.5%. However, only 34.2% are using any method of contraception, implying unmet need of over 17%. Of the 34.2% using any method of contraception, the majority are using modern methods. The most common of the modern contraceptive methods are condoms, used by 9.2% of women, followed by female sterilization, used by 8.8%. Use of IUDs and injectables is low (2.1% and 2.5% of women, respectively) while pills are used by only 1.7% of women.¹² Table 2 provides further details.

Table 2: Percentage of currently married women of reproductive age (15–49 years) using contraceptives and with unmet need for family planning in Pakistan, 2012–13 and 2017–18

Contraceptive Method	2012/2013	2017/2018
Any method	35.4%	34.5%
Condoms	8.8%	9.2%
Female sterilization	8.7%	8.8%
Injectables	2.8%	2.5%
IUD	2.3%	2.1%
Pill	1.6%	1.7%
Implant	-	0.4%
Male sterilization	0.3%	0.1%
Modern methods^a	24.4%	24.8%
Unmet need	20.1%	17.3%

IUD=intrauterine contraceptive device

^a Not including the lactational amenorrhea method and others

Source: Pakistan Demographic and Health Survey (PDHS) 2012-2013 and 2017-2018.

The most worrisome observation is that there has been no growth in the modern contraceptive prevalence rate (mCPR) in the five years since the last PDHS was conducted (2012–13). If we exclude implants, which were not captured in the 2012–13 survey, the overall mCPR (not including the lactational amenorrhea method and others) has remained the same at 24.4% during the period. Prevalence of injectables, IUD, and male sterilization—all provider-dependent methods—has come down by 0.3, 0.2, and 0.2 percentage points respectively, while condom use has increased by 0.4 percentage points and prevalence of female sterilization and oral pills has remained almost unchanged. Pakistan has therefore fallen far short of its goal of achieving a 55% CPR by 2020, as pledged at the 2012 London FP Summit, and the current CPR trend bodes ill for the SDG commitment to achieve universal access to RH/FP services by 2030.

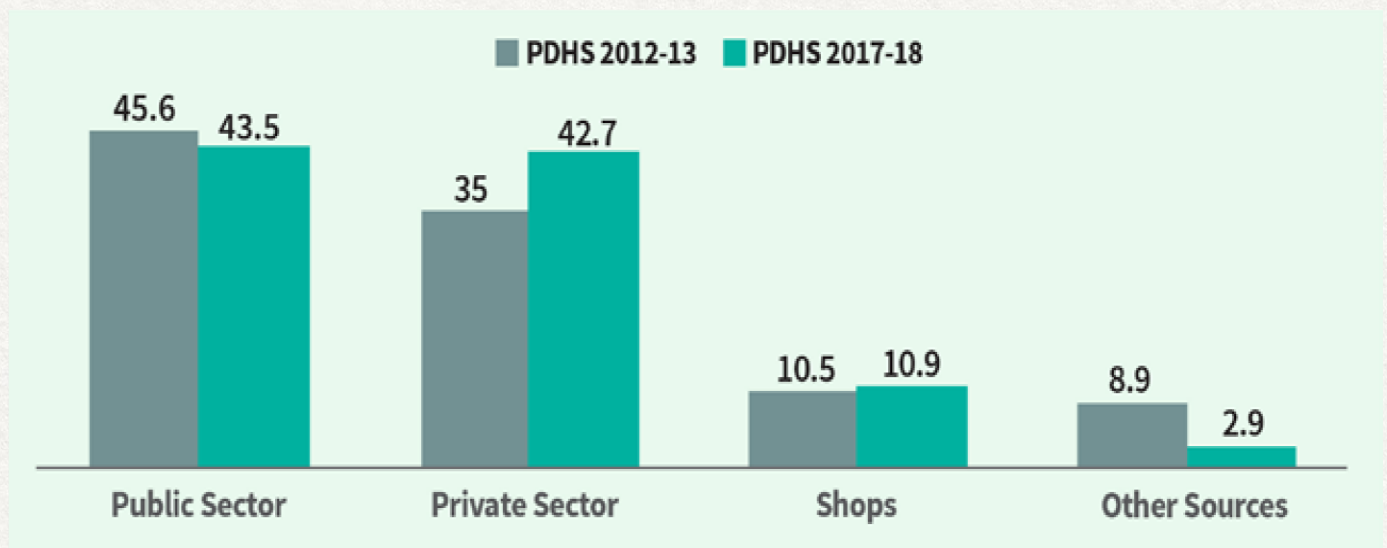
In response to a suo motu decision taken by the Supreme Court of Pakistan, the Council of Common Interests decided upon eight major initiatives to be undertaken to stabilize our population growth rate. One of these is to mandate all public and private health facilities to offer family planning services. Several demand-side and

