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Pastoral Care as a Third Pole: Medical Pluralism Among Christians in Indonesia

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Abstract

Christian congregations in Indonesia are commonly framed as standing outside a three-way tension between biomedicine, traditional healing, and faith, with pastoral guidance often if stronger faith predicts rejection of supernaturally tinged tradition. That assumption has not been tested quantitatively. This descriptive-exploratory survey examined illness etiology, treatment-seeking sequences, decision determinants, and the roles of health workers, traditional healers, and clergy among 198 Protestant (93.9%) and Catholic (6.1%) adults recruited via purposive-convenience sampling across 18 Indonesian provinces. Respondents held naturalistic (M = 4.20) and personalistic (M = 3.63) illness explanations simultaneously rather than choosing between them; 48.5% scored high on both, and only 5.6% held a purely supernatural view. Treatment-seeking followed a staged hierarchy: self-medication dominated the first action (44.9%), formal medical care rose to 44.9% by the third action, and pastoral prayer rose from 7.6% to 30.3%, while traditional healers never exceeded 3.0%. Half the sample (50.5%) combined two or more systems, and combining medicine with pastoral prayer (30.3%) occurred three times more often than combining medicine with traditional treatment (10.1%). Contrary to the study's founding assumption, spiritual maturity did not suppress supernatural attribution, both etiology types rose across maturity tertiles. While household habit, not belief, distinguished the minority (24.7%) with any traditional-healer contact. Clergy, in this sample, occupy the structural position traditional healers hold in comparable Indonesian pluralism research. Findings describe this sample and are not population estimates; implications for pastoral accompaniment and health communication are discussed.

Introduction

Treatment-seeking is never a purely biomedical transaction. People do not encounter modern medicine in isolation from the cultural, religious, and social structures in which they live, and their choice of care is shaped by the interaction of knowledge, affordability, personal belief, and social pressure rather than by clinical logic alone (Farlikhatun et al., 2021; Nurochmah et al., 2024). This coexistence of multiple healing systems within a single society, commonly termed medical pluralism, has required a conceptual apparatus for understanding how systems relate to one another since the early history of medicine itself (Yuen-man, 2012). Existing models of that relationship range from outright conflict, in which biomedicine and traditional healing are treated as fundamentally incommensurable, through integration, in which the two are merged into a single clinical framework, to genuine pluralism, in which distinct systems coexist on roughly equal footing and patients move between them as needed (Anderson et al., 2019; Chowdhury, 2025). Arthur Kleinman's reframing of health-care systems as cultural systems, organized into popular, folk or traditional, and professional sectors, provides the organizing lens for the present study (Kariv, 2007; Mubyazi, 2007).

In Indonesia, this pluralism is sustained by a persistent gap between constitutional guarantees of health access and the reality of service delivery outside Java (Isriawaty, 2015; Najla & Kansil, 2024; Setyowati, 2022). Physician shortages, geographic distance, and thin outreach frequency continue to leave many communities in Kalimantan, Sulawesi, and Nusa Tenggara without regular contact with formal health

services (Andini & Djunaedi, 2021; Maulina et al., 2025; Nantabah et al., 2019; Noor et al., 2021; Noya et al., 2024; Saputra, 2024). Where formal care is thin, traditional and supernatural healing function as a first-available response rather than a residual one (Brown, 1988; Sather, 1998; Ujeed, 2018). Indonesian pluralism research has documented sequential and complementary use of biomedical, herbal, and prayer-based care in several such settings (Dewi & Nurcahyo, 2025; Febriyanti et al., 2024; Nasrullah et al., 2026; Nurochmah et al., 2024), but none of this literature is bounded by religious identity, and none of it quantifies the order in which systems are tried.

Christian and Catholic communities in Indonesia sit at a specific three-way intersection of shared faith commitment, constrained medical resources, and ancestral tradition that often carries mystical content (Febriyanti et al., 2024). The church holds an explicit pastoral and diaconal mandate in matters of health (Mahardika, 2025; Tondang, 2025), yet the existing pastoral-theological literature engages traditional healing normatively and dichotomously, typically treating it as idolatry to be judged rather than a practice to be understood in its social context (Ademiluka, 2024; Berends, 1993; Mawere et al., 2021; Ranboki, 2018).

That normative stance rests on an assumption that has never been tested empirically: that stronger faith predicts a more automatic rejection of mystically-tinged traditional treatment (Ademiluka, 2024). Early comparative evidence points the other way. Medical pluralism is common precisely within religious communities rather than despite them (Febriyanti et al., 2024), and believers elsewhere draw on multiple healing systems concurrently without experiencing this as apostasy (Gabasiane, 2014; Tondang, 2025).

The one existing quantitative study of Indonesian Christian health behavior measured trust in medicine and pharmacists alone and did not examine the traditional or pastoral poles at all (Soegiantoro et al., 2022). No study to date has measured illness etiology, treatment-choice sequencing, the determinants underlying those choices, and the reasoning behind them within a single instrument administered to a religiously-defined population; treating these as four interlocking layers of one phenomenon rather than four separate questions.

