United International Journal for Research & Technology

Volume 07, Issue 11, 2026 | Open Access | ISSN: 2582-6832

Traditional Health Beliefs and Childcare Practices Among Parents in Albay, Philippines: A Qualitative Study

Sean Kenneth B. Daria

Student, AGO Medical and Educational Center Graduate School of Health

***Abstract*—** Traditional and community-based health beliefs continue to shape childcare practices in many Filipino families. This qualitative study explored traditional health beliefs and their influence on childcare practices among parents of children aged 6–12 years in selected communities in Albay, Philippines. Eight parents were purposively selected from four barangays representing urban, coastal-island, and upland settings. Data were collected through individual in-person interviews using a validated self-structured interview guide and analyzed through Braun and Clarke's six-phase thematic analysis. Findings identified nine categories of traditional health beliefs: bathing rules, menstruation rituals, spiritual healing, childcare and feeding traditions, herbal medicines, circumcision traditions, immunization myths, pregnancy myths, and traditional first aid. Elders were the most influential source of these beliefs, while social media had a secondary and conditional role and peers were generally the least trusted. Traditional practices provided familiarity, accessibility, and perceived effectiveness but sometimes contributed to delayed formal consultation, postponed immunization, discomfort, or other adverse outcomes. Parents nevertheless demonstrated willingness to modify long-standing beliefs when Community Health Workers provided clear and culturally understandable explanations. Participants recommended interactive forums, one-on-one health education, visual aids, use of the Bikol language, and culturally responsive community outreach to improve parental health literacy and childcare practices.

***Keywords*—** traditional health beliefs; childcare practices; parental health literacy; community health workers; qualitative research.

I. INTRODUCTION

Parents occupy a central position in determining how children understand health, respond to illness, and engage with healthcare. During childhood, health-related knowledge and practices are largely introduced within the home, where parents and other family members serve as the earliest and most immediate sources of information. Parental decisions regarding hygiene, nutrition, treatment of common illnesses, immunization, and consultation with healthcare providers therefore shape not only children's immediate health experiences but also the health behaviors they may carry into later life. Breiner et al. (2021) emphasized that parental attitudes and practices exert lasting effects on children's development and health outcomes, while Feinberg et al. (2022) associated parental health literacy with the quality of health behaviors developed within the family. Similarly, Bánfai-Csonka et al. (2022) argued that health literacy and healthy habits begin forming during childhood, underscoring the importance of the information and practices children encounter in their immediate environment.

The family environment is especially important in societies where intergenerational relationships remain strong. In Filipino households, traditions, behaviors, and health-related beliefs may be transmitted through repeated interactions among parents, grandparents, children, and other relatives. Felipe-Dimog et al. (2024) described the significant caregiving role of immediate family members in Filipino households and highlighted how communication and everyday practices learned from older family members can be carried across generations. Consequently, parental childcare decisions may reflect not only current medical knowledge but also practices learned during childhood and reinforced by respected family elders.

These practices may become normalized because they are familiar, culturally meaningful, readily available, and supported by the experiences of previous generations.

Traditional and community-based health practices remain important components of health-seeking behavior in many communities. Such practices may include herbal remedies, traditional healing, spiritual rituals, dietary practices, hygiene-related beliefs, and other culturally embedded responses to illness. In the Philippine context, Rondilla et al. (2021) examined folk medicine and demonstrated that traditional and alternative approaches continue to shape individuals' health beliefs and health-seeking behaviors. The manuscript also notes that resistance to abandoning traditional approaches may be associated with trust, previous experience, and perceptions of the formal healthcare system. Bagunu et al. (2025) similarly documented the persistence of traditional healthcare knowledge among indigenous communities in the Philippines and described the continuing interaction between traditional practices and contemporary community health programs. These findings indicate that traditional healthcare cannot be understood merely as an alternative to formal medicine; it is often embedded within wider cultural, familial, and social systems.

Traditional health practices may offer familiarity, accessibility, and perceived benefit, but concerns arise when particular beliefs delay appropriate medical assessment or expose children to potentially harmful interventions. International evidence reviewed in the manuscript demonstrates the complexity of this issue. Berhe et al. (2024), for example, identified both perceived benefits and serious risks associated with traditional healing practices, emphasizing that traditional care cannot automatically be assumed to be either beneficial or harmful in every context. Nzimande et al. (2021) likewise highlighted challenges surrounding the regulation and integration of traditional health practitioners into modern healthcare systems and emphasized the need for approaches that acknowledge indigenous knowledge while addressing safety and regulatory concerns. This distinction is particularly important in child health, where parental beliefs directly influence decisions regarding when, where, and from whom care is sought.

