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Original Research Article

A study on traditional beliefs and practices on newborn care among the mothers in selected hospitals Shillong, Meghalaya

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ABSTRACT

Background: Traditional beliefs continue to influence newborn care practices despite improvements in maternal and child health services. While some cultural practices are beneficial, others may adversely affect neonatal health. The present study assessed traditional beliefs and practices regarding newborn care among mothers attending selected hospitals in Shillong, Meghalaya.

Methods: A quantitative descriptive cross-sectional study was conducted among 160 mothers of infants aged 0–6 months attending the North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIHMS) and Ganesh Das Government Maternal and Child Health Hospital, Shillong, Meghalaya. Participants were recruited using a consecutive sampling technique. Data were collected using a structured questionnaire on socio-demographic characteristics and semi-structured questionnaires on traditional beliefs and newborn care practices. Data were analyzed using IBM SPSS Statistics version 26. Frequencies and percentages were used for descriptive analysis, and the Chi-square test was used to examine associations between newborn care practices and selected socio-demographic variables. Statistical significance was set at $p<0.05$.

Results: Overall, 68.1% of mothers demonstrated adequate newborn care practices, while 31.9% had inadequate practices. The commonly reported practices included hand hygiene before handling the newborn (91.2%), colostrum feeding (83.1%), avoidance of pre-lacteal feeding (82.5%), and dry cord care (80.0%). Potentially harmful practices included bathing within 24 hours of birth (30.6%), pre-lacteal feeding (17.5%), application of substances to the umbilical cord (15.6%), and use of herbal remedies (14.4%). Traditional beliefs concerning maternal dietary restrictions (76.9%), the influence of maternal diet on breast milk (53.1%), and elders' involvement in newborn-care decisions (45.0%) were also reported. Marital status was significantly associated with overall newborn care practices ($p=0.034$).

Conclusions: Although most mothers reported adequate newborn care practices, certain traditional beliefs and potentially harmful practices persisted. Culturally sensitive, evidence-based health education involving mothers and family members is essential to reinforce safe newborn care while respectfully addressing practices that may place newborns at risk.

Keywords: Newborn care, Traditional beliefs, Cultural practices, Mothers, Neonatal health, Meghalaya

INTRODUCTION

Newborn care is an essential component of maternal and child healthcare and plays a vital role in promoting neonatal survival and healthy development. More than 132 million babies were born worldwide in 2023, with India accounting for over 23 million births.[1] The neonatal period, defined as the first 28 days of life, is the most vulnerable stage for child survival. Despite remarkable advances in maternal and newborn healthcare, neonatal mortality remains a major global public health challenge. An estimated 2.3 million newborns died during the neonatal period in 2024, equivalent to approximately 6,200 deaths each day.[2] Appropriate newborn care, including early initiation and exclusive breastfeeding, maintenance of body temperature, hygienic umbilical cord care, hand hygiene, and timely immunization, is essential for reducing preventable neonatal illness and deaths.[2,3]

In India, improvements in maternal and child health services have contributed to progress in newborn healthcare; however, neonatal and infant mortality remain important public health challenges. According to the National Family Health Survey (NFHS-5, 2019–21), the neonatal mortality rate and infant mortality rate were 24.9 and 35.2 per 1,000 live births, respectively.[4] However, neonatal mortality continues to remain a significant public health concern, with marked regional disparities. Meghalaya reported an infant mortality rate of 34 deaths per 1,000 live births, which is higher than the national average of 25 deaths per 1,000 live births.[5] These findings highlight the need to strengthen newborn care practices, particularly in regions with poorer child health indicators.

Traditional beliefs and cultural practices continue to influence newborn care in many parts of India. While some traditional practices may be beneficial or culturally acceptable, others-including pre-lacteal feeding, early bathing, application of substances to the umbilical cord, maternal dietary restrictions, and the use of herbal remedies may delay or interfere with evidence-based newborn care and adversely affect neonatal health. Understanding these beliefs and practices is essential for promoting safe newborn care while respecting cultural values.[6-11]

Meghalaya is home to diverse indigenous communities with rich cultural traditions, where customary beliefs continue to influence maternal and newborn care. Despite improvements in institutional deliveries and maternal healthcare services, published evidence on traditional beliefs and newborn care practices among mothers in this region remains limited. Understanding these beliefs and practices is essential for identifying beneficial cultural traditions, discouraging potentially harmful practices, and developing culturally appropriate health education and nursing interventions that promote evidence-based newborn care.[12,13]

Therefore, the present study was conducted to assess traditional beliefs and practices related to newborn care among mothers attending selected hospitals in Shillong, Meghalaya, and to determine the association between newborn care practices and selected socio-demographic variables.

