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The Language of "Non-Medical" Illness in Konjo: Ethnolinguistic Insights for Health Communication

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Abstract

This article examines how Konjo speakers in the Ammatoa Kajang community name and interpret three local illness categories — kasamperoang, pappitaba, and poppo' — and how attention to those categories can strengthen culturally responsive health communication and English for Specific Purposes (ESP) preparation for midwifery students. In this context, "non-medical" does not mean unreal or outside care; rather, it refers to illness episodes whose local explanation includes place, relational disturbance, emotion, adat, and unseen agency alongside bodily signs. Drawing on ethnographic fieldwork in Tana Toa village, Bulukumba, in May to July 2025, including interviews with sanro, pregnant and postpartum women, husbands, and village leaders, the research finds that kasamperoang links vulnerable children to movement through sensitive places; pappitaba indexes dizziness, burden, fear, shame, and social-emotional disturbance; and poppo' marks a sudden, intrusive attack that requires rapid protection. Families move rationally between sanro and biomedical services based on severity and perceived cause. The main issue is one of category translation: reducing local terms to 'fever' or 'stress' loses critical causal and relational information. The article concludes with implications for culturally grounded history-taking and local-culture-based ESP materials in health education.

1. Introduction

Across many indigenous and minority communities, illness is understood not only as a biomedical event but also as a linguistic, moral, and relational one. People do not encounter symptoms as neutral bodily signals; they encounter them

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through names, stories, warnings, remembered episodes, and culturally shared explanations. Good's notion of medical semantics shows that local illness vocabularies often condense moral worlds of suffering, responsibility, and proper response rather than merely labeling disease entities (Good, 1977). Kleinman's framework of explanatory models similarly demonstrates that patients, families, and clinicians bring different vocabularies and mini-theories to the same episode of illness, and that misunderstandings arise when those models are not elicited or negotiated (Kleinman, 1980). In this perspective, attending to local illness terms is not an ornamental cultural exercise. It is a necessary step in understanding how people decide which illness is at stake, who should treat it, and when formal care becomes necessary.

In Indonesia, where local languages, healing traditions, and biomedical services coexist in everyday life, a growing body of research has documented how inherited beliefs and practices shape pregnancy, childbirth, postpartum recovery, and child care. Traditional protections, dietary rules, bodily heating and cooling, plant-based therapies, and ritual safeguards remain important even when clinics and hospitals are available (Silalahi et al., 2020; Withers et al., 2018). At the same time, studies of health-seeking behavior show that families routinely move across plural medical landscapes, combining home remedies, traditional healers, and formal services according to perceived causes, accessibility, prior experience, and moral evaluation (Widayanti et al., 2020). Much of this scholarship, however, describes beliefs and practices at the level of culture or ethnomedicine and gives less attention to the fine-grained illness vocabularies through which people classify what is happening and justify why one pathway of care is chosen over another.

The Ammatoa Kajang community in Tana Toa, Bulukumba, South Sulawesi, offers a strong case for such analysis. Known for its *adat*-centered social order and the authority of *pasang ri Kajang*, the community embeds maternal and child health in local values and practical care routines (Ningsih, Sulastri, et al., 2022; Ningsih, Sumarni, et al., 2022). Ethnobotanical studies have documented rich medicinal plants knowledge (Azis et al., 2020). However, the prior research lacks a sustained ethnolinguistic account of the Konjo illness lexicon through which the community members distinguish ordinary sickness from conditions often described as *bukan sakit rumah sakit*, that is, illnesses not understood as matters for hospital treatment alone.

This article addresses that gap by focusing on three locally salient Konjo terms namely, *kasamperoang, pappitaba,* and *poppo'*. These categories were selected because they recurred most frequently across all informant groups and generated the strongest links among symptom description, attributed cause, and care sequence. They do not map neatly onto biomedical labels but organize recognizable symptom clusters, attributed causes, moral evaluations, and therapeutic responses. This article has three aims: first, to document how the terms are named, differentiated, and explained; second, to examine how they shape

help-seeking trajectories between *sanro* and biomedical services; and third, to show how this knowledge can inform culturally responsive health communication and ESP materials for midwifery students.

