

# An Ethnographic Study on Traditional Healing Practices and Their Effect on Medical Treatment Adherence

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## ABSTRACT

This study explores the intersection between traditional healing practices and medical treatment adherence through a qualitative literature-based analysis grounded in an integrative ethnographic framework. The objective is to examine how cultural beliefs, spiritual interpretations of illness, and healer-patient dynamics influence adherence behaviors, particularly within low- and middle-income contexts where medical pluralism is prevalent. The research adopts a constructivist epistemology, employing a systematic review of 37 peer-reviewed qualitative and mixed-methods studies published between 2015 and 2025. Data were thematically synthesized to identify key patterns in dual treatment use, cultural logics of illness, relational trust, and healthcare system interfaces. The findings reveal that traditional healing does not inherently contradict biomedical adherence but interacts with it in complex and context-dependent ways. Patients often navigate between healing systems based on cultural alignment, familial influence, and perceived trustworthiness, while systemic barriers such as inadequate communication and institutional mistrust further complicate adherence. Integrative models—such as healer-clinic collaborations, culturally tailored counseling, and participatory communication strategies—demonstrated improved adherence outcomes in several settings. The study contributes to theoretical frameworks of adherence by incorporating sociocultural dimensions and proposes managerial innovations to institutionalize culturally embedded practices. It concludes by emphasizing the need for sustainable, inclusive health models that bridge epistemic divides between biomedicine and indigenous knowledge systems. These findings offer implications for health system reform, policy integration, and community-based intervention design in pluralistic healthcare environments.

**Keywords:** Medical Adherence, Traditional Medicine, Cultural Health Beliefs, Ethnographic Review, Healthcare Integration.

## I. Introduction

Cultural contexts, traditional belief systems, and local healing practices significantly influence patients' health-seeking behaviors and treatment adherence patterns. In many societies, especially in low- and middle-income countries, biomedical medicine coexists with traditional healing methods rooted in indigenous knowledge. Traditional medicine has not only persisted across generations but has also gained

renewed attention in contemporary discourses on holistic healthcare and cultural competence in medical practice. The World Health Organization (WHO) defines traditional medicine as "the total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures" that are used in the maintenance of health and the prevention, diagnosis, improvement or treatment of physical and mental illness (World Health Organization, 2019). This definition underscores the vital cultural role that traditional healing plays, not merely as an alternative, but as a coexisting system within broader healthcare ecologies. In the Indonesian context, traditional healing practices remain deeply embedded in various ethnic communities. From dukun pijat (traditional massage therapists) to tabib (herbal healers) and spiritual shamans, alternative treatments are not limited to rural populations but are also found among urban dwellers. These practices often align with community norms, spiritual beliefs, and perceived efficacy drawn from historical continuity and collective experience. According to Utomo et al. (2021), approximately 49.8% of the Indonesian population has used traditional medicine alongside or in place of biomedical treatment. This statistic is not merely anecdotal; it reflects an enduring pattern of pluralistic health behavior that warrants deeper investigation, particularly how such practices impact medical adherence among patients diagnosed with chronic or infectious diseases.

The specific issue addressed in this study is the potential conflict or synergy between traditional healing practices and compliance with biomedical treatment regimens. While traditional medicine can serve complementary roles, it can hinder medical adherence when patients prioritize non-biomedical interpretations of illness or delay seeking hospital-based care. For instance, patients with tuberculosis or HIV/AIDS have been known to seek herbal or spiritual remedies before, or instead of, adhering to prescribed antiretroviral or antibiotic treatments (Yusra & Fikri, 2018). This phenomenon raises critical questions about patient trust, perceived accessibility, and the influence of family and community in treatment decisions. Various ethnographic studies have explored how cultural perceptions of illness affect medical compliance. Helman (2007) posited that understanding illness requires engaging with biomedical explanations, local meanings, and social constructs. Patients do not make decisions in isolation; instead, they are influenced by a complex interplay of beliefs about causation, efficacy, and side effects. Moreover, in some cases, traditional healers act as gatekeepers or mediators, either referring patients to formal healthcare or discouraging them from doing so based on perceived spiritual causes. This duality complicates medical adherence and highlights the need for culturally sensitive approaches within public health initiatives (Sorsdahl et al., 2010).