Parental healthcare decisions are also shaped by factors beyond cultural tradition. Nicholson et al. (2020) found that decisions concerning pediatric healthcare are influenced by multiple interacting factors, including parents' trust in healthcare services and their previous experiences with care. Ho et al. (2022) similarly emphasized that family dynamics and broader educational, cultural, and socioeconomic factors influence the health decisions parents make for their children. These findings correspond with Bronfenbrenner's Ecological Systems Theory, which conceptualizes human behavior as developing within interconnected layers of social and environmental influence. In the present study, these layers include the immediate family, community relationships, health professionals, digital information environments, and broader cultural norms. The manuscript therefore uses Ecological Systems Theory alongside Bandura's Social Learning Theory to explain how parents observe, retain, and reproduce health practices learned from influential people and environments.

The contemporary information environment further complicates the formation of parental health beliefs. Social media now functions as a readily available source of health information, allowing users to encounter advice on nutrition, illness management, preventive care, and other health concerns. However, the accessibility of digital health information does not guarantee its accuracy. Sharevski and Loop (2023) demonstrated how children can be vulnerable to health misinformation encountered on social media, emphasizing the difficulty of distinguishing credible from fabricated information. In the Philippine context, Domasian et al. (2025) examined health-related TikTok content and identified concerns regarding the circulation of false or questionable health information, while Acosta et al. (2025) acknowledged both the potential usefulness of social media for disseminating health information and the difficulty some users experience in distinguishing factual from inaccurate content.

Health misinformation is particularly relevant when parents use online information alongside culturally inherited beliefs. Rather than replacing traditional sources, digital platforms may interact with existing beliefs by confirming, challenging, or complicating what parents already understand about health. The World Health Organization (2022) identified infodemics and misinformation as threats to health behavior and emphasized their potential to influence health-related decisions adversely. For parents responsible for young children, uncertainty regarding which sources are credible may therefore influence decisions concerning home treatment, preventive services, and formal consultation. This highlights the importance of health literacy—the capacity to access, understand, evaluate, and appropriately use health information—within the household.

Community Health Workers (CHWs) have an important role in addressing these information gaps. In the Philippine community setting, CHWs are positioned close to households and may serve as trusted providers of health information and basic services. The manuscript identifies nurses and midwives deployed at the barangay level through government health programs as key frontline personnel who can provide evidence-based health education and counter health misinformation. The Department of Health's Human Resource for Health Deployment Program was intended to improve access to basic services, including health education, particularly at the community level (National Economic and Development Authority [NEDA], 2019). However, the presence of healthcare personnel alone does not necessarily eliminate culturally embedded beliefs. Effective health education must account for the sources parents trust, the practices they already follow, and the cultural context in which health decisions are made.

Culturally sensitive health education may therefore offer a more appropriate approach than simply instructing parents to abandon traditional practices. Reyes et al. (2026) emphasized the importance of understanding existing community health practices when developing health education and noted the influence of culturally familiar information sources on health beliefs. Likewise, Van Boxtel et al. (2024) identified childhood as an important period for developing health-related knowledge and emphasized the role of parent-focused health education in supporting child health promotion. Health education that recognizes cultural context while providing clear explanations of potential risks may be more acceptable than approaches that dismiss inherited practices without considering their social meaning.

In Albay Province, the study was situated within communities where traditional and community-based health beliefs remained observable despite the availability of formal health services and community-based health education. The manuscript identifies a recurring concern in which some parents rely on traditional healers or culturally familiar interventions before considering consultation at a health center. Trust in practices that have been transmitted across generations appears to contribute to their persistence, while insufficient health literacy may make it difficult for parents to determine which beliefs are harmless and which may delay appropriate intervention. The local problem is therefore not simply the continued existence of traditional beliefs, but their potential influence on parents' decisions regarding childcare and health-seeking behavior. At the same time, elders, peers, social media, and CHWs represent competing or overlapping sources of health information. Understanding how parents evaluate these sources is necessary for designing health education that responds to actual community practices rather than relying solely on standardized messages.

Accordingly, this qualitative study explored traditional health beliefs and their influence on childcare practices among parents of children aged 6–12 years in selected communities in Albay, Philippines. Specifically, it sought to identify the common traditional and community-based health beliefs practiced by parents; examine how elders, peers, and social media influence parents' trust in these beliefs; explore how traditional health beliefs influence childcare practices and perceived child health outcomes; and identify culturally sensitive health education strategies that may strengthen Community Health Workers' efforts to address traditional health

beliefs and promote appropriate childcare practices. These objectives position parental experiences at the center of the inquiry and provide a basis for understanding how culturally embedded beliefs, social influences, and health education interact within everyday childcare decisions.

II. METHODOLOGY

This study employed a qualitative research design to explore traditional and community-based health beliefs and their influence on childcare practices among parents of children aged 6–12 years in selected communities in Albay Province, Philippines. Eight parents were purposively selected, with two participants drawn from each of four study sites: Barangay 57 Dap-Dap in Legazpi City, Barangay Pawa in Tabaco City, Barangay Nahapunan in Bacacay, and Barangay San Jose (Ogsong) in Guinobatan. These communities were purposively chosen to represent varied geographic and cultural contexts, including urban, coastal-island, and upland settings across Albay's three congressional districts. Eligible participants were biological parents with at least one child aged 6–12 years and had resided in their respective study communities for at least two years. Although non-biological legal guardians were eligible, none were included during data collection. The purposive approach was intended to generate rich, context-specific accounts rather than statistically generalizable findings.