The present study addresses that gap descriptively. Among Christian adults in Indonesia, we sought to map (a) perceived illness etiology, (b) the range and sequence of treatment choices accessed, (c) the determinants underlying those choices, and (d) the roles of health workers, traditional healers, and clergy within the local health ecosystem. Consistent with the descriptive-exploratory design detailed below, this aim is stated as one of characterization rather than of hypothesis-testing.

Methods

2.1 Design

This was a quantitative descriptive-exploratory survey. The design was chosen because the aim was to characterize a phenomenon that had not previously been measured quantitatively in this population, not to test a relationship between variables or to generalize a population estimate. Consistent with that aim,

analysis was restricted to frequencies, percentages, means, and simple cross-tabulation; no inferential procedure (correlation, regression, or significance testing) was applied to the substantive research questions.

2.2 Setting, Participants, and Sampling

The target population was Christian or Protestant and Catholic adults in Indonesia, with emphasis on communities where medical, traditional, and pastoral care are all accessed concurrently or in sequence. Given the size of that population, data collection was concentrated, through purposive site selection, in areas offering variation in religious composition, sociocultural context (including active traditional-healing practice), and access to formal health services across remote, rural, and urban settings.

Inclusion criteria were self-identified Protestant or Catholic affiliation; age 18 years or older; ability to read, write, and complete the questionnaire in Indonesian; and at least one illness episode with associated treatment-seeking in the preceding two years. Exclusion criteria were withheld with informed consent and questionnaires with 20% or more of items unanswered.

Sampling combined purposive site selection with accidental (convenience) respondent selection within those sites, a non-probability purposive-convenience design. Respondents were recruited through Sunday worship attendance, community and prayer-group gatherings, home visits in Christian-majority neighborhoods, and online distribution through church and community WhatsApp groups, Facebook, and Instagram. Because the design was descriptive-exploratory rather than estimation-oriented, sample size was set by an adequacy target of 100–200 respondents rather than by a power calculation.

Data collection ran for three months across paper and online channels. Paper administration occurred after worship services, at community gatherings, and during home visits, with enumerators reading items aloud and recording answers for older or non-literate respondents; completed forms were checked for completeness on-site. Online administration used a Google Form distributed through church and community WhatsApp groups (with group administrators' permission) and through faith-community-targeted posts on Facebook and Instagram; every link required digital consent before the respondent could proceed, and the form was configured to discourage repeat submissions.

Of 215 questionnaires returned, 10 were removed as duplicate submissions (identified by matching contact numbers) and 7 were removed because the respondent was under 18 despite the inclusion criteria, leaving an analytic sample of 198. No case was excluded for incompleteness or uniform-response patterning, and all 198 retained cases gave affirmative consent.

The sample departed from what the approved proposal anticipated. It skews young, educated, and student-heavy; is majority female; and includes a substantial urban and peri-urban contingent from Yogyakarta Special Region rather than being concentrated in the originally targeted communities outside Java. Two provinces, Yogyakarta Special Region and East Nusa Tenggara, jointly account for 61.1% of respondents, while the remaining 16 of 18 represented provinces each contribute between 1 and 14

respondents; the three Papua provinces contribute only 4 respondents combined. Table 1 summarizes the realized profile.

Table 1
Sample Characteristics (n = 198)

Characteristic	Category	%
Age (years)	18–25	66.7
	26–35	19.2
	36–45	5.6
	46–55	4.5
	Over 55	4.0
Sex	Female	67.2
	Male	32.8
Religious affiliation	Protestant	93.9
	Catholic	6.1
Highest education	Senior secondary	49.5
	Bachelor's degree	36.4
	Master's degree	5.1
	Diploma	4.5
	Junior secondary	2.5
	Doctoral degree	1.0
	Primary or none	1.0
Primary occupation	Student	47.5
	Private-sector employee	12.1
	Farmer	12.1
	Homemaker	7.6
	Civil servant / teacher	6.1
	Unemployed / job-seeking	6.1
	Self-employed / trader	4.5
	Clergy / church worker	2.5
	Other	1.9
Residence type	Small town / subdistrict	46.5
	City / regency or provincial capital	28.3

Characteristic	Category	%
	Village / remote	25.3
Region	Outside Java	58.1
	Java	41.9

2.3 Instrument

The self- and enumerator-administered questionnaire covered seven blocks: respondent characteristics (7 items); spiritual maturity across faith, disposition, and behavioral dimensions (15 items); personalistic and naturalistic illness-etiology beliefs (10 items); the sequence of treatment actions taken for a recent illness, coded from closed and open responses into nine mutually exclusive categories; individual, interpersonal, and structural determinants of treatment choice (16 items); a four-way Weberian rationality typology: instrumental, value, affective, and traditional (18 items); and six open-ended items on perceived advantages of each system and the situations under which each would be chosen. Likert items used a 1–5 agreement or influence scale, interpreted against five conventional bands from very low (1.00-1.80) to very high (4.21-5.00). Content validity was reviewed by a four-person expert panel spanning medical anthropology, theology, pharmacy, and research methodology. Institutional permission was obtained from UKRIM's research and community-service office, and ethical clearance was granted by the Research Ethics Committee of Universitas Ahmad Dahlan number REC-UAD/01/02/04-2026/124 dated May 4, 2026.