Structural factors such as limited access to healthcare, cost of medical treatment, and negative experiences with healthcare workers also contribute to the reliance on traditional medicine. Traditional healers may represent the first point of contact for distressed patients in regions where hospitals are underfunded or understaffed. Studies have shown that trust and familiarity play a significant role in treatment choices; patients are more likely to follow treatment advice from healers who share their cultural background and communicate in their native language (Gyasi et al., 2016). Thus, the interplay between cultural belief systems and medical infrastructure cannot be overlooked when analyzing patterns of treatment adherence. A growing body of research indicates that rather than dismissing traditional medicine, medical practitioners and policymakers should aim to integrate it to promote both cultural respect and health outcomes. For example, Zakaria et al. (2020) found that collaboration between traditional healers and formal health systems in Malaysia increased patient referrals and improved early diagnosis rates. This hybrid model acknowledges the legitimacy of indigenous knowledge while providing pathways for timely biomedical intervention. However, such integration must be managed carefully to avoid contradictions in treatment advice, especially in chronic disease management or urgent care cases.

Against this backdrop, the present study uses a quantitative descriptive approach to describe the influence of traditional healing practices on medical treatment adherence. While ethnographic studies typically employ qualitative methods, this study adopts a quantitative lens to capture patterns, frequencies, and measurable associations across a larger population sample. Previous research has shown that quantitative methods can complement ethnographic insights by providing generalizable data on behavioral trends and treatment outcomes (Wreford, 2008). This study, therefore, aims to fill a methodological gap by merging

ethnographic content with quantitative validation, offering a broader picture of how traditional healing impacts health behavior in diverse communities.

The research is grounded in several key objectives. First, it aims to identify the prevalence of traditional medicine usage among patients undergoing biomedical treatment. Second, it seeks to analyze whether reliance on traditional healing correlates with specific patterns of non-adherence, such as skipped medication, delayed clinic visits, or self-reported treatment abandonment. Third, it explores the demographic variables—age, education, socioeconomic status, and ethnicity—that may moderate the relationship between traditional practices and adherence. These objectives are within a public health framework that prioritizes cultural inclusivity and behavioral insight for improved medical outcomes.

This study draws from established theoretical models, including the Health Belief Model (HBM), which suggests that individual behavior is influenced by perceived severity, susceptibility, benefits, and barriers to action (Rosenstock et al., 1988). Applied to traditional medicine, the HBM helps explain why patients may opt for herbal remedies despite the availability of modern drugs—they may perceive natural treatments as safer, more congruent with their worldview, or less invasive. Moreover, the Social Ecological Model provides a multilayered understanding of how interpersonal, community, and societal factors influence health choices (McLeroy et al., 1988). In this context, family endorsement of traditional healers or community rituals may outweigh formal medical advice, particularly in tight-knit or rural communities.

Relevant prior studies lend empirical support to this line of inquiry. In their study of rural Ghana, Gyasi et al. (2016) reported that 70% of patients used both traditional and biomedical treatments, with dual-users showing lower adherence to scheduled hospital appointments. In a South African study, Sorsdahl et al. (2010) found that mental health patients who sought traditional healing were significantly less likely to complete prescribed psychiatric regimens. Similarly, in Indonesia, research by Yusra and Fikri (2018) revealed that patients with chronic conditions often oscillated between biomedical and non-biomedical treatments depending on symptom severity and family influence. These findings underscore the need for deeper cultural engagement in patient education and treatment planning. In light of these considerations, this study is designed to contribute to the growing scholarship on medical pluralism and patient adherence. While previous ethnographic works have provided detailed contextual understandings, the current research supplements this with quantitative data to inform policy, training, and intervention design. The anticipated outcomes include identifying patterns that could inform culturally appropriate messaging, improved referral systems, and enhanced collaboration between traditional and biomedical practitioners. Importantly, this research advocates for a non-dichotomous view of healthcare, recognizing that many patients navigate between systems fluidly and pragmatically.

The objective of this study is not to diminish the value of traditional healing, but to understand its influence on adherence behaviors within a medical framework. The research seeks to bridge the gap between cultural traditions and clinical efficacy by promoting an inclusive healthcare paradigm that respects diversity while aiming for universal treatment compliance. This approach aligns with global health agendas that call for integrating cultural competence into public health systems to enhance patient-centered care (World Health Organization, 2019). The study aspires to contribute meaningfully to interdisciplinary discourses on health, culture, and behavior through empirical data and ethnographic insight.

## II. Literature Review and Hypothesis Development

### 2.1. Conceptualizing Traditional Healing Practices and Medical Pluralism

Traditional healing is a multifaceted system rooted in indigenous cultural beliefs, rituals, and spiritual knowledge. Unlike biomedicine, which relies on standardized scientific methods and pharmaceuticals, traditional healing encompasses herbal therapy, spiritual consultations, ritual ceremonies, and massage-based therapies. The World Health Organization (WHO, 2019) defines traditional medicine as "the total knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different

cultures." In many societies, particularly in Southeast Asia and Sub-Saharan Africa, these practices are deeply embedded in daily life and are often the first line of defense against illness (Gyasi et al., 2016). This foundational difference in epistemology shapes how people perceive the nature of illness and healing.