METHODS

Study design

A quantitative descriptive cross-sectional study was conducted to assess traditional beliefs and practices related to newborn care among the mothers attending selected hospitals in Shillong, Meghalaya.

Study setting and population

The study was conducted at the North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIHMS), Shillong, Meghalaya, and Ganesh Das Government Maternal and Child Health Hospital, Shillong, Meghalaya. The study population comprised mothers of infants aged 0–6 months attending the postnatal wards, Paediatric wards, and outpatient departments of the selected hospitals during the study period.

Sample size and sampling technique

A total of 160 mothers were recruited using consecutive sampling technique. Eligible participants were enrolled consecutively from the selected study settings until the required sample size was achieved.

Eligibility criteria

Mothers were eligible for participation if they were aged 18 years and above, had an infant aged 0–6 months, were willing to participate, and provided written informed consent. Mothers were excluded if their infants were critically ill or had died, or if unwilling to participate.

Data collection tool

Data were collected using a structured and semi-structured questionnaire comprising three sections. Section I assessed socio-demographic characteristics, including age, marital status, number of living children, educational level, occupation, monthly family income, social category, area of residence, type of family, and religion. Section II comprised 10 items assessing traditional beliefs related to newborn care, including breastfeeding, colostrum feeding, maternal dietary restrictions, first bath, evil eye, charms and amulets, herbal remedies, and the role of family elders. Section III comprised 13 items assessing newborn care practices related to feeding, bathing and thermal care, cord care, newborn handling, protective practices, health and hygiene, and social practices. Responses were recorded using yes/no, multiple-choice, and open-ended response formats as appropriate. Out of these, only 8 items were used for scoring the adequacy of newborn care practices.

Scoring Criteria and Interpretation: Each of the 8 scorable items was assigned a score of 1 for a useful practice and 0 for a potentially harmful practice. The maximum obtainable score was 8. Based on the total score, practices were classified as adequate (6–8; ≥75%) or inadequate (0–5; <75%).

Data collection procedure

Following approval from the Institutional Ethics Committee (IEC) and the Thesis Review and Monitoring Committee (TRMC) of NEIGRIHMS, administrative permission was obtained from the concerned hospital authorities. Data were collected between 3rd November 2025 to 29th November 2025 among 160 mothers who fulfilled the eligibility criteria. The purpose and procedure of the study were explained to each eligible participant, and written informed consent was obtained before enrolment. Data were collected using the study questionnaire while ensuring the privacy of participants and the confidentiality of the information provided.

Statistical analysis

Data were coded and analyzed using IBM SPSS Statistics version 26. Frequencies and percentages were used to summarize socio-demographic characteristics, traditional beliefs, and newborn care practices. The Chi-square test was used to determine the association between overall newborn care practices and selected socio-demographic variables. A p-value of <0.05 was considered statistically significant.

Ethical considerations

The study received approval from the Research Committee, Thesis Review and Monitoring Committee (TRMC), NEIGRIHMS (Approval No. NEIGR-Acad/PG/5/2024-Academics, dated 10th June 2025), and the Institutional Ethics Committee (IEC), NEIGRIHMS (Approval No. NEIGR/IEC/M3/T4/25, dated 1st September 2025). Administrative permission was obtained from the Medical Superintendent, NEIGRIHMS, Shillong, and the Directorate of Health Services, Meghalaya. Written informed consent was obtained from all participants before data collection, and confidentiality of the collected information was maintained throughout the study.

RESULTS

Traditional beliefs regarding newborn care

The most commonly reported beliefs were maternal dietary restrictions (76.9%) and the belief that certain foods affect breast milk production (53.1%), as shown in Figure 1.

