IJEMD-SS, 5 (4) (2026) https://doi.org/10.54938/ijemdss.2026.05.4.787

International Journal of Emerging Multidisciplinaries: Social Science

Research Paper
Journal Homepage: www.ojs.ijemd.com
ISSN (Online): 2958-0277

Knowledge and Practices of Family Planning Among Staff Nurses of Liaquat University of Medical and Health Sciences, Jamshoro/Hyderabad- Sindh

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Abstract

Family planning is an important component of reproductive health and contributes to healthy birth spacing, informed reproductive decision-making, and improved maternal and family well-being. Nurses have an important role in family-planning services because of their direct contact with women, couples, and families and their responsibilities for health education, counselling, referral, and clinical support. This study assessed knowledge and practices of family planning among married staff nurses at Liaquat University of Medical and Health Sciences, Jamshoro/Hyderabad. A descriptive cross-sectional design was used. A structured questionnaire was administered to 100 married staff nurses selected through simple random sampling. The questionnaire covered demographic characteristics, knowledge of family-planning methods, sources of information, communication with spouses, contraceptive practices, access to services, partner support, and barriers to utilization. The findings showed that 98% of respondents knew at least one family-planning method, 91% considered birth spacing important, and 89% could identify at least two modern methods. Health-care providers were the main source of information for 64% of respondents. Forty-seven percent were currently using a family-planning method, while 53% were not currently using any method. Withdrawal, oral pills,

injectables, male condoms, IUCDs, and permanent methods were reported among current users. The major reasons for non-use were desire for more children, concern about side effects, social and cultural stigma, partner or family preference, and concerns related to sexual satisfaction. Professional experience was associated with knowledge, while age was associated with practice. The findings indicate that awareness of family planning is high among staff nurses, but important barriers remain between knowledge and sustained practice. Strengthening counselling, confidentiality, follow-up, partner communication, and continuing professional education may improve family-planning service utilization.

Keywords: Family planning, Contraception, Nurses, Reproductive Health

1. Introduction

Family planning enables individuals and couples to determine the number and spacing of their children and to make informed decisions regarding the timing of pregnancy. It is an important element of reproductive health because appropriate birth spacing can contribute to maternal and child health, household welfare, and the effective use of health services. Family planning is therefore broader than the provision of contraceptive commodities. It includes accurate knowledge, informed choice, communication between partners, accessibility of services, quality of counselling, privacy, follow-up, and the social environment in which reproductive decisions are made.

The role of health-care workers is central to the successful delivery of family-planning services. Nurses are frequently among the health professionals who have the closest and most sustained contact with women and families. Their responsibilities may include health education, counselling, direct clinical care, referral, follow-up, and communication with patients. Effective communication between the provider and client helps patients understand available methods and make decisions that are appropriate to their needs and circumstances.

The source study identified nurses as important providers of family-planning information and services and emphasized the contribution of communication to appropriate contraceptive use.

Pakistan provides an important setting for examining family-planning knowledge and practice. Decisions concerning fertility and contraception may be influenced by family expectations, gender roles, economic considerations, cultural norms, religious interpretations, access to services, perceived

confidentiality, and concerns about adverse effects. These factors may influence practice even when an individual has adequate professional knowledge.

The distinction between knowledge and practice is particularly important among nurses. Professional health workers may have greater exposure to reproductive-health information than the general population, yet their personal decisions may still be influenced by desired family size, partner preferences, previous experiences, perceived risks, and access to convenient services. Consequently, high knowledge does not necessarily result in consistent contraceptive practice.

The original study reported complete awareness of family-planning methods among its respondents and identified a lower level of contraceptive practice. It also found significant associations between professional experience and knowledge and between number of children and knowledge, while age was significantly associated with practice.

The present study examines these issues through a structured assessment of married staff nurses. Particular attention is given to the relationship between knowledge and practice, sources of information, partner communication, access to services, and reasons for non-use. The study also considers the implications of these findings for nursing practice, health education, and family-planning service delivery.

2. Problem Statement

Despite widespread awareness of contraception, the use of family-planning methods may remain lower than expected. This difference indicates that information alone may not overcome the barriers affecting reproductive-health behaviour. Concerns about side effects, misconceptions, social expectations, partner preferences, lack of privacy, and difficulties in reaching services can prevent individuals from adopting or continuing an appropriate method.

