



THE AGA KHAN UNIVERSITY

eCommons@AKU

Community Health Sciences

Department of Community Health Sciences

4-1-2013

Social franchising and vouchers to promote long-term methods of family planning in rural Pakistan: A qualitative stocktaking with stakeholders

Syed Khurram Azmat

Ghulam Mustafa


Waqas Hameed

Jamshaid Asghar

Aftab Ahmed

See next page for additional authors

Follow this and additional works at: https://ecommons.aku.edu/pakistan_fhs_mc_chs_chs

 Part of the [Maternal and Child Health Commons](#), [Obstetrics and Gynecology Commons](#), and the [Women's Health Commons](#)

Authors

Syed Khurram Azmat, Ghulam Mustafa, Waqas Hameed, Jamshaid Asghar, Aftab Ahmed, and Babar T. Shaikh

Social Franchising and Vouchers to Promote Long-Term Methods of Family Planning in Rural Pakistan: A Qualitative Stocktaking with Stakeholders

Syed Khurram Azmat, MBBS, MPH,¹ Ghulam Mustafa, MSc,¹ Waqas Hameed, MSc,¹ Jamshaid Asghar, MSc,¹ Aftab Ahmed, MA,¹ Babar T. Shaikh, MBBS, MBA, MPH, PhD, FRCP²

Abstract

Background: The overall use of modern contraception in Pakistan is quite low, especially in rural areas. Several studies have demonstrated the effectiveness of social franchising (SF) approaches in increasing access to modern contraception and improving the quality of healthcare in resource-poor areas in Asia and Africa. Drawing on best practices in SF, the Marie Stopes Society (MSS) implemented an SF model in certain rural areas of Pakistan to increase access to affordable and quality family planning (FP) services. The model was branded as Suraj (sun) and complemented with an innovative voucher scheme for intrauterine contraceptive devices (IUCDs). This paper describes the perspectives of Suraj clients, field workers mobilization (FWMs), and providers on various components of the Suraj model.

Methodology: A qualitative exploratory study was conducted in six randomly selected intervention districts in the Sindh and Punjab provinces. Data were collected using focus group discussions (FGDs) with clients and in-depth interviews (IDIs) with providers and FWMs. Data were manually analyzed using constant comparison and the thematic analysis approach.

Findings: Clients showed positive attitudes towards modern contraceptive methods and identified Suraj FWMs and signboards as sources of information. Almost all clients reported IUCDs as effective methods as they have manageable side effects and require fewer visits to clinics. They spoke highly of voucher schemes as these enabled them to avail free IUCD services. Clients also appreciated many components of Suraj clinics, including cleanliness, privacy, confidentiality, the sterilization of instruments, and courteous Suraj providers and FWMs. Most Suraj providers said that IUCD insertion and infection-prevention training enhanced their ability to provide IUCD services and increased their standing in

local communities. They reported that the role of FWMs was crucial in mobilizing the community and increasing their FP clientele. The FWMs said that attitudes towards FP were changing because of economic pressure at the household level, increases in literacy, and community mobilization efforts.

Conclusion: The Suraj intervention influenced attitudes towards FP and modern contraception, positively. Women using IUCDs showed greater satisfaction with the method. The findings emphasize that SF approaches like Suraj, when complemented with vouchers and community mobilization efforts, can improve the utilization of long-term contraceptive methods among rural and underserved women. The study also identified the need for integrating FP, antenatal care, and safe delivery services.

Keywords: Social franchise, Vouchers, IUCDs, Fieldworkers, Family planning, Key-informant interviews, Rural, Pakistan.

Introduction and Background

Pakistan's population is estimated to reach 180 million in 2012 with 65% living in rural areas.¹ Pakistan's population growth of 2.2% per annum is higher than many of its south Asian and eastern Mediterranean neighbours.² An estimated 61% of the total population lives below the income poverty line of USD 2 per day.³ In 2010, 12,000 maternal deaths occurred in the country and this number was the highest in south Asia after India. Pakistan was one of the six countries together with Afghanistan, where more than 60% of global maternal deaths occurred.⁴ Millions of married Pakistani couples lack access to voluntary family planning (FP) and reproductive health services⁵ despite the fact that 70% of the population has access to primary healthcare services within one hour's travel time.⁶ However, quality and management issues impede appropriate utilization of government services.