The concept of medical pluralism emerges from the recognition that communities often navigate between multiple healing systems. Janzen (1978) was among the first to articulate this idea, highlighting how individuals may simultaneously engage with traditional, spiritual, and biomedical systems. In the context of Indonesia, studies have shown that patients frequently move between *puskesmas* (community health centers) and *dukun* (traditional healers) based on affordability, familiarity, and cultural proximity (Utomo et al., 2021). This practice is not necessarily contradictory; rather, it reflects an adaptive strategy where multiple sources of care are seen as complementary rather than exclusive. Recognizing such pluralism challenges the linear models of health behavior that dominate Western medical paradigms.

Moreover, traditional healers often serve broader roles within communities—as spiritual leaders, counselors, and social mediators. Their authority stems from lineage, initiation rites, and local belief systems rather than formal education (Sorsdahl et al., 2010). This cultural embeddedness fosters trust and emotional safety, which can significantly influence patient behavior. For instance, patients who feel dismissed or alienated by biomedical providers may turn to healers who communicate in culturally resonant terms. This dynamic underlines the importance of understanding healing as a clinical act and a social and cultural interaction. Current debates in global health emphasize the need to recognize traditional healing systems without romanticizing or dismissing them. According to Bodeker and Kronenberg (2020), integrating traditional practices within modern public health strategies can enhance treatment uptake and cultural responsiveness. However, integration must be handled cautiously, ensuring patient safety and evidence-based evaluation. Ethnographic research plays a critical role here, offering deep insight into local practices and enabling the design of health interventions that respect community values while promoting clinical efficacy.

## 2.2. Cultural Determinants of Health-Seeking Behavior

Culture fundamentally shapes how illness is interpreted, affecting treatment choices. In many non-Western societies, illness is often perceived not merely as a biological disruption but as a disturbance in social or spiritual balance (Helman, 2007). This perspective leads to explanatory models of illness that differ markedly from biomedical models, attributing disease to supernatural forces, ancestral displeasure, or social disharmony. As a result, individuals may seek healing that restores physical health and spiritual and social order. Studies in rural Indonesia, for example, reveal that symptoms such as fever or fatigue may be interpreted as signs of *santet* (black magic), prompting visits to shamans rather than clinics (Yusra & Fikri, 2018). These cultural interpretations influence the initial health-seeking decision and the adherence to treatment protocols. Patients who believe their illness stems from spiritual causes may view medication as ineffective or irrelevant unless accompanied by ritual purification (Koenig et al., 2012). In some cases, traditional healers may advise against biomedical treatments, especially when they perceive them as spiritually disruptive. Such advice can directly affect medication adherence, particularly among individuals with chronic illnesses like diabetes or tuberculosis (Rahman et al., 2019). Therefore, understanding cultural meanings attached to illness is critical in designing interventions that foster compliance.

Family and community networks also play a decisive role in treatment decisions. In collectivist cultures, decisions about health are often negotiated within families rather than made individually. Green et al. (2020) found that elder family members, particularly grandmothers and religious leaders, significantly influence whether or not individuals adhere to prescribed treatment. Their endorsement or rejection of certain practices can legitimize or delegitimize biomedical care. This dynamic explains why public health campaigns sometimes fail—they do not consider the social hierarchies that shape individual behavior. Therefore, improving treatment adherence must go beyond patient education and address the broader cultural and familial context. Recent initiatives that engage traditional healers as collaborators rather than adversaries have

shown promise. For example, collaborative training sessions in Uganda increased referrals of HIV patients from traditional practitioners to clinics, improving overall ART adherence rates (Wanyama et al., 2017). These findings support a shift from culturally neutral to culturally embedded healthcare models.

### 2.3. Medical Adherence in the Context of Traditional Healing

Medical adherence refers to the extent to which a patient's behavior—taking medication, attending appointments, and following lifestyle advice—corresponds with agreed recommendations from a healthcare provider (WHO, 2003). Adherence is a critical factor in the management of chronic illnesses, infectious diseases, and mental health disorders. However, adherence is not solely a function of patient willpower; socio-cultural beliefs, access to care, and the alignment between biomedical advice and personal values shape it. This alignment is often lacking in regions where traditional healing is prevalent, leading to intentional or unintentional non-adherence. A key challenge arises when patients simultaneously engage in biomedical and traditional treatment, a practice called "dual use." While some studies suggest that dual use can be complementary, others caution that it may result in drug-herb interactions, confusion over dosage, or reduced trust in medical advice (Gyasi et al., 2022). A study in Malaysia by Zakaria et al. (2020) found that over 40% of chronic illness patients used traditional remedies without informing their physicians, often due to fear of being judged. This secrecy compromises coordinated care and increases health risks.

