ORIGINAL RESEARCH ARTICLE

Reproductive Health & Community Medicine

Developing and Evaluating an Expert-Benchmarked Educational Framework for Community Health Workers to Guide Women on Contraceptive Use and Family Planning: Insights from the Sukh Initiative, Karachi, Pakistan

Ayesha Anjum Khan

Pharm-D | Registered Pharmacist | Healthcare Researcher

Former Health Advisor Officer, The Aman Foundation (Sukh Initiative) | Karachi, Pakistan

Correspondence: dr.ayeshaanjumkhan@gmail.com

ABSTRACT

Background: Community Health Workers (CHWs) serve as pivotal bridges between underserved communities and formal healthcare systems. In peri-urban Karachi, persistent gaps in reproductive health knowledge, compounded by socioeconomic constraints and linguistic diversity, underscore the urgent need for a structured, evidence-based educational framework to empower CHWs in guiding women on contraceptive use and family planning.

Objective: This article describes the development and evaluation of an expert-benchmarked educational framework for CHWs, drawing on programmatic experience from the Sukh Initiative—a major community-based family planning program in Karachi funded by the Aman Foundation, the Bill & Melinda Gates Foundation, and the David & Lucile Packard Foundation.

Methods: Drawing on first-hand telehealth experience as a Health Advisor Officer within the Sukh Initiative at The Aman Foundation, combined with sociodemographic programme data from four target locations (Bin Qasim, Korangi, Landhi, and Malir), this paper presents the rationale, components, and evaluation approach of the CHW educational framework.

Results: Programme data demonstrated significant adoption of modern contraceptive methods, including notable increases in IUCD uptake among Married Women of Reproductive Age (MWRA). The framework incorporated culturally adapted, multilingual educational tools aligned to community-specific literacy and linguistic profiles.

Conclusion: A structured, expert-benchmarked educational framework for CHWs, tailored to the sociodemographic realities of peri-urban communities, can substantially improve contraceptive uptake and reduce unplanned pregnancies, contributing to FP2020 goals.

Keywords: *Community Health Workers, Family Planning, Contraception, IUCD, Educational Framework, Sukh Initiative, Karachi, FP2020, Reproductive Health, CHW Training*

1. Introduction

Pakistan remains one of the countries with among the highest unmet need for family planning globally, with an estimated 17–19% of married women wishing to delay or limit childbearing yet lacking access to modern contraceptives. In Pakistan's urban peripheries, this gap is further exacerbated by poverty, limited education, socio-cultural barriers, and healthcare systems stretched beyond capacity.

The Sukh Initiative was conceptualised as a community-driven response to this challenge. Funded jointly by the Aman Foundation, the Bill & Melinda Gates Foundation, and the David & Lucile Packard Foundation, Sukh was designed around a core vision: empowering women to access contraception by increasing knowledge, improving quality of services, and expanding the basket of contraceptive choices—directly contributing to the global goals of FP2020.

Community Health Workers (CHWs) occupied a central position in this vision. Operating through TeleHealth services, door-to-door outreach, Community Health Worker models, and Lady Health Worker models, CHWs served as the primary interface between women in peri-urban Karachi and the wider reproductive healthcare system. Their effectiveness, however, was contingent on the quality of their training—and it is this critical dimension that forms the focus of this article.

As a Health Advisor Officer within The Aman Foundation's Sukh Initiative, I had direct experience providing telehealth counselling, medication guidance, and reproductive health support to women across four high-need locations: Bin Qasim, Korangi, Landhi, and Malir. This article draws upon that programmatic experience alongside the sociodemographic and outcome data generated by the initiative, to describe and evaluate an expert-benchmarked educational framework developed to enhance CHW capacity for family planning guidance.

2. The Sukh Initiative: Programme Context and Theory of Change

2.1 Programme Vision and Goals

The Sukh Initiative was a large-scale community-based family planning programme implemented in peri-urban Karachi. Its overarching vision was grounded in a Theory of Change structured across four hierarchical levels: Interventions, Strategies, Outcomes, and Impact.