Married women in Pakistan experience at least one unwanted pregnancy in their lifetimes and the contraceptive prevalence rate (CPR) for all methods is

.....
¹Marie Stopes Society Pakistan, Pakistan, ²Health Services Academy, Islamabad.

Correspondence: Syed Khurram Azmat. Email: khurram.azmat@mariestopespk.org

low at 27%. It is 19% for modern methods which falls to 17% in rural areas.^{1,7} The unmet need for FP in Pakistan is 25% among currently married woman and is the highest among the poor with no education, in rural areas.⁷ The use of long-term methods including intrauterine contraceptive devices (IUCDs) is negligible at around two percent for married women.⁷

The share of private expenditure on health was estimated at 85% in 2010.⁸ There is a concentration of qualified doctors and trained nursing/paramedic staff in large cities, but untrained and unskilled indigenous workers provide the bulk of such services in smaller towns. Female practitioners such as village dais (traditional birth attendants), midwives, and nurse practitioners are the providers of choice for women with reproductive health needs.⁹ Although there is an urgent need for more trained-health personnel in underserved areas, programme efforts geared towards improving access to reproductive health services cannot exclude existing networks of providers that possess deep roots in communities.¹⁰

Family planning does not require any complex technology, which makes it the most cost-effective and practical strategy to reduce maternal deaths, especially in rural areas with poor health infrastructure.¹¹ It is estimated that 30% of maternal deaths can be avoided if women who wished for contraception, had access to it.¹² Family planning also has the potential to reduce poverty and hunger and avert a significant number of child deaths.¹³ Moreover, it is recognized that private providers are more readily accessible and available than the public sector providers. However, most of them do not provide FP, or provide only a limited range of methods, the quality of which is generally low.¹⁴ The World Health Organization (WHO) has repeatedly emphasized partnerships with private practitioners to fill service delivery gaps.¹⁵ Furthermore, the franchising of sexual and reproductive health services has recorded successes in FP programmes in Asia and Africa and provides a possible solution to meeting the public's growing demand for healthcare.¹⁶ In addition, social franchising (SF) models have made contributions to increased CPR and reduced costs per couple-year of protection (CYP).¹⁷ Recent research from Pakistan has also demonstrated that franchised private clinics have increased access to higher quality services compared to non-franchised clinics, due to their emphasis on rigorous training and monitoring.¹⁸

Following the success of SF approaches in meeting demands for contraception and healthcare in resource-

poor developing countries, the Marie Stopes Society (MSS) implemented an SF model called Suraj (sun) with an innovative voucher scheme for IUCD services, in Pakistan. The initiative was a partnership between MSS and mid-level private providers to enhance access to quality FP services in the rural areas of 18 districts of the Sindh and Punjab provinces of Pakistan — 12 in Southern and Northern Punjab, and six in Sindh. Overall, MSS developed a network of 100 local private providers and 100 fieldworker's mobilization (FWMs) in the project districts between 2008 and 2009. The number of providers in each district ranged from four to seven, and each provider had an average catchment population of 20,000. The providers were trained and accredited to provide condoms, emergency contraceptive pills, injections, and oral contraceptives, and to insert and remove IUCDs. Fieldworkers were trained to mobilize the community through door-to-door visits, provide counselling and referrals, and provide free vouchers for IUCDs to underserved women. The vouchers were redeemable for free IUCD insertion, a follow-up visit, and removal services, and were given to women who qualified on a set of poverty-ranking eligibility criteria. Of the all IUCDs provided by the Suraj providers, 75% of the clients were referred by the FWMs and amongst those, 30% were delivered through the free vouchers distributed by the FWMs.¹⁹

This paper presents the perspectives of Suraj clients, providers, and fieldworkers on important components of the Suraj model. These include improving access to, and quality of FP services among underserved women in Pakistan through the use of the IUCD voucher scheme, and the challenges faced enroute in establishing this model.

Methods

A descriptive qualitative study of exploratory design was conducted during 2010 to comprehensively document Suraj providers', clients', and FWMs' perspectives regarding the success and effectiveness of the SF model, Suraj in delivering quality FP services to underserved populations. The study specifically focused on motivation, perceptions, and attitudes towards IUCD vouchers, supervision and monitoring, services offered, voucher benefits and challenges, accreditation and training, referral systems, and other healthcare needs. The study also provided participants an opportunity to share their ideas and suggestions for programme improvement and sustainability.

