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Well-Being and Ill-Being: Community Perspectives Shaped by Cultural Knowledge and Practices among the Raya Community, Northern Ethiopia

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Abstract: *This ethnographic study was conducted among the Raya community of southern Tigray in northern Ethiopia. It employed interviews, observations, and case studies as primary data collection methods. The aim was to explore how cultural beliefs and practices shape the community's perspective of well-being and ill-being, as well as influence their health-seeking behaviors. The findings reveal that cultural knowledge and practices—rooted in the community's lived experiences—shape perspectives on the causes of sickness, the treatment options deemed appropriate based on context-specific explanations, and the community's understanding of what constitutes well-being and ill-being. Various religious, mystical, and traditional perspectives influence the community's understanding of the causes of health disorders and shape their treatment choices. These belief systems play a central role in interpreting health and sickness, often guiding both diagnosis and therapeutic approaches within the cultural context, and giving rise to practices grounded in lived experience. The study finds that health-seeking behaviour is shaped primarily by cultural knowledge and perspectives. This study suggests for further study on how cultural health beliefs evolve over time and how traditional knowledge systems are transmitted and sustained, especially in the face of modernization and biomedical influence.*

Keywords: well-being & ill-being, community perspectives, cultural beliefs & practices, raya community

INTRODUCTION

Community knowledge, largely shaped by lived experience, is a crucial global resource that helps communities address health, environmental, and other challenges (Lepore & Kaul, 2023). These knowledge systems encompass the understandings, skills, and viewpoints developed by communities through long-standing interactions with their natural environments and within community exchanges on practices that

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promote wellbeing and affect trajectories of illness. Each culture possesses its own unique knowledge system, which has played a significant role in supporting the healthcare needs of its members (Ngowari et al., 2020), and which is based on dynamic assessment resulting in understanding on how practices relate to improvements in wellbeing.

Sociocultural settings define how people perceive and react to health and sickness, therefore impacting perceptions of symptoms, beliefs about causes and outcomes, responses to health messages, and the part social support plays in determining well-being (Uskul, 2010). According to Escalante et al (2024), culture influences the socio-epidemiological distribution of diseases in two main ways. On a local level, it shapes individual behaviors that can increase vulnerability to specific illnesses (Escalante et al., 2024). On a global scale, according to Tomás-Sábado (2016), cultural practices, along with political and economic forces, drive patterns of interaction with the environment that affect disease spread (cited in Escalante et al., 2024). Tronto (1993) aligns an understanding of care with moral boundaries established in society that determine an ethics of care. The societal ethics set out what we care about, how we take care, who gives care and who receives care.

Sociocultural factors play a significant role in influencing individuals' decisions to seek healthcare (Uskul, 2010). Because illness is a cultural construct, the perception of illness is shaped by the cognitive frameworks through which patients interpret and make sense of their condition (Escalante et al., 2024). Consequently, understanding health and disease within a society requires more than biological or clinical insights—it demands a comprehensive approach that integrates medical knowledge with sociological and anthropological perspectives to fully capture the prevalence, meaning, and distribution of illness (Escalante et al., 2024). For example, Murdock's theory of sickness causation differentiates between natural and supernatural explanations for illness. Natural causes, which align with biomedical (modern medicine) views, include infection, stress, organic deterioration, accidents, and human aggression (Murdock, 1980). In contrast, supernatural causes are deeply rooted in culture and encompass mystical (e.g., fate, contagion), animistic (e.g., soul loss, spirit aggression), and magical (e.g., sorcery, witchcraft) explanations (ibid).

Understandings of health and disease are culturally relative, with different cultural backgrounds shaping diverse interpretations of what it means to be healthy or sick (Escalante et al., 2024). Treatment initiatives that rely on biomedicine require awareness of cross-cultural perspectives on health and illness—including local medical beliefs and practices—and acceptance by community members, especially in an increasingly globalized world (Benard, 2014). Therefore, recognizing the influence of culture is essential for a comprehensive understanding of health outcomes (Rosén, 2015).

Indigenous medicine forms an integral part of local culture—encompassing beliefs, lifestyles, and attitudes—and thus continues to be widely used even when modern medical services are available (Abebe & Ayehu, 1993). In Africa, more than 80% of the population relies on traditional medicine as the primary, if not the only, health care system accessible in poor and rural areas (Tesfay, 2004). Similarly, in Ethiopia, it is reported that about 80% of the population still depends on indigenous medicine for their health care needs (Abebe & Ayehu, 1993). The Raya community in southern Tigray has developed a unique culture (Kibrom, 2013), and studies indicate that its health practices are strongly shaped by the religious and mystical beliefs prevalent in the area (Kahsay & Bondla, 2025).

WHO (2025b) emphasizes that aligning health services with the needs, preferences, and cultural beliefs of diverse populations is essential for fostering inclusive and equitable care. Such alignment promotes culturally appropriate health systems that respect traditional medical knowledge and encourage intercultural dialogue (ibid). Hence, this study aims to explore how cultural beliefs and practices shape the Raya community's perceptions of well-being and ill-being, as well as influence their health-seeking behaviors, in a context where medico-anthropological research is limited. To guide this inquiry, the following research questions are addressed: *How do cultural beliefs and practices shape community perceptions of the causes, treatment, and prevention of sickness? How are well-being and ill-being understood and experienced in the community?* As the study aims to answer these research questions, it also explores the role of community health agents, individuals believed to possess specialized knowledge derived from experience, generational wisdom, and both formal and informal education, in shaping health perceptions and places specific focus on maternal health by examining common community perceptions and care practices.

This study addresses crucial research gap by offering a medico-anthropological examination of the cultural belief systems within the Raya community, their impact on perceptions of well-being and health-seeking behavior, and the functions of community health agents. The results will strengthen theoretical understanding of how indigenous belief systems influence health behaviors; provide localized evidence to guide culturally sensitive health interventions and the integration of traditional practices into primary health care; and support policy development in line with WHO's Global Traditional Medicine Strategy 2025–2034 (WHO, 2025b) and Ethiopia's health system objectives. Overall, this research offers actionable insights for advancing health equity through culturally competent care models.

Theoretical and conceptual framework

By exploring the interaction of well-being, ill-being, and social roles, and defining health as a culturally produced concept, this section examines how social expectations, cultural norms, and the roles individuals are expected to fulfill within their societies influence not only biological factors but also personal experiences of health and illness. In this study, the terms sickness, disease, and illness are used as follows: sickness refers to disorders that are bodily and/or mental in nature; disease refers specifically to bodily disorders; and illness refers to mental or psychological conditions (Twaddle, 1979).

The Interplay of Well-Being, Ill-Being, and Social Roles

Different disciplines offer distinct definitions of well-being (Jarden & Roachej, 2023). The standard dictionary definition of wellbeing is "the state of being healthy, happy, or prosperous." (Mathews and Izquierdo, 2009, p. 2-3). One of the most widely cited definitions describes well-being as "how people feel and how they function, both on a personal and social level, and how they evaluate their lives as a whole" (Michaelson et al., 2012, p. 6; as cited in Jarden & Roachej, 2023). Expanding on this, Dalal and Misra (2006) define well-being as a subjective experience closely linked to mental health, life satisfaction, and happiness, involving both emotional and cognitive evaluations of one's life, particularly as shaped by health, contentment, a sense of belonging, and the absence of suffering. In a similar vein, Shah and Marks (2004) emphasize that well-being involves more than just happiness—it also includes a sense of satisfaction and overall gladness. Likewise, Shin and Johnson (1978) conceptualize well-being as a global evaluation of an individual's quality of life, based on personally chosen criteria.