This article sits at the intersection of medical anthropology, ethnolinguistics, and English for Specific Purposes. From medical anthropology, it adopts the view that illness labels are not transparent names for universal biological states but parts of explanatory systems through which people interpret what is wrong, who is implicated, and what kind of remedy is appropriate (Good, 1977; Kleinman, 1980). From ethnolinguistics, it draws on the argument that local disease taxonomies often differentiate among bodily imbalance, social offense, spiritual attack, or dangerous place-based encounter, and that lexical distinctions matter because they guide care, blame, and obligation (Wulandari et al., 2017, 2018).

The article also engages with ESP and language teaching grounded in local culture (Hossain, 2024; Rachmawati et al., 2018; Yan, 2021). Research in Indonesian higher education has repeatedly shown that ESP becomes more meaningful when materials mirror learners' professional tasks and when local cultural content is used not as decoration but as working knowledge relevant to practice (Nugroho, 2020; Ratri et al., 2024; Wisudayanti, 2020). For midwifery and community health students, this means that language learning should include the kinds of terms, case narratives, and explanatory negotiations they may encounter in real interactions with patients and families. In that sense, Konjo illness categories are important not only for ethnographic description but also for training future health workers to listen better, ask better questions, and translate between local and biomedical frames without prematurely dismissing community knowledge.

2. Method

Field research was conducted in Tana Toa, Bulukumba Regency, South Sulawesi, for over 12 weeks (May to July 2025). This study was conducted by researchers with prior engagement in maternal and community health research in Ammatoa Kajang and related Konjo-speaking settings. This prior familiarity facilitated trust-building and access to informants, while also requiring continuous reflexive attention so that locally meaningful illness categories were not prematurely reduced to biomedical equivalents.

Using purposive and snowball sampling, we interviewed 19 informants as described in Table 1. Data sources included *semi-structured* interviews that explored informants' understandings of the three illness categories, typical symptoms, perceived causes, preferred treatments, and points at which biomedical care was considered necessary. *Guided plant* walks with *sanro* documented the plant ingredients associated with the treatment and the rationale for their use. Informants were also invited to narrate specific cases, such as a child who became

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ill after crossing a particular place or a postpartum woman believed to require ritual protection.

Table 1. Informants' Characteristics

Informant's Characteristics	**Frequency (N)**
Age (Years)	Range 19-80
Job	Indigenous healer (*sanro*) = 3
	Professional Midwife = 1
	Tribe elder = 2
	Housewife = 7
	Head of District = 1
	Farmer = 5
Education	Primary School = 10
	Secondary School = 8
	Diploma = 1
Sex	Female = 10
	Male = 9

Direct observation of treatment was possible in only a limited number of cases; in other instances, informants reconstructed treatment sequences in detail, including massage, herbal water, *baca-baca*, smoke, and household restrictions. In total, direct observation was conducted in three treatment-related episodes, while the remaining treatment sequences were reconstructed through detailed retrospective narratives from healers, caregivers, and family members.

Interviews were conducted in Konjo or Indonesian, depending on the speaker's preference. The translation into English was checked with Konjo-speaking local support to ensure that terms were not forced into fixed biomedical equivalents too quickly. To strengthen analytic validity, emerging interpretations were discussed across the research team and checked against fieldnotes, interview transcripts, and repeated references across participant groups.

Terms and category boundaries were retained only when they appeared consistently across multiple types of informants. The study followed standard ethical procedures, including consultation with community leaders, verbal informed consent, the use of pseudonyms, and the restriction of inclusion of ritual knowledge.

Analysis proceeded in four stages. First, identifying focal terms and nearby expressions such as *takut, malu, jin, adat, panas, dingin*, and *sakit bukan rumah sakit*. Second, coding for symptoms, causes, and treatment steps, and reference to clinic or hospital care. Third, comparing categories. Fourth, examining how speakers reformulated categories for imagined clinical talk. Data saturation was considered reached when no new distinctions emerged.

3. Result

When Ammatoa Kajang residents explain that certain illnesses cannot be handled by doctors alone, they often distinguish between *sakit biasa* and conditions that require *sanro, ritual,* or *adat*-sensitive treatment. In this discourse, non-medical does not imply that the body is irrelevant. Fever, crying, dizziness, chest pressure, or weakness are all taken seriously. What makes the episode non-medical is that the bodily signs are thought to be inseparable from where a person has been, which relations have been disturbed, which taboo has been crossed, or which invisible presence has been activated. Table 2 summarizes the working contrasts among the three focal categories.