Two administration errors are disclosed here rather than left for a reviewer to discover in the appended instrument. First, the four value-rationality statements were unintentionally presented twice, separated by four intervening items; the resulting first-versus-second correlations ($r = .784–.899$, mean shift ≤ 0.04 scale points across all four pairs) function as an incidental test-retest check and indicate stable responding rather than measurement noise. Only the first presentation of each item is used in the results below. Second, the instrument as fielded departs from the operational definitions in the approved proposal: the value-rationality block carries eight items rather than four, the affective block carries four rather than two, and the determinant blocks carry more items than originally specified. Table 2 reports the instrument as fielded, not as originally planned.

Table 2
Constructs, Item Counts, and Reliability as Administered

Construct	Items	Cronbach's α
Spiritual maturity	15	.801
Illness etiology (personalistic + naturalistic)	10	.742
Treatment-seeking determinants	16	.908
Treatment-seeking rationality (Weberian)	18	.846

2.4 Validity and Reliability

Item validity was assessed via Pearson product-moment item-total correlation, with an item retained if two-tailed significance fell below .05 and the observed *r* exceeded a critical value (Field, 2022; Sugiyono;, 2013). All 59 Likert items across the four constructs met this criterion (all $p < .001$; item-total *r* ranging .357 − .795), and internal consistency exceeded the conventional .60 threshold for all four constructs as seen in Table 2.

Two qualifications apply and are disclosed rather than smoothed over. First, validity and reliability were computed on the full pre-cleaning return (n = 215) rather than the analytic sample used throughout the Results (n = 198); the critical *r* value applied (.138) corresponds to n ≈ 203 rather than to either the pre-cleaning or analytic sample precisely (the exact values are .134 at n = 215 and .140 at n = 198). Because the weakest observed item-total correlation (.357) clears either critical value by a wide margin, the substantive validity conclusion is unaffected, but the psychometrics should be recomputed on the cleaned n = 198 before further use of the instrument. Second, the α = .908 obtained for the determinants block is high enough to suggest item redundancy rather than confidence: the four cost-and-access items within that block intercorrelate at .694 − .825, consistent with a single underlying affordability factor rather than four independent barriers, and an exploratory factor analysis is recommended before the scale is reused. The comparatively lower α = .742 for the etiology construct is an expected consequence of the scale's design, which deliberately combines two logically opposed subscales (personalistic and naturalistic) that respondents are free to endorse independently; a lower coefficient here reflects intended heterogeneity, not a defect.

2.5 Analysis

Data was entered and tabulated in Microsoft Excel; validity and reliability were computed in IBM SPSS Statistics 30.0. Open-ended responses were coded through simple thematic analysis: repeated reading, identification of recurring themes, and frequency counts of theme occurrence. Consistent with the descriptive-exploratory design, no inferential statistical test was applied to any substantive research question; cross-tabulations reported in the Results (spiritual-maturity tertile, urban–rural residence, age group, and traditional-medicine contact) describe patterns within this sample and are not tested for statistical significance.

Results and Discussion

3.1 Coexisting explanatory models, not competing ones

Naturalistic illness explanations were endorsed more strongly than personalistic ones (M = 4.20 vs. 3.63), but the two were not traded off against each other. As shown in Fig. 1, nearly half the sample (48.5%, n = 96) scored in the high range on both subscales simultaneously; 38.4% (n = 76) scored high on naturalistic explanations alone, 5.6% (n = 11) on personalistic explanations alone, and 7.6% (n = 15) on either. Fewer than one in twenty respondents held a purely supernatural account of illness causation.

This is close to exactly what Kleinman's explanatory-model framework predicts: an explanatory model is invoked for a specific illness episode rather than held as a fixed worldview, and the same person can call on more than one model depending on context (Mubyazi, 2007; Patel, 2007). The open-ended data show this selection rule operating directly, physicians were preferred for emergencies and clear physical signs, prayer for emotional and spiritual needs, and traditional healers for a narrow residual set of complaints seen as outside medicine's reach, with the same respondents applying all three rules without treating them as contradictory. Febriyanti et al. (2024) report the same coexistence in West Java and Nurochmah et al. (2024) in Kampung Naga; this study extends the observation to a Christian population and shows that religious affiliation does not resolve the plurality.