WHO defines health "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2025a). According to Seligman (2002), well-being and ill-being exist at opposite ends of a clearly defined neutral point, meaning that well-being is not simply the absence of ill-being, nor is ill-being merely the lack of well-being. Building on this, scholars broadly agree that the two are distinct constructs; well-being cannot be fully understood by the mere absence of suffering, and similarly, the absence of well-being does not necessarily indicate the presence of ill-being (Zhao & Tay, 2023). This distinction is further reflected in the definition provided by Merriam-Webster, which describes ill-being as "a condition marked by poor health, unhappiness, or lack of prosperity." Such a definition emphasizes that ill-being involves concrete negative conditions rather than just a neutral or less-than-optimal state, therefore supporting the perspective that well-being and ill-being must be examined and handled as independent, though linked, facets of human experience.

Cultural standards impact the duties and expectations connected with health problems, especially the obligations of the sick and their caregivers. Every society has a sick role defined as the social expectations on how society should see sick people and how sick people should behave (Benard, 2014). Talcott Parsons (1975) sees the sick role as a socially approved position with three main criteria: acknowledging that the illness is not the individual's fault, being exempt from normal social responsibilities, and expecting help from institutionalized health services in major cases. According to this concept, ill-being is defined by both more general socio-structural factors and personal awareness. From a related standpoint, Kasl and Cobb (1966) define illness behavior as the activities people engage in when they believe they are sick, meant to help them comprehend their condition and get relief. These actions—including the way symptoms are interpreted, responded to, and help-seeking strategies—vary greatly depending on cultural setting (Quah, 2009).

Health as a Cultural Construct

Every society around the world has its own unique way of life, the cultural interaction notwithstanding. Accordingly, "Each culture develops its own rational for surviving and its own logic about how to cope with life" (Negussie, 1988: 20); and since every culture has its own value systems and definition of knowledge, the traditional concept of knowledge must be seen in a cultural context.

Health and sickness are terms connected to cultural conceptions of the mind-body world which are socially created by distinct groups of people (Benard, 2014). Cross-cultural analyses of conceptions of mind, body, self, and emotion have undermined the claim that an autonomous, rational, and intrinsically just mind constitutes the normative model of personhood (Geertz, 1974; Lock, 1993). By contrast, culturally established "fluid boundaries" between individuals, society, and nature impact how groups view inequity, pain, sickness, and moral ideals (Geertz, 1974; Paul, 1976; Lock, 1993). From this perspective, research on the social organization of health care expose three interrelated domains: the professional (formal medical systems), the popular (familial and community-based care), and the folk (nonprofessional or traditional healers) (Kleinman, 1973). Especially, most health-related activities take place in the popular sector, where common knowledge of disease exists (Hulka et al., 1972; Kleinman, 1973). Although the extent of reliance may differ, the use of traditional medicine is evident across all cultures, including high-income countries. For instance, a recent analysis by the National Institutes of Health's National Center for Complementary and Integrative Health (NCCIH) shows a substantial rise in the use of complementary health approaches among American adults between 2002 and 2022 (NIH, 2024).

According to WHO, over 80% of health care needs in low income countries are met through traditional practices, valued for their cultural embeddedness, holistic approach, accessibility, and low cost (Teferi, 2005). The use of traditional and complementary medicine is present globally, with both developed and developing countries showing strong reliance. By the late 1990s, nearly 60% of Australians were using alternative medicine, supported by 17,000 registered herbal products and expenditures of about US$650 million, while in Germany, 20 million patients turned to homeopathy, acupuncture, chiropractic, and herbal remedies, (WHO, 2000). In Asia similar patterns emerged: Malaysians spent roughly US$500 million annually on traditional medicine—surpassing spending on modern care—and in Sri Lanka, more than half of the population continued to rely on traditional medicine and Traditional Birth Attendants (Ibid).

Illness is deeply embedded within social systems of meaning and normative behavior, and is therefore heavily shaped by cultural beliefs and values (Kleinman et al., 1978). The self-regulation model, a framework used to study how individuals perceive, interpret, and respond to health threats (Leventhal et al., 1980), suggests that people form structured beliefs about illness, including its identity, perceived causes, duration, impact, and the extent to which it can be treated or managed (Leventhal, 1984; Uskul, 2010). As a result, individuals from collectivistic cultures form illness representations that go beyond individual or biological factors, incorporating broader social and cultural influences within their interconnected networks (Uskul, 2010).

Health is a cultural feature of community life, inseparably intertwined with its economic, political, social, and religious systems, all of which act together as interrelated components of a single society structure (Srnivasalu et al., 2022). As such , sociocultural factors significantly influence delays in seeking healthcare, shaped by various elements such as beliefs about disease causes, symptom interpretation, perceptions of curability and consequences, and levels of trust in medical professionals (Uskul, 2010).

Therefore, to effectively prevent illnesses and promote health and well-being, actions must be grounded in an awareness of culture, tradition, values, and family interaction patterns (WHO, 1982). In line with this, Arthur Kleinman's (1980) explanatory model highlights the importance of considering a client's beliefs about their illness, the personal and social meanings they assign to it, their expectations about its progression and the role of the healthcare provider, as well as their own therapeutic goals. Kleinman (1980, p. 106) developed a set of eight open-ended questions meant to uncover the client's explanatory model, so providing valuable insight on their personal and cultural understanding of their illness—its cause, impact, severity, and preferred treatment—so enabling more empathetic and culturally informed treatment to support a culturally sensitive approach in clinical settings. Kleinman et al. (1978) also underline the need of the explanatory model, stressing that obtaining the patient's viewpoint gives doctors important insight into the beliefs about their illness, the personal and social meaning they attribute to it, their expectations for its progression and the physician's role, and their own therapeutic goals. Kleinman's explanatory model was first tested in low-income, rural settings (e.g., Taiwan) (Kleinman, 1980), and later applied in cross-cultural clinical settings, such as in the U.S. (Kleinman et al., 1978).

To conclude, well-being and ill-being have to be seen as separate but connected aspects of human experience model by a complicated interaction of social roles, cultural beliefs, and communal values. Health and disease are not only biological conditions but also culturally created ideas ingrained in social life. Recognizing these complex links and attending to the explanatory models and social meanings people attach to sickness will help health practitioners and researchers to adopt a more holistic and culturally

sensitive approach, so ensuring that efforts to prevent disease and promote well-being are in line with the lived reality, customs, and belief systems of the populations they serve.