supply-side issues underlie Pakistan's poor performance against contraceptive usage targets. The public sector lacks the capacity for universal family planning service delivery. Public sector facilities tend to be understaffed and lack sufficient resources.¹³ Service quality can be poor, due to low staff motivation, problems in training and supervision, and staff absenteeism.¹⁴

Over the years, private health facilities in Pakistan have increased their share of the healthcare market despite being more expensive. Unfortunately, many of these facilities do not offer family planning services at present.

Even so, Figure 1 below shows that in just five years, the private sector's share of modern contraceptive users has increased by almost 8 percentage points, while the share of the public sector has decreased. If this trend continues, the private sector could eventually attain a bigger share of the family planning market than the public sector.

Figure 1: Percent distribution of modern contraceptive method users (15-49 years) in Pakistan by most recent source of method, 2012-13 and 2017-18



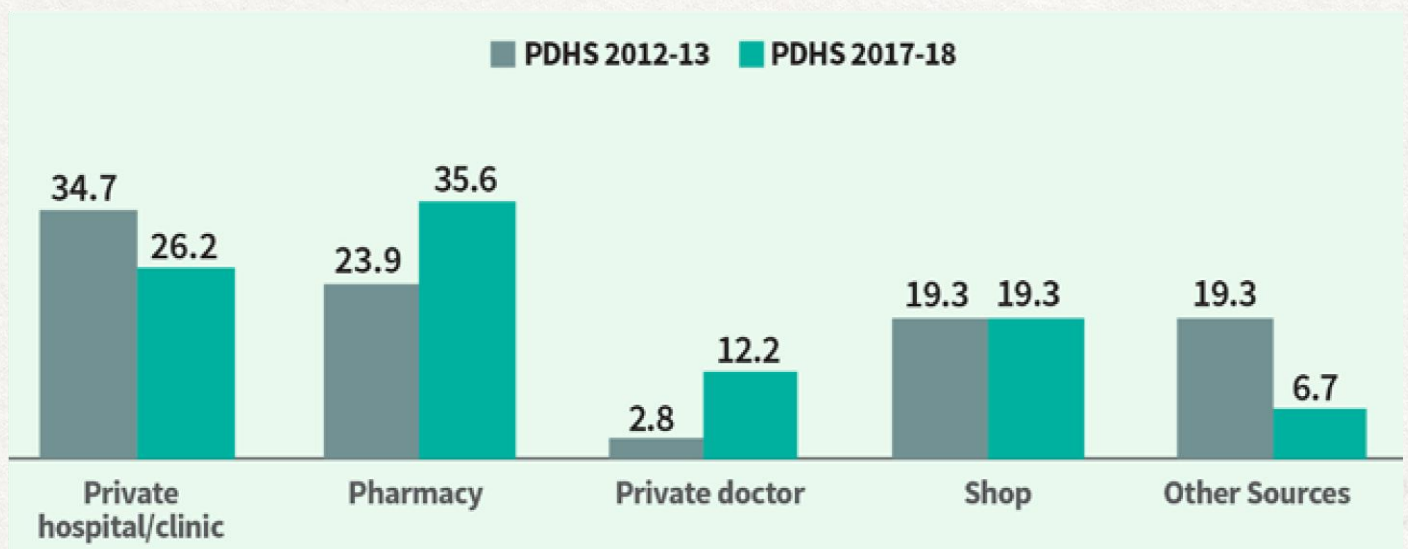
Note: Private sector sources include private service providers, pharmacies, medical stores, and shops.

