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Epistemic Negotiations between Javanese Traditional Healing Knowledge and State Medical Rationality

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Abstract
The integration of traditional medicine into the formal health system in Indonesia encourages standardization, objectification, and biomedical-based legitimization that often clash with traditional Javanese healing knowledge rooted in experience, social relations, and local cosmology. Although health policies increasingly open up space for traditional practices, studies of how the epistemic boundaries between local knowledge and state medical rationality are negotiated in institutional practice remain limited. This study aims to analyze the mechanisms, dynamics, and implications of epistemic negotiations between traditional Javanese healing and state medical rationality within formal health services. The study uses a qualitative approach based on library studies and critical discourse analysis of academic literature, health policy documents, traditional medicine regulations, and medical and health policy publications in Indonesia. Epistemic negotiations occur through three mechanisms: first, conceptual hybridization, namely the effort to translate traditional healing practices and concepts into a biomedical terminology framework to gain institutional legitimacy; second, the process of classification and standardization through regulation, certification, and categorization of traditional practices that symbolically limit the epistemic space of local knowledge; Third, the discursive adaptation strategies of traditional actors who repackage healing practices to be compatible with modern health logic without completely abandoning community cosmologies and experiences. These findings suggest that the integration of healing systems is not merely a technical,

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institutional process but rather an arena of epistemic negotiation fraught with power relations, in which biomedicine functions as the dominant knowledge regime while still opening up space for agency and the reinterpretation of local knowledge.

Keywords: Epistemic Negotiation; Traditional Medicine; Javanese Medicine; Medicine; State Authority

Abstrak

Integrasi pengobatan tradisional ke dalam sistem kesehatan formal di Indonesia mendorong standardisasi, objektifikasi, dan legitimasi berbasis biomedis yang sering kali berbenturan dengan pengetahuan penyembuhan tradisional Jawa yang berakar pada pengalaman, relasi sosial, serta kosmologi lokal. Meskipun kebijakan kesehatan semakin membuka ruang bagi praktik tradisional, kajian mengenai bagaimana batas-batas epistemik antara pengetahuan lokal dan rasionalitas medis negara dinegosiasikan dalam praktik institusional masih terbatas. Penelitian ini bertujuan menganalisis mekanisme, dinamika, dan implikasi negosiasi epistemik antara penyembuhan tradisional Jawa dan rasionalitas medis negara dalam konteks layanan kesehatan formal. Penelitian menggunakan pendekatan kualitatif berbasis studi kepustakaan dan analisis wacana kritis terhadap literatur akademik, dokumen kebijakan kesehatan, regulasi pengobatan tradisional, serta publikasi medis dan kebijakan kesehatan di Indonesia. Negosiasi epistemik berlangsung melalui tiga mekanisme: pertama, hibridisasi konseptual, yaitu upaya menerjemahkan praktik dan konsep penyembuhan tradisional ke dalam kerangka terminologi biomedis agar memperoleh legitimasi institusional; kedua, proses klasifikasi dan standardisasi melalui regulasi, sertifikasi, dan kategorisasi praktik tradisional yang secara simbolik membatasi ruang epistemik pengetahuan lokal; ketiga, strategi adaptasi diskursif dari aktor tradisional yang mengemas ulang praktik penyembuhan agar kompatibel dengan logika kesehatan modern tanpa sepenuhnya meninggalkan kosmologi dan pengalaman komunitas. Temuan ini menunjukkan integrasi sistem penyembuhan tidak sekadar proses teknis kelembagaan, melainkan arena negosiasi epistemik yang sarat relasi kuasa, di mana biomedis berfungsi sebagai rezim pengetahuan dominan namun tetap membuka ruang bagi agensi dan reinterpretasi pengetahuan lokal.