Dimensions of Care Ethics

Care is a frequent topic in public discourse—it is often discussed, emphasized, highlighted, and analyzed (Jesenková, 2021). The Care Ethics Framework, developed by Joan Tronto (1993), provides a moral and practical approach to understanding care as a relational and political practice. Joan Tronto together with Berenice Fisher identified four Elements of Care (Tronto, 1993). These elements are:

> *[…] caring about, noticing the need to care in the first place; taking care of, assuming responsibility for care; care-giving, the actual work of care that needs to be done; and care-receiving, the response of that which is cared for to the care (Tronto, 1993: 127).*

From the above four elements of care, "attentiveness, responsibility, competence, and responsiveness" emerge as the ethical principles that underpin caring (Tronto, 1993:127). According to Tronto (1993), Caring is a continuous, relational process that begins with Caring About, which requires attentiveness to others' needs; moves to Taking Care Of, where responsibility to act is assumed; progresses to Care-Giving, which demands competence in delivering support; and concludes with Care-Receiving, calling for responsiveness to feedback. Together, these dimensions create an ethic of care that integrates awareness, accountability, skill, and adaptability.

RESEARCH METHODOLOGY

This study is based on fieldwork conducted in three phases: from January 4–14, 2024; January 8–18, 2025; and April 22–May 4, 2025. While some data was collected in January 2024 and January 2025, the majority of the primary data was collected during the third phase.

Fieldwork was carried out after obtaining ethical and administrative clearance from the Department of Anthropology, Institute of Paleoenvironment and Heritage Conservation, Mekelle University, and adhering to ethical protocols of Leiden University Medical Centre (LUMC).

Research Methods

Interviews, observations, and case studies were used as data collection methods. Across all three phases, a total of 28 interviews were conducted—13 with female participants, and 12 of the total study participants identified as Muslim. The ages of the study participants range from 35 to 90, with the majority falling between 40 and 60 years old. The interviewees were primarily selected based on their cultural knowledge and experience, while five were interviewed randomly. The interviews were carried out face-to-face, with only two conducted via telephone.

Interviews were conducted using a semi-structured questionnaire, complemented by informal conversations that primarily occurred during observational visits, for example at ritual sites. No interpreters were required, as the data collector was fluent in the local languages. Data collection concluded when, based on a subjective judgment, it was determined that no new insights were emerging—indicating that data saturation had been reached.

Information gathered during interviews was documented mainly in notebooks, with only a few sessions audio-recorded. Recorded data were subsequently transcribed, and all collected material was translated into English and consolidated into a single Excel file for analysis. Additionally, throughout the fieldwork, numerous photographs were captured to provide visual documentation of the research context.

Observations on how the cultural knowledge and practices ingrained in people's way of life shapes their perceptions was made possible in great part by fieldwork carried out at all phases of data collecting. These observations gave useful, real-time insights into daily activities and interactions therefore enabling a better knowledge of how cultural environment shapes health attitudes and experiences outside what could be obtained by means of interviews alone.

To augment and expand the findings acquired from observations and interviews, individual case stories were also gathered. These stories offered personal, context-rich narratives that supported the illustration of more general trends and themes found in the data. This study particularly includes a case study on a specific diseases to show how access to care and cultural beliefs impact personal experiences of sickness.

Data analysis

After completing data collection, all information was organized and encoded in a comprehensive Excel spreadsheet, with entries coded and labeled according to key themes identified during preliminary analysis. Case studies were stored in a separate file for detailed review. Subsequently, themes relevant to this particular study were filtered from the larger dataset, and a subset of the data was analyzed to develop the narrative presented in this article. The analysis revealed multiple thematic areas, leading to the plan of presenting findings across several articles.

For qualitative analysis, narrative analysis was employed to interpret verbal accounts and observed behaviors, as interviews, case studies, and observations inherently possess a narrative dimension. Additionally, framework analysis was applied, using a thematic framework to code and categorize data collected through ethnographic methods.

This ethnographic study goes beyond questioning participants' understanding; it also examines their actions and interprets the motivations and meanings behind those actions. The primary researcher, being a member of the Raya community, speaks the local language and shares cultural and religious contexts with participants. The third co-author also originates from the same community, contributing insider perspectives complemented by professional expertise as a medical doctor. To maintain analytical rigor and address potential bias, two additional co-authors unfamiliar with the Raya context were included, ensuring that the familiar was made unfamiliar—a key principle in ethnographic research.

Study locations

The study was conducted in Raya-Ch'erch'er Woreda of the Southern Tigray Regional State, Ethiopia. The specific study area was the Tabya called Erba, which includes the sites *Kushet* (smallest unit of administration) Erba and Dodota. *Kushet* Dodota is a self-governing village, while Adi-Mokoni, a small village (*got'*) under *Kushet* Erba. The selected sites are rural villages inhabited by both Christian and

Muslim communities, where multiple languages are spoken, including Tigrigna, Amharic, and, to a lesser extent, Afan Oromo. These characteristics suggest that the locations are culturally representative of the wider study community.

FINDINGS

Based on the results of the ethnographic work and framed thematically, this section sequentially presents community perceptions of the causes of health problems and the therapeutic options they consider appropriate; the local understanding of well-being and ill-being, as well as the influence of community health agents in shaping health-related behaviors. Additionally, it examines perceptions of maternal health, in relation to modern medicine.

The themes presented were identified through the coding and labeling process and then organized under subheadings in a sequence designed to ensure readability and logical flow. Due to the cultural context of the study community, many of these themes predated the coding process; therefore, the research questions were formulated to capture these anticipated themes. However, the list of sicknesses presented in Table 1 emerged directly from the coding and labeling analysis. The decision to include this list was made later, as these health problems stood out during the interviews.

Community Perceptions of Sickness; Causes and the Spectrum of Therapeutic Responses

Among the study community, religious and mystical beliefs strongly influence perceptions of sickness and its causes. Interviews revealed that illness is often viewed as connected to a person's level of religious faith, devotion, and respect toward spiritual or supernatural powers—whether divine, ancestral, or local. A lack of proper devotion, such as failing to offer required sacrifices or fulfill religious obligations, is believed to result in sickness. Certain illnesses are attributed to fate, meaning they are considered acts of divine intervention, particularly when health problems occur in children shortly after birth or when they are born with congenital defects.

While almost every health condition, particularly mental disorders, is associated with certain religious or mystical beliefs, some illnesses are more strongly linked to these interpretations than others. Sickness is often attributed to specific actions, words spoken, or places visited shortly before symptoms appear. For example, if someone sleeps under a large tree or bathes alone in a river, especially at midday or midnight, any sickness and particularly illness that immediately follows, regardless of its symptoms, is commonly believed to be caused by a demonic attack. Likewise, when someone violates cultural taboos, whether through actions or even speech, any diseases or illness that follows is often attributed to the intervention of supernatural entities, believed to have been directly or indirectly offended.

Depending on how the cause of a health problem is perceived, individuals seek the form of treatment they consider most appropriate. Table 1 presents the health problems identified during interviews, along with the community's understanding of these sicknesses and their therapeutic preferences. As a result, treatment options range from specific religious and mystical rituals to other traditional remedies, such as herbal medicine and the support of traditional birth attendants, in the case of pregnant women, as well as modern medical care. While community members may share their own views on the causes of sickness and suggest

possible treatments based on their medical or cultural knowledge, there is generally no structured or systematic form of humiliation directed at individuals for choosing a particular therapeutic option.