Source: Pakistan Demographic and Health Survey (PDHS) 2012-13 and 2017-2018

Sources of Modern Contraceptive Methods within the Private Sector

Among the private sector FP users in Pakistan, 37.6% obtain contraceptives from a pharmacy or medical store, 27.7% from a hospital or clinic, 20.4% from shops, 12.5% from a private doctor, and 1.7% from a dispenser, or other sources (PDHS 2017-18). The share of users obtaining contraceptives from pharmacies and private doctors has increased rapidly in just five years, mainly due to the rise in the use of condoms, while the proportion of those obtaining services from private hospitals and clinics has decreased (Figure 2). This indicates that mainstreaming family physicians in the provision of FP service could play a huge role in lifting the CPR in Pakistan.

Figure 2: Percent distribution of users of private sector sources of modern contraceptive methods in Pakistan (15-49 years), by most recent source, 2012-13 and 2018-19



Source: Pakistan Demographic and Health Survey (PDHS) 2012-13 and 2017-2018

In Pakistan, patients state several reasons for preferring to avail health services from the private sector rather than the public sector, including a cleaner environment, more client-centered attitudes of private providers, and better quality of contraceptive products. Private sector facilities are more numerous and easily accessible compared to

public sector facilities, but only 41% of private sector providers in urban areas and 29% in rural areas are providing family planning services.¹⁵ While pharmacies perform better in terms of availability of family planning products, the methods they provide are limited to

condoms, oral pills, and emergency contraceptive pills only.

Private Sector Operators

The private sector can be divided into for-profit commercial and non-profit non-commercial entities, such as NGOs, social franchises, and social marketing organizations. The non-commercial private sector has been working in Pakistan for many years but has not yet succeeded in significantly expanding access to and uptake of family planning services. This sector is primarily supported by donor agencies or by government subsidies—it is not financially sustainable, and evidence suggests that it may be crowding out the commercial private sector.¹⁷

Social franchises have attracted considerable interest as a means for improving the quality and expanding the impact of private sector health care provision.¹⁸ This model provides a way to leverage the existing health infrastructure by enabling and organizing private sector providers to expand access to family planning services. Table 3 summarizes the main elements of major social marketing and franchising programs in Pakistan. A study found that social franchise facilities did increase women’s

knowledge of modern methods of contraception and their preference for long-acting methods in the country.¹⁹

However, experience of social franchising in Pakistan also yields other important lessons. In the GSM network for example, while social franchising allowed for a scale-up of service delivery, serious issues have been raised about monitoring and ability of the network to grow in the absence of a sustainable flow of commodities through donor assistance.²⁰ A recent review found that the evidence base for non-commercial and commercial private sector models to be weak, with a need for more data, and a stronger conceptual basis for linking outcomes with delivery models.²¹ Another study focused on Pakistan found insufficient evidence to suggest that the social marketing and social franchising models contributed to narrowing disparities in access to family planning; improvements in financial and geographical access were small.²² There is also a lack of evidence to suggest that these programs are effective in serving the poor population or achieving financial stability.²³

Table 3: Social franchising and social marketing programs in Pakistan

Organizations	Service and Products	Projects
Greenstar Social Marketing	Condoms, Injectables ECP, IUD, Implants	<ul style="list-style-type: none"> • Sabz Sitara clinics; 7,000 franchised providers • Provision of small clinics housed in containers • Community-based workers – Baji • Condoms through pharmacies and stores
Marie Stopes Society	Condoms, Injectables, ECP, IUD, Implant, female and male sterilization, abortions	<ul style="list-style-type: none"> • Behtar Zindagi centers (clinics) • Suraj social franchise network of LHVs • Demand-side financing through vouchers • Roshni mobile outreach vans, which also provide IUD, FP counseling, and general medicine
DKT International	Condoms, Oral Pills, ECP, Injections, IUD	Dhanak program is being implemented in rural areas using Community Midwives as key service providers. FP products and promotional material are provided to the service providers.

ECP=emergency contraceptive pills, IUD=intrauterine device, LHVs=Lady Health Visitors

Despite the limitations of the public and non-profit sectors in fully meeting demand for family planning in Pakistan, the for-profit private sector has not yet been enabled to provide these services at scale. Meanwhile, contraceptive prevalence remains chronically low, despite persistence of a high level of unmet need. A serious gap in service coverage prevails in most parts of the country, urban and rural, primarily owing to a semi-functional public health sector, sub-optimal provision in the private sector, and ineffective demand creation strategies. In this context, the for-profit sector offers a vast untapped potential for increasing access to services while achieving better targeting of subsidized resources.