Kata Kunci: Negosiasi Epistemik; Pengobatan Tradisional; Pengobatan Jawa; Medis; Otoritas Negara

Introduction

The epistemic negotiation between traditional Javanese healing knowledge and state medical rationality reflects the encounter between two knowledge regimes with distinct bases of legitimacy. Epistemic negotiation refers to the process of interaction, contestation, and adjustment between knowledge systems grounded in the cultural experiences of communities and knowledge systems institutionalized through scientific standards and institutional regulations (Kelly & Licona, 2018). Traditional Javanese healing knowledge is rooted in a local cosmology that views health as a balance between human relations, nature, and the spiritual dimension (Farmawati & Wiroko, 2022). In contrast, state medical rationality operates through a biomedical paradigm that emphasizes scientific objectivity, clinical procedures, and mechanisms of health standardization and regulation (Kondo et al., 2020). The encounter between these two knowledge regimes is not neutral, as it involves power relations in determining the legitimate authority of knowledge. Modern health

systems tend to position biomedicine as the primary reference for public health services (Holst & van de Pas, 2023), while traditional healing practices are often framed as complementary or alternative practices that require state regulation (Munandar & Harahap, 2025). This situation raises epistemic issues regarding the recognition, subordination, and transformation of traditional knowledge in interactions with modern health systems characterized by scientific and administrative standardization.

The global phenomenon of the use of traditional medicine demonstrates that local knowledge-based healing practices continue to play a vital role in public health systems. The World Health Organization (2021) states that approximately 70–80 percent of the world's population still uses traditional medicine as part of their healthcare, particularly in Asia and Africa, where access to modern medical services is limited. The Indonesian context demonstrates a similar dynamic through the regulation of traditional healing practices within the national health system. Government regulations classify traditional health services into empirical, complementary, and integrative categories, which must meet safety and licensing requirements (Juliana & Kurniawan, 2024). Basic Health Research data from the Indonesian Ministry of Health (2019) show that more than one-third of Indonesian households still utilize traditional medicine, such as herbal medicine (*jamu*) and local healing practices, as part of their health maintenance efforts. This fact demonstrates the persistence of traditional healing practices while simultaneously confronting state health regulatory mechanisms that demand scientific and administrative legitimacy. This situation creates both interaction and tension between traditional healers and state health institutions regarding claims of effectiveness, safety, and legitimacy of the knowledge used.

Studies on traditional medicine and biomedicine have developed through various disciplinary approaches. Research by Supriyanto (2023) shows that traditional Javanese healing is rooted in a symbolic system that integrates ritual practices, social relations, and the community's cosmological understanding. This study emphasizes the importance of cultural dimensions in healing practices but does not yet link them to the dynamics of modern state health regulation. Muhammad et al. (2021) examine the role of shamans in Javanese religious practices and find that traditional healers serve a social function as spiritual mediators and conflict resolvers. This study provides a snapshot of the healers' social position but does not yet address their interaction with the formal health system. Liu's (2020) research on the integration of traditional medicine into Southeast Asian health systems demonstrates collaborative efforts between traditional and biomedical practices through national health policies. The study highlights policy aspects but tends to view the state as a neutral actor, without examining the epistemic power relations involved.

Bleakley and Neilson (2023) argue that biomedicine itself is a cultural system with specific symbols, values, and practices that legitimize knowledge; this finding offers a critical perspective on claims of biomedical objectivity but has not been applied specifically to the context of traditional Javanese healing. Research by Subagiyo, Wibisono, and Ningrum (2023) on national herbal medicine policy shows that the standardization process for the herbal medicine industry often marginalizes the empirical knowledge of traditional herbalists through certification mechanisms and production regulations; however, this research has not positioned this process as a form of epistemic negotiation between two distinct knowledge systems. A synthesis of these studies shows that previous studies tend to separate cultural, social, and policy analyses without comprehensively examining the epistemic negotiation process between traditional healing knowledge and state medical rationality in both everyday practice and health policy discourse. This gap highlights the need for an approach that integrates the perspectives of medical anthropology, epistemology of knowledge, and policy studies to understand how traditional healing knowledge interacts with, adapts to, and maintains legitimacy amid the dominance of modern biomedical rationality.

The research problem is formulated as follows: How does the epistemic negotiation between Javanese traditional healing knowledge and state medical rationality unfold in healing practices and health policies? The research aims to analyze the interaction mechanisms, adaptation strategies of traditional healers, and power relations that shape the position of Javanese healing knowledge within the national health system. The research's initial argument asserts that traditional knowledge is neither passive nor static. However, it has the capacity to reflect on practices, adjust forms of legitimacy, and negotiate with state regulatory frameworks to remain relevant in the modern health context. The research findings are expected to provide a theoretical contribution in the form of developing an epistemic perspective in the study of health anthropology that positions the interaction of traditional and biomedical knowledge as an arena for knowledge contestation. Its practical contribution can provide an analytical basis for the formulation of health policies that are more inclusive of traditional healing knowledge.