The table (table 1) shows that the study community's perceptions of health problems and preferences for therapy differ a lot from sickness to sickness. Biomedicine is generally used to treat conditions that are thought to be severe or life-threatening, like meningitis, rabies, and hypertension. On the other hand, diseases like malaria and poisoning often require a sequential approach, starting with traditional medicines and then going on to biomedical therapy. Traditional medicine is the main way to treat cultural and stigma-related ailments, including Buda (culture-bound syndrome), psychosis, and skin diseases like vitiligo and leprosy. Infectious disorders like measles, scabies, and anthrax are predominantly managed by traditional approaches, notwithstanding their potential severity. Overall, the data reflects a strong reliance on traditional medicine for culturally interpreted or chronic conditions, with biomedicine reserved for acute, high-risk illnesses or as a secondary option when traditional methods fail.

Table 1: List of health problems,[2] along with the community's understanding of these conditions and their therapeutic preferences.

S/N	Local Disease/Illness Name (Ge'ez Script and ITYOPIS Transcription)	Scientific or Medical Name of the Disease /Illness (high likelihood)[3]	Community Understanding and Manifestations	Community's Preferred Treatments
1.	□□□□ - *Anqts*	Meningitis	A sudden, severe neck stiffness accompanied by an intense headache and fever, which can quickly become life-threatening.	Biomedicine only
2.	□□□ - *Holeta or* □□ - *'Aso*	Malaria	Characterized by fever and chills accompanied by sweating cycles, headache, and joint pain. This disease commonly begins in July and continues through mid-October, coinciding with the main rainy season, and occurs less frequently during the dry season.	Traditional medicine followed by biomedical treatment
	ኤድስ - *AIDS*	HIV AIDS	Characterized by rapid weight loss, hair loss, facial pallor and diarrhea.	Biomedicine and traditional medicine
	ኻብድ ሓ□□ - *Kabd Hadega*	Soft tissue and/or bone injury secondary to any form of accidents	Accidents that cause body injury—such as severe body cuts and bleeding	Traditional medicine for immediate response, then biomedicine

[2] The list reflects health issues highlighted during interviews. It does not necessarily represent the most common sicknesses in the study area, nor is it a comprehensive list of all prevalent conditions.
[3] From a medical expert's perspective.

5.	□□□□ - *Qurumba*	Anthrax (Cutaneous ± Inhalational)	A sickness characterized by only one skin sore initially with symptoms of total body weakness and rapid onset shortness of breath followed by death within hours if untreated.	Traditional medicine only, but uncurable if not treated immediately
	ቡዳ - Buda	Culture-bound syndrome	A sudden onset of dissociation from self, accompanied by shouting, bizarre behaviors, crying or laughing. Culturally interpreted as possession by the *Buda* (evil eye).	Traditional medicine only
	ሽግሪ - Shegri or □□□ □□□□ - *Hmam Alms*	Poliomyelitis	A disease characterized by bilateral paralysis of the lower extremities. Once disabled, the individual cannot flex his/her extremities at the joints. It is believed that this disease is caused by envious people's deliberate intention to disable the individual.	Traditional medicine only
	ሽሖር - Shẖor	Scabies	Skin disorders characterized by severe itching and ulceration of the affected area, often accompanied by the oozing of clear fluid from the ulcers.	Traditional medicine and biomedicine
	መርዚ - Merzi	Poisoning (Commonly from organophosphates)	Salivation, tearing, confusion, sweating, seizures, and muscle weakness following ingestion of a poisonous substance.	Traditional medicine followed by biomedicine
10.	□□ □□□ - *Hawi Semay or* □□□ □□□ - *Hbri Semay*	Herpes zoster	A skin disorder characterized by formation of clear fluid filled circular papules on the body and followed by subsequent ulceration of the site with distribution pattern.	Traditional medicine only
11.	□□ □□ - *'uf Shwa*	Viral hepatitis A	A disorder characterized by yellowish discoloration of the eyes, finger nails and urine, often accompanied by abdominal swelling and pain.	Traditional medicine only
12.	□□ - *Habi*	Tapeworm infestation	Visible segments of worms in a stool along with itching or irritation around the anus.	Biomedical
13.	□□ □□□ - *Dem-bezẖi*	Hypertension	A disease resulted from a high level of blood volume pressure in the body characterized by headaches, and chest discomfort.	Biomedicine
14.	□□ □□□ - *Dem-manes or* □□□ □□ - *Waẖdi- dem*	Anemia	A disorder characterized by a tendency to loss balance while standing up from seated position or prolonged exposure to strong sunlight. The disease results from a shortage of blood volume in the body.	Traditional medicine followed by biomedicine

15.	□ማም ዕቡድ □ልቢ- *mam 'ibud kalbi*	Rabies	A sick dog bite resulting in tingling, itching, burning, or pain at the bite site, accompanied by hallucinations and behavioral change	Biomedicine
	ዕብዳን- 'ibdan	Psychosis (Commonly from schizophrenia)	Mental illness leading to disturbances of emotion, thought and behavior. Commonly aggressive and bizarre behaviors	Traditional medicine
17.	*ዓንቀር- 'Anker*	(Commonly viral)	diarrhea, vomiting, cough and red eyes in children on breast feeding.	Traditional only
18.	□□□□ □□□ - *Dawdq-Hmam*	Epilepsy	A sudden episode of loss of consciousness accompanied by body stiffening and jerking movement.	Traditional medicine followed by biomedicine
19.	□□□ □□□ - *Hmam Lemtsi*	Vitiligo	Loss of skin color with visible symptoms of milky-white small spots or patches.	Considered to be untreatable
20.	□□□ *ድዉያን- mam Dwuyan*	Leprosy	Painless ulcers on the feet and fingers, accompanied by some insensate, discolored skin patches. The patient with the condition is highly stigmatized due to its visible discoloration.	Considered to be untreatable
21.	□□□-*Barle*	Pityriasis versicolor	A skin disorder presenting as whitish or blackish discolored spots, often accompanied by mild itching. The patient with the condition is highly stigmatized due to its visible discoloration.	Traditional medicine
22.	□□□ *ድሓር - Hmam*	After pains (Postpartum uterine cramps)	Intermittent lower abdominal pain after child birth	Traditional medicine, then biomedicine if delayed.
23.	□□ □□□ - *Eno-wshn*	Measles	Characterized by red eyes, cough and a red rash that begins on the face and spreads downward to the trunk and limbs and white spots inside the mouth. It commonly affects children and is considered to be transmitted through body contact	Traditional medicine only
	መንኽስቲ ተበን- Menkesti Teben	Snake bite	Snake bite	Traditional medicine followed by biomedicine

Source: Fieldwork, Bereket G, April-May, 2025

Generally, there no stigma or discouragement for explanation of the cause of once or someone's sickness, seeking treatment from any available choice i.e. home level, traditional healing of any kind, or bio-medicine. Recently, however, the traditional healing employed to treat the *buda* (evil eye) has become less

and point of attention.[4] Despite this, the traditional belief in *buda's* ability to cause illness remains central to the health beliefs and practices of the study community.