Data were collected through individual, in-person interviews using a self-structured interview guide reviewed and validated by the research adviser and other public health professionals. The interview questions examined participants' traditional and community-based health beliefs, the sources and origins of these beliefs, their influence on childcare practices and perceived child health outcomes, and participants' recommendations for improving Community Health Workers' health education. Following institutional and local approvals, the researcher coordinated with Barangay Health Workers and CHWs to identify eligible participants. Written informed consent and a study summary were provided before interviews, which were conducted in private areas and audio-recorded with participants' consent to support accurate transcription. The recordings were stored on an external hard drive accessible only to the researcher and were designated for permanent deletion within three months after transcription.

Interview data were analyzed using Braun and Clarke's (2006) six-phase thematic analysis approach. The process involved familiarization with the data through repeated listening, generation of initial codes, identification of themes from the codes, review and refinement of themes, final naming of themes, and preparation of the findings. Participants were assigned pseudonymous codes from P1 to P8 according to the order in which they were interviewed to preserve anonymity, and the resulting themes were organized according to the study objectives. Ethical safeguards included prior approval from the Ago Medical and Educational Center Thesis Advisory Group, authorization from relevant local government and barangay authorities, voluntary participation, written informed consent, participants' right to withdraw without consequence, and restricted access to interview recordings and study data.

III. RESULTS

Common traditional and community-based health beliefs practiced by parents of children aged 6–12 years in selected communities in Albay, Philippines

Table 1 presents the traditional and community-based health beliefs practiced by parents of children aged 6–12 years in selected communities in Albay. Nine major categories emerged from the participants' accounts: bathing rules, menstruation rituals, spiritual healing, childcare and feeding traditions, herbal medicines, circumcision traditions, immunization myths, pregnancy myths, and traditional first aid.

These findings demonstrate that traditional health beliefs are not confined to the management of illness but extend across routine hygiene, nutrition, reproductive health, preventive care, first aid, and other aspects of family life.

The manuscript consequently characterizes these beliefs as a system of culturally transmitted rules and practices that continues to guide everyday health-related decision-making.

Table 1. *Traditional and Community-Based Health Beliefs Practiced by Parents in Selected Communities in Albay*

Category of Health Belief	Traditional Beliefs and Practices Identified in the Manuscript	Key Finding
Bathing Rules	Bathing only in the morning; avoiding bathing in the afternoon or evening; avoiding bathing on Tuesdays and Fridays; avoiding bathing after strenuous play or when tired; using lukewarm water; avoiding bathing during menstruation	Bathing was governed not only by hygiene considerations but by beliefs concerning cold exposure, illness, unlucky days, and bodily vulnerability.
Menstruation Rituals	Washing the face with undergarments used during menarche to prevent pimples; sitting on the third stair step to shorten menstruation; restrictions on bathing during menstruation	Menstrual care incorporated ritual practices believed to influence appearance, menstrual duration, and physical well-being.
Spiritual Healing	Consulting hilot, albularyo, santigwar, or tawas before seeking formal care; applying a red cross to the forehead; using pangontra against evil spirits; burying an infant's umbilical cord with religious objects	Illness was interpreted through both physical and spiritual frameworks, making traditional healers a frequent first-line source of care.
Childcare and Feeding Traditions	Rubbing banana peel on the gums during teething; introducing chocolate as a first food and chicken tail thereafter	Traditional instructions from elders extended into infant feeding, teething, and routine childcare.
Herbal Medicines	Use of Lakadbulan, oregano, Buyo, and Matang-Kwaw; herbal preparations were commonly used before medicines or consultation at health facilities	Herbal remedies were perceived as effective, inexpensive, accessible, and culturally familiar, making them a common first-line intervention.
Circumcision Traditions	Preference for community circumcisers; association of traditional circumcision with masculinity; belief that women should not perform post-circumcision wound care	Cultural and gender beliefs influenced where circumcision was performed and how wounds were managed afterward.
Immunization Myths	Belief that children with cough, colds, or fever should not receive vaccines; belief that vaccines commonly cause fever or illness	Misconceptions contributed to postponement or delay of routine childhood immunization.
Pregnancy Myths	Combining prenatal care and vaccination with traditional protective practices such as using pangontra	Modern maternal-health practices coexisted with culturally rooted protective beliefs.
Traditional First Aid	Applying toothpaste to burns; placing cotton on painful teeth or swollen gums; placing paper on the forehead to stop hiccups	Traditional first-aid practices were commonly used for minor conditions, although some resulted in discomfort or documented harm.