The study utilized focus group discussions (FGDs) and in-depth interviews (IDIs) to collect data. Overall, 51 IDIs

Table-1: Project districts in Sindh and Punjab, Pakistan.

Punjab	Toba Tek Singh, Jhang, Lodhran, Okara, Vehari, Bahawalnagar, Kasur, Sheikhpura, Gujarat, Hafizabad, Sialkot, Khushab
Sindh	Jamshoro, Badin, Thatta, Hala/Matiari, Umerkot, Tando Muhammad Khan

Table-2: Distribution of sample by district, Punjab and Sindh, Pakistan.

District	No. of IDIs with providers	No. of IDIs with FWMs	No. of FGDs with FWMs	No. of IDIs with voucher-and-referral clients	No. of FGDs with voucher-and-referral clients
Punjab					
Jhang	3	4	1	6	2
Hafizabad	0	0	0	6	2
Gujarat	0	0	0	6	2
Vehari	0	0	0	6	2
Sindh					
Badin	4	4	1	7	2
Matiari	0	0	0	5	2
Total	7	8	2	36	12

and 14 FGDs were conducted with female Suraj providers, FWMs, and Suraj voucher-and-referral clients. These FGDs and IDIs were conducted by an independent research consultant trained in qualitative and social research techniques, using predetermined guidelines.

Fifty-one IDIs were conducted with Suraj providers, FWMs, and Suraj voucher-and-referral clients to obtain their perspectives on the effectiveness of the Suraj model. The IDIs comprised open-ended and semi-structured questions and took 1-1.5 hours to implement. The IDIs with Suraj providers and FWMs were aimed at determining the perceived value of external support such as vouchers, accreditation, training, communication and marketing, the role of FWMs, and ongoing monitoring. In addition, the study documented community attitudes and barriers towards FP and modern contraception, and their perceptions on different components of the model.

Similarly, 14 FGDs were conducted with FWMs and Suraj voucher-and-referral clients. The FGD guide comprised open-ended questions and each lasted one to two hours. The FGDs endeavoured to comprehensively document respondents' perceptions, motivations, and attitudes towards FP and their perspectives concerning different components of Suraj services so as to improve the quality and efficient delivery of Suraj FP services, and to make the Suraj model more client-centred. Moreover, the study captured Suraj clients' perceptions on the quality of care and actual and perceived barriers towards FP and modern contraception.

Study area

The study was carried out in six randomly selected

intervention districts out of the 18 project districts of Sindh and Punjab.

Sampling

The study was conducted with purposively-selected Suraj providers, FWMs, and voucher-and-referral clients, which included married women of reproductive age (MWRA) aged 15-49 years, who had received services from a Suraj provider.

Data collection

Focus-group discussion and IDI guides were developed and pre-tested to accommodate professional and cultural validation. Both guides were designed and developed by the research team. The interview guide was constructed based on literature review, and expert opinions were utilized to facilitate interviews.

The interviews were conducted in participants' native language and the data were collected by qualified researchers who were fluent in local languages and had experience in data collection. They were provided additional training on FP and reproductive health concepts, and qualitative methods of data collection.

Data analysis

The data were analysed using principles of grounded theory and constant comparison analysis as described by Strauss and Corbin.²⁰ The strength of grounded theory lies in its ability to pick up on themes emerging from the data and not being restricted by researcher bias. Audio data captured from interviews was transcribed verbatim and the transcripts were used for data analysis which were translated by a researcher fluent both in Urdu and

English. The thematic analysis approach was used. Researchers went through several transcripts in the initial phase to organise the data utilising the manual analysis technique. This generated nodes that consisted of themes emerging from the data. Nodes were formed based on a general consensus among researchers. These nodes were later categorised and triangulated to form a framework for the subsequent coding of other transcripts, using thematic analysis. These codes were refined and combined across transcripts to develop more general codes for further analysis. Subsequently, these categories were organised and merged into broader themes which corresponded with study objectives.

Ethical considerations

Study participants were informed about the purpose of the study and their right to refuse to answer questions/withdraw from the study, was assured. They were also assured of the confidentiality of their responses. The FGDs and IDIs were recorded with the participants' consent, and informed written and verbal consent were secured prior to the interviews. In addition, anonymity was assured to all respondents.