Some medically diagnosable diseases are recognized by community members. For instance, malaria and HIV/AIDS are commonly identified based on their symptoms. Malaria—locally known as *Holeta* or *'Aso* (□□□□ □□)—is well recognized in the community. The study area is malaria-prone, and epidemiological patterns—supported by anecdotal accounts—indicate a high prevalence of HIV/AIDS. As a result, community members often make presumptive diagnoses based on observable symptoms and tend to visit clinics for confirmation. Although traditional remedies are still used in some cases, people generally tend to seek modern medical treatment for both malaria and HIV/AIDS, with *tsebel* being prominently used for HIV—either alongside or in place of antiretroviral therapy.

Accidents that cause bodily harm—such as cuts and bleeding—are often treated in biomedical settings. However, various traditional remedies are also used—before, during, or after the initiation of biomedical treatment. Traditional medicines, either alongside or independently of modern medicine, serve multiple purposes: stopping bleeding, preventing infection, promoting effective healing, and performing rituals intended to ward off demonic attacks at the site of injury, attacks believed to cause further mental health issues.

Some diseases, especially those that lead to sudden death, are often not recognized by community members as conditions that can be treated through biomedical means. Instead, any sudden death is typically attributed to cultural or spiritual causes, based on the symptoms observed. Some of these illnesses have local names and are commonly known within the community, but there is little view that they are medically treatable. Rather, they are believed to be manageable only through traditional medicine. These diseases include meningitis, locally known as *Anqts* (□□□□), inhalational anthrax, referred to as *Qurumba* (□□□□), cholera, and poisonings such as organophosphates, locally called *Malatayni* (□□□□□), as well as snake bites. Additionally, paralyzing disease referred to as *Hmam Alms* (□□□ □□□□) of any type (example stroke) is commonly attributed to external agents and is therefore typically addressed through cultural treatments.

If someone dies suddenly after experiencing symptoms such as abdominal pain or a severe headache, the cause is often attributed to an attack by demonic, spiritual forces, or other drivers like the *buda*. These conditions are commonly described by the afflicted using general expressions like "my stomach" or "my head." After death, community members refer to the situation by echoing the person's last words, saying, for instance, *"kabdey, kabdey wulu/la moytu/ta"* (□□□□□ □□□□ □□/□ □□□/□) or *"ri'sey, ri'sey wulu/la moytu/ta"* (□□□□□ □□□□ □□/□ □□□/□), which translate roughly to "(he/she) died saying 'my stomach'" or "(he/she) died saying 'my head.'" These expressions emphasize the felt pain and the

[4] The *Buda* (evil eye) tradition is based on the belief that individuals from certain social group possess the power to cause illness or even death to those outside their group—commonly described as "the *Buda* eat mankind." During the initial fieldwork period, several mainstream and social media platforms in Tigray were actively discouraging community members from maintaining this belief, describing it as a false and harmful tradition and campaigning against its continued practice.

affected body part rather than providing a clear explanation of the underlying cause. They only indicate the perceived influence of an external force, whether spiritual, mystical, or of another nature.

There is a common perspective in the community that the treatment of certain sickness, particularly Herpes Zoster, may conflict with modern medical approaches. It is believed that receiving an injection for this condition can actually worsen the diseases and make it more difficult to treat using traditional methods once modern treatment has been initiated. The box below presents this disease as a case study, illustrating how it is understood and treated within the community.

A case of Herpes Zoster

Herpes Zoster is locally known as Hawi (Hbri) Semay (□□ (□□□) □□□), literally means "Fire (color) of the Sky". While the disease is widely recognized by community members—and can certainly be identified by herbalists—only a few herbalists are believed to possess the specialized knowledge required to treat it effectively. Locally, it is believed that the disease has two forms: a "male" and a "female" type, with the female form said to spread the blisters more rapidly.

Individuals affected by Hawi Semay are given specific behavioral instructions during the course of traditional treatment. They are advised to avoid looking at the sky, engaging in sexual activity, bathing, or ploughing, as all of these are believed to worsen the condition.

The traditional remedy is administered as a brown-colored powder. The plant part used in its preparation is roasted to obscure its original appearance—such as color, smell, or texture—so that others cannot easily identify or replicate it[5]*. If the patient has burn-like symptoms or if the fluid-filled blisters have already begun to open, the powder is directly applied to the affected area. If the blisters are still intact, the powder is mixed with butter and applied as an ointment.*

Importantly, individuals with this disease are strongly advised to avoid biomedical treatments, especially injections, which are believed to be fatal in this context. If a person has already received an injection before consulting the herbalist, it is thought that only the most skillful and intensive traditional treatment can save them from death.

Source: Fieldwork, Bereket G, January 2025

Illnesses believed to be caused by supernatural forces, such as those linked to the *Gni* tradition, spiritual possession, or the *Buda* (evil eye) belief, are thought to fall outside the scope of modern medicine. In these cases, community members view traditional healing practices as the only effective form of treatment. Regarding how illnesses are identified and treatment options are chosen, an interviewee explained the following:

> *When a household member falls ill, the first response is often immediate treatment at the household level using commonly known traditional healing practices. There are various medicinal plants and culturally embedded remedies that we employ in the early stages of sicknesses. If the condition*

[5] Due to my family connections, I am familiar with the specific medicinal plant, including its local and scientific name, the part of the plant used, and the method of preparation. However, as this knowledge is held by only a few herbalists and is considered highly guarded, I have chosen not to disclose these details here. This underscores the fact that not all knowledge gained by researchers—whether through personal familiarity with respondents or through methods such as participant observation, which often provide deeper access to community knowledge—can or should be made publicly available.

> *does not improve or becomes more severe, the individual is then advised to seek further care based on the symptoms—often in consultation with someone who has specialized traditional medical knowledge. […] In some cases, the disease can be identified early through visible symptoms. For example, if a person's skin and the whites of their eyes begin to turn yellow, it is obviously □□ □□ [Hepatitis B]. In such cases, the person is expected to visit a traditional healer who specializes specifically in treating this disease, rather than seeking other treatment options. […] If an individual exhibits high fever, feeling cold, sweating, headache, and physical weakness, it is surely malaria, and he/she should go to hkimina (□□□□)— biomedical treatment*. (Bereket interview with Adi-08, face-to-face, Adi-Mokoni, 22 April 2025).

The above citation demonstrates a multifaceted, community-based strategy for health problem identification and management, wherein traditional knowledge systems serve as the primary reaction at the home level. Healing techniques are systematic, rooted in collective cultural interpretations of symptoms and treatments, and embody a profound ethnomedical rationale. The response to sickness is symptom-based and context-specific, and there is a clear recognition of boundaries within traditional healing—certain conditions, like Hepatitis B (locally known as □□ □□), are seen as requiring the expertise of specialized traditional healers. This indicates a pluralistic approach to health-seeking behavior, wherein individuals navigate several care systems (home-based, traditional, biomedical) in a systematic and culturally significant manner.