A particularly prominent finding was the continued use of spiritual and traditional healing practices. Parents reported consulting hilot, albularyo, santigwar, and tawas, frequently before approaching formal healthcare providers. Spiritual protective practices, such as placing a red cross on an infant's forehead, using pangontra, and performing rituals involving the umbilical cord, further illustrate how health and spirituality remain interconnected in the participants' understanding of child well-being. In some instances, traditional healers were considered the first option because parents believed that previous encounters had resulted in recovery. This pattern suggests that the persistence of traditional healing is supported not merely by custom but also by perceived effectiveness and accumulated family experience.

Herbal medicine constituted another important component of parental health practices. Participants described herbal preparations as practical, accessible, inexpensive, and effective based on personal and intergenerational experience. The continued use of herbal remedies therefore appears to be sustained by both cultural transmission and material considerations. The manuscript's literature review similarly cites Bagunu et al. (2025), who observed continued reliance on traditional health practices among older generations and the transmission of such practices to younger community members. Their findings support the present study's observation that traditional knowledge can remain relevant even in communities where contemporary health services are available.

The findings also demonstrate that culturally embedded practices can influence childcare in areas that carry potential health implications. Traditional feeding practices, beliefs surrounding circumcision, and misconceptions about childhood immunization directly shape decisions parents make for their children. For example, participants described preferences for community circumcisers based partly on perceptions of masculinity, while misconceptions regarding fever, cough, or colds contributed to the postponement of vaccination. Such findings illustrate that traditional beliefs function as practical decision-making frameworks rather than

This pattern is consistent with the broader literature reviewed in the manuscript. Rondilla et al. (2021) reported that perspectives on traditional and alternative medicine in the Philippines influence health beliefs and behavior and that reluctance to abandon traditional practices can be associated with perceptions of the formal healthcare system.

Similarly, Berhe et al. (2024) emphasized that traditional healing remains relevant within communities but may carry both perceived benefits and potential risks, particularly when used without appropriate integration with formal healthcare.

These studies reinforce the need to understand traditional beliefs within their cultural context rather than simply categorizing them as incorrect practices.

Taken together, Table 1 indicates that health beliefs among the participating parents are deeply embedded in family and community life. The findings are consistent with the study's theoretical orientation, particularly Bandura's Social Learning Theory, which proposes that behavior is learned through observation and repeated exposure. The manuscript itself notes that traditional beliefs in Albay are learned through continuous exposure to elders and other influential individuals within the environment. Thus, culturally rooted childcare practices should be understood as learned behaviors maintained through social experience, perceived effectiveness, familiarity, and intergenerational continuity.

How elders, peers, and social media influence parents' trust in traditional and community-based health beliefs.

Table 2 shows a clear hierarchy among the sources influencing parents' traditional health beliefs. Elders emerged as the strongest source of influence, social media played a secondary and conditional role, and peers or neighbors were generally the least trusted. Almost all participants identified parents, grandparents, or other older community members as the origin of many of the practices they continued to observe. Elders were not merely sources of information; they also supervised childcare and demonstrated how specific practices should be performed. This form of repeated and direct exposure strengthens the transmission of beliefs across generations.

The influence of elders can be interpreted through Bandura's Social Learning Theory. The manuscript explains that behavior is learned through observing and imitating significant people within an individual's environment. Participants' accounts of following practices taught by parents and grandparents illustrate this process. When a young parent repeatedly observes an elder performing a traditional remedy, receives direct instruction to use it, and subsequently perceives a favorable outcome, the practice may become normalized and retained as part of the parent's own childcare repertoire. This interpretation is consistent with the manuscript's overall discussion that traditional beliefs are learned through daily exposure

to elders and maintained because they have been practiced by families for generations.

The literature cited in the thesis also supports the importance of family influence. The manuscript discusses Felipe-Dimog et al. (2024), emphasizing how Filipino family structures facilitate the transmission of norms and practices between generations. Ho et al. (2022) likewise highlighted the role of family dynamics in shaping parents' health-related decisions and noted that health choices emerge within broader educational, cultural, and socioeconomic environments. These perspectives are compatible with the present findings, in which parental health beliefs are formed within the immediate family rather than independently from it.

In contrast, peers and neighbors exerted relatively little influence. Some participants explicitly characterized information from neighbors as rumor or chismis, which reduced its perceived credibility.

Rather than reinforcing community-based health information through peer networks, distrust of neighbors sometimes appeared to strengthen parents' dependence on family elders as more authoritative sources. This result is notable because it suggests that physical proximity alone does not determine influence; credibility, authority, familiarity, and previous experience appear to be more important in determining which sources parents trust.