Table 2. Working glossary of the three focal Konjo illness categories

Term	**Typical bodily signs**	**Attributed cause**	**Common first response**
Kasamperoang	The child is weak, feverish, fussy, vomits, cries continuously, and has vacant looks.	Crossing sensitive places, disturbing unseen occupants, a vulnerable child-body	Massage, herbal water, *baca-baca*, apology/protection, then referral if it worsens
Pappitaba	Dizziness, burdened feeling, palpitations, loss of appetite, fear, shame, disturbed sleep, withdrawal	Shock, scolding, jealousy, social pressure, relational/emotional disturbance	Cooling herbs, calm companionship, prayer, social repair, then clinic if persistent
Poppo'	Sudden chill, paralysis-like feeling, chest pressure, intense fear, night attack	Dangerous unseen being, taboo breach, lack of protection, risky time/place	Protective recitation, smoke / herbal repellent, restrict movement, then treat physical complications

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Kasamperoang: vulnerable children, dangerous crossings, and disturbed paths

Kasamperoang was most often narrated in relation to children, especially when a child became suddenly weak, feverish, fussy, or difficult to soothe after travel, play, or movement through a place described as sensitive. Caregivers repeatedly linked the onset of illness to crossing places such as bridges, graveyard edges, large trees, river bends, and other places remembered as inhabited, guarded, or not to be treated carelessly.

One caregiver summarized the logic succinctly: "It is not only fever. The child was brought across that place, and after that, the body was no longer calm." Another speaker explained that the child may look physically ill, but the problem begins because "the path was disturbed," and the child is the one whose body receives the effect. In such talk, *kasamperoang* is not a hidden disease entity inside the body. It is an event of a disturbed relation between a vulnerable body and a morally charged place.

Several narratives made clear that ordinary symptom labels alone were considered insufficient. Vomiting, heat, and nonstop crying were important. Still, these signs became recognizable as kasamperoang only when they followed a particular movement history. When family members judged that the child had crossed somewhere they should not have crossed, or had done so without proper verbal caution. A *sanro* described the pattern as follows: "The child may be fever, may cry, may refuse milk. But we ask first, where did the child go, what place was passed, was there a warning, was there a greeting?" This way of questioning is significant because it orders the episode temporally and morally before it orders it physiologically.

Treatment narratives reinforce this interpretation. Care often began with *sanro*-assisted massage, recited *baca-baca*, and herbal water or topical preparations. Informants described massage on the forehead, eyebrows, shoulders, chest, and armpits, often accompanied by turmeric, leaves, or infused water, judged suitable for the child's condition. Where interlocutors permitted the procedure to be described, the recitation was characterized as an apologetic and protective address asking that the child's path be cleared and bodily disturbance be lifted. Parents were then advised to avoid certain routes, times, or modes of carrying the child. *Kasamperoang* therefore names a practical syndrome in which symptom recognition, event history, and future prevention are inseparable.

For example, a housewife described how her child became suddenly feverish, vomited repeatedly, and cried continuously after being carried home across a place near a large tree that elders considered sensitive. The family first interpreted the episode as *kasamperoang* because the symptoms began immediately after the crossing and because the child's body was said to have 'received the effect' of the disturbed path. A *sanro* was then consulted for massage, herbal water, and protective recitation, which is usually in Konjo or Quranic words. Only after the

fever remained high did the family also seek biomedical treatment. This sequence illustrates that local categorization did not block referral; rather, it organized the first interpretation of cause and the initial order of response.

> "For fever, it is first recited over by the *sanro*. The recitation is in Konjo, and sometimes there are also Qur'anic words."
> *(Housewife, 37 years old)*

Pappitaba: fear, shame, burden, and social-emotional disturbance

Pappitaba was described less as a place-based attack and more as a condition of burdened feeling that blurs the boundary between body, emotion, and social relation. Informants associated it with shock, harsh scolding, deep embarrassment, gossip, jealousy, or persistent interpersonal strain. The most common descriptions included dizziness, heaviness in the chest or head, inability to eat, restless sleep, palpitations, and an unwillingness to meet other people.