Source: primary data

One construct-validity caveat qualifies this finding and should be reported alongside it rather than folded into the composite score. The personalistic-etiology subscale, as specified, combines two conceptually distinct beliefs: attribution of illness to a malevolent agent, and acknowledgment that God can heal. The single item on divine intervention scored 4.36 and was endorsed by 85.3% of respondents, while the remaining four items (curse, malicious intent, spirit-related affliction) averaged 3.45, with attribution to a curse scoring lowest at 3.28. A respondent can affirm the fifth item while rejecting the first four without any inconsistency, and the large majority did exactly that. Reporting the personalistic construct as a single mean of 3.63 therefore overstates endorsement of occult causation specifically. We recommend the scale be split, or the divine-healing item relocated to the value-rationality block where it belongs conceptually, before further use, a correction consistent with the construct-specification scrutiny this journal has explicitly asked authors to apply to religiosity and spirituality measures (Koenig & Carey, 2024).

3.2 A staged hierarchy of resort, with the church occupying the third pole

The escalation pattern closely tracks Young's hierarchy of resort and the staged models of Igun and Chrisman. Self-medication was the most common first action (44.9%, n = 89); including the wait-and-see and lay-consultation categories, 68.2% of respondents began outside any professional or specialist system. Formal medical care was the most common second and third action, rising from 19.7% at the first action to 44.9% by the third. Pastoral prayer rose steadily across the same three stages, 7.6%, 14.1%, 30.3% as shown in Fig. 2, while traditional healers moved from 0.5% to 1.0% to 3.0% and never became a meaningful share of any stage. Recoding the nine action categories into Kleinman's sectors sharpens the pattern: the popular sector shrank from 68.2% to 11.6% across the three stages, the professional sector more than doubled from 20.7% to 50.0%, and the religious sector tripled from 10.6% to 34.8%, while the traditional sector never exceeded 3.0%.

Source: primary data

This is a substantive departure from the tension the source report was designed around, which framed the phenomenon as a three-way pull between faith, medicine, and tradition, with the traditional healer occupying the third position. In this sample, the third position is occupied by the church. Combining medicine with pastoral prayer was the single most common form of system-combination (30.3% of the whole sample, 57.1% of all respondents who reported combining systems at all), three times more frequent than combining medicine with traditional treatment (10.1%), and 55.1% of respondents said no situation would lead them to a traditional healer at all, with a further 9.1% redirecting the question to a doctor or clergy member instead. This should not be read as the disappearance of medical pluralism: half the sample (50.5%) combined two or more systems for the same illness, which is precisely the behavior that defines pluralistic practice in comparable Indonesian studies (Dewi & Nurcahyo, 2025; Nasrullah et al., 2026). What has changed is the composition of the plural repertoire. We describe this pattern as *pluralism with a substituted third pole*: the structural position a traditional healer occupies in Barru or West Manggarai is occupied here by clergy. The church, on this evidence, does not stand outside the pluralistic system to judge it; it is one of the sectors respondents move through.

One functional role within the professional sector deserves separate mention. Paramedics, village health workers, nurses, and midwives, were almost invisible as a first action (1.0%) but tied for the third most common second action (14.1%), indicating a triage function between the pharmacy counter and the clinic that parallels findings on the role of mid-level and generalist health workers in under-served settings elsewhere (Muirhead & Birks, 2020; Noya et al., 2024).

3.3 Determinants: a divided sample, not a moderately influenced one

The three determinant blocks produced closely clustered means individual 3.53, structural 3.44, interpersonal and social 3.25 but the mean conceals more than it reveals. Standard deviations in this section (1.13, 1.03, 0.95) were the largest recorded anywhere in the instrument, and most items split respondents toward the two opposite ends of the scale rather than clustering them in the middle. Perceived illness severity, for instance, averaged 3.25, but 24.7% of respondents rated it as barely influential while 40.9% rated it as influential or highly influential. This sample is divided over what matters, not moderately swayed by everything.

Within the interpersonal block, family advice (M = 3.89) was the only determinant reaching the high band; advice from neighbors or friends (3.05), community leaders (2.87), and inherited family tradition (2.90) all fell in the moderate range, with the latter two drawing the highest outright-rejection rates in the entire instrument (36.4% and 35.4% respectively in the two lowest response categories). The social unit shaping treatment choice in this sample is the household, not the wider community. Within the structural block, facility availability and local service quality (both 3.64) and health-insurance coverage (3.56) outweighed distance (3.21) and transport availability (3.28), the reverse of what the proposal anticipated for a remote population, and best read as a property of the sample actually reached (young, largely near-facility, concentrated in Yogyakarta and East Nusa Tenggara) rather than evidence that structural barriers

are unimportant in general. Comparative literature consistently identifies cost and access as primary drivers of non-biomedical care elsewhere (Ansari et al., 2025; Bekele et al., 2024; Bheenaveni, 2016; Tolani et al., 2024); this study simply did not reach the population where that mechanism operates most strongly, and the four respondents drawn from Papua's three provinces cannot carry a claim about remote-access communities.