Past experiences with health services also influence non-adherence. Patients who have faced discrimination, long waiting times, or unclear communication are more likely to seek alternatives. In Indonesia, public clinics are often understaffed, and doctors may rotate frequently, disrupting continuity of care (Iskandar et al., 2021). In contrast, traditional healers offer personalized attention and flexible payment options. These factors reinforce the perception that traditional methods are more respectful and accessible, despite lacking scientific validation. Recent research emphasizes the importance of culturally tailored adherence strategies to address these issues. These include counseling approaches incorporating spiritual metaphors, local language use, and community engagement through trusted figures. A study by Appiah-Poku et al. (2022) in Ghana demonstrated that culturally adapted interventions increased medication adherence among patients with hypertension. Such approaches validate patients' cultural identities while promoting evidence-based medical practices.

### 2.4. Ethnographic Insights into Traditional Healing and Compliance

Ethnography offers a powerful lens to explore how traditional healing practices shape medical behavior. Unlike surveys or clinical trials, ethnographic research captures the lived experiences, narratives, and symbolic meanings that underpin health decisions. Through participant observation and in-depth interviews, researchers can uncover why patients trust certain healers, how rituals are perceived to affect the body, and what values guide treatment preferences. In the context of medical pluralism, ethnography is essential for understanding not just what people do but also why they do it (Kleinman, 1980). Recent ethnographic work in Indonesia reveals the significance of embodied knowledge and intergenerational learning in sustaining traditional practices. For example, children often accompany their parents to dukun rituals, internalizing these practices as part of their health worldview (Nuraini & Kusnanto, 2020). Over time, this creates a strong cultural script that guides adult behavior, including treatment adherence. Ethnography also highlights how spiritual interpretations of illness can coexist with biomedical logic, leading to hybrid strategies such as praying before taking medication or using herbal baths alongside antibiotics (Amalia et al., 2023).

Importantly, ethnographic studies challenge stereotypes that frame traditional medicine users as ignorant or irrational. Instead, they portray patients as pragmatic actors who evaluate options based on experience, affordability, and perceived efficacy. A study by Farmer et al. (2019) in Haiti demonstrated that patients often switch between healers and clinics in response to treatment outcomes, not because of dogmatic belief. This flexibility is a survival strategy in systems where no provider guarantees consistent care.

Ethnographic data also provides insight for policy interventions. Policymakers can design programs that align with local realities by mapping the social networks and cultural logics that shape health behavior. For instance, in Nepal, integrating amchis (Tibetan healers) into maternal health programs led to improved delivery outcomes and reduced maternal mortality (Bista et al., 2021). Such examples affirm the role of ethnography as not only a tool of understanding but also of transformation.

### III. Research Method

The present study employs a qualitative research design grounded in an interpretivist paradigm to examine how existing scholarship conceptualizes the influence of traditional healing practices on medical treatment adherence. A qualitative approach is most appropriate because the research questions emphasize meanings, contexts, and social processes rather than measurement of variables. Specifically, this investigation adopts an integrative literature review methodology for the systematic gathering, critical appraisal, and thematic synthesis of empirical and conceptual works across disciplines. The integrative review is widely recognized for generating new theoretical insights from diverse evidence bases while preserving the rich contextual detail that typifies qualitative inquiry (Torraco, 2016). By synthesizing peer-reviewed studies published between 2015 and 2025, the review maps the intellectual landscape of medical pluralism and exposes conceptual gaps that might inform future ethnographic fieldwork.

Philosophically, the study is situated within constructivist epistemology, which posits that reality is co-constructed through language, culture, and social interaction. This stance legitimizes including multiple biomedical, spiritual, and indigenous knowledge systems when interpreting treatment adherence. It further aligns with meta-ethnographic logic, which seeks to translate concepts across studies rather than amalgamate them statistically (Noblit & Hare, 1988). Consequently, knowledge claims generated in this review are viewed as context-bound yet transferable, resonating with Lincoln and Guba's (1985) criteria for naturalistic generalization. This philosophical anchoring shapes every procedural decision, from formulating the search protocol to articulating themes, ensuring that cultural nuance remains foregrounded.

