HIP FAMILY PLANNING HIGH IMPACT PRACTICES

Knowledge, beliefs, attitudes, and self-efficacy:

strengthening an individual's ability to achieve their reproductive intentions

Knowledge, beliefs, attitudes, and self-efficacy

What is the proven high-impact practice in family planning?

Implement interventions to strengthen an individual's ability to achieve their reproductive intentions by addressing their knowledge, beliefs, attitudes, and self-efficacy.

Credit: Images of Empowerment

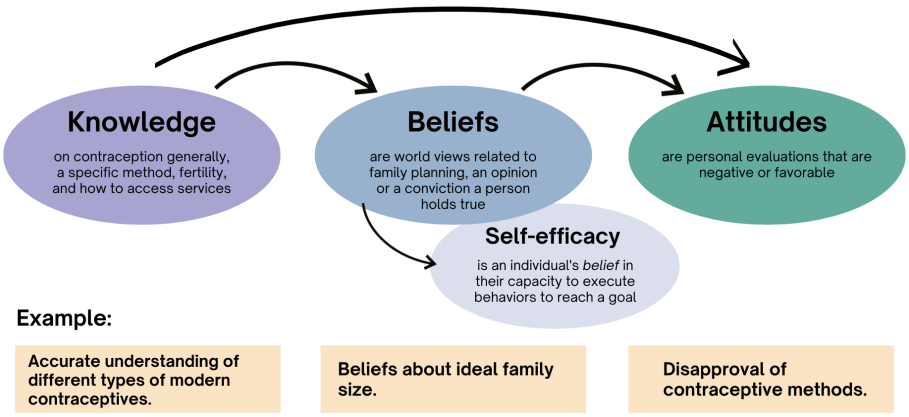
An Accredited Social Health Activist (ASHA) interacts with a young mother during a home visit.

Background

Accurate knowledge about family planning has long been understood as a critical factor to reach various family planning goals[1,2] and essential to informed choice.* Furthermore, inaccurate knowledge about fertility has been associated with unintended pregnancies.[3]

Experts believe that individuals with accurate knowledge that goes beyond knowing a few contraceptive methods, such as knowledge of fertility or contraceptive side effects, are more likely to use and less likely to discontinue using family planning to fulfill their fertility intentions. In addition to knowledge, other individual factors influencing someone's ability to reach their fertility intentions include **beliefs**, **attitudes**, and **self-efficacy**.† Several theories highlight the role of these factors in behavior change, including the theory of planned behaviour, social learning theory, and the ideational model, and there is significant research on their influence on health behaviors.[4]

Figure 1. Knowledge, beliefs, attitudes, and self-efficacy definitions[5,6] and example



Knowledge, beliefs, attitudes, and self-efficacy are closely related and influence each other (Figure 1). For example, beliefs in myths and misconceptions about contraception

* Informed choice emphasizes that clients select the method that best satisfies their personal, reproductive, and health needs, based on a thorough understanding of their contraceptive options.[13]

† Self-efficacy is often used synonymously with agency but they are a little different. Agency actually describes the physical ability, resources, and control necessary to deal with a task or situation (compared to one's perceived ability or beliefs).[5] Agency is not well-documented in the family planning literature and requires further study. Thus, it is not included in this brief.