Table 2. *Influence of Elders, Peers, and Social Media on Parents' Traditional Health Beliefs*

Source of Influence	Nature of Influence	Key Findings
Elders	Strong and direct intergenerational influence	Parents and grandparents were the principal sources of traditional health knowledge. Elders provided instructions, demonstrated practices, supervised childcare, and reinforced beliefs through repeated exposure. Their authority was especially evident among first-time parents.
Peers and Neighbors	Weak influence	Parents generally treated information from neighbors and peers cautiously. Some regarded community-based information from peers as rumor or chismis, reducing its credibility as a health-information source.
Social Media	Mixed and secondary influence	Social media could reinforce beliefs when online information matched practices parents already followed. Conversely, conflicting information and comments could cause uncertainty. Some parents selectively trusted online material that was understandable or produced by licensed health professionals.
Overall Pattern	Hierarchy of trust	Elders were the most influential and trusted source, social media had a secondary and conditional role, and peers were the least trusted source of health information.

Social media had a more complex role. Parents reported that online information could validate existing beliefs when the content corresponded with practices they already considered effective. Conversely, conflicting messages, comments, or unfamiliar information could create uncertainty. Some parents became more selective by considering whether they understood the information and whether it came from a licensed health professional. Thus, social media appears to operate partly as a confirmation mechanism: content may strengthen traditional beliefs when it agrees with pre-existing ideas, but it can also stimulate doubt or encourage verification.

This finding corresponds with studies included in the manuscript. Sharevski and Loop (2023) showed that health misinformation encountered through social media could influence how health-related information is interpreted, while Domasian et al. (2025) identified problematic health content circulating on TikTok in the Philippine context. Acosta et al. (2025) similarly described social media as an important channel for

health information while recognizing concerns regarding users' ability to distinguish credible from unreliable content.

Overall, Table 2 demonstrates that parental health beliefs emerge from a layered information environment. However, these sources do not carry equal authority. Elders remain the most influential because their health knowledge is embedded in family relationships, personal trust, repeated exposure, and lived experience. Social media provides an additional information layer that can either reinforce or challenge existing beliefs, whereas peers were generally regarded with greater skepticism. This hierarchy has implications for health promotion: strategies that seek to change culturally embedded practices may be more acceptable when they recognize the influential role of elders rather than attempting to communicate solely with individual parents.

How traditional health beliefs influence parents' childcare practices and perceived child health outcomes

Table 3 demonstrates that traditional health beliefs have both perceived benefits and potential negative consequences for childcare practices. Parents associated traditional practices with familiarity, affordability, convenience, accessibility, and previous experiences of recovery. Because practices such as herbal treatment, hilot, santigwar, and tawas were perceived to work, some participants considered them appropriate first-line interventions before seeking professional healthcare. These positive experiences can reinforce continued use and increase confidence in traditional practices.

Geographic accessibility further influenced this reliance. One participant living in a coastal or island setting explained that transportation could be limited by low tide or the absence of available boats. In such situations, traditional practices were described as the most immediately available intervention. The manuscript interprets this as an important reason why traditional health practices retain practical value in underserved settings: they require less time, cost, and travel than reaching a formal healthcare facility. Thus, traditional care should not be interpreted exclusively as rejection of formal healthcare; in some circumstances, it serves as an adaptive response to accessibility constraints.

Nevertheless, the findings identified significant risks when reliance on traditional practices delayed evidence-based intervention. Participants described using traditional healers before health centers, waiting for traditional interventions to fail, or postponing professional consultation until symptoms became more severe. The manuscript explicitly recognizes that this sequence may delay medical intervention and potentially delay the child's recovery. The concern is therefore not necessarily the existence of a traditional practice itself but the possibility that reliance on it may replace or postpone appropriate assessment when formal medical attention is needed.

Table 3. *Influence of Traditional Health Beliefs on Childcare Practices and Perceived Child Health Outcomes*

Identified Effect	Manifestation in Childcare Practice	Reported or Perceived Outcome
Reliance on traditional treatment as first-line care	Parents commonly used herbal remedies, hilot, tawas, santigwar, or other traditional interventions before consulting health professionals	Perceived recovery strengthened parents' confidence in traditional practices and reduced the perceived need for formal consultation.
Delayed formal medical consultation	Parents sometimes waited for traditional remedies to fail or for illness to become more severe before visiting a health center or hospital	Formal medical intervention could be postponed, particularly when traditional practices were perceived as effective.
Practical response to limited access	Parents in geographically constrained communities used traditional interventions when transportation or access to health facilities was difficult	Traditional practices provided convenience and reassurance when immediate formal care was not readily accessible.

Delayed immunization	Parents postponed vaccination because of beliefs concerning cough, colds, fever, or vaccine-related adverse effects	Some children experienced delays in receiving routine immunizations until misconceptions were corrected by health workers.
Physical discomfort or harm	Certain practices, such as applying traditional substances or protective markings, were continued until parents observed adverse effects	The manuscript documented irritation, discomfort, or worsening of a condition in some cases, prompting parents to discontinue the practice.
Harm from traditional first aid	Toothpaste was applied to a burn based on traditional advice	One parent reported that the burn became more swollen, leading to abandonment of the practice.
Coexistence of traditional and formal healthcare	Parents selected traditional practices for mild conditions but relied more on CHWs or other professionals when illness was considered serious	Traditional and evidence-based care were not viewed as mutually exclusive; parents shifted between them according to perceived severity.
Modification of beliefs after health education	Parents changed beliefs regarding bathing and immunization when CHWs or physicians provided understandable explanations	Clear, practical, and culturally understandable professional advice could correct long-standing misconceptions and modify childcare behavior.