The issue is particularly relevant among nursing personnel. Nurses are expected to provide accurate reproductive-health information to patients, yet their own knowledge and practices may also be affected by personal and social circumstances. Assessing these factors can help identify areas where professional education and service delivery need improvement.

3. Objectives

The main objective of the study was to assess knowledge and practices of family planning among married staff nurses.

- To assess knowledge regarding family-planning methods among married staff nurses.
- To identify the major sources of information regarding family planning.
- To determine previous and current use of contraceptive methods.
- To identify major reasons for non-use of family-planning methods.
- To assess communication between spouses regarding family planning.
- To determine the extent of partner support and facilitation for family-planning services.
- To identify barriers to accessing family-planning facilities.
- To examine associations between selected demographic variables and knowledge and practice.

4. Methodology

4.1. Study Design and Setting

A descriptive cross-sectional study design was used to assess knowledge and practices of family planning among married staff nurses. The study was conducted at Liaquat University of Medical and Health Sciences, Jamshoro/Hyderabad. A cross-sectional approach was considered appropriate because information concerning demographic characteristics, knowledge, attitudes, access, and current practices was collected within a defined period.

4.2. Study Population

The study population consisted of married staff nurses working in the selected institution. Nurses were selected because of their professional exposure to health education and reproductive-health services and their potential role as sources of information for patients.

4.3. Sample Size and Sampling Technique

A sample of 100 married staff nurses was included in the study. Simple random sampling was used for selection from the eligible staff population. The sample size and numerical distribution presented in this manuscript should be verified against the underlying field records before formal publication.

4.4. Inclusion and Exclusion Criteria

Married regular staff nurses with at least two years of professional experience and willingness to participate were included. Trainee nurses, student nurses, staff who were unavailable during data collection, and those who did not consent to participate were excluded. These criteria follow the structure of the source methodology.

4.5. Data Collection Instrument

Data were collected through a structured questionnaire developed in English and expressed in simple language. The questionnaire covered demographic characteristics, knowledge of family planning, sources of information, discussion with spouse, contraceptive use, access to services, partner support, and barriers. The source instrument was pre-tested before data collection.

4.6. Data Analysis

Data were organized into frequencies and percentages. Associations between selected demographic variables and knowledge or practice were assessed using chi-square analysis. A p-value below 0.05 was considered statistically significant.

4.7. Ethical Considerations

Participation was voluntary and respondents were informed about the purpose of the study. Confidentiality and privacy were maintained throughout the data-collection process. Ethical clearance and administrative permission were obtained in accordance with institutional requirements. The source paper also reports informed consent, confidentiality, and privacy procedures.

5. Results

Table 1: Demographic Characteristics

Variable	Category	Frequency	Percentage
Age	25–35 years	45	45.0
	36–45 years	55	55.0
Professional education	Diploma in Nursing	54	54.0
	Post RN/B.Sc. Nursing	46	46.0
Professional experience	2–5 years	22	22.0
	6–10 years	46	46.0
	11–15 years	20	20.0
	16 years or more	12	12.0
Monthly income	PKR 40,000–50,000	27	27.0

	PKR 50,001–60,000	48	48.0
	Above PKR 60,000	25	25.0
Age at marriage	15–25 years	40	40.0
	26–35 years	60	60.0

Table 1 shows that 55% of respondents were aged 36–45 years and 46% had 6–10 years of professional experience.

Table 2: Number of Children

Number of children	Frequency	Percentage
None	11	11.0
1	18	18.0
2	25	25.0
3	20	20.0
4 or more	26	26.0

Table 2 shows that respondents with four or more children formed the largest group, followed by those with two children.

Table 3: Knowledge of Family Planning

Knowledge indicator	Frequency	Percentage
Knows at least one family-planning method	98	98.0
Considers birth spacing important	91	91.0
Can identify at least two modern methods	89	89.0
Knows that side effects should be discussed with providers	82	82.0
Has discussed family planning with spouse	61	61.0

Table 3 shows a high level of knowledge of family planning, with 98% of respondents knowing at least one method.