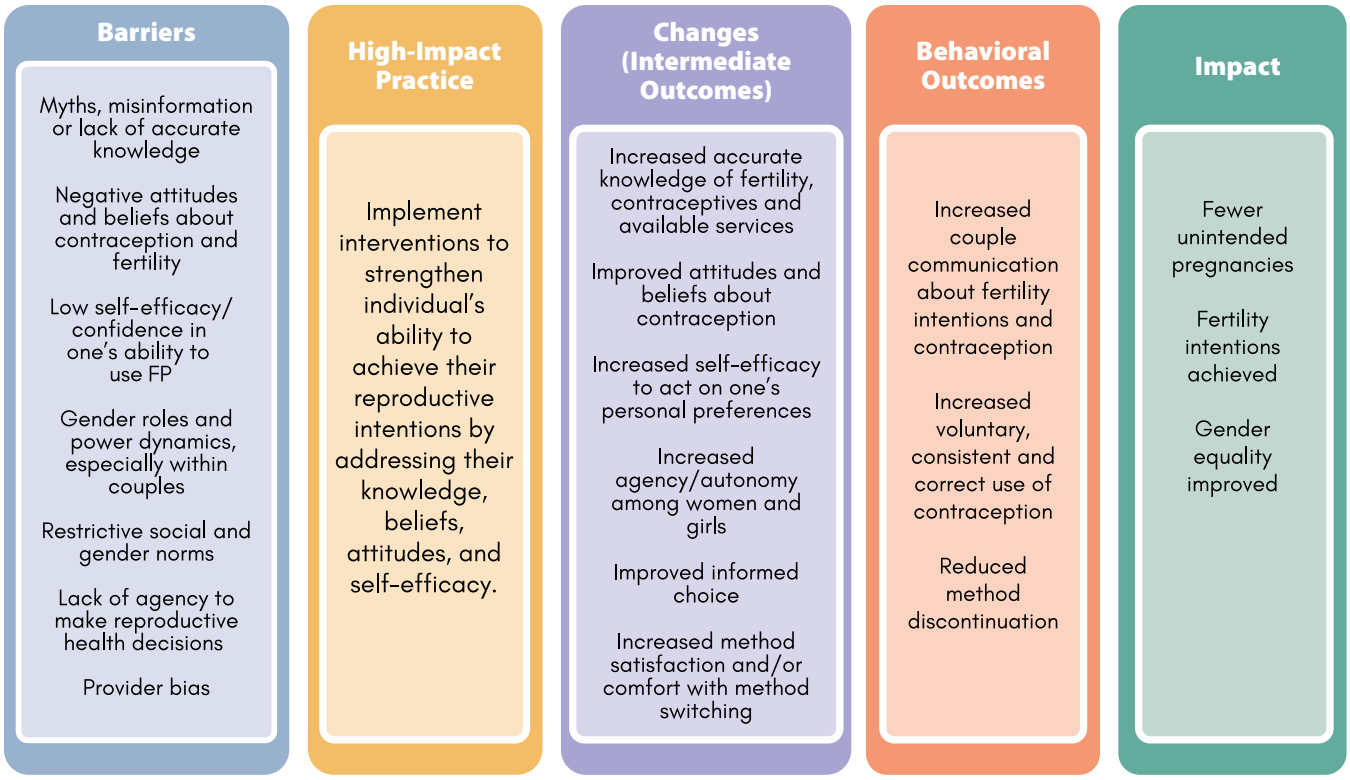
are often a function of poor or inaccurate knowledge.[7,8] In some settings, the misconception that family planning use may cause a woman to be promiscuous or lead to sterility is commonly held.[9–11] Misconceptions of contraceptive-induced menstrual changes are also common, such as that amenorrhea can cause a build-up of "bad blood" that can harm one's health or fertility.[12] Such beliefs can lead to negative attitudes about family planning and contribute to non-use or discontinuation.[14] Finally, self-efficacy is a powerful form of belief—belief in one's own ability—and is recognized as a key influence on behavior.[15]

Implementing interventions to strengthen an individuals' ability to achieve their reproductive intentions by addressing their knowledge, beliefs, attitudes, and self-efficacy is one of several proven "high-impact practices in family planning" (HIPs) identified by the HIP partnership and vetted by the HIP Technical Advisory Group. This HIP brief together with the other two HIP briefs focusing on understanding and addressing behavioral determinants (social norms and couples' communication) recognizes that factors influencing health behaviors exist on multiple levels, are interrelated, and extend beyond the individual (Figure 2). Together with the group of briefs on specific channels to reach your audience (mass media, community group engagement, digital health for social and behavior change), they provide critical information on what works in family planning social and behavior change (SBC) programs. Please see this overview of the SBC HIP briefs. For more information about HIPs in general, see this overview.

Why is this practice important?

