



KAP Survey: Does It Really Measure Knowledge, Attitudes and Practices?

Prakash Patel

Knowledge, attitude, and practice (KAP) surveys are widely used to gather information from people in India as well as in other countries. However, there is rarely any discussion about the usefulness of KAP surveys and various challenges of conducting surveys and interpretation of results in different settings. The purpose of this article is to highlight the use of KAP surveys in understanding and researching health-related knowledge, attitudes, and behaviours, as well as to identify some of the primary obstacles that KAP surveys face.

Within the foreign assistance sector, there is a growing acknowledgment that improving the health of underprivileged people across the globe requires a thorough understanding of sociocultural and economic characteristics of the community, which is critical for the implementation of public health programmes. The most popular and commonly used cross-sectional survey is the knowledge, attitude, and practise (KAP) survey, sometimes known as the knowledge, attitude, behaviour, and practise (KABP) survey.¹⁻⁴

The KAP survey tradition was first born in the field of family planning and population studies in the 1950s.⁵ Later KAP surveys established their place among the methodologies used to investigate health behaviour, and today they continue to be widely used to gain information on health-seeking practices.³

KAP survey has advantage of an easy design, quantifiable data, ease of interpretation and concise presentation of results, generalisability of small sample results to a wider population, cross-cultural comparability, speed of implementation, and the ease with which one can train enumerators.⁶

The usefulness and strengths of the KAP survey are mostly determined by the data collection techniques and strategy used, such as when using a self-

administered questionnaire (subjective replies), with the findings differing when using a group discussion and/or interview style. The way the questions are designed (open versus closed ended) will also have an impact on the results and conclusions. In addition, the technique should develop the assessment scale and score to test knowledge and split it into three categories: good, fair, and poor. Literacy, domicile, economic standards, level of education, and the degree to which the subject under research would be disclosed in the media all influence the findings of these studies.

Nonetheless, some researchers have criticised KAP surveys throughout the years for assuming that the data presented provides valid information on knowledge, attitudes, and behaviours that may be used for programme design.^{1,4,7} A number of social scientists have also expressed reservations about the KAP surveys' applicability.^{1,3,8,9} However, there hasn't been much critical debate about this topic among social scientists in the international health community or among health programme designers.

KAP surveys have several methodological benefits, such as being simple to perform, relatively cost-effective, and generalised across the country; the results, "hard data," might be used to prove progress to funding agencies.

WHOSE KNOWLEDGE COUNTS?

The knowledge section of KAP surveys is often used to measure community understanding of public health concepts relevant to national and international public health issues. Other forms of information, such as culturally specific knowledge about illness conceptions and explanatory models, or knowledge about health systems, such as access, referral, and quality, are mostly ignored.¹⁰ In times of disease, this knowledge is highly contextualised, practice-based,

How to cite this article: Patel P. KAP Survey: Does It Really Measure Knowledge, Attitudes and Practices? *Natl J Community Med* 2022;13(5):271-273. DOI: 10.55489/njcm.130520222063

Financial Support: None declared

Conflict of Interest: None declared

Date of Submission: 30-04-2022

Date of Acceptance: 14-05-2022

Date of Publication: 31-05-2022

Correspondence: drpbpatel@gmail.com

Copy Right: The Authors retains the copyrights of this article, with first publication rights granted to Medsci Publications.

and emergent, making it challenging to identify via KAP questionnaires.⁴

This issue of knowledge be explained by the definition of knowledge and the agreement on whose knowledge counts. Most research community have an implicit assumption that knowledge is based on scientific facts and universal truths. Beliefs, on the other hand, correspond to conventional conceptions that are incorrect from a biological standpoint and that obstruct proper behaviour and treatment-seeking methods. We strive to examine what the community knows about facts that we know in the knowledge evaluation. This naive concept of knowledge ignores the importance of the knowledge that societies have historically possessed.⁴ There is, however, no specific reason why knowledge related to health systems are rarely investigated in KAP surveys. In anthropology, knowledge and beliefs are not contrasting terms.⁷ KAP data isn't always comprehensive or realistic. Typically, in a KAP survey, one seeks to learn about people's understanding of certain subjects (say a disease). People do not conceive about sickness in terms of what researchers perform, according to anthropologists. People's views on sickness can only be understood in the context of their views on health. As a result, the question arises: What knowledge are we attempting to obtain? Do we want to know if others are aware of what we are aware of? We frequently describe illnesses (and other technical terminology) scientifically before attempting to determine if people are also aware of them.

ATTITUDES - CAN THEY BE MEASURED?

The second section of a normal KAP survey questionnaire is to measure attitudes. In daily English, the phrase attitude refers to a person's overall feelings regarding a topic, an item, or another person. Furthermore, attitudes are either good or negative and are connected to a person's knowledge, beliefs, emotions, and values. Many KAP studies do not really report data on attitudes, owing to the significant danger of incorrectly generalising the ideas and attitudes of a specific population.¹⁰

For a variety of reasons, the act of assessing sentiments through a poll has been criticised. When asked a survey question, people prefer to respond with responses they feel are accurate or that are generally acceptable and valued. Sensitive issues need more effort. The setting of the survey interview, such as whether it is performed in a clinic or in a hamlet, if there are other people there, and so on, may have an impact on the response. Even the way a question is phrased can alter people's views toward positive, "agreeing" responses. If the inquiry is about attitude, the researcher's presence can influence the person's response. It takes a lot of guts, especially from young women, to disagree with attitude-related statements when it comes to sensitive matters like sexual health problems.

