



Knowledge, Attitudes, and Practices

**On Complementary Feeding, Family
Planning, and Hygiene in Latona Village,
Supaul, Bihar**

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As part of the Fellowship, she undertook field-based research in **Latona village, Supaul, Bihar**, examining women's knowledge, attitudes, and practices related to complementary feeding, family planning, and household hygiene. Her study explores how cultural beliefs, misconceptions, and household decision-making influence maternal and child health practices. Her work reflects a strong interest in community-based development and improving public health outcomes in rural communities.



Executive Summary

In rural Bihar, maternal and child health is still a major public health issue even though there have been improvements in access to healthcare and in the coverage of health programmes as a result of government programmes. This study aimed to examine women's knowledge, misconceptions, and daily practices related to complementary feeding, family planning, and household hygiene in Latona village, Bihar, to identify behavioural and socio-cultural barriers affecting maternal and child health.

The results showed that a great many women possessed only a limited amount of knowledge regarding proper complementary feeding practices, modern contraceptive methods, and essential hygiene habits. The study found misconceptions about introducing complementary foods after six months, such as the belief that doing so would enlarge a child's stomach or negatively affect their appearance. With regard to family planning, contraception was generally linked mainly to sterilisation, and women's views and decisions were affected by their concerns and misconceptions about methods like the Copper-T and condoms. Inadequate handwashing, unsafe food handling, and a lack of attention to children's personal hygiene were observed, highlighting the gap between health information and its application in everyday life.

The study also indicates that these practices persist not only because of limited awareness but

also because of cultural beliefs, misinformation, social stigma, and household decision-making. Although current government programmes have increased access to health services and information, this has not led to accurate knowledge or lasting behaviour change at the community level.

Community-based behaviour change communication should be strengthened by involving Accredited Social Health Activists (ASHAs), Anganwadi Workers, and Auxiliary Nurse-Midwives (ANMs). Health education should stress the importance of starting breastfeeding early, promote exclusive breastfeeding during the first six months, ensure diverse and nutritious complementary foods are introduced in a timely manner, and continue breastfeeding until the child is two years old or longer. Family planning information campaigns should give accurate details regarding modern contraceptive methods, deal with common fears and misconceptions, and help encourage informed discussions between women, their partners, family members, and healthcare providers. Moreover, ongoing hygiene education should promote handwashing with soap, safe food handling, the use of clean feeding utensils, and good personal hygiene among children. Continuous community involvement, culturally appropriate health information, and more effective personal counselling by frontline health workers are essential to address persistent misconceptions and promote healthier practices.

Introduction

It is widely accepted that maternal and child health serves as a basic measure of a country's social and economic development. The state of a woman's health during pregnancy and childbirth, along with proper methods of feeding infants, good household hygiene, and access to reproductive healthcare, has a significant effect on child survival, growth, cognitive development, and long-term well-being. Malnutrition, poor sanitation, unsafe hygiene practices, and insufficient reproductive healthcare are among the main preventable adverse maternal and birth outcomes in low- and middle-income countries (LMICs) (Darnton-Hill & Mkparu, 2015; Viswanathan et al., 2008).

Continuous research has demonstrated that better maternal nutrition, sanitation, hygiene, and family planning together leads to a reduction in maternal and child mortality and results in an improvement of the general quality of life (WHO, 2023; WHO, 2013). According to Dewidar et al. (2023), improvements in the maternal behavioral and health outcomes were observed through interactive nutritional counseling during the pregnancy period. Children who are exposed to bad hygiene and unsafe sanitation become more susceptible to diarrhoeal diseases, intestinal infections, environmental enteropathy, and undernutrition, all of which have a negative impact on physical growth and cognitive development (WHO, 2016; WHO, 2023). As per NFHS-6 data, 33.8 per cent of the children are underweight in rural India, a rise from 32.1 per cent in NFHS-5, while in Bihar, 36.5 per cent of the children are underweight in rural areas (International Institute for Population Sciences (IIPS)., 2026).

In the same way, micronutrient deficiencies for the mother during pregnancy and the delay or incorrect introduction of complementary foods increases the risk of maternal capacity to conceive and support the pregnancy through birth. The most effective way to prevent micronutrient deficiencies among pregnant women is to assure a sustained diet of various micronutrient dense foods (Gernand et al., 2016; Hanson et al., 2015).

22.5 per cent women between the ages of 15-49 years have below normal BMI¹, while women in rural Bihar have 27.2 per cent of women who have below normal BMI (International Institute for Population Sciences (IIPS)., 2026).