At the impact level, Sukh targeted a 15% increase in the use of modern contraceptive methods and a measurable decrease in unplanned and unintended pregnancies. These impact targets were operationalised through a set of eight primary outcomes, including:

- Percentage increase in MWRA (Married Women of Reproductive Age) using modern methods of contraception
- Increase in the proportion of newly married couples (within 2 years) using modern contraceptives
- Improved access for women to information on modern family planning methods
- Enhanced quality of family planning, PPFP (Post-Partum Family Planning) and PAC (Post-Abortion Care) services at health centres
- Increased FH/RH (Family Health/Reproductive Health) calls from MWRAs and men from intervention sites to ATH (Ask The Health) telehealth services
- Increase in young people (ages 12–19) with knowledge on family life education
- Policies in place to support scale-up of best practices from the Sukh Initiative

These outcomes were pursued through three overarching strategies: (1) increasing demand for family planning and reproductive health services; (2) improving access to and quality of family planning services; and (3) ensuring long-term sustainability of programme focus.

2.2 Intervention Platforms

The Sukh Initiative deployed its strategies through four primary intervention platforms:

- TeleHealth – providing remote counselling and reproductive health guidance, including the Ask The Health (ATH) service through which MWRAs and men could seek information confidentially
- Door-to-Door Services – delivered via Community Health Workers (CHW) and Lady Health Workers (LHW), reaching women directly in their homes across targeted union councils
- Healthcare Facilities – through both public and private sector facilities offering clinical family planning services
- Youth Engagement and Advocacy – addressing family life education for adolescents and policy advocacy for programme sustainability

These platforms collectively created an ecosystem in which CHWs were not only demand generators but also trusted educational intermediaries—a role that necessitated a rigorous and standardised training framework.

---

3. Programme Communities: Sociodemographic Profiles

The Sukh Initiative targeted four peri-urban locations in Karachi, each presenting distinct sociodemographic profiles that directly informed the adaptation of CHW training materials and counselling approaches.

3.1 Bin Qasim

Covering 7 union councils, Bin Qasim presented a particularly high-risk demographic profile. More than 50% of women were aged 15–29—a young reproductive-age cohort highly susceptible to early and unplanned pregnancy. Teenage marriage and pregnancy were documented challenges. Strikingly, 46% of married women had received no formal education, creating significant barriers to health literacy. A further 39% of married women had 4 or more children, indicating high parity and limited birth spacing. Sindhi was the dominant language, underscoring the necessity for culturally and linguistically adapted CHW communications.

3.2 Korangi

Spanning 9 union councils, Korangi similarly exhibited significant vulnerability. More than 40% of married women had 4 or more children. Teenage pregnancy was a recognised concern. Approximately 47% of married women were between ages 15 and 29. While 30.8% had not received formal education—a slightly lower proportion than Bin Qasim—the figure remained substantial. Urdu was the most spoken language, enabling somewhat broader use of standardised Urdu-language CHW materials.

3.3 Landhi

The largest target area by union councils (12 councils), Landhi presented linguistic diversity as a defining characteristic. Pashto, Hindko, and Balochi were the most widely spoken languages—reflecting the settlement of migrant and internally displaced populations. Nearly half (49%) of married women were aged 15–29. More than 40% had 4 or more children, and 34% had not received formal education. This linguistic plurality made Landhi the most complex site for CHW training, requiring multilingual communication strategies.

3.4 Malir

Malir, also covering 7 union councils, showed comparatively lower but still significant vulnerability. About 38.5% of married women had 4 or more children, and 40% were aged 15–29. Approximately 22.7% had not received formal education—the lowest proportion among the four sites, yet still representing a substantial minority. Urdu was the primary language spoken.

Taken together, these four communities presented a mosaic of overlapping vulnerabilities: high rates of low literacy, young reproductive age cohorts, high parity, teenage marriage, and linguistic diversity. Effectively training CHWs to navigate this landscape demanded a framework grounded in rigorous evidence, expert guidance, and community-specific adaptation.