This is particularly evident in immunization. Participants reported postponing childhood vaccines because of beliefs that children with coughs, colds, or fever should not be vaccinated. One participant later acknowledged that this belief had delayed the child's immunization until a health professional explained that appropriate assessment should first be conducted. The finding illustrates how misinformation can affect preventive healthcare even when healthcare services are available.

Physical harm was also documented. One parent reported applying toothpaste to a burn because it was believed to prevent swelling; instead, the affected area became more swollen, and the parent subsequently discontinued the practice. Another traditional protective practice reportedly caused irritation or discomfort to a child. Such experiences were important because parents who directly observed adverse consequences became more willing to discontinue the relevant practice.

These findings are supported by the literature reviewed in the thesis. Nicholson et al. (2020) emphasized that parental healthcare decisions are shaped not only by clinical information but also by trust and previous experiences with healthcare services. The present findings extend that observation by showing that favorable experiences with traditional treatment can similarly strengthen reliance on non-formal care. The World Health Organization review cited in the manuscript also concluded that misinformation can negatively influence health behavior, underscoring the significance of correcting inaccurate health information before it contributes to harmful decisions.

Breiner et al. (2021) further emphasized that parental attitudes and practices have long-term implications for children's development and health, while Feinberg et al. (2022) associated parental health literacy with children's health behaviors and outcomes.

These studies strengthen the importance of addressing parental beliefs because parents function as immediate decision-makers and health-information gatekeepers within the household.

Importantly, the results do not suggest a complete rejection of formal medicine. Participants frequently shifted between traditional and professional care depending on their judgment of illness severity.

Some retained traditional approaches for mild symptoms while giving greater authority to nurses or other health professionals for severe conditions. This coexistence suggests an opportunity for culturally responsive intervention rather than direct confrontation.

Parents demonstrated that beliefs could change when CHWs or physicians provided understandable explanations, particularly when the explanation clarified why a practice might be harmful or why a formal intervention was necessary.

The manuscript consequently concludes that traditional beliefs may contribute to delays and harm, but parents remain capable of modifying them when health education is clear and culturally sensitive.

Culturally sensitive health education strategies that may strengthen community health workers' efforts to address traditional health beliefs and promote appropriate childcare practices

Table 4 presents participants' recommendations for improving health education delivered by Community Health Workers. Rather than relying primarily on conventional lecture-based approaches, parents favored interactive forums, community meetings, one-on-one education, visual aids, house-to-house teaching, use of the Bikol language, age-appropriate content, appropriate incentives, and health workers serving as visible role models. These recommendations reflect parents' direct experience with health services and identify practical communication barriers that may limit understanding and retention.

Table 4. *Parent-Identified Culturally Sensitive Strategies for Community Health Worker Health Education*

Recommended Strategy	Description Based on Participants' Responses	Intended Contribution to Health Education
Interactive health forums	Conduct face-to-face forums and barangay health activities that allow parents to ask questions, exchange ideas, and share experiences	Promote active participation and improve understanding compared with passive lecture-based teaching.
Community meetings	Organize meetings that explain appropriate consultation and healthcare-seeking processes to community members	Improve understanding of when and how to seek formal healthcare.
Visual aids	Use visual materials during information, education, and communication activities	Improve comprehension and retention, especially for participants who have difficulty relying on text alone.
Appropriate use of printed materials	Provide pamphlets or other materials when useful, while recognizing that leaflets and flyers may not always be read	Supplement verbal health teaching while adapting materials to participants' literacy needs.
House-to-house health education	Conduct household visits for parents unable to attend community activities	Reach underserved or absent community members and provide health information in the household setting.
Incentives and rewards	Incorporate appropriate incentives into community health activities	Encourage participation and support memory and engagement with health lessons.
Use of the Bikol language	Deliver health teaching in the local dialect instead of relying primarily on English	Make health information more understandable, accessible, and culturally appropriate.
Age-specific health education	Adjust content and teaching approaches for children, adolescents, and adults	Match health information with differences in developmental level and comprehension.

One-on-one health education	Provide individualized explanations during consultations and check-ups	Allow CHWs to address specific misconceptions and clarify health concerns according to individual needs.
CHWs as role models	CHWs should visibly practice the health behaviors they recommend to community members	Strengthen credibility and trust by demonstrating consistency between health teaching and personal practice.