Applying Weber's typology, value rationality (M = 3.85) and instrumental rationality (M = 3.71) were nearly equal in magnitude and, when each respondent was assigned to their dominant type, almost exactly balanced (41.9% vs. 42.4%); affective rationality was secondary (12.1%) and traditional rationality marginal (3.5%, and the lowest-scoring construct in the whole instrument at M = 2.88). Treatment choice in this sample is reasoned in two registers at once (Natalia et al., 2024; Sumintak & Sumirat, 2022). The internal structure of the value-rationality block is the more useful finding: the two items locating the decision in personal faith, belief that God heals through the treatment chosen (4.33) and the requirement that treatment not conflict with personal belief (4.11), scored well above the two items locating it in ecclesial authority, consistency with church teaching (3.59) and a clergyperson's advice (3.38). Value rationality here operates as personal theological conviction, not institutional compliance a distinction the pastoral-normative literature on traditional healing has not, to our knowledge, previously addressed (Ademiluka, 2024; Ranboki, 2018).

3.4 Two findings that run against the study's founding assumption

Dividing the sample into tertiles of composite spiritual maturity shows personalistic etiology rising monotonically across tertiles, from 3.43 to 3.91, and naturalistic etiology rising alongside it, from 3.91 to 4.43; traditional rationality did not move as shown in Fig. 3. The most devout third of the sample was more likely, no less, to affirm both supernatural and natural causation at once. Spiritual maturity in this sample broadens the explanatory repertoire rather than narrowing it, consistent with Gabasiane’s (2014) report that Botswanan believers use African traditional medicine, Western medicine, Christian medical missions, and independent African church healing concurrently without treating any one as apostasy, and with Tondang’s (2025) account of comparable accommodation around ancestral-spirit belief within Indonesian Christian faith.

Separately, comparing the 49 respondents (24.7%) who reported any contact with traditional healing against the 149 who did not show that belief is not what separates them: personalistic etiology was nearly identical between groups (3.62 vs. 3.63) and so was spiritual maturity (4.30 vs. 4.33). What differed was attachment to inherited household practice, a single item on generational family tradition differed by 0.57 scale points (3.33 vs. 2.76), alongside smaller gaps in instrumental rationality (0.32), traditional rationality (0.29), and interpersonal determinants (0.27). Contact with traditional healing tracks habits, not conviction. This has a direct implication for pastoral and clinical intervention design: teaching aimed at changing beliefs about illness causation is unlikely to reach the people who actually

use traditional healers, while intervention channeled through household and family practice has a more plausible route to them.

Source: primary data

Two smaller cross-tabulations qualify rather than overturn the access story. Rural and remote respondents reported more traditional-healing contact (32.0%) than small-town (23.9%) or large-city respondents (19.6%), matching the direction the design anticipated, but rural respondents did not rate structural determinants any higher than small-town respondents (3.46 vs. 3.51) and were, if anything, more likely than large-city respondents to go straight to formal medical care as a first action (26.0% vs. 19.6%). The "rural" stratum reached here is young, largely student, and concentrated in East Nusa Tenggara and peri-urban Yogyakarta, places where a community health center is typically within reach, so the compressed urban-rural gradient describes this sample rather than disproving the structural-access mechanism generally. Age moved in the opposite direction from what is usually assumed: traditional rationality declined with age (3.03 at 18–25, 2.63 at 26–35, 2.49 above 35), as did interpersonal determinants (3.40 to 2.80), while personalistic etiology and value rationality both rose moderately with age. With only 28 respondents over 35, this reversal should be treated as a pattern worth testing, not a settled finding, one plausible reading is that the youngest respondents, mostly students still living within family structures, are reporting current dependence on household and community norms rather than a durable generational trait, but the design cannot adjudicate between that reading and its alternatives.

3.5 What each system is valued for

The open-ended items sharpen rather than merely restate the closed-item findings. Biomedicine's advantages were framed in epistemic terms: speed of recovery (19.7%), scientific testing (19.2%), diagnostic accuracy (18.2%), professional competence and equipment (16.7%), and correct dosing and safety (13.1%). Divine healing's advantages were framed in terms that do not compete with those at all: strengthened faith and dependence on God (26.3%), inner peace and hope (21.7%), and healing understood as encompassing body, mind, and spirit rather than the body alone (11.1%). The two systems are valued in different registers and were not presented by respondents as mutually exclusive options. Traditional medicine was the exception: the single largest theme was outright denial of any advantage (27.8%), ranging from simple unfamiliarity to explicit rejection; where an advantage was granted, it was pragmatic and cultural, natural ingredients, cultural closeness, accessibility, low cost, rather than efficacy-based. Asked directly what situation would lead them to a traditional healer over a doctor or clergyperson, 55.1% said none, and a further 9.1% answered by a doctor or clergyperson instead, 64.2% rejecting the premise of the question outright. Among the 27.8% who did name a situation, musculoskeletal problems was the largest single indication (7.1%), followed by perceived failure of medical treatment (5.6%), illness attributed to supernatural forces (5.1%), desperation or panic (5.1%), and cultural or family habit (4.5%). Traditional healers in this sample occupy a narrow, specific niche rather than a general-purpose alternative to medicine or clergy.