Table 1: Summary of Sociodemographic Characteristics Across Sukh Initiative Target Areas

Indicator	Bin Qasim	Korangi	Landhi	Malir
Union Councils	7	9	12	7
Women aged 15–29	>50%	47%	49%	40%
No formal education	46%	30.8%	34%	22.7%
4+ children	39%	>40%	>40%	38.5%
Teenage marriage/pregnancy	Yes	Yes	Yes	Yes
Primary language(s)	Sindhi	Urdu	Pashto, Hindko, Balochi	Urdu

4. Developing the Expert-Benchmarked Educational Framework for CHWs

4.1 Rationale and Design Principles

The educational framework for CHWs was designed on the recognition that family planning counselling is not merely an information-transfer exercise—it is a nuanced, trust-based interaction mediated by cultural norms, health literacy, personal values, and available resources. The framework therefore adhered to four foundational design principles:

- Evidence-Based Content: All contraceptive information was derived from current clinical evidence, WHO guidance on family planning, and nationally relevant treatment guidelines.

- Expert Benchmarking: The framework underwent structured review by reproductive health specialists, public health practitioners, pharmacists, and gynaecologists to ensure clinical accuracy and contextual appropriateness.
- Cultural and Linguistic Adaptation: Materials were translated and adapted for Sindhi, Urdu, Pashto, Hindko, and Balochi-speaking communities, with literacy-sensitive visual aids developed for communities with high proportions of uneducated women.
- Competency-Based Evaluation: CHW training was assessed against predefined competencies, with benchmarked assessments measuring knowledge, counselling skills, and the ability to address common misconceptions.

4.2 Core Curriculum Components

The CHW educational curriculum was structured around six core modules:

Module 1: Foundations of Reproductive Health

This introductory module covered female reproductive anatomy, the menstrual cycle, fertility, and the concept of family planning as a health right. CHWs were trained to communicate these concepts sensitively, acknowledging socio-cultural frameworks and addressing common myths.

Module 2: Modern Contraceptive Methods

A comprehensive overview of the contraceptive basket was provided, encompassing:

- Short-acting methods: Oral contraceptive pills (OCPs), injectable contraceptives, barrier methods (condoms, diaphragm)
- Long-acting reversible contraceptives (LARCs): Intrauterine Contraceptive Devices (IUCDs), implants
- Permanent methods: Bilateral tubal ligation, vasectomy
- Emergency contraception: Indications, mechanism, and safe use

Particular emphasis was placed on IUCD counselling, given the significant uptake documented among Sukh Initiative participants. CHWs received detailed training on IUCD indications, benefits, insertion procedure (in liaison with clinical staff), common side effects, follow-up requirements, and the importance of dispelling misconceptions (e.g., that IUCDs cause infertility or cancer).

Module 3: Post-Partum and Post-Abortion Family Planning (PPFP/PAC)

Recognising the critical post-partum and post-abortion windows for contraceptive initiation, CHWs were trained to counsel women on the importance of immediate and early postpartum family planning. This module addressed birth spacing, breastfeeding and the lactational amenorrhoea method (LAM), and the provision of PAC services.

Module 4: Communication and Counselling Skills

CHWs were trained in client-centred counselling using the GATHER model (Greet, Ask, Tell, Help, Explain, Return). Role-playing exercises simulated common counselling scenarios, including resistance from husbands, religious objections, and misinformation from family members. Motivational interviewing techniques were introduced to support informed decision-making without coercion.

Module 5: Telehealth and Referral Pathways

In alignment with the Sukh Initiative's ATH (Ask The Health) telehealth platform, CHWs were trained to facilitate FH/RH (Family Health/Reproductive Health) referrals, assist women in accessing the helpline, and document cases appropriately. This module was directly informed by the author's experience as a Health Advisor Officer providing telehealth counselling to MWRAs and men across the intervention communities.

Module 6: Youth and Adolescent Reproductive Health

Given the documented prevalence of teenage marriage and pregnancy across all four target areas, CHWs received training on age-appropriate family life education for adolescents (ages 12–19), addressing puberty, reproductive rights, and the risks of early marriage.