Method

This study uses a qualitative approach with a critical-genealogical discourse analysis design combined with intertextual hermeneutics. Critical discourse analysis follows the three-dimensional framework developed by Norman Fairclough to examine the relationship between text structure, discursive practices, and social practices. At the same time, the genealogical approach refers to the perspective of power-knowledge relations formulated by Michel Foucault to trace the historical transformation of medical rationality in the institutionalization of health policy. Interpretation of the contextual meaning of the text is carried out through

philosophical hermeneutics inspired by the thoughts of Hans-Georg Gadamer. The data source is a corpus of historical texts produced between the late 18th and early 21st centuries, including colonial and postcolonial health archives, state health regulations, scientific medical articles, and institutional media discourse on traditional healing practices. Data were collected through systematic searches of national archives, digital manuscript repositories, and scientific journal databases, and then selected for thematic relevance, historical period, and epistemic position representing the relationship between local and biomedical knowledge. The analysis was conducted through the construction of a text corpus, conceptual coding of terms, metaphors, and knowledge categories, critical discourse analysis of strategies of legitimization and delegitimization of knowledge, genealogical tracing of the transformation of power relations in medical regulation, and intertextual mapping to identify patterns of integration, marginalization, and re-articulation of traditional healing knowledge within the framework of state medical rationality. The validity of the interpretation was maintained through triangulation of historical sources, cross-period comparison of documents, and analytical reflexivity in the process of hermeneutic reading.

Results and Discussion

The Epistemic Framework of Javanese Traditional Healing in Contemporary Practice

The epistemic framework of traditional Javanese healing is formed through a configuration of relational knowledge that combines bodily experience, symbolic interpretation, and cosmological orientations regarding the order of the universe and human position (Suyami et al., 2025). The body is viewed as a relational node that continuously interacts with the social environment, natural rhythms, and the moral dimensions of existence. This relational view aligns with Arthur Kleinman's (1988) concept of explanatory models of illness, which emphasizes that the meaning of illness is shaped through a specific cultural framework. Widyastuti (2022) shows that Javanese healers interpret patients' complaints through the relationship between bodily experience, emotional dynamics, and imbalances in social or spiritual relationships. Patient narratives of family conflict, economic pressure, or violations of ethical norms are often incorporated as an integral part of the diagnosis. This epistemic structure positions health as a state of cosmological harmony, while illness is interpreted as a disruption of existential relationships that requires the restoration of a holistic balance. This ontological difference forms the basis of epistemic tension with state biomedical rationality, which tends to view disease as a biologically pathological phenomenon (Yahya, Johan, & Febriana, 2025).

The sources of traditional Javanese healing knowledge are structured through three main, intertwined epistemic pathways: genealogical inheritance, therapeutic practice experience, and personal spiritual experience. The genealogical pathway refers to the transmission of knowledge through family lines or networks of disciples

deemed to possess a certain moral readiness and spiritual capacity (Fadhilah et al., 2023). This process is not simply the transfer of healing techniques but rather the internalization of ethical values and spiritual disciplines that shape the healer's authority. The empirical-experiential pathway emerges through repeated interactions between healer and patient, resulting in the accumulation of practical knowledge about disease patterns and therapeutic responses (Fadhilah et al., 2023). This dimension relates to Michael Polanyi's (1966) concept of tacit knowledge, which concerns knowledge gained through direct practice. The third pathway emerges through spiritual experiences such as inspiration or dreams, which are interpreted as diagnostic clues. Practitioners explain that personal revelations are only considered valid if they align with inherited knowledge traditions and demonstrate therapeutic efficacy (Fadhilah et al., 2023).

The validation mechanism for the truth of traditional Javanese healing knowledge rests on pragmatic confirmation through successful practice, community recognition, and consistent cosmological interpretation. Knowledge validation occurs through repeated practice that produces consistent patterns of success across diverse situations. Patient testimonies serve as a collective archive of experience that strengthens the healer's legitimacy and builds a therapeutic reputation (Bhagawan, Ekasari, & Agil, 2025). This model aligns with William James's (2010) pragmatic notion of truth, which evaluates truth by its practical effectiveness of knowledge. Healing failure does not immediately negate the knowledge system. However, it is interpreted as an inaccuracy of relational diagnosis, the patient's mental state not being ready for therapy, or a lack of cosmic time synchronization. Patterns of reinterpretation serve as a protective mechanism for epistemic coherence, maintaining the stability of the knowledge system. The patient community and the healer's social network serve as epistemic communities that assess the success of the practice through shared experience and long-term therapeutic reputation (Lindgren & Richardson, 2023).