In this paper, we focus on family physicians—a large segment of health service providers—as one of the best bets to expand FP use in the country, mainly because they offer the following advantages:

- **Available in very large in numbers across Pakistan**
- **Well qualified as MBBS doctors and trusted by patients**
- **Best suited to expand use of hormonal methods, the prevalence rates for which have been stagnating**
- **Male providers can motivate husbands and offer non-invasive hormonal methods**
- **Already have linkages with the pharmaceutical sector.**

Family physicians are well placed to increase uptake of contraception and their involvement is financially feasible.

However, at present, while midwife clinics and female doctor clinics play a significant role in FP services provision, male doctors are conspicuously absent.

Private sector players face several challenges in providing FP services. The most frequently cited issues point to a lack of demand among patients. Providers find that patients hold myths and misconceptions about contraception and fear of side effects is a significant

barrier. On the supply side, which is the most critical constraint to expansion of services through this sector, availability of contraceptives, effective training programs, and lack of female staff in facilities are the most significant obstacles. Service providers request public sector support in ensuring contraceptive supply and providing training. Interviews with pharmacists lead to similar findings, with demand-side issues including lack of demand for contraceptives and supply-side issues including lack of knowledge about contraceptives amongst pharmacy staff.²⁴

The Case for Provision of Family Planning Services through Family Physicians supplied by Pharmaceutical Companies

While social franchising and social marketing have a strong footprint in Pakistan, and pharmacies have served as a channel to buy condoms and pills, there has not yet been a concerted effort to enable other private sector players such as family physicians to provide family planning services in a sustainable, for-profit model. This is a significant opportunity—thus far, missed—to leverage the existing health infrastructure to scale family planning services and at the same time improve maternal and child health (MCH) outcomes in Pakistan. A combination of the strategies identified in Table 1 must be used to unlock the potential of the for-profit private channel, including collaborating, regulating, training,

and informing. Key steps would include: (a) appropriate selection of providers; (b) training and workshops to educate on the health benefits of FP and birth spacing, relative advantages and disadvantages of each method, and management of side effects; (c) bringing selective pharmaceutical companies on board to recognize family physicians as a channel for their contraceptive products and ensure regular supply of contraceptives; and (d) formulating an advocacy plan to create an enabling regulatory environment for the companies and service providers.

Perspective of Family Physicians

Given the penetration of family physicians across the country—they are prevalent in rural and urban areas and often the first point of delivery for healthcare services—there is a case to be made for leveraging them in the provision of family planning. The potential efficacy of this channel is increased by the fact that 70% of family physicians in Pakistan are male. As such they can provide counseling and detailed information about FP to male household members, fulfilling a longstanding need in the country to directly engage men in family planning. Table 4 below provides an overview of the Strengths, Weaknesses, Opportunities, and Threats (SWOT) entailed in engaging family physicians in family planning. This analysis is based largely on discussions with members of the Family Physicians Association, other prominent service providers, and representatives of pharmaceutical companies.

Table 4: SWOT Analysis of Provision of Family Planning Services by Family Physicians

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • Large number (over 100,000 estimated) • Male providers can encourage inter-spousal discussion and offer non-invasive methods such as pills, injectables, and implants • Enjoy an elevated status in their communities as trusted health providers • Already qualified as MBBS doctors 	<ul style="list-style-type: none"> • Lack adequate knowledge of FP products and services • Male family physicians do not currently recognize FP as a male domain • Have very busy practices and may not want to spend extra time to motivate clients to use FP products or services
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> • Offer large existing patient base that can be leveraged to scale FP • Can reduce discontinuation rates by providing better counseling and support to clients in appropriate method selection • Prequalified by MBBS training to offer FP and provide follow-up services • Already have linkages with pharmaceutical companies • Can create alliances with Obstetrics and Gynecological Society of Pakistan (OGSP) and other associations for credibility and training opportunities 	<ul style="list-style-type: none"> • May be crowded out by the public sector • Too much paper-based reporting could be a strong disincentive • Possible penetration of low-priced subsidized contraceptives could demotivate pharmaceutical partners • Poor selection of providers could increase risk of complications and damage reputation • Lack of demand creation activities and mass media support may discourage both physicians and pharmaceutical partners