Family planning is also a vital aspect of maternal and child health. When couples have access to modern methods of contraception, they are able to plan their pregnancies, achieve adequate spacing between births, decrease the number of unintended pregnancies, and reduce complications associated with pregnancy. The World Health Organisation (WHO) suggests that there should be a gap of at least 24 months between one live birth and the next in order to lessen adverse outcomes for both the mother and the newborn. There is evidence that proper spacing between births makes a significant difference in reducing maternal mortality, lowering neonatal mortality, improving birth weight, and enhancing the nutritional condition of children (WHO, 2007; Singh et al., 2019).

The aspects of nutrition, hygiene, and family planning are closely linked rather than operating separately. For instance, even if sufficient food is available, repeated cases of diarrhoea due to bad sanitation leads to a reduced absorption of nutrients. In a similar way, pregnancies that are very close together can deteriorate a mother's nutritional condition and as a result affect foetal growth and the health of the infant. It follows that in order to improve maternal and child health, it is necessary not only to provide accessible healthcare services but also to achieve continuous changes in behaviour concerning nutrition, hygiene and practices related to reproductive health.

Seeing these interconnected challenges, the Government of India has launched a number of large-scale programmes designed to improve maternal and child health outcomes. The Integrated Child Development Services (ICDS), which was started in 1975, is still one of the largest

1 Body Mass Index below 18.5 kg/m²

early childhood development programmes in the world and offers supplementary nutrition, growth monitoring, health education, immunisation support, and pre-school education via Anganwadi Centres.

On the basis of this work, the POSHAN Abhiyaan (National Nutrition Mission) was launched in 2018 with a focus on prevention and a lifecycle approach, rather than treating acute malnutrition only after it happens. The program focuses on the first 1,000 days, from conception to a child's second birthday. The Poshan Tracker was launched on 1st March 2021. The tracker serves as the primary governance tool for monitoring infrastructure and service delivery. The application has enabled near real-time data collection for Anganwadi Services, including the opening of Anganwadi Centres, daily child attendance, ECCE activities, and growth monitoring. Currently, the system monitors Pregnant Women, Lactating Mothers, Children up to 6 years of age, and Adolescent Girls. As of March 2026, the mission tracks nearly 14,03,170 Anganwadi Centres and approximately 8,95,29,425 eligible beneficiaries (Government of India, 2026).

The Swachh Bharat Mission (Gramin), which was launched in 2014, has greatly increased access to household sanitation and has encouraged changes in people's behaviour with regard to sanitation and hygiene. As per Ministry of Jal Shakti (2026), the data suggests that more than 11 crore household toilets have been built as part of the programme, leading to a substantial rise in sanitation coverage in rural areas. Although there has been a significant improvement in the availability of infrastructure, various studies indicate that ongoing changes in behaviour concerning the use of toilets, hand hygiene, food hygiene, and environmental sanitation still need concentrated community engagement.

India has likewise boosted reproductive and maternal healthcare by means of various initiatives including the National Family Planning Programme, the Janani Suraksha Yojana (JSY), the Janani Shishu Suraksha Karyakram (JSSK), and the Pradhan Mantri Matru Vandana Yojana (PMMVY). The aim of these programmes is to enhance institutional deliveries, maternal nutrition, antenatal care, access to contraception, and the spacing of births.

Even though there have been considerable policy investments and significant improvements in health infrastructure, large behavioural and knowledge gaps still hinder the effectiveness of these interventions, especially in rural India. Although government programmes have managed to increase the availability of services, their use is often limited by poor awareness, misinformation, strong cultural beliefs, rigid gender norms, and a lack of access to reliable health information (WHO, 2023, International Institute for Population Sciences (IIPS) and ICF, 2022).

Although large-scale surveys like the National Family Health Survey (NFHS) do provide useful estimates at the district and state levels regarding nutrition, family planning, maternal health, and sanitation, they mainly focus on quantifying outcomes and the use of services rather than the underlying knowledge, beliefs, and daily practices which influence these outcomes.

It is therefore necessary to understand people's perceptions of their community, the local myths and the existing practices if effective health communication strategies are to be designed and if programme implementation is to be improved at the grassroots level.

Literature Review

It is generally accepted that family planning forms a fundamental part of reproductive health, since it leads to better results for maternal and child health, reduces the number of unintended pregnancies, and increases women's reproductive autonomy. Yet the fact that contraceptive services are available does not mean that women will actually use them. An increasing amount of evidence indicates that the level of confidence women have in making decisions about their reproduction, the existing gender norms, and the socio-cultural beliefs they hold all have a decisive influence on family planning behaviour (Bayram Değer & Dilmén Bayar, 2026).

Research also shows that misconceptions about complementary feeding, contraception, menstrual hygiene, breastfeeding, and sanitation practices still affect decisions made at the household level. Instead of relying on evidence-based health information, women tend to follow family traditions and community beliefs, which prevents them from adopting the recommended health practices. As a result, simply improving infrastructure does not always lead to better health outcomes unless there are also ongoing changes in behaviour and increased awareness at the community level (WHO, 2016).