Strengthening family planning knowledge is fundamental to voluntary, informed, and correct contraceptive use. Individuals who have correct information about contraception, including about its side effects, tend to look favorably upon and to be more likely to use family planning.[16] Among adolescents from low- and middle-income countries (LMICs), low levels of sexual and reproductive health knowledge are associated with reduced access to contraception, particularly among unmarried adolescents.[17] This includes providing information about menstrual health and the menstrual cycle and how it relates to pregnancy and fertility. A study in 29 African countries among adolescent women 15–19 found high incorrect knowledge of ovulation and an association between incorrect knowledge and unintended pregnancy.[3] Additionally, some women may use a family planning method but lack the knowledge about how to use it correctly, leading to inconsistent and/or incorrect use which reduces contraceptives' full ability to prevent pregnancy. For example, some young women may only

Figure 2. Theory of change



take oral contraceptives just before or just after intercourse rather than daily as prescribed.[18] In addition, some women may not have complete knowledge about the potential side effects of contraceptives or about contraceptive-induced menstrual changes. They may view side effects or menstrual changes as dangerous or unhealthy, which can act as a major barrier to uptake and use.[12,19] The importance of accurate family planning knowledge has been heightened with the advent of the Internet and social media, which can be used to rapidly spread misinformation.[20]

Addressing knowledge, beliefs, and attitudes can help to dispel myths and misconceptions about contraception, which are significant barriers to voluntary and consistent contraceptive use. Holding myths and misconceptions is a strong predictor of non-use[21–24] or has been cited as a barrier to contraceptive use[16] in several countries. For example, a study in Uganda using PMA2020 data found that contraceptive uptake was lower among women who strongly agreed that contraception influenced future fertility compared to those who strongly disagreed.[25] A study in urban areas in Kenya, Nigeria, and Senegal found that widely prevalent family planning beliefs included linking contraceptive use to health problems and to harmful effects on women and the womb. These beliefs negatively affected modern contraceptive use at the individual level in the three countries.[22]

Favourable attitudes about family planning influence voluntary[26] and consistent contraceptive uptake. In Baringo North District in Kenya, for example, significant predictors of contraceptive use included method approval by self and partner.[27] In contrast, studies in India and Kenya indicate that negative attitudes deter use[28,29] or influence to method discontinuation.[30] Supportive attitudes by influential individuals (including religious leaders, husbands, and mothers-in-law) also strongly influence contraceptive uptake by women.[10,31,32]

Self-efficacy is associated with voluntary contraceptive use, avoiding unintended pregnancies, and intention to use contraception. A high level of perceived self-efficacy increased intention to use contraception in Pakistan[33] and Kenya and Nigeria.[24] A study using data from the Nigerian Urban Reproductive Health Initiative (NURHI) intervention in Nigeria (Table 1), divided study participants into categories based on various factors, including self-efficacy. A group labeled "empowered," which exhibited high self-efficacy, in addition to rejecting myths and having support, had the highest proportion of non-contraceptive users who indicated an intention to use contraceptives after being exposed to the intervention.[34] High self-efficacy was associated with use of modern contraceptives at 12 months postpartum in Kenya and Nigeria.[35] Finally, a qualitative study in Mozambique found that fostering individual-level protective factors such as hope and self-efficacy among young women can help to prevent pregnancy and child marriage.[36]

What SBC interventions addressing knowledge, beliefs, attitudes, and self-efficacy strengthen an individual's ability to achieve their reproductive intentions?

Among the SBC family planning studies addressing knowledge, beliefs and attitudes, there have been several successful and unsuccessful interventions. This highlights the importance of designing interventions that respond to local needs and address context-specific barriers and facilitators to achieve fertility intentions. Successful interventions typically not only addressed knowledge, beliefs, attitudes, and self-efficacy but also other important social and behavioral factors, such as promoting couples' communication and addressing social norms. Evidence indicates SBC interventions that address factors at more than one ecological level (also known as multi-level interventions) are most effective in reaching their ultimate behavioral and health goals. See the SBC HIP overview brief for further information. Additionally, experience in family planning and other areas shows that successful multi-level interventions also address barriers to accessing services.[37,38]

While there are numerous SBC family planning studies advancing family planning outcomes by addressing knowledge, beliefs, and attitudes, there are less family planning interventions that address self-efficacy in LMICs and that have done it successfully. To prepare this brief, four studies that were successful in strengthening self-efficacy and achieving the intended family planning outcome were identified.[38–41] More research is needed in this area (See research questions).