In interviews conducted by the second listed author in Lahore, family physicians shared that they have not been approached by the government to provide FP services. Their perception was that:

1. Lack of awareness and knowledge about contraceptives is the primary reason why many physicians are not currently offering FP services.
2. The government has not shown enough commitment to FP. The public sector should raise awareness among the general population and should equip and train the physicians.
3. Although pharmaceutical companies proactively market other drugs, they do not approach physicians with contraceptives, nor do they educate them about these products. One of the respondents explained that one pharmaceutical company conducted several workshops for their brand of inhalers but has never mentioned any family planning products.

The major benefits to family physicians for providing FP services include increase in income through consultation fees and charges for procedures, as well as expansion of clientele in the form of men and women who visit them for FP services and avail other services as well.

The physicians felt that they would not be able to spend much time with each patient to proactively educate them on family planning. Those who already provide FP services only do so for patients who ask for them. They therefore suggested that they be provided marketing

materials (pamphlets and posters) to keep in their waiting rooms, and community mobilization support if possible.

Effective enabling of family physicians will therefore require, at the minimum, their training, a regular supply of long-acting contraceptives, promotional support, and preferably also subsidies for customers who cannot pay the full price.

Perspective of Pharmaceutical Companies

To unlock family physicians as a channel for provision of FP services, they will have to be effectively linked with pharmaceutical companies. Without a reliable, predictable, and affordable supply of contraceptives, regular promotional support, and updated information, family physicians will fail to deliver the required outcomes.

Currently, the availability of contraceptives marketed by pharmaceutical companies in Pakistan is limited to four major players, namely Zafa pharmaceuticals, Aspen Pharma, Bayer Pharmaceuticals, and Mass Pharma. Both Zafa and Mass Pharma manufacture combined and emergency contraceptive pills. In addition, Zafa also produces the 3-month DMPA (depot-medroxyprogesterone acetate) injectables. Bayer Pharma provides the Jadelle brand of contraceptive implants to

the provincial government of Sindh and also has other contraceptive products available in the retail markets.

The overall market size for pills is small as they constitute less than 2% of the total CPR. However, many of the oral pill brands are imported and earn a good margin on sales. In comparison, there are many more brands of condoms available through pharmacies and shops, which is understandable since condoms are the most popular contraceptive method. Other than the *Sathi* and *Touch* brands of condoms from GSM, which are donated, all other condom brands are commercially imported by local companies. There is no commercial availability of IUD or implants in Pakistan.

In interviews, representatives of pharmaceutical companies pointed to the following major barriers and constraints in supplying contraceptives to family physicians:

1. Family physicians are mostly male, and women will not come to them for FP services. (However, many believed that male physicians could insert implants and administer injectables to their female clients since there are no privacy issues with these methods.)

The Business Case

It is important to consider the financial benefits of providing FP services through family physicians along with the potential impact on contraceptive prevalence and sustainability in Pakistan. Below, we provide a broad estimate of these benefits, along with the costs likely to be entailed for the public sector.

The business case assumes that health departments at the federal or provincial level, including Health Care Commissions, will make provider-dependent methods, i.e., IUDs, implants, and injectables, available to family physicians through pharmaceutical partners, and will also finance other key aspects of support, such as training of physicians and medical representatives, market research, and demand generation activities. Since the government will sell the contraceptives, the commodity cost will be recoverable. Ultimate success will be achieved when the commercial sector is able to secure its own commodities, but this will require long-term planning and initial investment.

We also assume that the provincial DOH will play a key facilitating role through its work with a TMA Working Group, proposed in the next section.

2. Regulatory issues are a significant barrier to pharmaceutical companies in marketing and selling contraceptive products to family physicians.
3. Mass media advertisements for hormonal contraceptive products are restricted, affecting demand creation for contraceptive brands.
4. The Drug Regulatory Authority of Pakistan (DRAP) is not clear about which drugs fall in which categories.
5. It is difficult for commercial companies to compete with socially marketed pill and condom brands, which have low prices and enjoy large-scale promotional support.
6. Most contraceptive products are imported, and pharmaceutical companies face challenges in finalizing their prices, especially when there is currency fluctuation.