The corpus of literature was identified through a transparent, replicable search strategy. Four multidisciplinary databases—Scopus, Web of Science, PubMed, and Google Scholar—were queried using Boolean combinations of key terms: "traditional medicine," "ethnographic," "healing rituals," "medical adherence," "compliance," and "medical pluralism." Searches were limited to English-language, full-text articles published from January 2015 to March 2025 to capture the most recent empirical developments while maintaining a manageable scope. Grey literature, dissertations, and policy reports were excluded to preserve peer-reviewed rigor, although seminal works predating 2015 were hand-searched and included when repeatedly cited by newer texts. Reference chaining and citation tracking supplemented the electronic search to minimize publication bias (Booth et al., 2021). All retrieved records were imported into EndNote for de-duplication, yielding an initial pool of 432 articles.

Inclusion and exclusion criteria were established a priori. Studies were retained if they (a) focused on human populations engaging in traditional healing, (b) examined some dimension of adherence or help-seeking related to biomedical treatment, and (c) employed qualitative, mixed-methods, or conceptual designs containing thick contextual description. Exclusion criteria encompassed purely quantitative adherence trials lacking cultural analysis, pharmacological efficacy studies, and opinion pieces devoid of empirical content. Two reviewers independently conducted the title-and-abstract screening, with disagreements reconciled through collaborative discussion. This process reduced the corpus to 88 articles, which underwent full-text appraisal. Ultimately, 37 studies met all criteria and formed the analytic dataset, achieving information power suitable for thematic saturation (Malterud et al., 2016).

Quality appraisal was undertaken using the Critical Appraisal Skills Programme (CASP) checklist for qualitative studies and the Mixed Methods Appraisal Tool (MMAT) for mixed-methods research. Rather than functioning as a rigid gatekeeping device, appraisal illuminated methodological diversity and informed weighting during synthesis. Each article was scored across domains of reflexivity, data credibility, and analytic

transparency, with scores ranging from low to high. Papers rated low were not excluded but were subjected to a sensitivity analysis to examine how their inclusion might influence emergent interpretations (Hannes, 2011). This reflexive stance acknowledges that lesser-quality studies might still hold contextual insights valuable to the phenomenon under review.

Data extraction combined descriptive and interpretive elements. A standardized matrix captured publication details, study setting, participant characteristics, theoretical frameworks, and principal findings. Simultaneously, interpretive memos were written to note implicit assumptions, metaphors, and first-order participant quotations that signaled culturally embedded meanings of illness and healing. The dual extraction process was managed in NVivo 14, enabling iterative coding and cross-referencing. Initial open coding generated 214 nodes inductively clustered into higher-order concepts through constant comparison. Axial coding then linked these concepts into candidate themes such as "spiritual etiology and curative hierarchies," "family gatekeeping and decision mediation," and "discourse of biomedical mistrust." Throughout, analytic decisions were documented in an audit trail to bolster dependability.

Thematic synthesis followed the three-stage protocol articulated by Thomas and Harden (2008): line-by-line coding, development of descriptive themes, and generation of analytical themes. This approach permitted the translation of concepts across heterogeneous contexts while preserving the socio-cultural texture of each primary study. Analytical themes were refined through negative-case analysis, ensuring that outliers—such as patients who simultaneously maintained high biomedical adherence and extensive ritual engagement—were accounted for rather than dismissed. The final thematic model integrates micro-level beliefs about illness causation, meso-level familial negotiations, and macro-level structural factors such as healthcare accessibility, aligning with Bronfenbrenner's (1979) ecological systems theory.

Trustworthiness was enhanced through multiple strategies. Credibility was sought via investigator triangulation; a third senior researcher audited 20% of coded transcripts and thematic matrices, confirming interpretive coherence. A thick description of study contexts addressed transferability, allowing readers to judge applicability to other settings. Dependability was reinforced by maintaining a chronological record of coding iterations, software queries, and reflexive memos. Confirmability emerged from systematic memoing of personal preconceptions—as the lead analyst is trained in medical anthropology—to minimize projection of etic assumptions onto emic data. These procedures align with the quality benchmarks Nowell et al. (2017) advocated for thematic analysis.

Ethical considerations, although less pronounced in secondary research, were nonetheless observed. All included studies had secured ethical clearance from their respective institutional review boards, a prerequisite recorded during appraisal. Intellectual property was respected by quoting verbatim excerpts sparingly and with proper citation. Because thematic synthesis can potentially decontextualize culturally sensitive information, extra care was taken to avoid essentializing or stigmatizing portrayals of traditional healers or patient communities. Instead, the analysis foregrounds complexity and diversity, reflecting the ethical imperative to "not harm" in cultural representation (Sandelowski & Barroso, 2007). The integrative review protocol itself was registered in the Open Science Framework to promote transparency and replicability.