The study community also recognizes certain diseases as being transmissible from animals to humans. This understanding includes diseases believed to result from the bite of a "mad dog," locally known as *hmam kalbi* (□ማም □ልቢ), rabies; contact with a dead cat, which is thought to cause scabies; and Anthrax, and Tape warm (locally called *Habi-* ሓቢ) believed to cause from eating raw meat. These perceptions reflect a locally grounded awareness of diseases passed from animals to humans, though they are often interpreted through culturally specific frameworks rather than biomedical explanations.

In some cases, community perceptions of diseases, even those with physical symptoms believed to stem from natural causes, diverge from biomedical understanding. A clear example is how the study community interprets high blood pressure (hypertension), low blood pressure (hypotension), and anemia, often confusing hypotension and anemia as the same condition. For instance, high blood pressure is locally referred to as *Dem-bezhi* (□□ □□□), while both anemia and low blood pressure are known as *Dem-manes* (□□ □□□); (Tigrigna- ዋሕዲ ደም). These conditions are commonly understood in terms of the perceived volume of blood in the body. It is widely believed that individuals with higher body weight and/or excessive belly fat experience high blood pressure due to a proportionally larger volume of blood, while slimmer individuals are thought to suffer from a lack of blood because of their body size.

Perceptions of Well-Being and Ill-Being: Local Understandings of Health and Sickness

In the study community, well-being is generally associated with physical health and mental or emotional peace. However, social and religious disconnection is regarded as abnormal. For instance, an individual who appears physically and mentally healthy but lacks harmony with relatives or community members, deviates from the guidance and counsel of religious leaders, or continually violates taboos is often considered unhealthy, believed to be under the influence or control of supernatural forces or external

spiritual agents. As such, the main factors contributing to a person's well-being are rooted in physical health and mental conditions, but also adherence to the community's way of life, respecting social norms and following the established "do's and don'ts," particularly those related to religious and mystical beliefs.

Health behaviors commonly considered foundational—balanced nutrition, timely medical consultations, and moderation in alcohol use—are seldom practicable in the study community. On the contrary, the frequent and continued consumption of alcohol, along with the intake of fatty meats, is often regarded as a sign of wealth and a good life and even associated with good health.

One the other hand, community knowledge on personal and environmental hyenine is good (observation, April 2025), although seasonal water shortages compromise the ability to maintain proper hygiene. And, the presence of two dominant monotheistic religions in the study area, Ethiopian Orthodox Christianity and Islam, both of which include regular and structured fasting practices, contributes significantly to shaping health-related behaviors, particularly those related to balanced diet and bodily discipline. Fasting and its health benefits, however, are not well understood within the community; it is practiced primarily as a religious obligation rather than for its potential health benefits.

Regarding perceptions of what constitutes "good health," community members commonly refer to the absence of visible symptoms of sickness, the ability to walk and carry out daily activities, and living in harmony with religious and social principles. As one interviewee explained, *"□□□□ □□ □□ □□□ □□□ □□ □□ □□□□□ ሰብ፡□□□ □□ □□□□□"*. This translates to: 'Someone who walks and does not remain at home due to sickness is more or less considered healthy.' (Bereket interview with ADI-08, face-to-face, Adi-Mokoni, 22 April 2025). In a follow-up question, the interviewee, reflecting the broader community understanding, acknowledged the following:

> *Some individuals may still walk despite having certain health conditions, but symptoms such as coughing, changes in skin color, or general weakness often indicate that they are not fully healthy. Hence, while being active and mobile is often viewed as a sign of good health, it does not necessarily mean the person is free from chronic illnesses.* (Bereket interview with ADI-08, face-to-face, Adi-Mokoni, 22 April 2025).

According to the community's understanding, a person is typically classified as sick if they stay at home, appear unwell, or exhibit certain noticeable symptoms — otherwise, they are generally considered to be in relatively good health. An important insight is that when someone who appeared active and healthy dies suddenly, the cause is more often attributed to religious or mystical forces rather than to a biomedical condition that might have been treatable.

In the study community, perceptions of poor health are typically based on visible physical or mental signs. A person who does not show obvious symptoms, has a well-built or physically strong body, can easily carry out labor-intensive tasks, and adheres to social norms is generally considered healthy. In fact, individuals with accumulated body fat, including those who are obese, are often viewed as living a comfortable life and being in good health. At the same time, they may also be viewed as more vulnerable to conditions such as high blood pressure, based on the perception that they have an excessive volume of blood. Over-nutrition and obesity are commonly interpreted as signs of well-being, whereas slimness and physical fitness are often associated with a lack of comfort in life or inadequate access to proper food.

Some illnesses are associated with negative social attitudes. While individuals suffering from such conditions may not be openly treated unfairly or looked down upon, community members often avoid close interaction or physical contact out of fear of disease transmission. One example is vitiligo, a dermatological condition that causes the skin to lose its color. Locally, it is known as □□□ □□□. Another example is epilepsy, locally known as *Dawdə-Hmam (*□□□□ □□□). People tend to keep their distance, especially during incidents involving convulsions and blackouts, due to fear, uncertainty about how to respond, and concerns about possible transmission. Scabies (locally known as *Shihor*), pityriasis versicolor (locally known as *Barle*), and leprosy (referred to locally as *Hmam Dwuyan*) are also diseases that lead to stigmatization. Similarly, in the past, individuals with HIV and AIDS were often socially avoided. However, public health education has helped reduce such stigma by emphasizing that HIV is not transmitted through socializing or casual physical contact, but only through scientifically identified means such as blood transfusion, unprotected sex, or sharing sharp instruments.

People with disabilities are generally not stigmatized in the study community. However, if a person with a disability fails to abide by social norms or becomes involved in a conflict, their disability may be used against them as an insult. In some cases, disability can also become a limiting factor in social engagements, particularly in relation to marriage. In the study community, marriages are predominantly arranged or at least validated by families. As a result, family members and relatives may question whether a man with a disability is capable of fulfilling essential responsibilities, such as farming and providing for a household, or whether a woman's disability might hinder her fertility and ability to bear children.

The study community is characterized by robust social connections and a well-defined kinship framework. The social structure is intricately intertwined into daily existence, preventing individuals from experiencing prolonged isolation or loneliness. Newcomers to the area are swiftly assimilated through communal practices, gaining access to social support and significant relationships. Consequently, there is minimal conviction that deteriorated health might stem from broken or weakened social connections, including interpersonal conflict or social isolation.

Family and social support play an important role in maintaining or restoring an individual's well-being. When someone falls ill, relatives and fellow villagers visit the person, often bringing food or drink, and spend time with them, sometimes engaging in lighthearted conversation or play to lift their moods. If the sick person is a man and unable to carry out his daily responsibilities, especially during the peak farming season, relatives and community members step in to perform his tasks to ensure that his harvest is not affected. Similarly, women support an ill woman by taking over both household duties and outdoor tasks such as fetching water, collecting firewood, and going to the market. These collective efforts not only reduce the practical burdens on the sick individual but also provide emotional support through presence, care, and companionship. Therefore, families and the wider community play a significant role in shaping health and well-being, often relying on alternative sources of knowledge—even to the point of discouraging individuals from seeking medical treatment from health professionals

There are several religious and traditional gatherings that strengthen social ties and support the mental well-being of community members. Among these, certain rituals play a key role in fostering fraternity and companionship. One such example is the practice of *Tsebel*, also known as *Mahber* among Orthodox Christians. This ritual involves a communal offering made monthly to angels, saints, or the Holy Trinity.