The representatives believed that, if the option was available, most pharmaceutical companies would be willing to purchase contraceptives from the government and preferably sell them in their own brand names. They would also welcome marketing and regulatory support.

Moreover, we propose that family physicians only be trained in providing clinical and hormonal methods. They will not offer pills, condoms or emergency contraceptive pills but only prescribe or advise them to their clients as appropriate. This will prevent cannibalization and lead to an increase in sales from private sector pharmacies and shops. It will also contribute to a more favorable image of family physicians as providers of more specialized FP services only.

The following hypothetical assumptions underlie our calculations of potential benefits of this initiative:

- The potential customer base for family physicians and pharmaceutical partners lies in the highest, fourth, and middle wealth quintiles as they are currently not availing FP services despite need, and could pay commercial prices (Table 5).

Table 5: Unmet need for family planning in Pakistan, by wealth quintile

Wealth quintile	% of CMWRA with unmet need for FP	Estimated no. of CMWRA in quintile	Estimated no. of CMWRA with unmet need
Lowest	22.5	6,800,000	1,530,000
Second	19.2	6,800,000	1,305,600
Middle	17.5	6,800,000	1,190,000
Fourth	14.5	6,800,000	986,000
Highest	13.7	6,800,000	931,600
Total	17.3	34,000,000	5.9 million

CMWRA=currentlly married women of reproductive age (15–49 years) PDHS 2017-18

- The average consultation fee of physicians is PKR 250.00.
- Average insertion or administration charges for IUD, implant, or injections, inclusive of any product margin, is PKR 500 per client.
- The number of family physicians trained and providing FP services will be 5,000 in Year 1 of the program and another 5,000 in Year 2.
- One provider will serve 10 women per month for 10 months annually (adjusting for Ramadan and other holidays), i.e., 100 women annually.

Based on the above assumptions, we arrive at the following potential impact:

- In Year 1, physicians will fulfil unmet need for family planning of 500,000 women in the middle to highest wealth quintiles (100 women/provider x 5,000 providers), or 16% of all women with unmet need from the three quintiles (5,000 women/3,107,000 women), and 8.5% of all women with unmet need (500,000/5,900,000).
- In Year 1, each physician will earn PKR 25,000 from FP consultation fees alone (100 women x PKR 250 per visit).
- In Year 1, each physician could potentially earn PKR 50,000 per year from administration of IUDs, implants, or injections (100 women x PKR 500).
- In Year 2, we assume that 5000 more providers join the initiative thereby further increasing excess to services and reducing unmet need

Notably, the above projections of benefits would vary considerably with any changes in the underlying assumptions, such as the number of family physicians that can be trained, number of women with unmet need that can be served by a physician in a given time period, change in demand, etc.

Based on current training and awareness building costs of the Population Welfare Departments (PWD) in all provinces, and adding 5% of the total cost of the PWDs as oversight cost, it is estimated that the total annual cost to the public sector for supporting this initiative will be PKR 876,943,834. Of this 5% will be expended on training, 77% on creation and implementation of the oversight mechanism, and 18% on demand creation programs. These costs are only rough estimations and a more realistic costing exercise must be taken if this initiative moves forward.

Experience in many developing countries shows that for-profit private sector physicians are not only motivated by financial return but also want to be recognized for their contribution to a bigger cause. They constantly seek avenues to gain knowledge and new skills through regular training and other learning opportunities. Therefore, non-financial motivational aspects must also be built into the proposed plan.

Recommendation

We propose that a Total Market Approach Working Group (TMAWG) be set up to initiate the process of inducting private sector family physicians, supported by selected pharmaceutical concerns, in family planning service provision. The Group could be led by the MNHSRC at the federal level or the Department of Health at the provincial level, and include representatives of the Family Physicians Association, pharmaceutical partners as necessary.

The TMAWG would be responsible for steering the initiative and its core functions could include, among others, selection and training of participating private physicians and pharmaceutical concerns; facilitation of health authorities in contraceptive procurement; facilitation of appropriate contraceptive pricing policies; coordination of partners' marketing plans; commissioning of demand creation and necessary research activities; and progress monitoring.

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