Findings

FMWs' perspective: Barriers to FP

The majority of FWMs said that people in their communities lacked awareness of FP and harboured negative attitudes towards it. Most of them believed that the religious interpretations and negative attitudes of husbands and mothers-in-law, were the main obstacles to FP. Mostly, people were opposed to FP on religious grounds, according to FWMs. One FWM from Sindh remarked, "People in my community say that FP is wrong and Allah will be angry with us as it is a big sin." However, the majority of FWMs were of the opinion that attitudes towards FP were gradually changing.

FMWs' perspective: Perceptions regarding voucher schemes

The majority of FWMs considered voucher schemes the best aspect of the Suraj model and said clients felt the same. They said voucher schemes helped them during community mobilization efforts. An FWM from Sindh stated: "The best thing about Suraj is its voucher system which has helped us mobilize women in the communities to adopt long-term methods of FP." Similarly, an FWM from Punjab stated: "The Suraj model's best aspect is the voucher because people are very poor here. It is because of vouchers that they can get free services." In addition, most FWMs from Sindh and Punjab believed that the catchment area for voucher disbursement should be increased and additional mother-

and-child health services should be included in the voucher system. They said that this will enhance the scope of services and improve people's health."

FMWs' perspective: Tackling myths and rumours

According to FWMs, IUCDs were the most preferred method for women in their respective Suraj areas. They said women preferred them because they were provided through vouchers, were a long-term method, and did not cost anything. On the whole, the majority of FWMs said they had not had problems promoting IUCDs except in select instances where a rumour surfaced that IUCDs move around in the body, eventually causing death. They said community mobilization — door-to-door visits, voucher scheme, quality of services — had helped change people's behaviours and overcome myths and rumours. A participant from Punjab stated: "It would be difficult to enhance FP services without mobilizing the community and we might not be able to run the programme efficiently without the voucher scheme. The voucher plays an important part in this service provision model." The FWMs from Sindh appeared more confident, believing that phasing out the voucher programme would not affect their ability to promote FP services. One stated: "We can promote the services without the voucher, but it depends on counselling skills. Our counselling has to be very strong."

Overall, the FWMs were of the opinion that the Suraj initiative had increased awareness and use of FP services, provided choices to women in need of contraception, and should continue. An FWM from Punjab said "There is a positive change in attitudes in the community towards FP; it was initially difficult to convince people, but FP acceptance has grown." Another FWM from Sindh stated: "There has been a change in attitudes and perceptions about FP and it is due to our consistent visits and our ability to establish a rapport with the local community."

Private providers' perspective: Perceptions regarding FP

More than 80 percent of the Suraj providers were certified lady health visitors (LHVs) owning a personal clinic run on a 24/7 basis. Generally, all providers emphasized the importance of FP for birth spacing, maternal health, and reducing poverty. They described it as: "planning to keep a proper space between children and to improve maternal and child health and reduce poverty."

Private providers' perspective: Barriers towards FP services

Many providers perceived that the people in their

community lacked FP awareness, had an unreceptive attitude towards it, and considered it 'interference in God's work.' They said many people in their communities wanted to use FP services but were reluctant to do so in the face of social and religious barriers. A provider from Punjab said: "The elders, mostly women, oppose FP. Some also think it is a sin against God's will and that it is God who decides where and when children should be born. There are some women who want these services but are unable to use them because of opposition from husbands and mothers-in-law."

Some providers also said that women facing such opposition often sought FP services in secrecy. A provider in Punjab stated: "There are some women who have difficulty dealing with husbands and mothers-in-law. They come to us without informing their families. Mostly, they get injections from us. Pills are too risky and can be discovered at home. Similarly, multi-load can be felt by the husband. These women know their injection dates and may be a few days late, sometimes, but they make it." Regarding women's perceptions on IUCDs, providers said most women consider them effective protection for five years against pregnancy except a few who believe that it caused serious complications. A provider from Sindh said: "Some clients are scared because they have heard rumours that once inserted, IUCDs cannot be removed without surgery."

Private providers' perspective: The voucher scheme

Almost every single provider in Sindh and Punjab reported that the voucher scheme was beneficial for both community and providers. They said it helped FWMs increase their FP clientele during their community mobilization activities and helped establish a rapport with clients. A Suraj provider in Sindh said: "Vouchers are good for the fieldworker who brings clients to our clinic. If there was no free service, then the clients would not come to us in such huge numbers." However, some providers disagreed. One from Punjab said: "People come to us because of our reputation, not because of the free vouchers."