In Bihar, where the fertility rate and the unmet need for contraception are still relatively high, these behavioural and social factors are especially important. It shows how important it is for women to have the power to influence their decisions about contraception. In a study of 13,901 married women, Bhan et al. (2024) discovered that women who had higher self-efficacy in family planning were considerably more likely to talk to their spouses about contraception and to use modern contraceptive methods. Yet only a small number of women said that they felt confident in using contraception when faced with opposition from their husbands or other family members, indicating that patriarchal patterns of decision-making and unequal gender relations still have an effect on people's reproductive choices.

The fact that there is still an unmet need for family planning shows that behavioural and structural obstacles continue to restrict the use of contraception even though programme coverage is increasing. Pal et al. (2018), using data from NFHS-4 and applying multilevel spatial analysis, found that about one in five married women in Bihar had an unmet need for family planning. It was discovered that younger women, women with certain parity patterns, women who were employed in skilled jobs, women with particular religious affiliations, and those who had been exposed to mass media were all significant factors in relation to unmet need. Crucially, the study also pointed out that this gap is not merely due to limited access to spacing methods but also results from persistent misconceptions about contraception, insufficient counselling, and low-quality family planning services. Together, these behavioural barriers are just as important as service-related limitations in affecting the use of contraception.

The findings specific to Bihar are in agreement with a wider range of literature showing that myths and misinformation still have an impact on family planning behaviour in rural India. In a qualitative study of young married couples in Maharashtra, Ghule et al. (2015) discovered that fears about infertility, as well as serious side effects and long-term health problems linked to the use of oral contraceptive pills and intrauterine devices, were still common. Together with pronatalist social norms, a preference for having sons, and limited male participation in making reproductive decisions, these concerns were further strengthened.

In a similar way, Tiwari (2018), when looking at an urban poor community in Jamshedpur, found that even though there was near-universal awareness of family planning, misconceptions concerning the Copper-T causing chronic back pain or abdominal discomfort, along with fear of sterilisation, led both men and women to avoid using modern contraceptive methods. Taken together, these studies show that having awareness of family

planning services does not mean that people necessarily possess accurate knowledge or are confident in using them.

The impact of myths and socio-cultural beliefs goes well beyond the area of family planning and can be seen in a number of preventive health practices, especially those concerning maternal and child nutrition. Misconceptions about feeding infants still manage to weaken the advised health practices even though there has been extensive public health communication. Even though breastfeeding is widely regarded as being beneficial for a baby's health, some harmful traditional practices still obstruct proper breastfeeding behaviour.

In a study based on multi-round household survey data from eight districts in Bihar, Das et al. (2019) found that prelacteal feeding, defined as giving newborns food or liquids other than breast milk before breastfeeding has started to be a continuous obstacle to exclusive breastfeeding. The study also pointed out great variation of this practice according to demographic factors and spotted certain vulnerable groups who need specific nutritional interventions. These results show that a positive attitude towards breastfeeding can at the same time exist alongside culturally rooted practices which delay the proper start of breastfeeding, indicating that behavioural norms tend to take precedence over knowledge of the recommended practices.

Misconceptions about feeding infants carry over into the stage of introducing complementary foods. In a cross-sectional study was carried out in rural Lucknow, Varghese et al. (2023) found that only a small number of children between 6 and 23 months of age received a diet that was adequate according to the NFHS-5 guidelines, even so, the consumption of unhealthy foods was still common and dietary diversity was low. Likewise, qualitative research by Zahiruddin et al. (2016) in rural Wardha showed that many mothers did not regard liquids such as rice water, pulse water or cow's milk as complementary feeding and instead believed that only semi-solid or solid foods should count as such.

Garg and Chadha (2010) also noted that nearly three-quarters of the mothers interviewed in Ghaziabad had poor complementary feeding practices, this was mainly due to limited dietary diversity and a lack of adequate nutritional knowledge. Importantly, Bhandari et al. (2004) proved that when rural mothers in Haryana were given structured educational interventions, and noted a significant improvement in their complementary feeding practices and in the physical growth of the children. All of these findings indicate that inadequate complementary feeding is mostly the result of misinformation and traditional beliefs rather than simply a lack of awareness, and they also show that behaviour change interventions designed appropriately can greatly improve maternal practices.

The same is true of behaviour in relation to household hygiene and sanitation. Even though national sanitation programmes have greatly increased the number of toilets and hygiene facilities, it has been found that these improvements have not always led to lasting changes in people's behaviour. In a cluster-randomised trial examining the School of 5 hygiene campaign in the Samastipur and Vaishali districts of Bihar, Lewis et al. (2018) noted that only small and statistically non-significant improvements in handwashing with soap among both schoolchildren and their mothers. Similarly, Biswas and Karmakar (2022) pointed out that people in rural areas still wash their hands with soap at lower rates than those in urban areas, soap being scarce, financial difficulties, and established household routines serving as ongoing obstacles. Together, these studies indicate that simply providing infrastructure is not enough to enhance hygiene practices unless there is continued, context-appropriate behaviour change communication that takes into account existing beliefs and daily routines.