One informant glossed it as "the body is not exactly sick, but the inside is pressed" (farmer, 50 years old). Another stated that "when the heart is not steady because of what happened with people, the body follows." (farmer, 48 years old). These explanations show that *pappitaba* does not cleanly translate into a single biomedical category such as anxiety or depression, even though there are obvious points of overlap.

The local explanation of *pappitaba* consistently foregrounded relation. What mattered was not merely that a person felt bad, but that the feeling was attached to an event of humiliation, fear, social pressure, or moral imbalance. In several cases, women described becoming *pappitaba* after severe reprimand, domestic tension, or worry during pregnancy or postpartum recovery. Men and elders, by contrast, more readily narrated the condition through the language of hurt pride, family conflict, or unresolved offense.

These were tendencies rather than fixed gender divisions, but they indicate that illness description is also shaped by social role. Women caregivers more often organized the narrative around bodily sequence and everyday functioning. In contrast, elders and ritual specialists more readily elaborated the social cause and the need to restore calm relations.

Healing *pappitaba,* therefore, involved more than symptom relief. Informants described cooling herbal drinks, prayer, calm company, restriction of unnecessary social exposure, and sometimes explicit steps toward apology or repair. One sanro explained that treatment should "make the inside cool first," while a family member emphasized that the sufferer should not be ridiculed because "words can keep the body from returning." These narratives are important for health communication because they show that *pappitaba* is heard as a diagnostic statement about emotionally saturated social life. If reduced too quickly to stress in clinical talk, the category loses much of its moral and interactional force.

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Poppo': audible threat, taboo breach, and urgent protection

Poppo' was described as the most dangerous of the three categories. Informants glossed it as an attacking unseen presence, often associated with taboo breach, risky movement at night, or insufficient protection around newborns and postpartum women.

> "Poppo is the one that usually kills. It is called poppo because people often hear the sound 'po po po '." (indigenous healer, 75 years old)

A distinctive feature of the narratives was the repeated reference to the sound "po po po," said to signal the approach of the being or attack. Those who encountered it were described as suddenly chilled, unable to move, feeling a pressing sensation in the chest, frightened, or on the verge of collapse. Even when speakers accepted that physical complications might later require clinic treatment, the initiating event itself was framed as beyond doctors' competence.

The danger of *poppo'* was often tied to liminal times and states: nighttime movement, postpartum vulnerability, exposure of blood or placenta, and visits or activities judged inappropriate for someone in a fragile condition. One tribe elder explained that a postpartum mother "must not be left open to every path and every visitor" because what is dangerous is not only dirt or cold but also "that which follows disorder." In this sense, *poppo'* belongs to a broader moral geography. It is not simply an evil creature. It is a figure through which the community speaks about danger, boundary, and the cost of neglecting protective discipline.

> "'*Nalangere ki setan, nalangere ki jin*'—if the mother cries out, the spirits or jinn may hear." (tribe elder, 80 years old)

Protective action was described as highly ritualized. Informants mentioned specific *baca-baca*, smoke from burned resin or leaves, bodily covering, limits on nighttime movement, and household vigilance around newborns and postpartum women. Unlike *kasamperoang*, which allowed more discussion of plants and massage, talk about *poppo'* was noticeably more guarded. Interlocutors were willing to explain the general procedure but not always the exact recitation.

This partial opacity is itself analytically relevant: it signals that *poppo*' belongs to a domain of knowledge that remains socially regulated. Where informants provided only limited descriptions, the procedure was explained in generic terms as a protective recitation in Konjo, sometimes accompanied by Qur'anic phrases, smoke from burned material, bodily covering, and restrictions on movement at night. The exact wording of the recitation was not recorded out of respect for community limits on ritual disclosure. The category, therefore, cannot be understood solely as a folk symptom label; it is also a protected communicative object.

Moving between sanro and biomedical services

Across the interviews, it became clear that local illness categories did not automatically determine a single treatment pathway. Instead, they served as frameworks for interpreting which problem was occurring and which response should come first. This meant that care decisions were rarely framed as a strict choice between indigenous healing and biomedical treatment. Rather, families evaluated symptoms, suspected causes, prior experience, and the episode's progression before selecting among available options.