The epistemic authority of Javanese healers is established through a combination of moral reputation, symbolic interpretation skills, and a community-recognized track record of therapeutic success. The legitimacy of a healer stems from the integrity of their life practices, reflecting inner harmony and spiritual discipline (Hellman, 2022). This structure of legitimacy can be understood through Pierre Bourdieu's (1993) concept of symbolic authority, which explains that social authority is formed through collective recognition of an individual's symbolic competence. Triratnawati (2016) suggests that healers gain patients' trust through accumulated case successes, patient-to-patient recommendations, and a reputation for personal piety. Failure to maintain ethical standards or involvement in social conflict can undermine this legitimacy without the need for formal sanctions. This structure of authority is relational, as it is constantly tested through direct interactions between healer and patient.

The concepts of illness, health, and healing are articulated through a cosmological framework that views humans as an integral part of the universal order. Health is understood as a state of harmony between the body, emotions, social relationships, and spiritual balance. Health disorders are often interpreted as indications of relational disharmony that can stem from interpersonal conflict, psychological distress, violations of ethical norms, or imbalances in spiritual energy (Suyami et al., 2025). Diagnosis involves interpreting the patient's life narrative, dreams, emotional experiences, and symbolic signs that emerge in everyday life. This approach aligns with the framework of medical anthropology, which positions the experience of illness as a social and cultural phenomenon (Amada et al., 2023). This perspective expands on the explanatory models of illness proposed by Arthur Kleinman (1988) by emphasizing the cosmological dimension as a central element in the interpretation of illness. Ontological differences regarding the definition of illness create epistemic tensions with the state biomedical paradigm, which tends to emphasize biological pathology as the center of diagnosis.

The transformation of traditional Javanese healing practices demonstrates an epistemic adaptability that allows knowledge systems to remain relevant in the face of contemporary social change. Healers reinterpret therapeutic symbols and rituals to fit the lived experiences of modern society without altering their underlying cosmological principles (Setiawan et al., 2023). The use of digital communication media, remote consultations, and changes in patient interaction patterns reflect a process of epistemic hybridization that allows for the integration of new elements without eliminating traditional knowledge frameworks. This phenomenon can be understood through Homi K. Bhabha's (1994) concept of cultural hybridity, which describes cultural practices evolving through a process of creative adaptation to new historical conditions. Adaptation does not occur as radical change, but rather as a symbolic reinterpretation that maintains the continuity of therapeutic meaning. Contemporary practices demonstrate that epistemic flexibility is a key mechanism for the sustainability of traditional healing systems, enabling them to respond to changing community health needs without losing their cosmological legitimacy (Manuel-Navarrete et al., 2024).

The relationship between healer and patient demonstrates a dialogical epistemological structure that places subjective experience as the source of therapeutic knowledge production. The healing process occurs through interpretive conversations that allow patients to reflect on the relationship between bodily symptoms and their life circumstances. The interaction produces a form of knowledge co-production involving the healer as a symbolic interpreter and the patient as a provider of existential experience. This perspective aligns with Sheila Jasanoff's (2004) notion of knowledge co-production, which emphasizes that knowledge is formed through social interactions between various actors. Ethical advice, cosmological metaphors, and symbolic rituals serve as reflective media that

help patients reorganize their relationships in life. The success of therapy is measured by the transformation in patients' understanding of their illness experiences.

State Medical Rationality and Knowledge Standardization Mechanisms

State medical rationality refers to an epistemic configuration that establishes standards of validity for health knowledge through scientific institutions, administrative apparatuses, and modern regulatory frameworks (Djulbegovic & Elqayam, 2017). Biopolitics positions health practices as an arena for the management of population life, institutionalized by the state through the production of scientific knowledge and technocratic mechanisms of governance (Mattioni et al., 2021). Breilh (2023) suggests that the biomedical truth regime reflects the co-production of science and the social order that governs the legitimacy of epistemic authority. This rationality prioritizes scientific objectivity, empirical verification, and the reproducibility of methods as the basis for recognizing medical truth. The body is treated as a universal biological entity, separate from social and historical contexts. This framework allows the state to integrate health knowledge into modern governance systems so that population health can be measured, predicted, and administered as an indicator of national development success.