The same kinds of behaviour can be seen in the way adolescents manage their menstruation, since cultural taboos and a lack of knowledge about reproductive health still affect the practices of adolescent girls. In their study of NFHS-5 data from over 95,000 rural adolescent women, Singh et al. (2022) found that the exclusive use

of hygienic methods for menstruation was still considerably lower in rural India, the practice being significantly influenced by the mother's education, the characteristics of the household and factors at the community level. Other cross-sectional studies have also shown that rural adolescent girls are much less likely than their urban peers to have accurate knowledge of menstruation before their first period, mothers acting as the main and often only source of information. As a result, both correct knowledge and persistent misconceptions are passed on from one generation to the next, which underscores the need to tackle the beliefs held at the household level as well as to improve access to menstrual hygiene products.

The literature as a whole shows that myths, misconceptions, and socio-cultural norms still have an impact on preventive health behaviours in a number of areas, such as family planning, infant feeding, hygiene, and menstrual health. Even though there has been an improvement in health infrastructure and in the availability of services, which has increased access to reproductive and child health interventions, behavioural obstacles based on misinformation, gender norms, and low health literacy still prevent people from making effective use of these services.

The studies mentioned above start to overcome this shortcoming by giving qualitative and community-level insights into the myths, misconceptions, and behavioural barriers connected with complementary feeding, family planning, breastfeeding, menstrual hygiene, and sanitation. Yet the evidence is still geographically scattered and is mostly based on data from Maharashtra, Uttar Pradesh, Jharkhand, Haryana, and West Bengal. In the case of Bihar, existing research has usually looked at individual areas separately, for example on family planning self-efficacy (Bhan

et al., 2024), unmet need for contraception (Pal et al., 2018), or prelacteal feeding (Das et al., 2019), rather than considering these behaviours as part of a connected set of household health practices.

There is also a lack of published evidence that looks at the knowledge, beliefs, myths, and daily practices of rural women in Latona village, in the Supaul district, with regard to all these various health areas at the same time. It is important to understand these behavioural aspects at the community level if locally appropriate health education programmes are to be designed and if the effectiveness of current government programmes is to be improved. This study aims to fill that gap by investigating the women's level of awareness, the myths that are held, and their everyday practices concerning family planning, the feeding of infants and young children, and household hygiene in the particular rural setting of Latona village, thus providing specific evidence for use in future efforts to change behaviour and in public health interventions.

The study aims to:

1. Evaluate the women's knowledge of the methods of supplementary feeding for infants and young children.
2. Examine how rural women perceive and think about modern methods of family planning.
3. Examine household hygiene practices related to maternal and child health.
4. Identify the myths, misconceptions, and socio-cultural beliefs that are common in these areas, as they impact health-related behaviours.
5. Provide evidence in support of community-based health promotion and behaviour change interventions.

3. Study Area

Lataona village is a region in the Triveniganj Block of Supaul District, Bihar, India. It is regarded as one of the region's more important rural and semi-urban areas in terms of population and settlement development. Lataona village covers about 1,836 hectares (18.36 km²) and has a population of around 22,270. According to the Census of India 2011, the region has a sex ratio of about 927 females per 1,000 males with a literacy rate of 67.85%. Lataona village was chosen as a study area because of its

population concentration, geographical size, and changes in its administrative arrangements. The area has significantly poor health, nutrition, and sanitation practices among the local population. This study examines the relationship between population growth, settlement expansion, land-use transformation, and the shift from rural to peri-urban areas, and the need to improve health, nutrition, and sanitation practices among the local population.

Image 1: Children coming back from the school



4. Methodology

This study used a pre- and post-intervention approach to measure women's awareness and understanding of health, hygiene, sanitation, nutrition, and childcare practices in Lataona village. Before the intervention, the team gathered baseline data by talking with women individually and in groups to learn about their current knowledge, attitudes, and practices related to personal hygiene, complementary feeding, family planning, maternal health, and children's health and nutrition. The team also explored common misconceptions, awareness gaps, and the challenges women face in adopting good health and sanitation habits.

After collecting the baseline data, the team held awareness sessions, group discussions, and training activities to help women better understand these topics. The interventions highlighted the importance of proper complementary feeding,

breastfeeding, family planning, personal hygiene, handwashing, safe food handling, sanitation, and preventive healthcare for women and children. The sessions also addressed common misconceptions and encouraged women to adopt healthy practices in their daily lives.