---

5. Evaluation Approach and Outcomes

5.1 Framework Evaluation Design

The educational framework was evaluated using a pre-post competency assessment model, supplemented by supervisory observations and client satisfaction surveys. Expert benchmarking was conducted through structured review panels comprising reproductive health physicians, pharmacists, public health specialists, and community representatives. The panel assessed curriculum content for clinical accuracy, cultural appropriateness, literacy accessibility, and alignment with FP2020 objectives.

5.2 Key Outcome Indicators

Consistent with the Sukh Initiative's Theory of Change, the following outcome indicators were used to evaluate programme performance:

- Percentage increase in MWRA currently using modern contraceptive methods

- Percentage of women using each individual method (disaggregated by IUCD, injectables, OCPs, condoms, implants)
- Proportion of newly married couples (within 2 years) using modern contraceptives
- Number of FH/RH calls to ATH telehealth services from intervention communities
- Proportion of young people (12–19) demonstrating knowledge of family life education topics

5.3 Contraceptive Uptake: Highlighted Findings

Programme data from the Sukh Initiative documented significant adoption of modern contraceptive methods across all four target communities. Particularly noteworthy was the increased uptake of Intrauterine Contraceptive Devices (IUCDs) among women who had previously relied on less effective or no contraceptive methods. This finding is of clinical significance: IUCDs, as long-acting reversible contraceptives, offer superior efficacy (>99%), are cost-effective over time, and do not depend on daily adherence—characteristics that make them especially suitable for high-parity, low-literacy communities.

The meaningful increase in IUCD adoption observed under the Sukh Initiative was directly attributable to targeted CHW counselling that addressed the prevalent misconceptions about IUCDs in these communities, including fears about pain, infertility, and religious permissibility. By equipping CHWs with evidence-based, culturally sensitive counter-messaging and ensuring seamless referral pathways to trained clinical staff for insertion, the educational framework enabled women to make genuinely informed contraceptive choices.

5.4 TeleHealth as a Force-Multiplier

The ATH (Ask The Health) telehealth component proved a critical complement to CHW-based outreach. As a Health Advisor Officer within this service, I routinely received calls from women—and occasionally men—seeking guidance on contraceptive options, side effects, and how to navigate family or community resistance. The telehealth platform provided a confidential, accessible channel for women who could not or would not visit a facility, effectively extending the reach of the CHW framework into the private sphere of the household.

The integration of telehealth into the CHW educational framework ensured that CHWs were not positioned as solitary gatekeepers of information but rather as connectors within a broader continuum of care—a design principle that proved central to the initiative’s success in increasing contraceptive uptake.

6. Discussion

The Sukh Initiative provides a compelling case for the value of structured, expert-benchmarked educational frameworks in enabling CHWs to guide women on contraceptive use and family planning. Several key lessons emerge from this experience.

First, contextualisation is not optional—it is the prerequisite for effective CHW-based interventions. The sociodemographic heterogeneity of Bin Qasim, Korangi, Landhi, and Malir demanded that training materials, counselling scripts, and referral pathways be carefully tailored to community-specific linguistic, literacy, and cultural profiles. A uniform, centralised training curriculum—however evidence-based—would have been insufficient without this adaptation layer.

Second, the choice of contraceptive method matters, and CHWs must be equipped to counsel on the full basket of options without bias or oversimplification. The significant uptake of IUCDs in the Sukh Initiative communities underscores that women in low-income, high-parity settings are willing to adopt long-acting methods when they receive accurate information, compassionate counselling, and assured access to quality clinical services. CHW training must therefore go beyond promoting the easiest or most familiar methods and embrace the complexity of individualised contraceptive decision-making.

Third, telehealth and community-based outreach are most powerful when integrated. The Sukh Initiative's hybrid model—combining door-to-door CHW visits with the ATH telehealth helpline—created multiple access points for women at different stages of readiness and with different privacy needs. From my experience on the telehealth front line, I observed that many women who had received initial information from a CHW used the helpline to ask follow-up questions they had felt unable to raise face-to-face. This sequential interaction between CHW and telehealth educator represents a promising model for scaling reproductive health counselling in resource-limited settings.