Interactive health education was strongly emphasized. Participants recommended forums where parents could ask questions, exchange experiences, and clarify information with nurses and other health workers. The findings suggest that passive listening alone may be insufficient for addressing deeply established traditional beliefs because participants require opportunities to compare what they have learned from elders with explanations provided by health professionals. Interactive discussion may therefore be especially valuable when the purpose of health teaching is not simply to provide new information but to address beliefs that have been retained for many years.

Visual communication was another recurring recommendation. Participants stated that visual aids could improve retention, particularly where literacy levels vary. However, the manuscript also identified limitations in the use of printed leaflets and flyers, as some participants observed that these materials were not consistently read. This suggests that educational materials should not merely be distributed but should form part of an active teaching process that explains and reinforces their content. The use of visual aids may be especially useful in presenting practical comparisons between traditional practices and safer evidence-based alternatives.

Language emerged as a critical cultural consideration. Parents recommended delivering health education in Bikol because English-language communication may not be equally understandable to all community members. The use of a local language can reduce communication barriers and allow health concepts to be discussed in familiar terms. Participants likewise recommended adapting educational content according to age because children, adolescents, and adults differ in their ability to understand health information. These recommendations emphasize that culturally sensitive health education involves not only what information is taught but also how it is communicated.

One-on-one health education during consultations was also proposed. Individualized discussion allows CHWs to address a parent's particular concerns, correct specific misconceptions, and explain why certain traditional practices may or may not be appropriate. Such an approach is especially relevant to the findings of Table 3, which demonstrated that parents can alter established beliefs after receiving practical and understandable explanations. The effectiveness of individualized health education therefore lies in creating an opportunity for clarification at the point when parents are actively making health decisions.

Parents also emphasized the importance of credibility through role modeling. They wanted CHWs to demonstrate in their own behavior the health practices they recommend to the community. The manuscript interprets this as evidence that credibility depends partly on whether health workers visibly practice what they teach. This observation is consistent with Social Learning Theory because individuals learn not only from verbal instruction but also through observation of credible role models.

The recommendations are supported by literature reviewed in the manuscript. Reyes et al. (2026) emphasized the need to understand normal community health practices when developing culturally sensitive health education and reported greater trust in culturally familiar sources of information. Bánfai-Csonka et al. (2022) likewise emphasized the importance of tailoring health information to developmental level and equipping parents with accurate knowledge that can subsequently be communicated to children. Van Boxtel et al. (2024) similarly identified childhood as

an important period for developing health-related knowledge and skills and emphasized the potential value of effective health education directed toward parents.

The participants' recommendations therefore extend beyond simply increasing the amount of health information provided. They call for communication that is culturally and linguistically understandable, participatory, accessible, individualized, and supported by credible health workers. The manuscript consequently recommends that CHWs directly address identified traditional beliefs during consultations and outreach activities, involve elders and community leaders where appropriate, use interactive forums and visual aids, incorporate Bikol into health teaching, and provide practical explanations concerning the risks of over-reliance on traditional practices.

Overall, the four tables demonstrate a connected process: traditional health practices are embedded within everyday family life; elders play the strongest role in transmitting and reinforcing them; these beliefs influence parents' choices between traditional and formal care; and parents themselves identify culturally responsive approaches through which CHWs may improve health education. The findings therefore support an approach to community health education that recognizes cultural beliefs while clearly distinguishing practices that are harmless from those that may delay appropriate care or contribute to adverse outcomes.

IV. CONCLUSION & RECOMMENDATION

The study found that traditional and community-based health beliefs remain embedded in the childcare practices of parents in selected communities in Albay, Philippines. These beliefs encompassed bathing rules, menstruation rituals, spiritual healing, childcare and feeding traditions, herbal medicines, circumcision traditions, immunization myths, pregnancy myths, and traditional first aid. Elders were the most influential source of these beliefs, while social media exerted a secondary and conditional influence and peers were generally the least trusted. Although many traditional practices were perceived by parents as effective, accessible, familiar, and practical, some contributed to delays in formal medical consultation, postponed immunization, physical discomfort, or other adverse outcomes. At the same time, parents did not completely reject formal healthcare and demonstrated willingness to modify long-standing beliefs when Community Health Workers or other health professionals provided clear, practical, and culturally understandable explanations. These findings indicate that improving parental health literacy requires health education that recognizes the cultural foundations of traditional practices while addressing beliefs that may interfere with timely and appropriate childcare.

Community Health Workers should strengthen community-based health education by directly addressing the traditional health beliefs identified in the study while using culturally sensitive, participatory, and context-appropriate approaches. Health education may be delivered through interactive forums, one-on-one teaching during consultations, community meetings, house-to-house activities, visual aids, and age-appropriate materials, with the Bikol language used where appropriate to improve comprehension and participation. Because elders were identified as the most influential source of traditional health beliefs, their involvement, together with community leaders, may help increase the acceptance of evidence-based health information. CHWs should also provide practical explanations that distinguish harmless cultural practices from those that may delay formal care or cause harm and should demonstrate consistency between the health behaviors they teach and those they practice. Local health offices may consider integrating these parent-identified strategies into routine health promotion activities, while future studies may involve larger and more diverse populations and use quantitative or mixed-method approaches to examine the prevalence and health effects of the identified beliefs.