SBC efforts to address knowledge, beliefs, attitudes, and self-efficacy to strengthen an individual's ability to achieve their reproductive intentions have been documented through:

- **Mass media (TV, radio, and print), particularly in the context of multi-level interventions.**[38,42,43] A systematic review found that in eight of nine family planning mass media studies, exposure to mass media content was associated with higher levels of knowledge and/or positive attitudes about

Table 1. SBC interventions that successfully addressed knowledge, beliefs, attitudes, and self-efficacy and improved family planning outcomes

Intervention	Effect on knowledge, beliefs, attitudes, and/or self-efficacy	Impact on family planning outcome(s)
Nigeria (Krenn et al, 2014)[38]		
Mass media multi-level intervention. NURHI was a package intervention with several components. Phase 1 provided basic family planning information and heightened awareness of family planning; Phase 2 deepened understanding of family planning and specific methods; and Phase 3 increased the level and localization of communication efforts. Messages were designed to address knowledge and attitudes, as well as self-efficacy and norms. The main activities included "**mass media, entertainment-education, social mobilization, improved quality of services and integrated branding with a memorable, colorful puzzle logo and tagline that helped tie all program activities under one identity**" (pg.6). The tagline was "Know. Talk. Go": "know" your family planning options, "talk" to your partner, and "go" for services.	Among married or cohabitating women exposed to NURHI, knowledge increased from 55.5% at baseline to 69.2% at the midterm evaluation. Attitudes toward family planning also significantly increased from 53.7% to 70.9%. The proportion of women who held myths or misconceptions about family planning decreased in multiple cities from the beginning of the intervention to midline. For example, the proportion of women who incorrectly believed that "contraceptives are dangerous to your health" decreased from 37.4% to 20.4% in Ilorin and from 57.1% to 42.2% in Ibadan. Finally, mean self-efficacy (3.1 to 3.6, $p<0.001$) increased significantly among project recipients.	After three years of data collection, the data indicated an increase in modern contraceptive use varying from 2.3 to 15.5 percentage points in different cities. The increase was attributable to the intervention activities. There was a dose response where contraceptive use was greater the greater the number of intervention activities women were exposed to.
Nigeria (Akamike et al., 2019)[59]		
Multi-level interventions (not including mass media). Community mobilization activities, including a **community awareness campaign and community-based distribution of information, education, and communication (IEC) materials** were carried out in two rural communities in Ebonyi State, Nigeria using a quasi-experimental design. Community awareness was conducted among community leaders, including market, church, and social group representatives. IEC materials were distributed widely.	Women in the intervention group reported a statistically significant increase in awareness and approval of family planning. Awareness increased from 68.2% at baseline to 87.2% at endline. The majority of participants approved of family planning (90%); this proportion significantly increased to 97% at endline. No significant increases were observed in the control group.	Women in the intervention group reported a significant increase (+16.7%) in family planning use three months following the intervention.
Jordan (El-Khoury et al., 2016)[60]		
Multi-level intervention (not including mass media). The program provided **home-based family planning counseling** to married women. Counselors visited women every four to six weeks and discussed the benefits of family planning and birth spacing, the modern methods available, answered questions, and made referrals to family planning services. Counselors conducted follow-up visits with women who started using a method to answer questions. The intervention also addressed access barriers among women of low socioeconomic status via provision of vouchers.	Compared to no counseling, family planning knowledge improved in the women-only counseling and couples-counseling groups.	When comparing women-only counseling with the control group and couples counseling with the control group, each of the interventions was associated with a larger increase in modern contraceptive use than the control group and the difference was significant.