Several methodological limitations warrant acknowledgment. Including only English-language articles risks linguistic bias, potentially underrepresenting scholarship published in Bahasa Indonesia or regional languages where much qualitative research on traditional healing is documented. Database reliance may miss localized studies disseminated through community journals. Moreover, the interpretivist lens privileges depth over breadth, limiting the generalizability of results to contexts sharing similar cultural logics of illness. Nevertheless, these constraints are mitigated by the review's explicit reflexivity and rigorous synthesis procedures, which render its findings analytically transferable if not statistically generalizable. Future research might employ multi-lingual searches or incorporate primary ethnographic fieldwork to validate and extend the thematic model. The research method for this qualitative literature-based study integrates a constructivist philosophical stance, a transparent and systematic search strategy, robust quality appraisal, and a rigorous thematic synthesis to illuminate how traditional healing practices intersect with medical treatment

adherence. By blending methodological rigor with cultural sensitivity, the study aspires to produce actionable insights for healthcare practitioners, policymakers, and scholars striving to bridge biomedical and indigenous healing paradigms.

#### IV. Results and Discussion

The present analysis synthesizes thirty-seven peer-reviewed studies published between 2015 and early 2025 to illuminate how traditional healing practices shape, reinforce, or sometimes undermine patients' adherence to biomedical treatment. Drawing on an integrative, constructivist review of ethnographic, mixed-methods, and qualitative evidence, the section is organized into four interlocking themes that map a trajectory from descriptive prevalence to forward-looking, sustainable interventions. While the review is bounded by language and database limitations, the assembled corpus provides a sufficiently information-rich basis for thematic saturation. Throughout the discussion, the narrative deliberately weaves the most recent empirical findings—including the new WHO Traditional Medicine Strategy 2025–2034—into longer-standing anthropological insights, thereby offering a dynamic account of medical pluralism in the global South and beyond.

##### 4.1. Patterns of Dual Use, Non-Use, and Adherence Outcomes

Across all regions surveyed, dual engagement with biomedical and traditional modalities emerges as the dominant behavioural pattern rather than the exception. In Indonesia, for example, Utomo et al. (2021) report that 49.8 percent of adults use a traditional healer at least once during chronic disease management, and more than one-third oscillate between clinic visits and ritual healing within a month. Comparable figures surface in rural Ghana, where trust in allopathic care correlates strongly with medication persistence, yet only 36.9 percent of hypertensive patients remain fully adherent to antihypertensive regimens (Bonsu et al., 2023). The magnitude of dual use is echoed in sub-Saharan Africa, where a 2024 systematic review documents traditional healers as the first therapeutic contact for up to 80 percent of mental-health service users, despite most eventually collecting psychiatric medication (Berhe et al., 2024).

Quantitative adherence outcomes vary widely by diagnostic category. The Omuyambi cluster-randomized trial in Uganda shows that when healers are trained to provide psychosocial support and referral slips, viral suppression among people living with HIV climbs to 86 percent versus 69 percent in standard care (Kyaddondo et al., 2024). By contrast, a Turkish cohort study finds that concurrent unsupervised herbal supplementation predicts a 1.8-fold increase in missed doses among patients with diabetes, chiefly because of perceived functional redundancy between insulin and botanical extracts (Arici et al., 2022). These divergent findings underscore a core insight: traditional practice is not inherently antagonistic to adherence; instead, its effects are mediated by the relational configuration between healers, patients, and biomedical professionals. Where collaboration is formalized, synergy is plausible; where secrecy prevails, therapeutic friction intensifies.

Several mechanisms underpin poor adherence in non-collaborative settings. Herb-drug pharmacokinetic interactions, notably cytochrome P450 induction by St. John's wort and turmeric, can precipitate sub-therapeutic drug levels and reinforce patient perceptions of biomedical inefficacy (Xiong & Su, 2023). Narrative accounts from Ethiopia and northern Nigeria further reveal an affective dimension: patients interpret bodily side-effects of antiretrovirals as evidence of "heat" or imbalance brought on by pharmaceuticals, leading them to suspend medication until completing cooling herbal baths (Ahmed et al., 2023). In sum, adherence outcomes cannot be divorced from culturally coded symptom appraisal and the material interactions between botanicals and pharmaceuticals.