Overall newborn care practices

Overall, 68.1% of mothers demonstrated adequate newborn care practices, whereas 31.9% demonstrated inadequate practices, indicating the need for continued health education and culturally appropriate counselling.

Table 1: Socio-demographic characteristics of mothers (n=160).

Demographic variables	Category	Frequency (f)	Percentage (%)
Age (in years)	18-29	104	65.0
	30-39	48	30.0
	40-49	08	05.0
Marital status	Married	153	95.6
	Single parent	07	04.4
Number of living children	1-2	91	56.9
	3-4	44	27.5
	≥5	25	15.6
Educational level	No formal education	18	11.2
	Primary school	36	22.5
	Secondary school	55	34.4
	Higher secondary	28	17.5
	Graduate and above	23	14.4
Occupation	Homemaker	107	66.9
	Daily wage worker	37	23.1
	Government employee	04	02.5
	Private sector employee	08	05.0
	Others (Village data volunteer)	04	02.5
Monthly family Income	Rs. 69,584 - Rs. 92,764	03	01.9
	Rs. 46,405 - Rs. 69,584	03	01.9
	Rs. 27,815 - Rs. 46,405	06	03.8
	Rs. 9,276 – Rs. 27,815	55	34.3
	< Rs. 9,276	93	58.1

Continued.

Demographic variables	Category	Frequency (f)	Percentage (%)
Social category	General	02	01.2
	Scheduled Caste (SC)	04	02.5
	Scheduled Tribe (ST)	151	94.4
	OBC	02	01.2
	Other	01	00.6
Area of Residence	Rural	133	83.1
	Urban	27	16.9
Type of Family	Nuclear family (only parents and children)	95	59.4
	Joint family (with parents-in-law)	58	36.2
	Extended family (with other relatives)	07	04.4
Type of Religion	Christianity	144	90.0
	Hinduism	10	06.3
	Others (Niam Tynrai, Niam Khasi)	06	03.7