Researchers should exercise extreme caution when interpreting data from attitude surveys. It's critical to evaluate the underlying contextual elements that influence data dependability. One technique to increase the accuracy of assessing attitudes is to turn some of the attitude statements into direct questions in other sections and see if there is any disparity between the answers.

DOES A KAP SURVEY REALLY TELL US ABOUT PRACTICES?

Investigation of health-related activities is a third and crucial component of KAP surveys. The questions are usually hypothetical and revolve on the usage of various treatment and preventative strategies. KAP surveys have been criticised for just giving descriptive data and failing to explain why and when certain treatment prevention and strategies are adopted. To put it another way, the polls don't explain why people behave the way they do.

Another issue with gathering data on practises is getting individuals to tell you what they truly do. If you ask individuals if they wash their hands before eating food, more than 90% will answer "yes". However, if you remain with them for a few days and study their hand washing practises, you will find that the percentage of people who truly wash their hands before eating food is substantially lower.

Many times, the illness state has an impact on the practises. The degree of the underlying symptoms determines whether self-care, over-the-counter drugs, traditional healers, or health centres are used, and methods alter as the severity varies. Lastly, some people ask, how can we measure "Practice" in a KAP survey? We measure it as "knowledge of practice" or we can observe the practice in reality?

Before implementing a BCC approach, KAP surveys are often undertaken. The goal of the KAP survey and the BCC method is to modify and impact human behaviour. People should be given accurate information in order to alter their KNOWLEDGE, it is claimed. It is also expected that as their knowledge improves, their attitudes would improve. After that, a shift in attitude will result in a shift in their behaviour or practices. This oversimplification is incorrect. Knowledge alone does not determine human conduct. Many other elements come into play as well. I am aware of the dangers of smoking. I'm very aware of the impact it has on my body and health. But I continue to smoke. My behaviour/smoking habit hasn't changed as a result of learning about the health risks of smoking. So, what's the use of KAP?

When doing KAP, researchers attempt to quantify qualitative factors such as KNOWLEDGE, ATTITUDE, AND PRACTICES. These issues should be seen in the perspective of the broader community. People frequently do not put what they preach into practise. When the researcher is not there, their attitude may change.

In order to gain a thorough grasp of a community's Knowledge, Attitudes, and Practices, anthropologists recommend using participant observation, focus group discussions, and in-depth interviews. KAP data alone is insufficient.

Despite its many limitations, there is always room to improve the quality of the KAP survey. Continuous quality control and investigator training might be a valuable addition to the KAP survey. Because it does not allow for the development of rapport between the interviewer and the responder, a questionnaire is a poor tool for gathering information on sensitive matters. The limited ability of the KAP survey to create reliable data, paired with a limited awareness of the socio-cultural environment, is likely to result in a limited understanding of the underlying causes, or, worse, a false interpretation of data. In order to obtain information beyond "yes" and "no" responses, open-ended questions seeking more explanations were included.

Finally, there was courtesy bias, which meant that respondents gave responses that they thought the researcher and health care worker wanted to hear.

In conclusion, conducting a KAP survey is challenging for a variety of reasons. When the goal of the study is to gather broad information on public health awareness about treatment and preventative techniques, or sociological characteristics like income, education, occupation, and social status, a KAP survey might be effective. However, knowing and understanding what kind of data may be collected by which approach, as well as selecting acceptable methods in connection to the study objectives, is critical. Focus group discussions, in-depth interviews, participant observation, and different interactive approaches are all appropriate ethnographic methodologies for studying health-seeking knowledge, attitudes, and behaviours in context. A mix of qualitative and quantitative methodologies might be useful.

REFERENCES

1. Green, C. E. Can qualitative research produce reliable quantitative findings? *Field Methods* 2001;13(3):3-19.
2. Hausmann-Muela, S., R. J. Muela and I. Nyamongo. Health-seeking behaviour and the health system's response. *DPPP Working Paper* no. 14; 2003.
3. Manderson, L. and P. Aaby. An epidemic in the field? Rapid assessment procedures and health research. *Social Science & Medicine* 1992;35(7): 839-50.
4. Nichter, M. Social science lessons from diarrhea research and their application to ARI. *Human Organization* 1993;52(1):53-67.
5. Ratcliffe, J. W. Analyst biases in KAP surveys: A cross-cultural comparison. *Studies in Family Planning* 1976;7(11):322-330.
6. Bhattacharyya, K. 1997. Key informants, pile sorts, or surveys? Comparing behavioral research methods for the study of acute respiratory infections in West Bengal. In *The anthropology of infectious diseases: Theory and practice on medical anthropology and international health* (eds) M. C. Inhorn and P. J. Brown, 211-238. Amsterdam: Routledge Publishers.
7. Pelto, J. P., and G. H. Pelto. Studying knowledge, culture, and behavior in applied medical anthropology. *Medical Anthropology Quarterly* 1997; 11(2), 147-163.
8. Caldwell, J.C., P. Caldwell, and P. Quiggen. 1994. *The social context of AIDS in sub-Saharan Africa*. New York: Population Council.
9. Cleland, J. 1973. A critique of KAP studies and some suggestions for their improvement. *Studies in Family Planning* 4(2), 42-47.
10. Hausmann-Muela, S., R. J. Muela and M. Tanner. Fake malaria and hidden parasites - the ambiguity of malaria. *Anthropology and Medicine* 1998; 5(1): 43-61.

The writer is Associate Professor in Community Medicine Department at Surat Municipal Institute of Medical Education & Research (SMIMER), Surat, India. He has more than 15 years of experience of working in bio-medical research.