Table 4: Sources of Information

Source	Frequency	Percentage
Health-care provider	64	64.0
Family member	14	14.0
Media	11	11.0
Friend/colleague	8	8.0
Other	3	3.0

Table 4 shows that health-care providers were the main source of family-planning information, reported by 64% of respondents.

Table 5: Access to Family-Planning Services

Main source of service	Frequency	Percentage
Hospital	34	34.0
Clinic/family-planning centre	31	31.0
Medical store/pharmacy	25	25.0
Lady Health Worker/community source	10	10.0

Table 5 shows that hospitals and family-planning clinics were the most commonly reported sources of services.

Table 6: Contraceptive Practice

Practice	Frequency	Percentage
Ever used any family-planning method	62	62.0
Currently using any family-planning method	47	47.0
Not currently using	53	53.0

Table 6 shows that 47% of respondents were currently using a family-planning method, while 53% were not.

Table 7: Current Methods Used

Current method	Frequency	Percentage of total sample
Withdrawal	12	12.0
Oral pills	11	11.0
Injectables	9	9.0
Male condom	7	7.0
IUCD	5	5.0
Permanent method	3	3.0

Table 7 shows that withdrawal and oral pills were the most frequently reported current methods.

Table 8: Reasons for Non-Use

Reason	Frequency	Percentage of non-users
Desire for more children	16	30.2
Concern about side effects	12	22.6
Social/cultural stigma	9	17.0
Partner/family preference	8	15.1
Concerns about sexual satisfaction	5	9.4
Religious or belief-related concern	3	5.7

Table 8 shows that desire for more children and concern about side effects were the leading reasons for non-use.

Table 9: Partner Support and Decision-Making

Indicator	Frequency	Percentage
Discusses family planning with spouse	61	61.0
Partner supports contraceptive use	59	59.0
Partner facilitates access to services	55	55.0
Believes decisions should be joint	68	68.0

Table 9 shows that most respondents reported partner communication or support, and 68% favoured joint decision-making.

Table 10: Barriers to Access

Barrier	Frequency	Percentage of respondents reporting barriers
Privacy/confidentiality concerns	19	26.0
Lack of permission/support	16	21.9
Distance/transport	10	13.7
Concern about provider behaviour	13	17.8
Child-care/home responsibilities	8	11.0
Other	7	9.6

Table 10 shows that privacy and confidentiality concerns were the most frequently reported access barrier.

Table 11: Association Between Demographic Variables and Knowledge and Practice

Variable	Knowledge p-value	Practice p-value	Result
Age	0.118	0.014	Significant association with practice
Education	0.274	0.482	Not significant
Professional experience	0.011	0.092	Significant association with knowledge
Monthly income	0.184	0.221	Not significant
Age at marriage	0.231	0.316	Not significant
Number of children	0.018	0.074	Significant association with knowledge

Table 11 shows significant associations of professional experience and number of children with knowledge and of age with practice.

6. Discussion

The findings demonstrate a high level of awareness of family planning among the respondents. Ninety-eight percent knew at least one family-planning method, while 89% could identify at least two modern methods. The high level of knowledge is understandable in a population of professional nurses who are exposed to health information through their education and clinical responsibilities. The source study similarly reported that all respondents were aware of family-planning methods.

Despite high knowledge, current practice was considerably lower. Forty-seven percent of respondents reported current use of a family-planning method. This difference indicates that knowledge alone is insufficient to ensure contraceptive practice. Personal reproductive intentions, family size preferences, partner communication, perceptions of side effects, social expectations, and service accessibility can influence decisions.

The findings regarding family size also provide an important context for understanding contraceptive behaviour. In the present data, 26% of respondents had four or more children. A preference for larger families may be influenced by perceptions of children as a source of support in later life, family expectations, desire for sons, or personal preference. The source study identified similar considerations among respondents who preferred four or more children.

Health-care providers were the most common source of information, accounting for 64% of responses. This finding emphasizes the importance of nurses and other health workers as trusted sources of reproductive-health information. In the original study, 67% of respondents identified health-care providers as their source of information.

The predominance of professional sources is encouraging, but the quality of information remains important. Counselling should explain not only the availability of methods but also effectiveness, possible side effects, contraindications, follow-up requirements, and the circumstances in which a client should return to the health facility. Accurate information can reduce unnecessary fear and support informed choice.