3.6 Limitations

The sampling method was purposive and accidental, not representative of Protestant and Catholic Christians in Indonesia as a whole. Two provinces account for 61.1% of respondents; two-thirds are aged 18–25; nearly half are students; two-thirds are women; and 93.9% are Protestant, leaving a Catholic subsample (n = 12) too small to support any denominational comparison. No finding here should be read as a population estimate.

Online recruitment through church WhatsApp groups and social media reached respondents who are digitally connected and already affiliated with a congregation; those with weaker church ties or no smartphone access were structurally excluded, and both traits plausibly relate to the outcomes measured. Social desirability bias is a further, specific concern: the instrument identified itself as coming from a Christian university and asked about practices most Indonesian Protestant congregations do not sanction. Under-reporting of traditional-healing contact should be assumed rather than merely acknowledged; 24.7% who nonetheless reported it is best treated as a floor, and the substitution finding in Section 3.2 should be read with that qualification attached rather than as a precise estimate. The treatment-sequence items were retrospective and not anchored to a dated episode, so the reported order may partly reflect a normative script for "what one is supposed to do" rather than a dated behavioral record; the predominance of self-limiting complaints in the illness data (only 7.6% reported a chronic or severe condition) further limits how much escalation the sequence items could reveal in the first place. Finally, as detailed in Sections 2.4 and 3.1, validity and reliability were computed on a sample that does not match the analytic sample, and the personalistic-etiology scale requires re-specification before reuse.

Conclusion

Among 198 Christian (Protestant and Catholic) adults surveyed across 18 Indonesian provinces, medical pluralism operates as coexistence rather than competition. Naturalistic and personalistic illness explanations are held together, not traded off, by most respondents. Treatment-seeking follows a staged escalation consistent with established hierarchy-of-resort models, but the structural position typically occupied by a traditional healer in comparable Indonesian research is occupied here by clergy: pastoral prayer, not traditional treatment, is what respondents add to biomedicine as their illness persists. Spiritual maturity broadens the range of causes a respondent will entertain rather than narrowing it toward the natural, directly contradicting the normative assumption that motivated this study, and household habit rather than belief is what actually distinguishes the minority who use traditional healers. Decisions are reasoned in roughly equal measure through personal-theological and instrumental logic, and the theological reasoning in question is personal rather than institutionally directed.

For health communication, the implication is to treat the pharmacy counter, not the clinic, as the true first point of contact, and the household, not community leadership, as the operative unit for intervention. For pastoral practice, the implication is narrower than the source report's original proposal assumed:

congregants are not choosing between faith and medicine but lack an articulated theology for how the two belong together, and pastoral counsel itself carries only moderate weight relative to personal conviction, which argues for equipping congregants to reason theologically about illness rather than issuing directives about which practices are permitted. These findings describe this sample; they are not a population estimate for Indonesian Christians generally, and confirming the mechanisms identified here, particularly the habit-not-belief finding around traditional-healing contact, will require a stratified, episode-anchored, and denominationally better-balanced follow-up.