After the intervention, the team collected data again through follow-up conversations and discussions to see how women's knowledge, awareness, attitudes, and reported practices had changed. The results were compared from before and after the interventions to measure improvement and find out where more awareness and support were still needed. This method helped the team understand the intervention's impact and showed how community-based health education can support better health, nutrition, hygiene, and sanitation for women and their children.

5. Results

The National Family Health Survey (NFHS-6), carried out by the International Institute for Population Sciences (IIPS) and the Ministry of Health and Family Welfare (MoHFW), shows that Bihar has made tangible advances in a number of health areas. Improvement has been seen in maternal and child health indicators, which rose from 51.9 per cent in NFHS-5 to 63.4 per cent in NFHS-6, and the use of family planning services has increased from 54.6 per cent to 58.6 per cent over the same period (International Institute for Population Sciences (IIPS), 2026). Yet, the state continues to lack behind in progress especially in the rural areas due to a mix of social-cultural barriers and misconceptions

5.1 Knowledge and Misconceptions Regarding Complementary Feeding

The results showed that knowledge about complementary feeding among women in Latona village was quite limited. Even though the majority of mothers understood that breastfeeding was

important in the early months of life, very few knew that complementary feeding should start as soon as the child had finished six months of age while at the same time continuing to breastfeed. Generally, their knowledge of when to introduce complementary food, how often to give it, and the nutritional value of these foods was poor, since many of the women obtained their advice from older members of their family rather than from health workers or other official health information sources.

Several misconceptions about the introduction of complementary foods also came up during the discussions. One widely held belief was that starting to give food after six months would make the child's stomach larger, which would cause the child to look unhealthy or unattractive. Because of this, many families deliberately postponed the beginning of complementary feeding even though government health programmes had given recommendations.

Image 2: Conversation with a woman on Child Growth Monitoring



One participant explained:

“अगर छह महीने के बाद बच्चे को खाना देना शुरू करेंगे तो उसका पेट बड़ा हो जाएगा और बच्चा अच्छा नहीं लगेगा।” (If you start feeding the child after six months, their belly will become distended, and the child won't look healthy).

The fact that such responses show that decisions about feeding infants are mainly based on traditional beliefs and advice passed on from one generation to the next, rather than on scientific knowledge, means that these misconceptions could lead to a delay in introducing appropriate complementary foods and thus increase the risk of undernutrition in the crucial first two years of life.

5.2 Knowledge, Myths, and Social Barriers Related to Family Planning

The study showed that among the women who were interviewed, there was very little awareness of modern methods of family planning. Most of the participants regarded family planning as meaning only female sterilisation and had only a limited amount of knowledge of temporary contraceptive methods such as the oral contraceptive pill,

condoms, the Copper-T, injectable contraceptives, or other methods of spacing.

Apart from a lack of awareness, there were also a number of misconceptions about contraceptive methods which were commonly held in the community. Many women said that they had been told the Copper-T could move up within the body and end up in the chest. At the same time, it was believed that condoms would stay in the woman's body after sex and as a result cause serious health problems. These misconceptions caused fear and led women to avoid thinking about using modern contraceptive methods.

One participant shared:

“दीदी, अगर कॉपर-टी लगवाएंगे तो वह पेट से ऊपर जाकर छाती तक पहुँच जाता है, ऐसा हमने सुना है।” (Didi, we've heard that if you get a Copper-T inserted, it travels up from the abdomen and reaches the chest).

Another woman remarked:

“कंडोम अगर अंदर रह जाए तो बहुत दिक्कत होगी, इसलिए यह सब चीज़ अच्छी नहीं होती।” (If the condom gets stuck inside, it causes a lot of trouble; that's why these things aren't good).

Image 3: Group Discussion with women on Family Planning



Aside from misconceptions, social norms also proved to be a major obstacle to family planning. It was generally regarded as socially inappropriate to talk about contraception in the village, especially when it came to women. A great many of the participants said that they felt embarrassed when discussing reproductive health with doctors or health workers and thought that such talks were only acceptable in urban areas.

One respondent stated:

“दीदी, यह सब बातें तो शहर के लोग करते हैं। गाँव में कोई नहीं करता। हम इतने पढ़े-लिखे भी नहीं हैं कि डॉक्टर से जाकर इस बारे में बात कर सकें।” (Didi, it's people in the city who talk about such things; no one in the village does. We aren't educated enough to go and speak to a doctor about this).

The fact that has been found indicates that behaviour concerning the use of contraception is affected not just by limited knowledge but also by existing gender norms, social stigma, and a low level of confidence when it comes to obtaining information on reproductive health. As a result, misinformation and cultural expectations still prevent people in the community from making informed decisions about family planning.

5.3 Hygiene Practices and Everyday Behaviour

A number of shortcomings in the routine hygiene practices of households in Latona village were

also reported. When observing the participants and talking to them, it was found that many families gave rather little attention to basic hygiene habits which are essential for preventing infections and for keeping children healthy.