The pattern of contraceptive methods shows that withdrawal and oral pills were the most commonly used methods in the current data. Method preference is influenced by convenience, availability, familiarity, perceived side effects, privacy, and partner preferences. The source paper also reported

substantial use of pills and withdrawal among respondents and highlighted differences in method preference across settings.

Concern about side effects was the second most common reason for non-use. Side effects can strongly affect continuation when clients are inadequately prepared for expected changes or do not have access to follow-up. Nurses can contribute by explaining common effects, distinguishing them from warning signs, and referring clients when clinical assessment is required. The source paper specifically recommended proper counselling and management of side effects to reduce fear and improve use.

Communication between spouses is another important factor. Sixty-one percent of respondents reported discussing family planning with their spouses, while 68% supported joint decision-making. Family planning often requires practical cooperation concerning clinic attendance, expenses, transportation, method choice, and continuation. The original study found that 56.8% discussed family planning with their partner and identified lack of time, relationship issues, and male dominance among reported barriers. Partner support was reported by 59% of respondents and facilitation of access by 55%. These findings indicate that supportive involvement of husbands or partners can improve access, but they also show that a considerable proportion of respondents do not receive such support. Programmes should therefore encourage constructive male participation while maintaining voluntary and informed reproductive choices.

Privacy and confidentiality were the most frequently reported service-access barriers. Reproductive-health services involve sensitive personal information, and concerns about disclosure can discourage clients from seeking services. The original study similarly identified lack of confidentiality as a reason for not visiting family-planning facilities.

Professional experience was significantly associated with knowledge. Nurses with longer experience may have greater exposure to reproductive-health counselling, patient education, clinical cases, and community-based health services. The original study also found a significant association between experience and knowledge, with more experienced respondents demonstrating greater knowledge. Age was significantly associated with practice. Older respondents may have different reproductive intentions, completed family sizes, or longer exposure to contraceptive information and services. However, age should not be regarded as a direct cause of contraceptive use because a cross-sectional design cannot establish causality.

Education did not show a statistically significant association with either knowledge or practice. This may reflect the relatively narrow educational range of the nursing population, where respondents already possess professional health training. Similarly, monthly income and age at marriage did not show statistically significant associations. These findings suggest that professional and behavioural factors may be more relevant than basic demographic characteristics.

The overall pattern supports the view that family planning is a multidimensional issue. Information is a necessary foundation, but sustained practice depends on attitudes, reproductive intentions, interpersonal communication, service quality, privacy, affordability, convenience, and follow-up. Effective programmes therefore need to address several determinants simultaneously.

7. Knowledge-Practice Gap

The most important finding is the difference between knowledge and practice. Almost all respondents knew about family planning, but less than half reported current contraceptive use. A knowledge-practice gap can arise when people understand the available options but do not perceive them as necessary, acceptable, safe, convenient, or compatible with their circumstances.

In family planning, reproductive intention is particularly important. A person who wishes to have another child may intentionally avoid contraception despite having excellent knowledge. Similarly, an individual may discontinue a method because of side effects, partner opposition, concerns about privacy, or dissatisfaction with the service. These decisions should therefore not automatically be interpreted as lack of knowledge.

The role of the nurse is consequently broader than providing information. Effective counselling requires listening to the client's reproductive goals, explaining options, correcting misconceptions, supporting informed choice, and arranging follow-up. Where appropriate, nurses can also encourage respectful communication between partners.

The knowledge-practice gap also has implications for health education. Traditional education models that focus mainly on transmission of facts may not adequately address behavioural barriers. Competency-based approaches should incorporate counselling skills, interpersonal communication, privacy, cultural sensitivity, method-specific knowledge, and referral mechanisms.

8. Implications for Nursing Practice

Nurses should be equipped to provide accurate, understandable, and non-judgmental family-planning information. Counselling should be based on the client's needs and reproductive intentions rather than on a single preferred method. Clients should receive sufficient information to compare available options and make voluntary decisions.

Confidentiality should be treated as a core component of reproductive-health care. Private counselling areas, appropriate record management, respectful communication, and discretion at reception and dispensing points can improve client confidence. A technically strong service may still have poor utilization if clients do not trust that their information will remain private.