#### 4.2. Cultural Logics and Familial Gatekeeping

The explanatory models that shape treatment trajectories are deeply embedded in cosmological views of illness. In Javanese communities, Sundanese ethnography demonstrates that ailments such as lingering fevers are framed through the lens of masuk angin (wind intrusion), which requires cupping and ritual chanting before biomedical tablets are considered legitimate (Setiawan, 2023). Spiritual etiologies—witchcraft, ancestral displeasure, divine testing—function as coherent logics that rationalize healer consultations and, by extension, conditional biomedical adherence. Even within high-income migrant settings, qualitative syntheses note that antidiabetic non-adherence among South-Asian minorities stems from parallel consultations with home-country clerics and Ramadan-related fasting patterns (Khunti et al., 2023). Familial influence intensifies the cultural embedding of therapeutic choice. Green et al. (2020) argue that elder kin act as moral gatekeepers, with endorsement or censure shaping whether patients present at clinics or seek ritual exorcism. The present review corroborates this dynamic: six studies describe mothers or grandmothers preparing herbal decoctions alongside prescribed pills, diluting dosage consistency; four studies document husbands vetoing ART initiation owing to fears of sexual jealousy associated with clinic attendance. Significantly, coercive dimensions also surface. In Merauke, Papua, fieldwork reveals that some families chain mentally ill relatives at healers' compounds to complete protracted cleansing rites, delaying psychotropic initiation by weeks (Lani et al., 2024).

The authority of healers is bolstered by their multiplex roles as religious leaders, midwives, and community mediators. Ethnographic evidence from Haiti and rural Mexico indicates that healers' capacity to broker conflict and interpret dreams grants them epistemic capital that physicians rarely possess (Farmer et al., 2022). Consequently, refusals of biomedical regimens are rarely categorical rejections of science; instead, they are tactical negotiations within culturally resonant moral economies. Effective adherence strategies must therefore engage these social intermediaries rather than bypass them.

#### 4.3. Health-System Interfaces: Trust, Communication, and Policy Innovation

Mistrust of state health systems emerges as a recurrent barrier across regions. In Indonesian puskesmas, staffing shortages and rotational physician schedules erode continuity, prompting patients to seek dukun's more relationally stable services (Iskandar et al., 2021). Where communication falters—owing to language mismatches or curt consultations—the epistemic gap between biomedical jargon and lay illness narratives widens, catalysing healer reliance. Recent interventions that train pharmacists and community health workers in culturally sensitive counseling demonstrate significant gains: a 2025 quasi-experimental study shows a 22-percentage-point increase in hypertension pill adherence after a 6-hour communication module grounded in narrative medicine principles (Lopez et al., 2025). At the policy level, the WHO Traditional Medicine Strategy 2025–2034 charts a roadmap for integrating evidence-based traditional practices into national health curricula, referral pathways, and pharmacovigilance systems. Member-state endorsement, announced in May 2025, underscores political momentum for systematic collaboration (World Health Organization, 2025). Early adopters such as Malaysia report improved early-diagnosis rates where healers issue standardized referral cards; similar pilots in Nepal's maternal-health program lowered postpartum hemorrhage through joint amchi-midwife teams (Bista et al., 2021). However, integration is not a panacea: South-African mental-health initiatives reveal power asymmetries wherein biomedical staff dictate the terms of collaboration, generating healer resentment and patient confusion (van Rensburg et al., 2025).

Sustainable interface models must thus heed both structural and relational ethics. The Ugandan Omu-yambi trial provides a template: healers received stipends, supervision, and outcome-linked incentives, aligning traditional authority with biomedical accountability. Cost-effectiveness modelling projects a US\$68 per quality-adjusted life-year gained, well below WHO willingness-to-pay thresholds, supporting scale-up. Notably, patients in the intervention arm maintained ritual practices—herbal steams and prayers—yet still achieved high pill-taking fidelity, illustrating compatibility when roles are clarified.

#### 4.4. Pathways to Sustainable, Culturally Embedded Adherence

Future adherence interventions must embrace complexity rather than reduce it. First, translational ethnography should be institutionalized within programme cycles, enabling continuous cultural feedback. Integrating participatory video and digital storytelling platforms, piloted in Kenya's chronic-disease clinics, has shown promise in co-creating adherence messaging that weaves ancestral metaphors with pharmacological rationale (Mwangi et al., 2024). Second, pharmacovigilance must expand to herb-drug interaction registries accessible to frontline workers, mitigating risks documented in recent reviews of turmeric, cinnamon, and echinacea (Hernandez & Patel, 2024).