Commonly observed practices included children having long, unclean fingernails; handling and serving food without first washing their hands, leaving cooked food uncovered, and not giving children much attention to their personal hygiene. Many women admitted that these things formed part of their daily routine and were not generally regarded as harmful.

The fact that these behaviours exist shows that hygiene practices are not mainly the result of intentional neglect but rather due to a lack of awareness about disease prevention and the safe ways of carrying out household activities. Although some women were aware of the general importance of cleanliness, they usually did not know the connection between ordinary hygiene habits and the prevention of diarrhoeal diseases, infections, and other common illnesses which affect women and children.

The evidence as a whole shows that simply improving sanitation infrastructure may not be enough unless it is combined with continuous behaviour change communication which looks at household practices and encourages practical hygiene behaviours at the community level.

6. Discussion

Even though Bihar has in the past had worse maternal and child health results than a number of other Indian states, over the last few years there have been improvements due to the introduction of a number of national health and nutrition programmes, such as the Integrated Child Development Services (ICDS), POSHAN Abhiyaan, the Swachh Bharat Mission (Gramin), and the National Family Planning Programme.

When community engagement activities were carried out in Latona village, it was found that a large number of women had only a limited knowledge of proper complementary feeding practices, modern contraceptive methods, and household hygiene. Misconceptions about child nutrition, family planning, and sanitation practices still affected people's daily health decisions, indicating that behavioural and informational barriers remain even though there have been improvements in programme coverage. The same pattern has been noted across India, since a lack of awareness of health services does not always result in correct knowledge or in the adoption of healthy practices (Pal et al., 2018; Varghese et al., 2023).

The fact that these observations point to the importance of going beyond general health indicators and looking at the behavioural aspects of maternal and child health at the community level shows that it is necessary to gain a clear understanding of women's knowledge, the myths that are currently held, and their everyday practices if context-specific behaviour change programmes are to be designed and if the existing government health programmes are to be made more effective.

With regard to complementary feeding, many of the participants thought that giving the child food after six months would make the child's stomach larger or have a negative effect on the child's appearance. Zahiruddin et al. (2016) have also recorded similar misconceptions, showing that mothers usually did not know what appropriate complementary foods are due to strong cultural beliefs. In the same way, Bhandari et al. (2004) showed that focused nutrition education can greatly improve feeding practices and therefore indicated that misinformation, not lack of willingness, is the main obstacle. Moreover, there is a need for nutritional counselling for pregnant women, access to quality ANC and postnatal care services, promoting delivery at the health facility, which has improved overall in the country, and adequate infant and young child feeding practices and techniques (Alam et al., 2005; Girard & Olude, 2012; Perumal et al., 2013).

The study also identified a number of misconceptions about family planning, since a great many women saw contraception only in terms of sterilisation and had fears about modern methods such as the Copper-T and condoms. This is in line with the findings of Ghule et al. (2015), Tiwari (2018) and Bhan et al. (2024), which show that myths, social stigma and low self-efficacy still affect the way contraceptive decisions are made in rural areas.

In the same way, the poor hygiene practices seen in the community, such as insufficient handwashing, unsafe food handling, and a neglect of the personal hygiene of children, again reflect earlier evidence that behavioural change continues to pose a major challenge even when sanitation infrastructure has improved (Lewis et al., 2018; Biswas & Karmakar, 2022).

7. Recommendations

In light of the results of this study, it is important to strengthen community-based behaviour change programmes in order to improve maternal and child health in rural areas. The health education sessions carried out by ASHAs, Anganwadi Workers and Auxiliary Nurse-Midwives (ANMs) should be aimed at correcting the common myths concerning complementary feeding, family planning and hygiene by using simple and culturally suitable communication. Mothers should start breastfeeding within one hour of birth and to continue with exclusive breastfeeding for the first six months. Complementary feeding should then be introduced after six months, together with continued breastfeeding until the child is two years old or for a longer period. Children should be given a variety of nutritious and age-appropriate foods including cereals, pulses, vegetables, fruits, eggs and other locally available sources of protein. Junk food and drinks that contain sugar should be avoided.

Awareness programmes should not only provide accurate information about modern methods of contraception, also deal with the misconceptions associated with their use, and promote open discussions between couples and healthcare providers. Activities which involve husbands and older members of the family might help to reduce the social stigma and lead to more informed decision-making.

Furthermore, regular awareness campaigns ought to stress the importance of key hygiene practices such as washing one's hands with soap, handling food safely, using clean feeding utensils, and maintaining personal hygiene among children. It is probably more effective in leading to sustainable changes in behaviour and in enhancing the effectiveness of current government health and nutrition programmes to carry on community engagement rather than relying on one-off awareness campaigns.