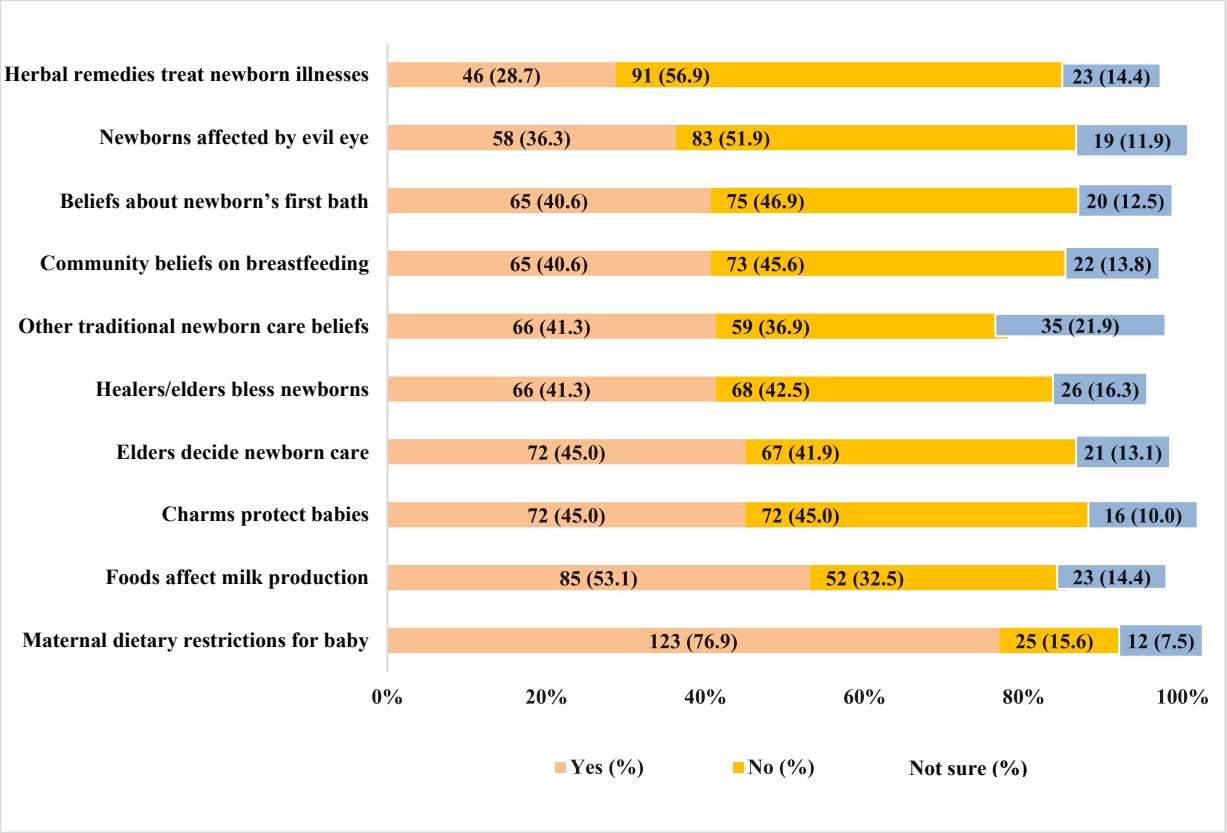


Figure 1: Traditional beliefs related to newborn care among mothers in (n=160).

Traditional practices related to newborn care

The classification of newborn-care practices into useful, potentially harmful, and neither useful nor harmful practices are presented in Table 2. The commonly reported useful practices were hand hygiene (91.2%), colostrum feeding (83.1%), dry cord care (80.0%), and avoiding taking the newborn outside (70.0%). Potentially harmful practices included early bathing (30.6%), pre-lacteal feeding (17.5%), application of substances to the cord (15.6%), and use of herbal remedies (14.4%). Evil-eye protection practices were reported by 30.0% of mothers.

Table 2: Classification of newborn care practices into useful, potentially harmful and neither useful nor harmful practices among mothers of Shillong, Meghalaya, (n=160).

Category	Practices	Responses	Frequency (f)	Percentage (%)
Useful practices	Pre-lacteal feeding	No	132	82.5
	Initiation of breastfeeding	As early as possible	60	37.5
	Colostrum feeding	Yes	133	83.1
	First bath timing	After 24 hours	81	50.6
	Oil massage	Yes	46	28.7
	Cord care	Nothing applied (dry cord care)	128	80.0
	Hand hygiene	Yes	146	91.2
	Restricting visitors	No (not allowing others)	79	49.4
	Avoid taking baby outside	Yes	112	70.0
Potentially harmful practices	Pre-lacteal feeding	Yes	28	17.5
	Early bathing	Within 24 hours	49	30.6
	Application on cord	Oil/other substances	25	15.6
	Hand hygiene	No	14	8.8
	Herbal remedies	Yes	23	14.4
Neither useful nor harmful practices	Evil eye practices	Yes	48	30.0

Classification of practices was based on WHO Essential Newborn Care guidelines and supporting literature.[6-11]

Feeding practices

The majority of mothers did not practice pre-lacteal feeding (82.5%), while 17.5% reported giving pre-lacteal feeds. Among those who practiced pre-lacteal feeding, sugar water was the most commonly given feed (50.0%), followed by plain or warm water (25.0%) and honey (17.8%). Regarding initiation of breastfeeding, 37.5% of mothers-initiated breastfeeding as early as possible, while half (50.0%) initiated breastfeeding within 1–6 hours after delivery. Only 1.9% initiated breastfeeding within 6–24 hours and 10.6% after 24 hours. Colostrum was given by 83.1% of mothers, whereas 16.9% did not provide colostrum. Among mothers who did not provide colostrum, the commonly reported reasons were the baby being sick (29.6%), beliefs related to illness or stomach pain (22.2%), cultural practices (18.5%), and maternal illness (14.8%).

Bathing and thermal practices

Regarding bathing practices, half of the mothers (50.6%) reported giving the newborn's first bath after 24 hours, while 16.9% reported bathing the newborn immediately after birth and 13.8% after 6 hours. About 18.7% could not recall the timing of the first bath. The majority of mothers (83.7%) did not add any substances to the bath water. Among those who added substances, lemon leaves were most commonly used (50.0%), followed by Dettol or other antiseptics (19.2%) and ginger slice (19.2%). Most mothers (71.3%) did not practice oil massage before bathing. Among those who practiced oil massage, mustard oil was the most commonly used (52.2%), followed by coconut oil (19.6%) and mineral oil (17.4%).