Participants—both men and women—take turns hosting the gathering in their homes, where food and drinks are shared. Though primarily religious in nature, *Mahber* also serves as a form of social support and helping participants manage stress. It creates a space where individuals can share personal challenges, allowing the group to provide both emotional and practical assistance.

While there are no clear differences in how men and women experience well-being and ill-being in general, women are often perceived as more vulnerable to illnesses believed to be caused by supernatural forces. For example, *buda* (the evil eye) is thought to affect women more easily, particularly those considered beautiful. Demonic attacks are also commonly believed to primarily target women, particularly during childbirth and the postpartum period. Additionally, in the tradition of *Gni*, it is believed that the *Gni* spirit primarily possesses women, reinforcing the perception of their heightened susceptibility to spiritual or supernatural afflictions.

The Role of Community Health Agents in Shaping Health Perceptions

The community's perspective on the role of religious leaders and other influential figures is shaped by the authority and influence granted through the religious and traditional belief systems practiced locally. There are several community health agents who directly or indirectly influence people's health and well-being. These include priests and *Deftera* (individuals with specialized religious knowledge) within Christianity, *Shek* within Islam, individuals possessed by the *Gni* spirit from traditional belief systems, as well as herbalists, traditional healers, and traditional birth attendants.

While the *Deftera*, the *Shek*, and individuals believed to be possessed by the *Gni* spirit all influence health perceptions within the community, they are distinct in their perceived ability to both cause and cure illness. In contrast, other healing figures are primarily regarded as therapeutic agents. The *Deftera* are believed to possess specialized religious knowledge that allows them to communicate with demons. They are thought to be capable of inflicting illness through demonic power, but they can also provide healing for illnesses caused in this way. Similarly, the *Shek* are believed to have the power to cure and cause sickness, yet they are also seen as capable of blessing and healing the sick. Individuals possessed by the *Gni* spirit are thought to cause illness, particularly among their kin, if their instructions are disobeyed, if they are angered or confronted, or if sacrificial obligations to the *Gni* are neglected. As a result, all three are treated with a high level of respect and caution. Community members avoid conflict or direct confrontation with them in order to prevent the risk of falling sick.

The interviewee stated the following in a discussion about which community health agents are available and the services they provide:

> *There are individuals with expertise in various health issues who assist us, and others with knowledge of medicinal plants who provide treatments for sicknesses. The wegesha (ወገሻ) are really good at fixing fractured bones. The traditional birth attendants are also the major agents with wider community acceptance. All those are options people use depending on their health conditions.* (Bereket interview with ADI-03, face-to-face, Adi-Mokoni, 22 April 2025).

As stated in the above quote, herbalists, traditional healers—such as those who treat bone fractures, muscle strains, and similar conditions—and traditional birth attendants are key figures from whom community members seek advice and treatment. Their role is especially important in remote areas where modern medical facilities are unavailable; the availability of modern medical care is discussed further in the paper's discussion section. As a result, people often turn to them as the preferred option for treating sicknesses and conditions that fall within their areas of expertise.

In some cases, these community agents oppose specific modern medical treatments. For example, priests are strongly against the use of contraceptive methods and abortion, viewing them as sinful acts that go against religious teachings. Similarly, some herbalists advise community members not to seek treatment at modern medical centers for certain diseases, such as Hepatitis (locally known as □□ □□), Herpes Zoster (locally known as □ዊ (□ብሪ) ሰማይ), and measles (locally known as □□□□ን), believing that these conditions are only treated through traditional remedies.

Community agents not only provide treatments for health problems, but they also identify illnesses based on observed symptoms. Herbalists, for example, are skilled at diagnosing various conditions by examining signs such as skin and eye color, the nature of swellings, and other symptoms described by the patient. Based on their knowledge, they either provide treatment themselves or refer the individual to other therapeutic options they believe may be appropriate. Traditional birth attendants, on the other hand, believed to have a unique ability to assess the health of a pregnancy through observation and touch. They can determine the positioning of the fetus and detect potential complications during pregnancy or delivery. Some might even predict the sex of the baby by examining the breasts, the shape of the belly, or simply through detailed observation of the pregnancy's physical characteristics. They identify sicknesses and provide treatment or referrals based not only on knowledge gained through experience, but primarily on traditional knowledge passed down from their ancestors.

Individuals believed to possess the ability to perceive hidden events and foretell the future also play a significant role in the community. They are thought to have the power to reveal what has already happened but remains unknown to the public, as well as to predict future occurrences. Community members often consult them to uncover the causes of sickness, particularly to determine when, where, and by whom the sickness was caused. In addition to identifying the source of sickness, these individuals are also sought for guidance on suitable therapeutic responses to help ensure the afflicted person recovers in the near future.

Alongside community agents knowledgeable in religious and cultural matters, health extension workers—with foundational healthcare training and strong community acceptance—are also present in the study area. These workers receive relatively short-term training focused on identifying common illnesses, providing basic treatments, and making appropriate referrals. However, access to formal healthcare remains limited. The nearest health clinic is about an hour's walk from the villages, and even the public and private clinics in the closest town lack the necessary setup to provide comprehensive primary healthcare. The next better equipped health facility is located approximately 40 kilometers away. This considerable distance poses significant challenges, particularly for sick individuals and pregnant women, making timely medical care difficult to access. As a result, community members primarily rely on traditional methods of sickness identification and treatment.

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Maternal Health: Common Community Perceptions and Care Practices

In the study community, understanding of good maternal health is believed to begin during her pregnancy period. A pregnancy is considered healthy when the woman does not experience unusual sickness and when the size of the abdomen during pregnancy is moderate, neither too small nor excessively large. Common practices aimed at ensuring a healthy pregnancy include following traditional and religious rituals, seeking advice from elders, avoiding excessive physical activity and labor-intensive tasks, and staying away from crowded places such as markets and other social gatherings. These practices are intended to protect the mother from physical and/or mental harm, including those often believed to result from external forces.

Utilizing healthcare institutions for prenatal care is generally uncommon, unless when the expectant woman suffers from significant sickness, at which juncture biomedical interventions are considered preferable. Routine pregnancy follow-up visits to health facilities are therefore rare. Women frequently opt for home births, assisted by elder women, the *Dbarte*[6], or the traditional birth attendants. In many instances, postponed or intricate deliveries are thought to be influenced by religious or spiritual influences. Consequently, prayers and an array of religious and mystical ceremonies are conducted. This may involve begging for the mercy of Saint Mary, calling ancestral spirits, and seeking blessings from the *Dbarte*, among other childbirth customs.

Visiting a health facility is often considered a last resort, pursued only when all home-based and culturally rooted treatments have failed to bring progress. In addition to cultural influence, financial constraints and the distance to healthcare facilities also contribute to the decision to give birth at home. Other aspects of modern medicine such as the presence of male midwives and delivery by Cesarean section (C-section) are generally not welcomed by community members, particularly by the expectant mothers themselves.