8. Conclusion

In all three areas of focus; complementary feeding, family planning, and hygiene, the results show a consistent pattern: limited knowledge, widespread misconceptions, and strong socio-cultural beliefs still affect the women's health practices in Latona village. Even though government health and nutrition programmes have increased the availability of services and information, awareness among households remains fragmented and myths continue to influence daily decisions. It is therefore important that if health outcomes are to improve, it is necessary not only to expand access to services but also to strengthen community-based health education, deal with misinformation,

and promote behaviour change by using communication strategies that are appropriate to the culture.

Behaviour change programmes have to deal with local myths, cultural beliefs, and social norms by means of ongoing community involvement, health education that is tailored to the specific context, and by having frontline health workers improve their interpersonal communication. These approaches are necessary if awareness is to be turned into lasting behavioural change and if the current maternal and child health programmes are to become more effective.

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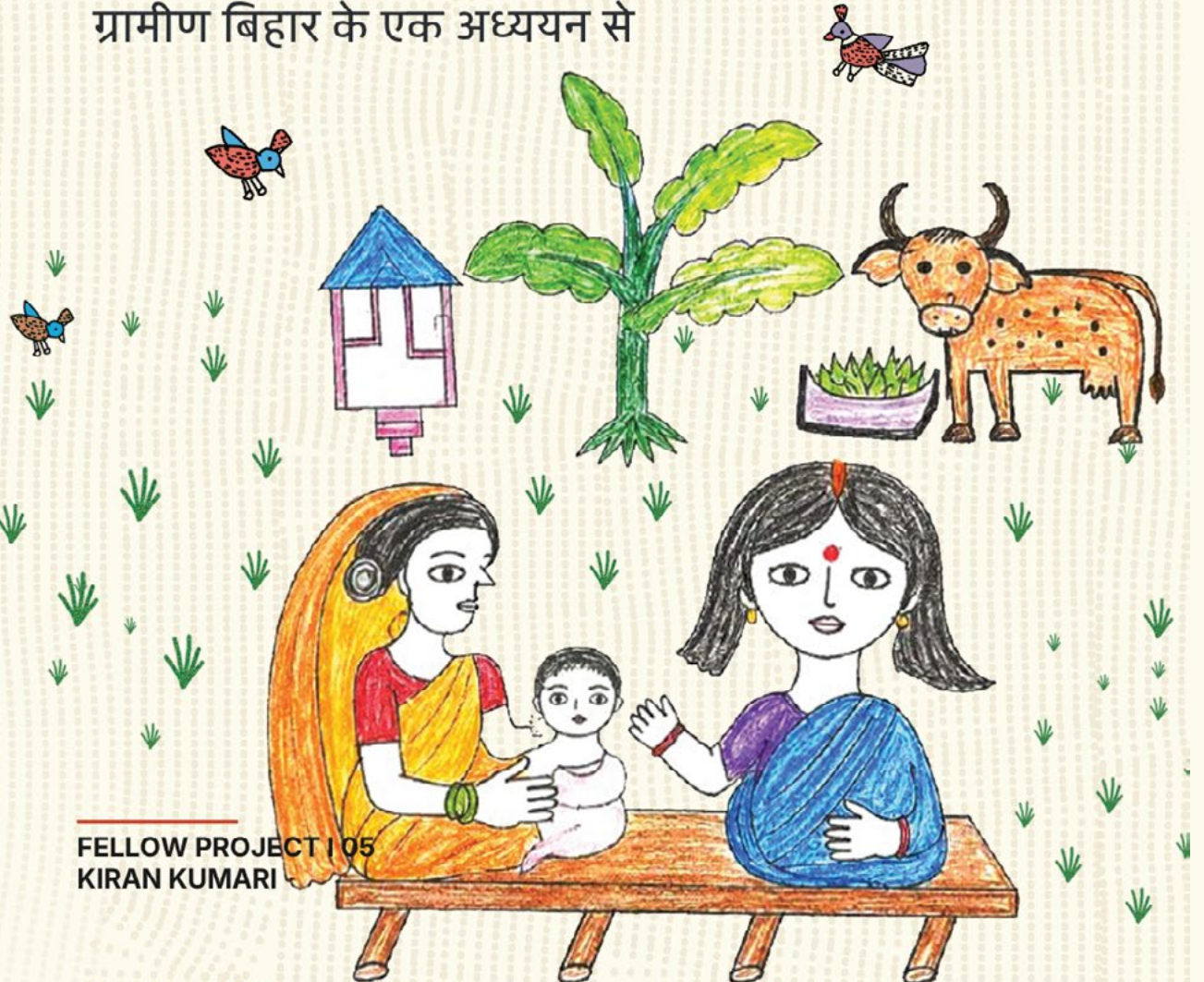
Design Application