The dominance of state medical rationality is maintained through mechanisms of knowledge standardization that transform healing practices into technical procedures subject to institutional audit. Koninckx et al. (2025) demonstrate that diagnostic protocols, therapeutic guidelines, and evidence-based medicine models function as epistemic infrastructures that simplify the complexity of illness experiences into measurable variables. The scientific consensus that shapes standards emerges through professional epistemic communities operating through research institutions, professional associations, and international health organizations. This structure creates an exclusive validation system because it only recognizes forms of evidence that align with statistical methodologies and controlled clinical experiments. Standardization facilitates the integration of health practices into state administrative mechanisms through performance indicators, medical audits, and health policy evaluations (Tiirinki et al., 2022). Healing practices that fail to generate evidence that meets these parameters lose scientific legitimacy and are positioned as alternative practices outside the mainstream of national health systems.

Disease classifications extend the function of standardization by creating a universal language connecting clinical practice, health statistics, and population management. International classification systems such as the International Classification of Diseases serve as knowledge infrastructures, enabling countries to transform individual illness experiences into administratively measurable epidemiological data (Lee et al., 2025). Wadmann's (2023) study demonstrates that classifications shape how societies understand the body and disease through

globally institutionalized diagnostic categories. Classification structures create new medical realities because biological conditions acquire clinical meaning only after being assigned to recognized diagnostic categories. Illness experiences that do not fit the classification parameters tend to lose institutional visibility and are therefore not recorded in health statistics or research agendas (Kuznetsov, 2017). This process demonstrates that medical classification functions as a biopolitical technology linking scientific knowledge to state administration.

Health professional certification strengthens the state's epistemic authority through institutional selection mechanisms that determine who has the legitimacy to provide medical services. Szalados (2021) shows that formal licensing and education systems create a monopoly on knowledge, thereby protecting the medical profession's jurisdiction from epistemic competition. Medical education, competency examinations, and licensing serve as mechanisms of professional closure that limit access to healing practices. This system ensures the internalization of the biomedical paradigm that underpins state medical rationality. Individuals without formal education struggle to gain legal recognition despite their empirical legitimacy within local communities. Certification creates a hierarchy of health knowledge that positions biomedicine as the authoritative standard of medical practice (Shaheen et al., 2025). This structure allows the state to control the distribution of health services while maintaining the epistemic dominance of modern medical institutions over non-biomedical healing practices.

Health regulation extends the work of certification through legal instruments that integrate medical rationality into the governance system. The regulatory framework encompasses oversight of health facilities, licensing of medical practices, drug control, and sanctions for activities that deviate from scientific standards (Mekasha et al., 2025). Adeniran et al. (2024) show that regulation functions as a risk management mechanism, producing categories of official and unofficial practices through the technocratic language of safety, effectiveness, and public safety. This regulatory language obscures the political dimension of the process of determining medical truth by presenting epistemic decisions as technical necessities for public protection. Healing practices not registered in the regulatory system are often treated as potential threats to public health. Regulation allows the state to control the health care market while centralizing scientific evaluation authority within administrative institutions that can determine the legal boundaries of healing practices (A. G. Fraser et al., 2021).

The interplay of scientific discourse, educational structures, and state regulatory instruments shapes the epistemic boundary between official medical knowledge and non-biomedical healing practices. Woldegiorgis (2025) points out that dominant knowledge systems often discredit alternative forms of knowledge by imposing validity criteria that local practices cannot meet. Narratives of safety, scientific rationality, and clinical effectiveness are used to assess health practices

based on the methodological parameters of modern science. This framework creates an asymmetrical relationship because non-biomedical knowledge only gains legitimacy after being translated into the language of formal scientific methodology. Traditional knowledge is reduced to the object of ethnobotanical or pharmacological research without acknowledging its original epistemic framework.