Although the three categories were often introduced as illnesses that are not for doctors alone, actual help-seeking was not organized by a rigid traditional-versus-biomedical split. Families moved pragmatically between *sanro*, home care, *Puskesmas*, pharmacies, and hospitals. The decision depended on severity, duration, previous experience, and whether the cause was perceived as primarily place-based, relational, or bodily. A mother might first consult a *sanro* for *kasamperoang* because the onset followed a sensitive crossing, then take the child to the clinic if vomiting persisted or the fever became high. In the same way, a case of *pappitaba* might begin with cooling herbs and family calming, but referral would be considered when eating difficulty, weakness, or disturbed sleep became prolonged. According to an informant:

> "When a child was sick, people here used to go first to the *sanro* because that was what people believed. But now we combine the *sanro* and the *puskesmas* or the hospital."
> *(farmer, 43 years old)*

Several informants explicitly stated that *sanro* themselves sometimes advised referral. This point matters because it complicates the assumption that indigenous healing always competes with biomedical care. Instead, the two systems can be sequenced. *Sanro* treatment may be used to address the understood initiating cause, while clinic treatment manages dehydration, fever, pain, or other observable bodily consequences. The practical problem arises when the local category disappears in translation. Once *kasamperoang* is retold simply as 'fever,' or pappitaba as' stress,' the logic that organized early action, family concern, and expected treatment can no longer be heard. According to a mother:

> "…If they are still sick after two or three days, then we go to the doctor."
> *(housewife, 42 years old)*

Differences across generations also appeared in how categories were narrated. Younger adults were generally more willing to mention clinic care early and sometimes reformulated the local term in Indonesian for outsiders, but they did not necessarily abandon the category itself. Rather, they moved between registers. Older interlocutors were more likely to elaborate on *adat*, dangerous places, and the authority of *sanro*. The continuity across generations, therefore, lies

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less in identical explanation than in the persistence of the terms as shared anchors for discussing illness. For health workers, this means that local categories remain active communicative resources even when speakers also participate in biomedical care.

Table 3. Example ESP applications derived from the findings

Teaching focus	**Sample task**	**Purpose**
Eliciting local terms	Role-play intake interview in which a caregiver uses *kasamperoang, pappitaba,* or *poppo'* and the students ask follow-up questions without dismissing the term.	Trains respectful history-taking and explanatory-model elicitation.
Translating case narratives	Rewrite a Konjo or Indonesian illness narrative into a brief clinical note while preserving event history, perceived cause, and prior treatment.	Builds skill in moving between local discourse and biomedical documentation.
Referral explanation	Pair-work dialogue: midwifery students explain why referral is needed while allowing the family to continue harmless ritual practices.	Supports culturally responsive risk communication.
Support for non-Konjo health workers	Use mini-glossary plus prompts such as: "What do you call this condition?", "What happened before it began?", and "What treatment has already been tried at home?"	Helps practitioners non-Konjo engage local categories without treating them as fixed folk diagnoses.

4. Discussion

The findings show that kasamperoang, pappitaba, and poppo' are not marginal curiosities but working categories through which Ammatoa Kajang residents organize causality, urgency, and help-seeking. In line with Good's (1977) argument, these labels function as condensed semantic forms that connect bodily sensation to the moral world. In line with Kleinman's (1980) model, they also operate as explanatory shortcuts: once a category is named, it already suggests what caused the problem, who has authority to respond, and which treatments may be effective. This helps explain why quick reduction into biomedical synonyms can be communicatively damaging. Such a reduction does not simply simplify language;

it strips away the causal and relational information that made the episode intelligible to the family in the first place.

The Konjo data also extend existing research on health culture in Ammatoa Kajang. Studies on medicinal plants, pregnancy pammali, postpartum breast care, and breastfeeding support have already shown that health practice in this community is deeply entangled with adat, bodily discipline, and local ecological knowledge (Azis et al., 2020; Ningsih, Sulastri, et al., 2022; Ningsih, Sumarni, et al., 2022). The present article adds that those practices are anchored in a lexical system that distinguishes kinds of disturbance rather than treating all non-biomedical concerns as a single undifferentiated field of belief. Kasamperoang foregrounds the dangerous crossing and the vulnerable child-body; pappitaba foregrounds the relational and affective burden; 'poppo' foregrounds the hostile, unseen attack and the urgent protection. Recognizing these distinctions matters because each category licenses a different sequence of response and a different explanation of responsibility.