Social Impact Design Fellowship 2026

आज भी सामाजिक धारणाओं और परंपराओं से प्रभावित हैं मातृ एवं शिशु स्वास्थ्य से जुड़े फैसले

ग्रामीण बिहार के एक अध्ययन से



FELLOW PROJECT | 05
KIRAN KUMARI



हाल ही में जारी NFHS-6 की रिपोर्ट के अनुसार, बिहार में मातृ एवं शिशु स्वास्थ्य संकेतकों (maternal and child health indicators) में सुधार हुआ है।

NFHS-5 से NFHS-6 के बीच यह आँकड़ा 51.9% से बढ़कर 63.4% हो गया है। इसी दौरान परिवार नियोजन (Family planning) अपनाने की दर भी 54.6% से बढ़कर 58.6% हो गई है।

लेकिन सुपौल ज़िले के लतोना गाँव में किए गए फील्ड रिसर्च से एक अलग तस्वीर सामने आई। नई शादीशुदा महिलाओं और युवा माताओं के साथ किए गए इंटरव्यूज से पता चला कि गलत जानकारी, सामाजिक मान्यताएँ और गहरी जड़ें जमा चुकी धारणाएँ आज भी उनके स्वास्थ्य से जुड़े रोज़मर्रा के फैसलों को प्रभावित कर रही हैं।





ज्यादातर माताएँ स्तनपान (breastfeeding) के महत्व को समझती थीं।



लेकिन बहुत कम माताओं को यह जानकारी थी कि छह महीने की उम्र के बाद, स्तनपान के साथ बच्चे को पूरक आहार (ऊपरी खाना) देना शुरू करना चाहिए।

एक माता के कहना था,
"अगर छह महीने के बाद बच्चे को खाना देना शुरू करेंगे, तो उसका पेट बड़ा हो जाएगा और बच्चा अच्छा नहीं लगेगा।"



अधिकांश महिलाएँ फैसले लेने के लिए, स्वास्थ्य कर्मियों की सलाह के बजाय बड़े-बुजुर्गों की सलाह पर निर्भर पाई गई।



कई महिलाओं के लिए परिवार नियोजन का मतलब केवल महिला नसबंदी था। आधुनिक गर्भनिरोधक तरीकों के बारे में बहुत कम जानकारी के साथ बहुत से भ्रम भी पाए गए।



एक महिला ने अपनी चिंता बताते हुए कहा, "दीदी, अगर कॉपर-टी लगवाएंगे तो वह पेट से ऊपर जाकर छाती तक पहुँच जाता है, ऐसा हमने सुना है।"



एक अन्य महिला का मानना था, "कंडोम अगर अंदर रह जाए तो बहुत दिक्कत होगी, इसलिए यह सब चीज़ अच्छी नहीं होती।"



इसके अलावा, गर्भनिरोधक के बारे में बात करना भी सामाजिक रूप से उचित नहीं माना जा रहा था। एक महिला ने अपनी झिझक व्यक्त करते हुए कहा: "दीदी, यह सब बातें तो शहर के लोग करते हैं। गाँव में कोई नहीं करता। हम इतने पढ़े-लिखे भी नहीं हैं कि डॉक्टर से जाकर इस बारे में बात कर सकें।"



अध्ययन में यह भी पाया गया कि रोज़मर्रा की स्वच्छता संबंधी आदतों में अभी भी कई कमियाँ हैं।

बच्चों के गंदे नाखून, बिना हाथ धोए खाना बनाना, पके हुए भोजन को बिना ढके रखना और बच्चों की साफ़-सफ़ाई पर कम ध्यान देना जैसी बातें आम तौर पर देखने को मिलीं।



ये आदतें लापरवाही नहीं, बल्कि बीमारियों से बचाव और बच्चों के स्वास्थ्य की सुरक्षा के बारे में जागरूकता की कमी को दर्शाती थीं।



यह अध्ययन एक साफ़ निष्कर्ष की ओर इशारा करता है। स्वास्थ्य परिणामों में सुधार लाने के लिए, सिर्फ़ बेहतर सुविधाएँ और सरकारी योजनाओं का होना पर्याप्त नहीं है।

अगर ICDS, पोषण अभियान, स्वच्छ भारत मिशन और राष्ट्रीय परिवार नियोजन कार्यक्रम जैसी योजनाओं को वास्तव में प्रभावी बनाना है, तो सेवाएँ उपलब्ध कराने के साथ-साथ लोगों के व्यवहार में बदलाव लाने पर भी उतना ही ज़ोर देना होगा। इसके लिए आशा कार्यकर्ता, आंगनवाड़ी कार्यकर्ता और एएनएम के माध्यम से समुदाय-आधारित स्वास्थ्य जागरूकता बेहद महत्वपूर्ण है।