Intervention	Effect on knowledge, beliefs, attitudes, and/or self-efficacy	Impact on family planning outcome(s)
Guinea (Camara et al., 2018)[48]		
Individual counseling intervention. Clinic staff provided pregnant women either reinforced or routine antenatal counseling. **Reinforced antenatal counseling** included an additional one-on-one session with a provider and focused on modern and traditional postpartum family planning methods. Routine counseling consisted of group sessions covering a range of topics including nutrition, childbirth, immunization, and family planning.	At nine months postpartum, women who received reinforced counseling were significantly more likely to know about pills, IUDs, implants, and traditional methods than women who received routine counseling.	At six months postpartum, use of family planning was low and similar across both the intervention and control groups. However, at nine months postpartum, the proportion of women using a modern family planning method was significantly higher among women in the intervention group (5.7%) than the control (1.1%).
Bangladesh (Huda et al., 2019)[53]		
Community group engagement, participatory group discussions, or workshops. Building off the community-based health program Manoshi, married adolescent girls in urban slums could attend up to 12 club sessions during the one-year intervention period. **Club sessions** included **educational discussions** on sexual and reproductive health, early marriage, and family planning, as well as **recreational activities**. Participants also received a small **pocketbook** with information from the club sessions.	Married adolescent girls exposed to the intervention were significantly more likely to know modern methods of contraception, identify consequences of early pregnancy, and believe that family planning is a joint husband-and-wife responsibility. Women in the intervention areas were also significantly more likely to discuss family planning with their husband, support the use of family planning, and report that their husband supports using family planning.	Married adolescent girls in the intervention areas were significantly more likely to report using a modern family planning method than those in the control areas.
Nigeria (Babalola et al., 2019)[54]		
Digital tools. The Smart Client digital health tool was designed to inform, empower, and promote smart clients through **information provided via their mobile phones** via 17 pre-recorded calls: one welcome call, 13 regular program calls, and three quiz calls interspersed. The intervention used "fictional role models, who demonstrate the desired behaviors and behavior change process in a drama format, as well as personal stories and examples of smart client dialogues" (pg. 275).	The intervention increased women's perceived level of self-efficacy to discuss family planning with a provider by 27.7 percentage points. The intervention also increased rejection of the myth that contraceptive methods can hurt a woman's womb by 22.7% points.	The intervention increased modern contraceptive prevalence by 14.8 percentage points.

contraception.[44] Ultimate family planning outcomes were not measured in all the nine studies. However, when measured, most positive results on family planning outcomes happened in studies where mass media was combined with other intervention components, such as interpersonal communication activities.[44] The successful NURHI intervention, for example, included mass media, social mobilization, improved quality of services, and integrated branding (Table 1).[38] NURHI not only addressed knowledge, beliefs, attitudes, and self-efficacy but also promoted couples' communication and addressed norms.

- **Multi-level interventions (not including mass media).** These interventions use several communication channels and activities addressing factors at different socio-ecological levels (i.e., individual, interpersonal, community, organizational, enabling environment) (See SBC overview brief; Figure 3) For example, the PRACHAR intervention implemented in Bihar, India, used a wide range of activities, including female change agents who provided individual and group family planning information and counseling, male change agents who provided this information to men and opinion leaders in the community, wall paintings displayed at the communities, activities specifically for youth, and infotainment activities for newlywed couples. Additionally, activities were also implemented with family planning service providers to enhance service delivery.[45] A study found that the intervention increased knowledge and awareness as well as contraceptive use among women exposed to the program in years beyond the end of the program.[45]

Figure 3. Socio-ecological framework for SBC

Source: Adapted from McLeroy et al., 1998[46]

- **Individual and couples' family planning counseling.** Addressing knowledge, beliefs, and/or attitudes is often a core component of SBC interventions to promote healthy couples' communication. For example, an intervention in Ethiopia primarily reaching couples via couples' counseling and monthly community gatherings increased contraceptive use among those who were not using contraception when the study started and improved men's attitudes about women accessing family planning without men's involvement.[47] Additionally, family planning counseling addressing knowledge, beliefs, attitudes and/or self-efficacy is also provided individually, at the facility, or in the community. An intervention in Guinea comparing reinforced antenatal counseling to routine antenatal counseling found that the reinforced counseling further enhanced knowledge and contraceptive use. The reinforced counseling included face-to-face individual counseling with the antenatal care provider for 15–20 minutes, focusing on family planning methods. The provider used contraceptive samples and a toolbox to guide the counseling.[48] Experience shows that counseling is most successful when it addresses individual client preferences and needs.[49]

- **Community group engagement, participatory group discussions, or workshops.** These interventions are facilitated discussions following a pre-designed curriculum and they can be offered in the form of short one-time sessions,[50] longer workshops,[51,52] or monthly meetings.[53] One of the main characteristics is that they use participatory methodologies such as small group discussions, role plays, and small group work. When offered in the form of several sessions engaging community leaders and community members in reflective dialogue about prevailing attitudes and beliefs, this type of intervention not only addresses family planning knowledge, beliefs, and/or attitudes but also social norms.