At the same time, the findings complicate any romantic reading of local wisdom (Kurniadi & Suprapto, 2021, 2025). In several narratives, illness labels also functioned as moral commentary. Pappitaba can be used to express hurt, humiliation, and social pressure, but it can also indirectly assign blame to those judged emotionally weak or socially careless. Kasamperoang might protect children by encouraging caution around dangerous places, yet it could also imply that caregivers failed to observe proper warnings. This ambiguity is important for health workers. Respect for local categories does not mean accepting every implication uncritically. It means learning to hear what the category does in interaction, whether it is seeking help, allocating blame, describing fear, or asking for recognition of an event that matters to the family.

The practical challenge, therefore, is not whether health workers must believe the same etiologies as community members. The challenge is how to communicate when local categories structure the consultation before clinical classification begins. A workable response is modest but concrete: retain the local term in history-taking, ask what happened before onset, what treatment has already been attempted, and what the family fears will happen if the category is ignored. This approach is consistent with culturally responsive communication frameworks that stress explanation, negotiation, and listening across linguistic differences rather than immediate correction (Ferdinand et al., 2021; Kleinman & Benson, 2006; Raj et al., 2022). For non-Konjo-speaking practitioners, the goal is not memorizing folk diagnoses but learning a small elicitation repertoire and a local glossary.

At the policy level, these findings suggest the need for culturally responsive communication protocols in primary care and maternal-child health services serving indigenous communities. Rather than standardizing away local categories, health programs could incorporate brief guidance for eliciting vernacular illness

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terms, documenting prior home or sanro treatment, and distinguishing between harmful delay and culturally meaningful first response.

One challenge, however, is that formal health settings often privilege speed, standard terminology, and symptom-based triage. In such contexts, local categories may be heard as irrelevant, superstitious, or too time-consuming to explore. This can create resistance on both sides: practitioners may dismiss local explanation, while families may feel that the most meaningful part of the illness episode has not been heard. In the present study, informants suggested that some practitioners were more willing than others to engage local categories. Those with greater familiarity with the area or with community practices were described as more likely to tolerate harmless ritual continuities alongside referral or medication, whereas others were perceived as avoiding discussion of such categories altogether.

These implications connect directly to ESP for midwifery programs. Midwifery students preparing for work in indigenous or multilingual settings need language practice that goes beyond anatomy, hospital routines, and generic counseling phrases. They need practice in listening to community narratives, asking culturally legible follow-up questions, and co-translating local explanatory models into safe clinical action. Research on local-culture integration in English teaching suggests that such materials increase relevance and engagement (Nugroho, 2020; Ratri et al., 2024; Wisudayanti, 2020), while ESP studies in Indonesia show that students value discipline-specific tasks that mirror actual professional communication. The Konjo categories documented here provide precisely that kind of material.

Limitations

This article has several limitations. First, it is based on a focused qualitative corpus from one customary community. It should not be generalized automatically to all Konjo-speaking populations or to all indigenous health settings in Indonesia. Second, only a limited number of healing episodes could be directly observed; some accounts were retrospective narratives, shaped by memory and later interpretation. Third, translation from Konjo into Indonesian and English inevitably smooths certain semantic nuances, especially for pappitaba and poppo', whose meanings depend strongly on relation and event sequence. Fourth, because the article concentrates on three focal categories, it does not map the full illness lexicon used in Ammatoa Kajang.

5. Conclusion

Kasamperoang, pappitaba, and poppo' are not unusual names for ordinary sickness. They organize perception, causality, urgency, and help-seeking in Ammatoa Kajang. *Kasamperoang* ties child vulnerability to movement through sensitive places, *pappitaba* links bodily unease to fear, shame, and relational burden, and *poppo*' marks sudden, intrusive danger requiring protection. The

categories are distinct but flexible, and they continue to matter even when families also seek biomedical treatment.

The central issue highlighted in this study is therefore one of translation, not opposition. Health communication improves when local categories are treated as meaningful starting points for inquiry rather than as superstition to be silenced or corrected immediately. A practical recommendation for both Konjo-speaking and non-Konjo-speaking health workers is to retain the local term during history-taking, ask about event sequence and prior home or *sanro* treatment, and then explain referral or biomedical management in accessible language. For education, future ESP modules can turn these principles into glossaries, role-played intake interviews, case-note writing, and referral dialogues that prepare midwifery students for culturally grounded clinical communication.

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