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Figures

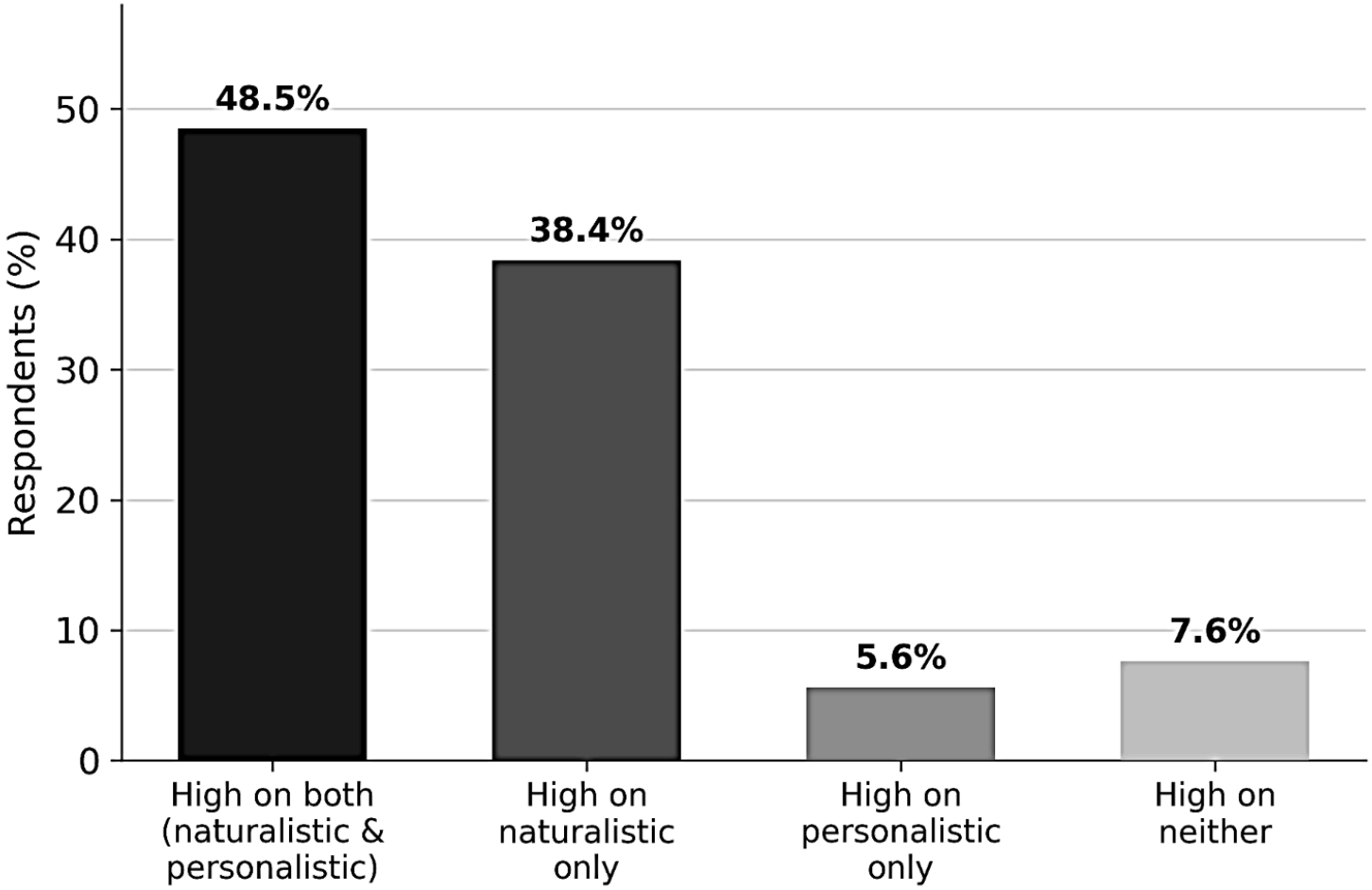


Figure 1

Joint distribution of naturalistic and personalistic illness-etiology beliefs (n = 198).