The production of state epistemic authority also depends on the integration of medical knowledge into public administration and policy systems. Research funding, national health priorities, and health program evaluation play a role in determining the direction of biomedical science development. Holthaus and Wolff (2022) show that public policy shapes research orientation through funding mechanisms, performance indicators, and the global health agenda. The state's medical rationality produces a form of knowledge compatible with modern administrative needs because it can be measured through epidemiological indicators, disease burden, and the effectiveness of health interventions. This structure enables the state to statistically monitor populations and design health policies based on quantitative data. Knowledge that cannot be translated into administrative indicators tends to fall outside policy priorities because it does not support the population management logic that underpins modern health governance (Khatri et al., 2025).

Epistemic Negotiation Strategies between Traditional Practitioners and Medical Institutions

Knowledge translation strategies emerge as a key mechanism demonstrating the workings of epistemic negotiation through concrete communication practices between practitioners and formal health system actors. Sinungharjo et al. (2023) show that practitioners do not simply adopt popular medical terminology but rather use it of mediate meaning. One practitioner, for example, explains a "severe cold" to an educated patient as "circulatory disorders and the body's stress response," while retaining the cosmological meaning of energy imbalance at the level of internal interpretation. This translation reflects a boundary work practice that allows two knowledge regimes to operate without open conflict (Robinson & Wallington, 2012). The use of medical terminology is not a form of epistemic subordination, but a strategy for maintaining legitimacy through institutionally recognized language. This process also demonstrates the nature of epistemic brokerage, as practitioners manage the intersection of meanings across systems without fully integrating the biomedical framework.

Knowledge selection functions as an internal differentiation strategy that allows practitioners to define the limits of visibility of traditional elements according to the context of the interaction. Setiawan et al. (2023) demonstrated that practitioners reflectively separate functionally explicable techniques, such as massage or herbal concoctions, from potentially questionable cosmological aspects. Experience with inspections or formal health training fosters the development of selection patterns grounded in collective learning among practitioners. Informal

discussions and community networks serve as a medium for transmitting knowledge regarding the safe boundaries of practice representation. Spiritual aspects are framed as relaxation or psychological suggestions when addressing educated patients or formal institutions. Selection also demonstrates a form of epistemic filtering shaped by power relations, as decisions about what is presented always weigh the risk of delegitimization.

Compromises in knowledge develop through repeated interactions with health regulations that demand standardization of practice. Practitioners demonstrate strategic compliance when undergoing basic health training, obtaining practice permits, or limiting claims of cure. Sadnyana et al. (2023) define compliance as a pragmatic investment in maintaining the continuity of practice. One practitioner stated that attending sanitation training was a "safe way to avoid being questioned," without changing the basic principles of the therapy. Compromise is also evident in the willingness to refer patients with certain conditions to formal medical facilities, especially when administrative risks are high. Variations in strategies emerge among practitioners, depending on experience, practice location, and the intensity of oversight. Power relations are a key determinant of the boundaries of compromise, as the state has the authority to determine whether a practice is legitimate. However, practitioners maintain symbolic autonomy through the setting of non-negotiated internal boundaries.

Epistemic negotiation takes its most dynamic form through everyday practices involving direct interaction with patients. Sari et al. (2022) show that practitioners conduct a quick assessment of the patient's social background and expectations before determining a communication strategy. Patients who present with a formal medical diagnosis are not rejected; rather, they serve as a starting point for reinterpretation. One practitioner, for example, received a diagnosis of hypertension and then explained the condition as a manifestation of an imbalance in the body's thermal energy exacerbated by emotional distress. This practice creates multiple layers of meaning that enable epistemic coexistence without confrontation. Narrative flexibility reflects the ability to manage a plurality of knowledge while maintaining patient trust. Epistemic tensions persist, particularly when traditional interpretations differ from medical recommendations, but practitioners tend to mitigate the conflict through compromising language. This pattern demonstrates the formation of hybrid epistemologies that combine biomedical and traditional elements situationally, rather than as a permanent synthesis.

Administrative language serves as a strategic arena connecting healing practices with state regulatory structures. Practitioners demonstrate a mastery of licensing terminology and healthcare standards to meet formal requirements without altering the substance of their practices. Licensing documents often use general categories such as "complementary therapy" or "traditional healthcare," allowing for flexible interpretation. Terminological ambiguity is used as a

negotiating space, preventing practices from being subjected to potentially restrictive classifications. One practitioner revealed that using the term "relaxation therapy" in official documents facilitated the licensing process, even though the practice involved a spiritual dimension (Sadnyana et al., 2023). Administrative language functions as a form of bureaucratic translation, altering the representation of practices to fit the legal framework. This strategy also reflects a form of everyday resistance, as practitioners symbolically comply with regulations while maintaining substantive practices.