Cord care

Most mothers (80.0%) reported applying nothing to the umbilical cord stump, indicating the practice of dry cord care. However, 11.8% reported applying oil, 4.4% used an antiseptic, and 1.9% each reported applying breast milk or talcum powder to the cord stump.

Newborn handling practices

Approximately half of the mothers (50.6%) allowed other individuals to hold their newborns, whereas 49.4% did not. Among those who permitted others to hold the newborn, family members were most commonly allowed to do so (55.6%), followed by everyone (33.3%) and specific caretakers (11.1%).

Traditional protective practices

70.0% of mothers reported no traditional method of protection against the evil eye, while 30.0% reported using at least one protective practice. Among those who used such practices, applying a black dot or Nazar tilak was most common (41.6%), followed by tying thread or matchsticks (39.6%), applying a dot of lime to the sole of the foot (14.6%), and using charms or amulets (4.2%).

Traditional health and hygiene practices

The majority of mothers (85.6%) did not use herbal remedies for newborn care, while 14.4% reported using them. Among those who used herbal remedies, local herbal medicines were most commonly reported (34.7%), followed by *Citrus latipes* (Khasi papeda) (30.5%), mustard oil with garlic (13.0%), steam inhalation (13.0%),

and yam leaf application (8.8%). Most mothers (91.2%) reported practicing hand hygiene before handling the newborn. Among them, 98.6% used soap and water, while 1.4% used water alone.

Traditional social practices

A substantial proportion of mothers (70.0%) reported avoiding taking their newborn outside the home, while 30.0% did not follow this practice. Among those who restricted taking the newborn outside, 54.5% maintained the restriction for 1–3 months, 36.6% for 1 week to 1 month, and 8.9% for 4–6 months.

Association with socio-demographic variables

A statistically significant association was found between marital status and overall newborn care practices (p=0.034). However, no statistically significant association was observed between newborn care practices and age, education, occupation, income, religion, family type, or area of residence.

DISCUSSION

The present study assessed traditional beliefs and newborn care practices among mothers attending two selected hospitals in Shillong, Meghalaya. Overall, 68.1% of mothers demonstrated adequate newborn care practices, suggesting that most participants followed recommended practices; however, selected traditional beliefs and potentially harmful practices remained prevalent. These findings suggest that, despite exposure to institutional healthcare and health education, cultural beliefs and traditional practices continue to influence maternal decisions regarding newborn care.

The majority of mothers (65%) were aged 18–29 years, which was comparable with findings reported by Swain A. et al in Odisha, where 64.1% of mothers were aged aged 25 years or below, and Nethra et al in North Karnataka, where 45% were aged 19–22 years.[14,15] These findings highlight the importance of integrating newborn-care education into routine antenatal and postnatal services.

Maternal dietary restrictions were reported by 76.9% of mothers, comparable with the 71.3% reported by Bangari et al in Dehradun.[16] The involvement of elders in newborn-care decisions reported by 45% of mothers also reflects the continuing influence of family and cultural traditions, as reported by Das et al and Thomas et al.[17,18]

In the present study, 37.5% of mothers-initiated breastfeeding within the first hour and 50.0% within 1–6 hours. Swain et al in Odisha, reported initiation of breastfeeding within the first hour 54.1% and within 1–6 hours 24.7% of mothers, whereas Pagali et al in Kadapa reported 13.6% and 63.5% respectively.[14,19] Vernekar et al in Goa reported a substantially higher rate of early breastfeeding initiation (97.5%).[20] The variation may be related to differences in healthcare settings, counselling practices, and population characteristics. Although breastfeeding initiation was relatively favorable, immediate postnatal breastfeeding support requires further strengthening.

Colostrum feeding was reported by 83.1% of mothers, comparable with findings reported by Swain A. et al. in Odisha (91.8%), Pagali et al in Kadapa (89.3%), and Vernekar et al in Goa (96.3%).[14,19,20] In contrast, Arumugam et al reported colostrum feeding among only 38.9% of mothers in a tribal community in Tamil Nadu.[21] The relatively high acceptance in the present study may reflect improved awareness of the nutritional and immunological benefits of colostrum.