- **Digital tools.** An intervention in Nigeria using interactive voice response via phones successfully strengthened self-efficacy to discuss family planning with a provider and led to rejection of myths related to contraception.[54] However, digital health interventions that successfully addressed knowledge, beliefs, and/or attitudes via SMS did not achieve their intended family planning outcomes in India,[55] Kenya,[56] and Ghana.[57] Experts believe that the impact of interventions using digital tools to achieve family planning goals may be enhanced by pairing digital tools with multi-level intervention components, such as activities to address service and contraceptive access barriers. For example,

the CyberRwanda intervention, currently under evaluation, is a digital platform addressing sexual and reproductive health knowledge, beliefs, and self-efficacy among in-school youth while also facilitating access to contraceptives through youth-friendly pharmacies.[58] Further research is needed to fully understand the elements needed to make digital health interventions successful in reaching family planning outcomes.

How to do it: Tips for implementing SBC interventions

- **Use formative research to understand local knowledge, beliefs, attitudes, and self-efficacy about family planning.** Formative research ensures that interventions address specific barriers and facilitators in the local context. Formative research can entail reviews of existing studies, or using qualitative methods (e.g., focus group discussions, individual interviews)[61] or new methodologies such as human-centered design to collect information.[62] NURHI, for example, sought to increase use of voluntary contraception in four large Nigerian cities. Formative research included: a household baseline survey, focus group discussions, a facility assessment, and social mapping. Several important findings emerged from the research, such as the importance of fear of certain methods and misconceptions about their side effects. This information helped ensure that the program was designed for greatest impact.[38]

- **Design messages that are culturally appropriate and meaningful to the audience.** When designing messages, connect insights about the audience (e.g., their values about family size) gathered during formative research with key information the audience needs to know, think, or feel in order to change the behavioral outcome (e.g., use a modern family planning method). Fact-based messaging is important to increase correct knowledge of family planning, but provoking an emotional response (e.g., by appealing to values) can change attitudes and beliefs.

- **Consider existing levels of individual knowledge about family planning and fertility.** When general knowledge of family planning is high, but method-specific knowledge is low, focus on increasing method-specific knowledge, beliefs, attitudes, and self-efficacy which can help users anticipate and manage side effects such as contraceptive-induced menstrual changes. This can be done through improved high-quality counseling or working with communities to increase acceptability of specific methods for certain populations (e.g., long-acting reversible contraception for nulliparous women). When existing levels of knowledge are high, focus on increasing self-efficacy (along with supportive norms) so that individuals can act on their knowledge.

- **Address myths and misconceptions directly, but carefully.** Your formative research should uncover what myths and misconceptions are common and who holds them (see tip above). Train counselors, family planning providers, and/or community health workers on how to address myths and misconceptions, including those about common side effects and contraceptive-induced menstrual changes. This can be done using job aids such as the NORMAL tool.[63] Also, reframe common misconceptions. For example, highlight the benefits of long-acting methods for nulliparous women and provide reassurance about return to fertility. In all messaging around myths and misconceptions, use compelling language delivered by trusted sources for your specific audience.

- **Address potential "side benefits" of contraception, including other potential health and lifestyle advantages in addition to addressing barriers or challenges.** In addition to addressing potential side effects of contraception, it is important to highlight the potential non-contraceptive health and lifestyle benefits that contraceptive methods can offer. Addressing benefits as well as barriers or challenges has worked well in other areas such as promoting health service uptake.[37]

- **Consider opportunities before, during, and after family planning services to intervene.**[64] Improving attitudes about family planning is useful to create a supportive environment for uptake and continued use and can be achieved by, for example, working with religious leaders or messaging on mass media. For women seeking family planning services, focus on myths and misconceptions and promoting favorable attitudes by highlighting the effectiveness of family planning methods. Among family planning users, messaging that increases women's self-efficacy to manage side effects and information on contraceptive-induced menstrual changes, promotes continuation.