Source: primary data

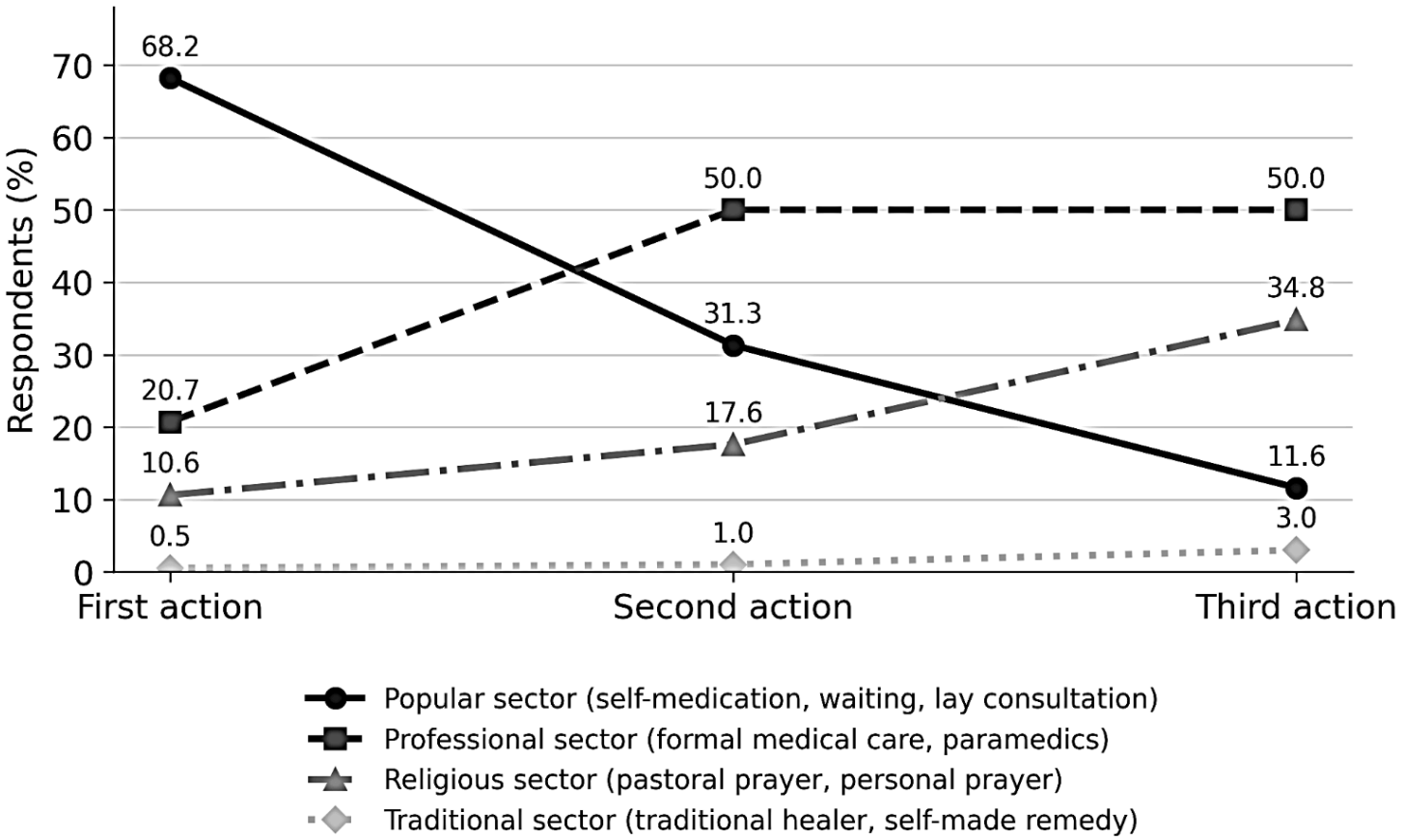


Figure 2

Share of respondents in each Kleinman health-care sector across the first, second, and third treatment-seeking actions (n = 198)

Source: primary data

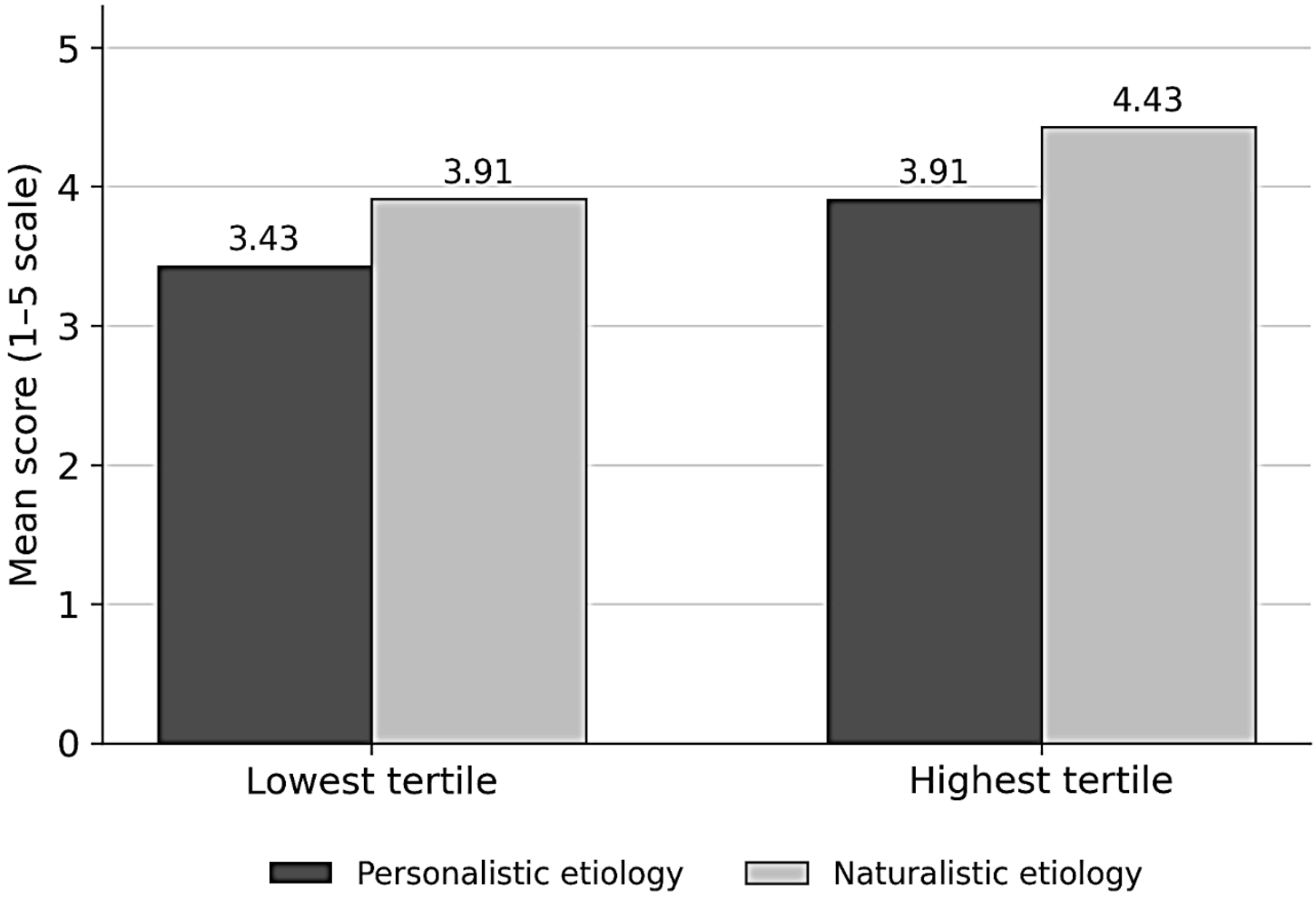


Figure 3

Mean personalistic and naturalistic etiology scores in the lowest and highest tertiles of composite spiritual maturity (n = 198).

Source: primary data