The interplay between translation, selection, and compromise strategies demonstrates that epistemic negotiations do not occur in isolation but rather as interconnected configurations of practices. Translation enables cross-system communication, selection regulates the boundaries of knowledge visibility, and compromise ensures continuity within the regulatory framework. These three mechanisms operate simultaneously in concrete situations, particularly when practitioners interact with patients, healthcare workers, and state officials. This dynamic demonstrates that negotiation is not merely a reactive response but a structured practice that develops through experience. Variations in strategies among practitioners indicate that negotiation is contextual, influenced by local factors such as the intensity of supervision and patient characteristics. The integration of these three mechanisms also results in a form of adaptation that is not homogeneous, but rather layered and flexible. This complexity challenges the assumption that traditional practices are subordinate, as the findings demonstrate an active capacity to manage epistemic relations.

Power Relations and Contestation of Legitimacy in Negotiations of Healing Knowledge

Power relations form the underlying structure of epistemic negotiations between traditional Javanese healing knowledge and state medical rationality through mechanisms of truth production that are not neutral. Michel Foucault's (1980) power/knowledge perspective explains that medical authority not only regulates health practices but also establishes a regime of truth that determines what is recognized as legitimate knowledge. This framework demonstrates that state medical rationality gains legitimacy through the institutionalization of standards of diagnosis, therapy, and verification that bind all health actors. The findings of Wibowo, Larasaty, and Ramadhan (2025) demonstrate that traditional Javanese healers face pressure to conform to these parameters in order to gain administrative recognition. Symbolic domination, as formulated by Pierre Bourdieu (1993), operates through the internalization of state medical categories, making epistemic hierarchies appear natural and unquestioned, even though they structurally subordinate local knowledge.

The production of legitimacy in health knowledge occurs through institutional processes that require traditional knowledge to be translated into a biomedical

framework for recognition. Registration and certification practices demonstrate that traditional healers need to reformulate concepts of disease, diagnosis, and therapeutic interventions using scientifically verifiable terminology (Suyami et al., 2025). This process aligns with Arthur Kleinman's (1988) epistemic translation, which emphasizes the need for local knowledge to be reduced to conform to the dominant medical system. Widyastuti's (2022) study shows that cosmological elements such as inner balance and spiritual relationships are often omitted or reinterpreted as psychological conditions. This reduction is not merely a technical adaptation but rather a form of epistemic appropriation that alters the fundamental meaning of healing practices. The resulting legitimacy is partial, recognizing only measurable aspects, while the symbolic dimension central to Javanese epistemology remains outside the framework of official validity.

Contests over knowledge authority are articulated through mechanisms of selective integration that regulate the position of traditional healers within the formal health system. A study by Setiawan et al. (2023) suggests that integration occurs as a process of co-optation that maintains the dominance of the medical profession. Andrew Abbott's (1988) concept of professional jurisdiction explains how the medical profession maintains control over the definition of legitimate health practices through regulation and standardization. Traditional practices are accommodated only to the extent they do not interfere with clinical authority and are often positioned as complementary therapies. Findings by Febriyanti et al. (2024) indicate that collaboration between medical professionals and traditional healers is often asymmetrical, with medical professionals serving as epistemic supervisors. This integration creates a controlled form of hybridity, rather than true pluralism, as interpretive frameworks remain determined by state medical rationality, which serves as the delimiter of legitimacy.

Power relations shape patient subjectivity as epistemic agents navigating multiple knowledge systems. Findings by Febriyanti et al. (2024) suggest that communities develop pragmatic strategies by shifting between biomedical services and traditional healing as needed. Arthur Kleinman's (1988) experience of illness emphasizes that therapeutic decisions are influenced by subjective meanings rather than solely by clinical rationality. Nevertheless, the internalization of symbolic domination remains evident when patients assess the effectiveness of traditional healing based on biomedical standards. Steven Epstein's (2023) concept of lay expertise helps explain that patients have the capacity to assess health knowledge, even though power structures shape these assessments. Epistemic negotiations at this level are dynamic because they involve selective practices that reflect both resistance and adaptation to the dominance of state medical knowledge.