- **Improve self-efficacy for clients to communicate with family planning providers about their needs, wishes, and questions.** For example, client referral cards can include information on different family planning methods and a list of questions clients can ask, such as "How effective is this method?" and, "What side effects should I expect?".[64] Mobile phone-based interventions that have sought to empower "smart clients" have also seen success in increasing women's confidence to discuss family planning with a provider.[54]

- **When seeking to *strengthen* knowledge, beliefs, attitudes, and self-efficacy among men and boys, recognize their needs as family planning clients, as well as their roles as supportive partners and agents of change.** It is essential to ensure that increasing men's role in family planning does not jeopardize women's safety and decision making. For example, when promoting the benefits of family planning to men, be sure to tie these messages to encouraging couples' communication and shared decision making. Also aim for gender-synchronized interventions, which involves working with men and women, and boys and girls, in an intentional and mutually reinforcing way, to challenge restrictive gender norms and improve health (see Engaging Men and Boys in Family Planning: A Strategic Planning Guide).

- **Use trusted sources of information.** Health providers are often considered a trusted source of information and clients rely on their counseling to choose a contraceptive method,[65] so it is imperative that family planning providers have accurate knowledge and minimize personal bias.[66] Trusted sources for adolescents may be different so it is important to hear from youth how and from whom they want to learn about fertility and contraception. This information should be delivered via friendly and welcoming sources—such as supportive family planning providers, parents, other family members, comprehensive sexuality education, or trusted community groups (e.g., Scout and Guide movements). Also consider opportunities to confidentially provide tailored information, such as through digital media.

- **Pay particular attention to the needs of diverse adolescents.** Adolescent boys and girls require information and education tailored to their specific life stage and needs. Because adolescents are not a monolithic group, messaging and approaches should be tailored based on life stage and other psychosocial characteristics. For example, the PRACHAR project tailored its mutually reinforcing interventions to delay the age at first birth for unmarried adolescents, newlywed couples, married young women with up to two children, husbands of young women, and mothers-in-law with different intervention approaches.[67]

Implementation measurement

There are numerous indicators to measure the implementation of this HIP. For more information on indicators refer to the SBC indicator bank.

- Percent of target audience that knows potential contraceptive side effects

Tools and resources

- How to Design SBCC Messages: This SBC how-to guide provides step-by-step instructions, useful hints, and key resources and references to support development of evidence-informed SBCC messages.
- The Compass: This website includes a curated collection of SBC resources to help SBC professionals improve their work. It includes how-to guides on how to perform fundamental SBC tasks; resources highlighting trending topics; and spotlights on how successful SBC programs were designed, implemented, and evaluated.
- Guidance on Social and Behavior Change for Family Planning During COVID-19: This guide includes considerations, messages, and resources to guide adaptation of SBC programming focused on family planning and reproductive health in response to COVID-19 challenges.

- Percent of target audience with favorable attitudes of modern family planning methods
- Percent of target audience with high self-efficacy/confidence in their ability to use family planning
- Percent of target audience with high self-efficacy/confidence in their ability to talk to an family planning provider

Priority research questions

- Do digital applications that promote family planning use by addressing knowledge, attitudes, beliefs, and self-efficacy, contribute to achieving various family planning outcomes?
- How might we develop and apply standard measures for self-efficacy to SBC programming focused on contraceptive use across LMICs?
- Do SBC interventions, including enhanced family planning counseling models, that address self-efficacy and agency improve various family planning outcomes?

References

A complete list of references used in the preparation of this brief can be found at: https://www.fphighimpactpractices.org/briefs/knowledge-attitudes-and-beliefs/

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The World Health Organization/Department of Sexual and Reproductive Health and Research has contributed to the development of the technical content of HIP briefs, which are viewed as summaries of evidence and field experience. It is intended that these briefs be used in conjunction with WHO Family Planning Tools and Guidelines: https://www.who.int/health-topics/contraception.

The HIP Partnership is a diverse and results-oriented partnership encompassing a wide range of stakeholders and experts. As such, the information in HIP materials does not necessarily reflect the views of each co-sponsor or partner organization.

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