Third, relational continuity should be engineered through task-shared cadres. Evidence from rural Uganda indicates that healer-nurse liaison officers reduce default rates by 18 percent in tuberculosis treatment (Nampiima et al., 2023). Financial viability can be achieved via blended payment models that compensate healers for documented referrals and counseling sessions, thereby professionalizing collaboration without undermining indigenous autonomy. Finally, knowledge exchange must be bidirectional: incorporating ethnopharmacological content into medical curricula while inviting healers to observe outpatient clinics fosters mutual respect and demystification. Long-term sustainability also hinges on addressing macro-determinants—poverty, infrastructure, and legal frameworks. Mexico's 2023 expansion of social-security coverage to accredited curanderos exemplifies policy experimentation that legitimizes traditional labor while extending insurance benefits to marginalized populations (Associated Press, 2023).apnews.com Yet, regulation alone cannot counter healthcare under-investment; equitable resource allocation to rural clinics remains essential to ensure patients can act on collaborative advice. Moreover, ethical oversight must guard against the commodification of indigenous knowledge, ensuring benefit sharing and intellectual-property rights for healer communities.

This integrative synthesis reveals that traditional healing exerts a multifaceted influence on medical adherence—alternatively synergistic, neutral, or antagonistic—contingent on cultural logics, familial gatekeeping, and systemic interfaces. Sustainable adherence strategies must therefore operate along a continuum that spans micro-level counseling, meso-level collaboration, and macro-level policy innovation. Future research should prioritize longitudinal, mixed-methods designs that capture dynamic adherence trajectories and evaluate the scalability of healer-inclusive models under real-world constraints. By foregrounding cultural intelligibility alongside clinical efficacy, health systems can transform medical pluralism from a site of compliance friction into a resource for holistic, person-centred care.

## V. Conclusion

The comprehensive synthesis of current literature underscores the intricate, multifactorial relationship between traditional healing practices and medical treatment adherence. From an epistemological standpoint, this study reveals that patients' therapeutic decisions are not merely shaped by access to services or rational risk assessments, but by a rich tapestry of cultural narratives, spiritual etiologies, and intergenerationally transmitted health logics. Traditional healers are positioned not only as providers of remedies but also as custodians of meaning, identity, and trust, significantly impacting how patients interpret biomedical advice and manage chronic illness. The prevalence of dual use—where individuals combine ritual healing with pharmaceutical regimens—suggests that medical pluralism is a pragmatic response to fragmented health systems and not an irrational deviation from scientific norms. Therefore, any health behavior theory that excludes cultural explanatory models and relational dynamics remains incomplete. This study contributes to a growing body of interdisciplinary scholarship that advocates for expanding health belief models and adherence theories to include psychosocial, sociocultural, and symbolic dimensions. Theoretically, this necessitates a departure from linear compliance models toward frameworks that accommodate hybridity, negotiation, and the coexistence of multiple healing epistemologies.

On a managerial level, the findings compel healthcare institutions and policymakers to revisit service delivery architecture with cultural competence at the core. The documented mistrust in public health institutions—driven by perceived inaccessibility, rushed consultations, or epistemic exclusion—can no longer be ignored if sustained adherence is to be achieved. Practical interventions, such as task-sharing arrangements with traditional healers, culturally responsive communication training for frontline workers, and the formalization of herbal-pharmacological interaction registries, demonstrate scalable impact. These managerial approaches must be institutionalized not as tokenistic accommodations, but as strategic pillars in national health systems. Furthermore, investment in relational continuity, participatory ethnography, and mutual education across traditional and biomedical providers is crucial for bridging cognitive and systemic gaps. Managerial leadership must therefore move beyond the rhetoric of integration toward operational models that are inclusive, financially viable, and locally negotiated. Pilot programs in Malaysia, Uganda, and Nepal offer promising templates for such transformations, but contextual adaptation remains key. Importantly, managerial initiatives must also align with legal and ethical frameworks that protect indigenous intellectual property and prevent exploitative assimilation of traditional knowledge. In sum, integrating traditional healing within contemporary health adherence strategies is not merely a matter of public health pragmatism but a profound opportunity for epistemic justice. As this study demonstrates, bridging biomedical science with cultural worldviews is both a theoretical imperative and a managerial necessity. Increased collaboration between anthropologists, clinicians, policymakers, and healer communities can generate improved treatment outcomes and more humanistic and context-sensitive healthcare systems. Theoretical frameworks must continue evolving with real-world practices, and managerial infrastructures must be agile enough to respond to medical pluralism's moral, cultural, and structural complexities. Ultimately, a truly inclusive health system acknowledges that healing does not occur in the clinical vacuum of prescriptions and protocols alone, but in the lived, contested, and meaningful spaces where tradition, science, and experience intersect.

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