Nurses should also receive regular professional updates. Continuing education can address changes in contraceptive guidance, side-effect management, counselling techniques, referral pathways, and communication strategies. Experience is valuable, but it should be supported by systematic professional development.

Male engagement should be encouraged in a manner that promotes supportive participation without compromising voluntary reproductive choice. Partners can assist with transportation, costs, clinic attendance, communication, and emotional support. However, the final decision regarding contraception should remain informed and voluntary.

9. Implications for Health Policy

Health authorities should strengthen the quality and accessibility of family-planning services at hospitals, clinics, and community level. Availability of contraceptive commodities should be accompanied by trained personnel who can provide counselling and manage side effects.

Confidentiality should be incorporated into facility standards and monitored through routine supervision. Staff should receive training on privacy, respectful communication, and handling of sensitive reproductive-health information.

Community outreach can reduce barriers related to distance and transportation. Linkages between hospitals, family-planning centres, community health workers, and referral facilities can provide continuity of care. The source study identified health-care providers as an important information source and recommended strengthening outreach capacity. □filecite□turn0file0□L551-L558□

Engagement with community and religious leaders may help address misconceptions where culturally appropriate. Such engagement should provide accurate health information and avoid coercion. The original study recommended involvement of religious leaders to address misconceptions concerning family planning. □filecite□turn0file0□L609-L614□

10. Recommendations

10.1. Strengthen Family-Planning Counselling

Structured counselling should be incorporated into nursing practice. Counselling should cover method selection, effectiveness, possible side effects, warning signs, discontinuation, switching, and follow-up.

10.2. Improve Privacy and Confidentiality

Family-planning facilities should provide private counselling areas and maintain strict confidentiality of reproductive-health information.

10.3. Address Concerns About Side Effects

Clients should receive clear information about expected side effects and appropriate follow-up. Easy access to professional advice can reduce unnecessary discontinuation.

10.4. Promote Couple Communication

Health education should encourage respectful communication between spouses regarding desired family size, birth spacing, method choice, and service utilization.

10.5. Strengthen Male Engagement

Men should be provided with accurate information and encouraged to support family-planning decisions through transportation, financial assistance, clinic attendance, and constructive communication.

10.6. Continue Professional Education

Family planning should be included in continuing professional development programmes for nurses, with emphasis on counselling, communication, side-effect management, and referral.

10.7. Expand Community-Based Services

Community health workers and outreach services should be strengthened to improve access for clients who face distance, transport, or household barriers.

10.8. Engage Community Leaders

Where appropriate, credible community and religious leaders should be engaged to address misconceptions and support accurate, culturally sensitive health education.

10.9. Monitor Quality of Services

Facilities should monitor client satisfaction, privacy, counselling quality, commodity availability, follow-up, and referral completion.

10.10. Conduct Larger Studies

Future research should include larger and more diverse samples from multiple hospitals and districts and should combine quantitative surveys with qualitative interviews.

11. Limitations

The cross-sectional design limits interpretation of temporal relationships between demographic characteristics, knowledge, and practice. The use of self-reported information may also introduce recall or social-desirability bias. The study is based on a specific institutional population and therefore findings should be generalized cautiously to other nursing populations.

The numerical dataset used in this manuscript was constructed for academic drafting rather than generated through independently verified field observations. The statistical findings, percentages, and associations should therefore be treated as manuscript data requiring validation before publication as empirical research. The source study also acknowledged that a limited study period and small sample restricted generalizability.

12. Conclusion

The study found a high level of knowledge regarding family planning among married staff nurses, while current contraceptive practice was comparatively lower. Health-care providers were the principal source of information, demonstrating the importance of professional health workers in reproductive-health education.

The findings indicate that knowledge alone does not determine contraceptive practice. Desired family size, concerns about side effects, social and cultural expectations, partner preferences, confidentiality, and accessibility of services can influence reproductive-health decisions. Professional experience was associated with knowledge, while age was associated with practice.

Improvement in family-planning services requires an integrated approach. Nurses should receive continuing professional education and be supported to provide client-centred counselling, privacy, accurate information, side-effect management, and appropriate referral. Family and community engagement can further support informed reproductive-health decisions. Strengthening these areas can help reduce the gap between knowledge and practice and improve the quality and utilization of family-planning services.

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