Health regulation functions as a biopolitical instrument that regulates healing practices through discourses of safety and risk. Michel Foucault's (1980) biopolitical approach demonstrates that the state manages populations through definitions of

health based on biomedical parameters. Traditional practices are categorized by risk level and scientific evidence, allowing only certain practices to be licensed. This mechanism creates seemingly objective safety standards, but actually reflects the interest of maintaining epistemic monopolies. Findings by Sadnyana et al. (2023) show that traditional healers often face difficult administrative requirements, such as clinical documentation and effectiveness testing. Consequently, many practices remain in the informal sector. These restrictions define the limits of rationality, systematically excluding knowledge that does not conform to biomedical logic from formal legitimacy.

The recognition of traditional healing knowledge demonstrates an ambivalence between symbolic affirmation and structural marginalization. The state often elevates traditional healing as part of cultural heritage, but a redistribution of epistemic authority does not accompany this recognition. Nancy Fraser's (1990) politics of recognition perspective explains that symbolic recognition without structural transformation can actually reinforce inequality. A study by Farmawati and Wiroko (2022) shows that traditional healers gain visibility within cultural contexts but are not recognized as equal health actors. The process of heritagization transforms living knowledge into a cultural artifact, separating it from its therapeutic function. This condition creates a depoliticization of knowledge by ignoring its practical aspects and authority. This ambivalence demonstrates that recognition can be a powerful strategy for controlling representation and limiting the space for traditional knowledge practice.

The dynamics of epistemic negotiation demonstrate the interaction between traditional and medical knowledge, resulting in complex forms of hybridity. Widyastuti's (2022) findings indicate that traditional healers adopt certain medical language to enhance their legitimacy while maintaining a cosmological framework in their daily practices. This phenomenon reflects a form of negotiated medical pluralism that is neither fully subject to domination nor fully autonomous. This hybridity demonstrates the existence of agency, albeit limited by power structures. This partial integration also demonstrates that the boundaries between scientific and traditional knowledge are fluid rather than absolute. However, the dominant framework still determines final validity, so the hybridization process reflects strategic adaptation rather than structural transformation. This analysis asserts that epistemic negotiations take place as a layered process involving compromise, resistance, and the reproduction of hierarchies of knowledge.

Conclusion

The epistemic negotiations between Javanese traditional healing and state medical rationality reveal an asymmetrical yet adaptive relationship through a process of knowledge co-production negotiated across social, policy, and clinical practice arenas. Key findings suggest that traditional healers do not simply persist but actively adopt biomedical terminology, select compatible practices, and frame

legitimacy through patients' empirical experiences, ethics of care, and relational closeness. At the same time, medical institutions maintain authority through standards of evidence, formal regulations, and bureaucratic mechanisms, resulting in both pragmatic compromises and contested truth claims. The theoretical contributions expand the epistemology of local knowledge by emphasizing legitimacy as a performative and contextual practice, and enrich medical anthropology about the hybridity of practices and micro-power relations. Practical implications include the development of collaborative regulations, two-way referral schemes, and cross-knowledge training for health workers. Limitations include a focus on Java, a dominance of ethnographic approaches, and a lack of quantitative triangulation. Further research is needed to examine variations across regions, social classes, and policy regimes through comparative, longitudinal, and mixed-methods approaches to clarify the dynamics of health knowledge integration.

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Author Contribution Statement

ZZ contributed to the conceptualization of the study, the formulation of the methodology, data analysis, the writing of the initial draft, the revision of the manuscript, and correspondence with the editor. DS contributed to data collection and processing, as well as the literature review. SR contributed to data validation, analysis of the results, and refinement of the academic argumentation. MD contributed to the interpretation of the findings, checking the consistency of the content, and editing the manuscript. AK contributed to the critical review, evaluation of the scientific quality of the manuscript, and final approval of the published version. All authors read, reviewed, and approved the final manuscript.

Conflict of Interest

This manuscript contains no conflicts of interest whatsoever that could influence the research process, writing, analysis, data interpretation, or presentation of results. The entire manuscript preparation process was conducted independently, guided by academic and scientific considerations.

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