Private providers' perspective: Role of FWMs

Providers in both Sindh and Punjab were of the opinion that their client base had increased after their partnership with MSS. The role of FWMs was also considered important for this. A health provider in Sindh said: "We are receiving more FP clients-sometimes 15 to 20 a week-after the partnership with Suraj and fieldworkers' door-

to-door visits." A provider from Punjab said: "After we became part of the Suraj network, people previously unaware of our work are now well-informed about our FP services. We are now taking our services to their doorsteps through fieldworkers."

Generally, health providers had a very positive opinion of the role of FWMs in the Suraj model. A provider in Punjab said: "Fieldworkers will still be required because there are some women who require constant reminders and follow-ups."

Private providers' perspective: Suraj model of care — next steps

The SF providers said that training on IUCD insertion, prevention of infections, and equipment sterilization had greatly benefited them and helped provide FP services in a better way. A health provider in Punjab narrated: "The training has definitely helped us in providing quality FP services. It has also improved our reputation in the community." Similarly, a health provider in Sindh said: "The training has benefited us a lot and increased our confidence. Previously, we lacked confidence and did not know the importance of infection prevention." Some health providers said that such trainings should be more regular with more practice sessions, and suggested that communication skills be included in the training. Providers in both Sindh and Punjab appreciated the project's regular monitoring system and wanted it to continue to ensure the efficacy of the programme.

Providers in both Sindh and Punjab were of the opinion that FWMs and the voucher scheme were the most important and effective components of the Suraj model. An SF provider in Sindh said: "I think the voucher scheme is the most important aspect of the Suraj model as it allows poor people to avail long-term FP methods, free of charge. We are able to cater to the needs of this deprived section of society because of the voucher system." Many providers also emphasized that the FWMs were not adequately paid and suggested their salaries be increased to keep their motivation and morale high. As a health provider in Sindh said: "We can make this system better by raising their salaries to those of fieldworkers at other NGOs."

The majority of providers in Sindh and Punjab suggested that the Suraj model integrate maternal and child health services with FP services. A health provider in Punjab said: "In my opinion, the Suraj model should also have antenatal care and delivery services to cater to the health needs of larger segments of the population."

Clients' perspective: Awareness and sources of information for FP

Overall, clients knew about the Suraj clinics' FP services and methods and considered FP essential for birth spacing and for the health of mother and child. Notably, almost all clients identified Suraj FWMs as the most common source of information, followed by the electronic media and senior community women. A participant from Sindh said, "We have learnt everything about FP methods from the fieldworkers, including condoms, injections, and IUCDs." In addition, most clients stated that the fieldworkers in their respective areas were highly cooperative, responsive, and courteous. It was also evident from the fact that participants always referred to fieldworkers by the title of *baji* (older sister). A participant from Gujarat said: "Baji really cares for me regarding my FP needs. She provided me all the information about its benefits and usage."

Many clients also reported Suraj signboards as a source of information. They pointed out that the signboards were symbolically important, allowing people to follow and locate Suraj clinics, even to people unable to read. A participant from Punjab said: "We have seen the Suraj signboards and can recognize them, easily." Another participant from Punjab said: "We have seen the Suraj signboards and can recognize them easily. There is a large image of the sun on them." Likewise, a participant from Sindh said: "We are not educated and cannot read the signboards. However, we have come to relate with them, gradually."

Clients' perspective: Barriers and change in attitudes towards FP

Most of the participants were of the opinion that the overall attitude of the community towards FP was positive and people were realizing the benefits of a smaller family unit. Unlike in the past, they did not face any major mobility obstacles. The participants said that community perceptions towards FP were determined by socio-economic, educational, and religious backgrounds. A participant from Punjab said: "Everybody has a perception about FP based on their educational background, religious orientation, and economic status. However, I believe that FP should be practiced. I consider it good for the family." A participant from Sindh said: "There are religious persons who believe that God is responsible for providing us children and we should not worry about this. These mullahs (religious clerics) are difficult to convince."

Interestingly, most of the clients in Sindh and Punjab

were encouraged by their husbands and in-laws to use FP services. A participant from Sindh reported: "My husband and in-laws are in favour of FP and do not stop me from practicing it." A participant from Punjab said: "My husband always encourages me to use birth spacing methods and says that it is vital for my health and my children's."