Fourth, male engagement cannot be an afterthought. Although the primary focus of Sukh was on MWRA, the inclusion of men in FH/RH calls to the ATH service was a recognition that contraceptive decision-making in many Pakistani households is not solely a woman's prerogative. Effective CHW training must equip workers to navigate and gently challenge restrictive gender dynamics, advocating for women's autonomy while engaging male partners constructively.

---

7. Recommendations for Scaling the Framework

Based on the Sukh Initiative's programmatic experience and the lessons derived from implementing the CHW educational framework, the following recommendations are proposed for policymakers, programme implementers, and healthcare administrators:

- Institutionalise expert-benchmarked CHW training as a mandatory component of all community-based family planning programmes, with structured pre-service and in-service competency assessments.
- Develop and maintain a national repository of culturally and linguistically adapted reproductive health education materials for Pakistan's major languages, ensuring regular updating in line with evolving clinical evidence.
- Scale the integration of telehealth services with CHW outreach, standardising referral pathways and ensuring CHWs are trained as active connectors rather than terminal service providers.
- Prioritise LARC counselling—particularly IUCDs and implants—within CHW training frameworks, with specific attention to addressing misconceptions and ensuring seamless clinical referral for method initiation.
- Expand youth-focused family life education components to address teenage marriage and pregnancy, recognising that CHWs can serve as credible, accessible educators for adolescents outside formal school settings.
- Invest in robust monitoring and evaluation systems that capture disaggregated contraceptive uptake data by method type, enabling evidence-based programme refinement and policy advocacy.

---

8. Conclusion

The Sukh Initiative demonstrated that a community-based, CHW-driven approach to family planning—anchored by structured, expert-benchmarked education and integrated with telehealth services—can generate meaningful and measurable increases in modern contraceptive uptake in underserved peri-urban communities. The significant adoption of IUCDs alongside other modern methods among women in Bin Qasim, Korangi, Landhi, and Malir is testament to what is achievable when CHWs are equipped with the right knowledge, tools, and support systems.

As a Health Advisor Officer within the Sukh Initiative's telehealth platform, I witnessed daily the transformative power of accurate, compassionate, and culturally sensitive reproductive health counselling—delivered not in a clinic, but through the voice of a trusted community worker or the anonymity of a phone call. This experience has profoundly shaped my conviction that CHW capacity-

building is among the highest-leverage investments available to public health systems seeking to reduce unplanned pregnancy, improve maternal health, and advance gender equity in Pakistan and beyond.

The framework described in this article is offered as a model for replication, adaptation, and scale—with the hope that it contributes to the ambitions of FP2020 and the broader agenda of universal reproductive health.

References

1. Aman Foundation. Sukh Initiative Programme Documentation. Karachi: Aman Foundation; 2016–2018.

2. World Health Organization. Family Planning: A Global Handbook for Providers. 3rd ed. Geneva: WHO; 2018.

3. FP2020 Partnership. FP2020: Family Planning Goals and Progress. Washington, DC: FP2020; 2020.

4. National Institute of Population Studies (NIPS) [Pakistan] and ICF. Pakistan Demographic and Health Survey 2017–18. Islamabad, Pakistan, and Rockville, Maryland, USA: NIPS and ICF; 2019.

5. Bhattacharyya K, Winch P, LeBan K, Tien M. Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability. Washington, DC: BASICS II for the US Agency for International Development; 2001.

6. World Health Organization. WHO Recommendations on Health Promotion Interventions for Maternal and Newborn Health. Geneva: WHO; 2015.

7. Stephenson R, Hennink M. Barriers to family planning service use among the urban poor in Pakistan. Asia Pac Popul J. 2004;19(2):5–26.

8. Mumtaz Z, Salway S, Waseem M, Umer N. Gender-based barriers to primary health care provision in Pakistan: the experience of female providers. Health Policy Plan. 2003;18(3):261–269.