REFERENCES

[1] Acosta, J. M., Detsomboonrat, P., Pisarnturakit, P. P., & Urwannachotima, N. (2025). The use of social media on enhancing dental care and practice among dental professionals: Cross-sectional survey study. JMIR Formative Research, 9. https://doi.org/10.2196/66121

[2] Bagunu, J. V., Totaan, E. V., King, N. C., Supan, N. B., & Valencia, K. A. (2025). Ethnography of the traditional knowledge and healthcare practices of the Aytas in Pampanga, Philippines: Its contribution to the Traditional Knowledge Digital Library on Health for Sustainable Development. Journal of Lifestyle and SDGs Review, 5(e03997), 1–17. https://doi.org/10.47172/2965-730X.SDGsReview.v5.n07.pe03997

[3] Bandura, A. (1977). Social learning theory. Prentice-Hall.

[4] Bánfai-Csonka, H., Betlehem, J., Deutsch, K., Derzsi-Horváth, M., Bánfai, B., Finánccz, J., Podráczky, J., & Csima, M. (2022). Health literacy in early childhood: A systematic review of empirical studies. Children, 9(8), 1131. https://doi.org/10.3390/children9081131

[5] Berhe, K. T., Gesesew, H. A., & Ward, P. R. (2024). Traditional healing practices, factors influencing to access the practices and its complementary effect on mental health in sub-Saharan Africa: A systematic review. BMJ Open, 14(9), e083004. https://doi.org/10.1136/bmjopen-2023-083004

[6] Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

[7] Breiner, H., et al. (2022). Parenting knowledge, attitudes, and practices. In Parenting matters: Supporting parents of children ages 0–8. National Academies Press. www.ncbi.nlm.nih.gov/books/NBK402020/

[8] Domasian, K., Am, Gabuyo, K., & Leynes, E. (2025). Health-related videos published by Filipino content creators on TikTok: A thematic analysis. 63(1). https://thepafp.org/journal/wp-content/uploads/2025/07/PAFP-Journal-63-1-67-72.pdf

[9] Feinberg, M., et al. (2022). Family health development: A theoretical framework. Pediatrics, 149(Supplement 5). https://doi.org/10.1542/peds.2021-053509i

[10] Felipe-Dimog, E. (2023). Caring behavior of Filipinos toward their elderly family members. Acta Medica Philippina, 58(15). https://doi.org/10.47895/amp.vi0.6880

[11] Ho, Y.-C. L., et al. (2022). The role of the family in health promotion: A scoping review of models and mechanisms. Health Promotion International, 37(6). https://doi.org/10.1093/heapro/daac119

[12] National Economic and Development Authority. (2019, January 8). Human Resources for Health (HRH) Deployment Program. SDGs–Philippines. https://sdg.neda.gov.ph/human-resources-for-health-hrh-deployment-program/

[13] Nicholson, E., et al. (2020). Factors that influence family and parental preferences and decision making for unscheduled paediatric healthcare—Systematic review. BMC Health Services Research, 20(1). https://doi.org/10.1186/s12913-020-05527-5

[14] Nzimande, S., Zuma, T., & Moshabela, M. (2021). What is the nature of research conducted on regulating traditional health practitioners? A scoping review. Journal of Global Health Reports. https://doi.org/10.29392/001c.28357

[15] Reyes, A. T., Manilay-Robles, C., Serafica, R., Cacciata, M. C., Kawi, J., & Evangelista, L. S. (2026). Health education modalities and influencing factors in rural Philippine communities: A mixed-methods study. Healthcare, 14(2), 210. https://doi.org/10.3390/healthcare14020210

[16] Rondilla, N. A., Rocha, I. C. N., Roque, S. J., Lu, R. M., Apolinar, N. L. B., Solaiman-Balt, A. A., Abion, T. J., Banatin, P. B., & Javier, C. V. (2021). Folk medicine in the Philippines: A phenomenological study of health-seeking individuals. International Journal of Medical Students, 9(1), 25–32. https://doi.org/10.5195/ijms.2021.849

[17] Sharevski, F., & Loop, J. V. (2023, December 14). Children, parents, and misinformation on social media. arXiv. https://doi.org/10.48550/arXiv.2312.09359

[18] Van Boxtel, W., Jerković-Ćosić, K., Schoonmade, L. J., & Mai. (2024). Health literacy in the context of child health promotion: A scoping review of conceptualizations and descriptions. BMC Public Health, 24(1). https://doi.org/10.1186/s12889-024-17955-7

[19] World Health Organization. (2022, September 1). Infodemics and misinformation negatively affect people's health behaviours. World Health Organization. www.who.int/europe/news/item/01-09-2022-infodemics-and-misinformation-negatively-affect-people-s-health-behaviours--new-who-review-finds