However, some clients did report facing barriers to mobility and claimed that they could not move around easily without the consent of their husbands and in-laws. A participant from Punjab said: "There are some women who are unable to get FP services even when they are willing and desperately need the services. They are not allowed to go out of their homes." In addition, some clients reported affordability and the fear of side effects as huge barriers towards FP and modern contraception. They said they had heard many rumours regarding IUCDs, including cancer and the need for uterus removal. However, they also said that counselling by Suraj providers and FWMs had helped overcome such rumours and misconceptions. A participant from Sindh said: "I heard about certain side effects and complications related to IUCDs. But Suraj providers and the fieldworkers discussed and allayed my fears: I opted for the method." Many clients reported economic barriers but also said the voucher scheme and free services at the Suraj clinics helped. A participant from Punjab said: "Money is a huge barrier to FP, especially for poor women. But these free services have helped a lot."

Clients' perspective: Experiences regarding quality of care at Suraj clinics

The majority of clients associated FP service quality with accessibility, affordability, fewer clinical visits, and the absence of side effects and complications. A participant from Punjab stated: "The Suraj centre is providing high quality services, something which is generally found at expensive private hospitals." Similarly, a participant from Sindh said: "We would have to spend lot of money elsewhere, but services are free-of-cost, here."

Most participants were using voucher-IUCDs and identified effectiveness, reliability, long-term use, fewer clinic visits, fewer complications, and higher levels of satisfaction, as reasons for doing so. A participant from Punjab said: "IUCDs are the best method as they prevent pregnancy for longer periods of time and have no complications." In addition, many clients that previously used condoms, pills, and/or injections, had switched to IUCDs. A participant from Sindh said: "IUCDs are more practical; injections are painful and pills cause weight-

gain." Likewise, another participant from Sindh said: "We prefer IUCDs over pills because it is easy to forget to take the pills."

Clients' perspective: The role of fieldworkers in increasing knowledge of FP services

Clients almost unanimously emphasized the role of FWMs as crucial in promoting FP services in their areas, now and in the future. They said fieldworkers' active persuasion, motivation, persistence, and caring attitude influenced and changed their [clients'] attitudes towards FP and modern contraception. A participant from Punjab stated: "We like her attitude; she is good, talks to us very nicely, and gives us suggestions." A participant from Sindh said: "Her persistence is admirable; despite being refused three times, she came again and finally convinced us." Likewise, another from Sindh said: "We like the way she counsels us; she speaks softly and convincingly, and persuaded us to visit the Suraj clinic."

Clients' perspective: The voucher scheme

The majority of participants reported that the voucher scheme was one of the best aspects of Suraj and considered it very important for promoting FP services among poor women in rural areas. A woman from Punjab said: "We used the vouchers and benefited from them, and think the scheme is a good one. It provides the poor an opportunity to avail high-quality FP services." Similarly, another participant from Punjab said: "We are practicing birth spacing thanks to the voucher scheme. We would otherwise have ended up with 12 children to look after." Participants felt that withdrawing the voucher system would ultimately affect contraceptive uptake, particularly the use of IUCDs. A participant from Punjab said: "Without the voucher scheme, I cannot afford IUCD services. I was practicing traditional FP methods before I switched to IUCDs." Similarly, another participant from Punjab said: "My family consented to my use of FP because the service was free." However, a few other clients maintained that IUCDs were effective enough to keep using even if they had to pay for them.

Clients' perspective: Suraj model of care — next steps

It is noteworthy that almost all clients from Sindh and Punjab suggested that Suraj clinics provide antenatal care and delivery services alongside FP services. A participant from Punjab said: "I feel that Suraj clinic is the best place for FP services, and I would request you to also build a set-up for women's other health-related issues."

Some participants also suggested that sterilization services should be provided. Still others suggested transport facilities for women from far-flung rural areas who cannot afford transport fares. In addition, almost all Suraj clients suggested the number of Suraj clinics, fieldworkers, and the range of services be increased so as to reach out to the maximum number of women.

Conclusion

This study presents multiple perspectives and an in-depth analysis of a new SF model, Suraj, implemented to meet the long-term contraceptive needs of women in underserved rural areas in Pakistan. As a multidimensional study, it provides some important insights that may prompt new research and reproductive health interventions.