Pre-lacteal feeding was reported by 17.5% of mothers, which was considerably lower than the 61.1% reported by Arumugam et al in Tamil Nadu, South India and 93.7% reported by Gaur et al in Santhal Pargana.[21,22] This comparatively low prevalence may indicate greater exposure to institutional care and professional guidance in the present study.

Safe cord care was practiced by 80.0% of mothers, with no substances applied to the cord stump. This was higher than the 58.75% reported by Vernekar et al in Goa but contrasted with Arumugam et al in Tamil Nadu, where 94.9% of mothers applied substances to the cord.[20,21] The finding may reflect improved awareness of infection prevention through hospital-based counselling.

Oil massage before bathing was reported by 28.7% of mothers, considerably lower than the proportions reported by Swain et al (83.1%), Bangari et al (71%), and Gaur et al (86.9%).[14,16,22] This may indicate declining reliance on certain traditional newborn-care practices.

Hand hygiene before handling the newborn was reported by 91.2% of mothers, with almost all mothers using soap and water. This finding suggests good awareness of basic infection-prevention practices and represents one of the strongest areas of recommended newborn care in the present study.

Herbal remedies were used by 14.4% of mothers, considerably lower than the 70.5% reported by Pagali et al and 40.6% reported by Arumugam et al.[19,21] The lower use of herbal remedies may suggest increasing reliance on professional healthcare services. However, the continued use of local herbal preparations demonstrates the importance of counselling mothers and family members regarding potential risks associated with administering unverified substances to newborns.

Protection against the evil eye was practiced by 30% of mothers, indicating the persistence of culturally rooted protective beliefs. Similar practices have been reported by Bangari et al and Thomas et al.[16,18] Avoidance of taking the newborn outside was reported by 70.0% of mothers, and

more than half of those who followed this practice maintained the restriction for 1–3 months. This was considerably higher than the 22.5% reported by Vernekar et al.[20] The difference may reflect variations in cultural practices and family traditions across communities.

Among the socio-demographic variables examined, marital status showed a statistically significant association with newborn-care practices, whereas age, education, occupation, income, religion, family type, social category, and area of residence were not significantly associated. This suggests that social and family circumstances may influence newborn-care behavior beyond individual socio-demographic characteristics.

Overall, the findings demonstrate a positive shift towards recommended newborn care, particularly regarding colostrum feeding, safe cord care, and hand hygiene, while pre-lacteal feeding, herbal remedies, and oil massage were less prevalent than reported in several previous studies.[13,15-18] Nevertheless, maternal dietary restrictions, protective rituals, and social restrictions continue to reflect cultural influences.[17,18,20,21] Therefore, culturally sensitive antenatal and postnatal education, strengthened breastfeeding counselling, and involvement of family members and elders are essential to address potentially harmful practices while respecting beneficial cultural traditions and promoting safe, evidence-based newborn care.[21,22]

Strengths

A major strength of the study is that it contributes evidence from Meghalaya, where published research on traditional newborn-care beliefs and practices is limited. The study also provides information from a predominantly tribal population and assesses both traditional beliefs and reported newborn-care practices, thereby providing a broader understanding of cultural influences on newborn care.

Limitations

The cross-sectional design limits the ability to establish causal relationships. The study was conducted in two selected hospitals in Shillong, and therefore the findings may not be generalizable to all mothers in Meghalaya. In addition, newborn-care practices were self-reported and may have been affected by recall bias or social desirability bias.

CONCLUSION

Most mothers in the selected hospitals in Shillong demonstrated adequate newborn-care practices, particularly in relation to hand hygiene, colostrum feeding, avoidance of pre-lacteal feeds, and maintaining dry cord care. However, cultural beliefs and traditional practices continued to influence newborn care, including maternal dietary restrictions, protective rituals, social restrictions, early bathing, application of substances to the umbilical cord, and the use of herbal remedies. These findings highlight the importance of culturally sensitive health education that respects beneficial traditional practices while discouraging practices that may pose risks to newborn health. Strengthening antenatal and postnatal counselling, together with the active involvement of family members and elders, may facilitate sustained adoption of safe and evidence-based newborn-care practices.

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