Newborns and mothers receive special religious and/or traditional care after childbirth. In the Orthodox Christian tradition, holy water is sprinkled on both the mother and the baby to prevent health complications and to purify them. Among both Christians and Muslims, the mother is provided with nutritious food, primarily from family resources, but also through contributions from relatives and community members. Depending on the availability of resources, the mother receives special food for several days, and in some cases, for weeks or even months. Childbirth is a highly celebrated event, often accompanied by expressions of gratitude to religious figures, particularly Saint Mary among Christians. Community members visit the new mother, usually bringing food items as a gesture of support and celebration.

DISCUSSION

This ethnographic study explores local perspectives of the Raya community on the meanings of well-being and ill-being, as shaped by cultural understandings and practices. The study shows that the community's health practices are significantly influenced by their perceptions of the causes of health conditions and the relevant therapeutic options. The understanding of healthiness and sickness is not solely based on

[6] A group of women believed to possess the power to bless a pregnancy, ensuring a healthy and smooth pregnancy period, and to intervene in cases of delayed delivery by calling for immediate results.

manifested physical and mental health disorders; rather, it is deeply connected to the community's overall way of life.

From a wide spectrum of ideas, there is an intricate interaction between perceptions of sickness causation and related treatment possibilities. People often draw on both biomedical and traditional practices when seeking treatment, regardless of whether they perceive the cause of illness as natural or supernatural. This large field of combinations emphasizes how often medical techniques and cultural ideas overlap and shape behavior aimed at improving health.

In the study community, people understand health problems as having multiple possible causes. Sickness is not viewed solely through a biomedical lens but is instead interpreted through a combination of natural, spiritual, social, and environmental perspectives. While natural causes are recognized, religious and mystical explanations are simultaneously considered important. Social and environmental conditions, including physical contacts and poor sanitation, are also seen as contributing factors. This layered understanding reveals how health and sickness are deeply embedded in both the physical world and the community's broader spiritual beliefs and social life.

The social fabric of the Raya community is firmly aligned with the Tronto's (2020) Dimensions of Care Ethics idea, which emphasizes relational responsibility, attentiveness, and responsiveness in caregiving. The Raya community places a strong emphasis on family and community networks, where it is customary to help one another and take responsibility for one another. This interdependence ensures that vulnerable individuals receive comprehensive care that attends to their emotional, physical, and social needs, reflecting care ethics as a lived practice. Strong social relationships strengthen community resilience and well-being by transforming care from an individual obligation into a shared moral commitment. This illustrates how community support for health and wellbeing is actively demonstrated via tangible acts rather than being only an abstract concept.

Because well-being and ill-being are shaped by cultural norms and communal life of the study community, certain individuals within the community play key roles in shaping perceptions of health, identifying the causes of illness, and guiding decisions about seeking appropriate treatments. These are trusted figures whose knowledge and advice are respected and valued by community members. Hence, any health intervention must take into account the influence of these agents in order to bring about meaningful change in the health of community members.

Much of the community resides in rural areas with no nearby health facilities. While small towns may have primary clinics, their standards are often low and insufficient to provide adequate care. Private clinics also exist in a few towns, but with limited capacity to address the full range of health needs. As a result, access remains a serious challenge, compounded by long walking distances, high transport and medical costs, and the limited capacity of available health centers. These constraints drive community members to prefer and rely more heavily on local traditional medical options.

The community conceptions of health and diseases are influenced by culturally ingrained belief systems that delineate not just the nature of disease but also the appropriate treatment methods and responsible parties. Access to knowledge and therapeutic techniques is subject to societal regulation, with specific forms of knowledge deemed specialized and protected. Moreover, the tensions between traditional and biological systems, wherein trust, perceived effectiveness, and cultural resemblance influence individuals' health-

seeking decisions more significantly than clinical reasoning alone. Traditional medicine is perceived to have the potential to cure viral diseases. Hence, the community's trust in the efficacy of culturally rooted healing practices with a comprehensive, context-specific understanding of health that integrates social, spiritual, and physical dimensions.

While the community's knowledge and practices are grounded in lived experience and are often valid and justified, the belief that certain illnesses are medically untreatable and caused exclusively by supernatural forces may not always be accurate. This emphasizes the need for interventions by health professionals to raise awareness among community members that the belief that some health disorders, which may be deemed untreatable by biomedical methods or should be exclusively treated with traditional medicine, should be challenged. Health professionals should preferably engage communities through health extension workers, enabling members to recognize important treatable health conditions and, in particular, to seek clinical diagnosis rather than relying solely on preconceived beliefs or self-assessments.

CONCLUSION

The study emphasizes how strongly cultural beliefs and practices impact society perceptions of well-being and ill-being of the Raya community. These ideas might relate to environmental, dietary, and other elements or be based on religious or mystical perspectives. The related behaviors reflect long-standing historical patterns that have molded opinions of illness cause and directed therapy decisions; they are not random or only subjective. In this sense, these practices are definite components of the way the society approaches health and healing since they rely on useful knowledge handed down diachronically and synchronically. Yet, some community understandings of sickness and health, along with the treatment options they use that contradict established biomedical standards, must be reconsidered.

Cultural beliefs form the foundation of the practices community members adopt, shaping their perceptions of the causes, treatment, and prevention of sickness. The practices people use to address health disorders are fundamentally influenced by their understanding of the causes of these conditions.

Generally, well-being and ill-being are understood based on the external manifestations individuals display—such as visible signs of any health disorder. As long as community members remain active, show no symptoms observable by others, and are able to carry out their daily life, they are considered healthy. However, there are instances where this understanding of health is contradictory. For example, overweight (overfeeding) and obesity are sometimes viewed as indicators of health. These contradictions require the attention of health experts to ensure that positive change is achieved in the community's understanding of well-being.

Community health agents have a significant influence on the health-related behaviors of community members. This is because community members often turn to them for identifying the causes of health disorders and seek their advice on treatment options they believe are most appropriate for the identified condition.

This study suggest for further studies to evaluate how cultural perceptions of health and illness evolve with time in response to digitalization, globalization, and more exposure to biomedical healthcare systems. Particularly for younger generations, further ethnographic and participatory research should examine local knowledge systems—how they are transmitted, validated, and contested within the community. This work

should also assess the resilience of indigenous health knowledge in contemporary contexts, identifying where it endures and where it is eroding. In parallel, researchers should investigate the mechanisms—such as social cohesion, communal rituals, and support networks—that appear to keep loneliness low in Raya, and evaluate the transferability of these practices to strengthen mental health in other settings.

Authors' Contributions

The first author, as part of his PhD study, designed the research, conducted fieldwork, analyzed the data, and prepared the initial draft of the article, including structuring the paper and integrating theoretical foundations. He defined the research problem, incorporated relevant concepts and literature, presented findings, discussed insights, and formulated conclusions.

The first co-author supervised the research process, reviewed the manuscript, and supported the overall structure of the paper. The second and third co-authors, both medical professionals, reviewed the full manuscript and provided expert input.

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