The Suraj intervention had a significant effect on several determinants of contraceptive behaviour, including contraceptive knowledge and FP approval. The intervention increased the proportion of MWRA reporting the use of modern contraceptives and increased the use of IUCDs for birth spacing. Effective counselling by FWMs, improved service quality by trained Suraj providers, and fewer post-IUCD insertion complications reported by clients seem to have enhanced the acceptance and uptake of IUCDs. The voucher scheme was highly appreciated by clients, fieldworkers, and providers. In addition, service quality, awareness-raising efforts, the increasing cost of rearing children, and increasing levels of education were also cited as reasons for the positive change in attitudes towards FP. Overall, participants emphasized the need to integrate antenatal care and delivery services with FP services at Suraj clinics.

Our findings suggest that SF models such as Suraj can effectively improve the acceptance and utilization of long-term and short-term contraceptive methods among poor and underserved women in rural areas. This is especially true when such models are complemented with vouchers, community mobilization, and quality service provision close to people's homes, by trained local providers.

Acknowledgements

The Marie Stopes Society (MSS) implemented this project and led the process. MSS's research, monitoring, and evaluation (RME) department analyzed the data. All authors are fulltime employees at MSS.

Conflict of interest

There are no conflicts of interest.

Reference

1. World Population Data Sheet 2012. Washington DC: Population Reference Bureau; 2012.
2. Sathar Z, Zaidi B. Fertility prospects in Pakistan. New York (NY): United Nations, Department of Economic and Social Affairs, Population Division; 2011.
3. World Development Indicators 2011. Washington (DC): World Bank; 2011.
4. World Bank, WHO, UNICEF, UNFPA. Trends in maternal mortality: 1990 to 2010. Geneva: World Health Organization; 2012.
5. Hardee K, eahy E. Population, fertility, and family planning in Pakistan: A programme in stagnation. Washington (DC): Population Action International; 2008.
6. World Health Organization. Health system profile: Pakistan. ; 2007. Cairo: Regional Health Systems Observatory-EMR; 2007.
7. Pakistan Demographic and Health Survey (PDHS) 2006-7. Islamabad, Pakistan: National Institute of Population Studies (NIPS); Macro International Ltd.; 2008.
8. WHO. Country statistics Pakistan. The World Health Organization Global Health Observatory Data Repository. 2012.
9. Shaikh BT, Hatcher J. Health seeking behaviour and health service utilization in Pakistan: challenging the policy makers. *J Public Health (Oxford)* 2005;27(1):49-54.
10. Hafeez A, Bile MB, Sheikh MR, Shah SA, Jooma R. Lady health workers programme in Pakistan: challenges, achievements and the way forward. *J Pak Med Assoc* 2011;61(3):210-5.
11. Goldie SJ, Sweet S, Carvalho N, Natchu UCM, Hu D. Alternative strategies to reduce maternal mortality in India: a cost-effectiveness analysis. *PLoS Med* 2010;7(4).
12. Cleland J, Conde-Agudelo A, Peterson H, Ross J, Tsui A. Contraception and health. *Lancet* 2012;380(9837):149-56.
13. Cleland J, Bernstein S, Ezeh A, Faundes A, Glasier A, Innis J. Family planning: the unfinished agenda. *Lancet* 2006;368(9549):1810-27.
14. Mills A, Brugha R, Hanson K, McPake B. What can be done about the private health sector in low-income countries? *Bull World Health Organ* 2002;80(4):325-30.
15. Public policy and franchising reproductive health: Current evidence and future directions. Geneva: Department of Reproductive Health and Research, World Health Organization, 2007.
16. Prata N, Montagu D, Jefferys E. Private sector, human resources and health franchising in Africa. *Bull World Health Organ* 2005;83:274-9.
17. Frost N. Social franchising of sexual and reproductive health services in Honduras and Nicaragua. London: Marie Stopes International; 2006.
18. Shah NM, Wang W, Bishai DM. Comparing private sector family planning services to government and NGO services in Ethiopia and Pakistan: how do social franchises compare across quality, equity and cost? *Health Policy Plan* 2011;26(1):63-71.
19. Azmat SK, Shaikh BT, Hameed W, Bilgrami M, Mustafa G, Ali M, et al. Rates of IUCD discontinuation and its associated factors among the clients of a social franchising network in Pakistan. *BMC Women's Health* 2012;12(8).
20. Strauss AL, Corbin JM. Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, California: Sage Publications; 1990.