

Cultural Influences on Hypertension Self-Care in Southeast Asia: A Systematic Review

Ni Putu Ayu Ratna Dewi, Nursalam,* Sriyono, Komang Ardidhana Nugraha Putra, Titik Suhartini

Abstract: Hypertension is a significant public health burden, and cultural factors influence the perception and management of hypertension in Southeast Asia. However, regional synthesis of evidence remains limited, hindering the development of culturally appropriate and scalable interventions. This study examined how cultural beliefs and practices influence hypertension self-care behaviors among adults with hypertension in selected Southeast Asia countries. Five electronic databases (PubMed, Scopus, Web of Science, ProQuest, and SAGE Journals) were searched in 2025 for studies published from 1 January 2015 to 31 March 2025. Eligible studies included adults (≥ 18 years) with hypertension in Southeast Asia settings and reported cultural influences on self-care. Two reviewers conducted a narrative synthesis with thematic coding (third-party adjudication for disagreements), and methodological quality was assessed using the critical evaluation tools from the Joanna Briggs Institute. Twelve studies involving 2,252 participants were included, and the protocol was registered in PROSPERO (CRD420250656487).

Five themes emerged: illness perceptions, traditional and spiritual self-care practices, dietary traditions, sociocultural barriers to engagement with biomedical care, and community-based approaches. Examples included preferences for natural or spiritual practices in Malaysia, herbal and spiritual rituals that delay biomedical engagement in Indonesia, and the illness metaphor *malapot na dugo* (“thick blood”) that shapes treatment decisions in the Philippines. Communal dietary practices and collective decision-making also influenced the negotiation of self-care within families and communities. Hypertension self-care in Southeast Asia is embedded in collectivist and culturally specific contexts. For community nursing practice, culturally responsive assessment, communication, and family–community engagement are essential to support adherence and integrate cultural practices with evidence-based care. Policy should support culturally safe care; further research in underrepresented settings is needed.

Keywords: Cultural competence, Hypertension, Self-care, Southeast Asia, Systematic review

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Introduction

Hypertension, or chronic high blood pressure, occurs when the force of blood against the arterial walls is consistently too high. Clinically, this is typically defined as having a systolic measurement of 140 mmHg or greater, a diastolic measurement of 90 mmHg or greater, or both.¹ Hypertension is frequently characterized as a “silent” risk factor, significantly

Ni Putu Ayu Ratna Dewi, MNurs, RN, Faculty of Nursing, Airlangga University, Surabaya, Indonesia, 60115, Faculty of Health, Institute of Technology and Health Bali, Bali, Indonesia, 80227. E-mail: ayuramna622@gmail.com/ni.putu.ayu-2024@fkip.unair.ac.id; <https://orcid.org/0000-0002-6840-4234>

Correspondence to: Nursalam, * PhD, MNurs (Hons), Faculty of Nursing, Airlangga University, Jl. Dr. Ir. H. Soekarno, Mulyorejo, Surabaya 60115, Indonesia. E-mail: nursalam@fkip.unair.ac.id; <https://orcid.org/0000-0002-9052-6983>

Sriyono, PhD, MNurs, CNS, RN, Faculty of Nursing, Airlangga University, Surabaya, Indonesia, 60115. E-mail: sriyono@fkip.unair.ac.id; <https://orcid.org/0000-0002-6533-1973>

Komang Ardidhana Nugraha Putra, MNurs, RN, Faculty of Health, Institute of Technology and Health Bali, Bali, Indonesia, 80227. E-mail: ardidhana.itekesbali@gmail.com; <https://orcid.org/0000-0001-6598-6841>

Titik Suhartini, MNurs, RN, Faculty of Health and Natural Sciences, Sunan Gresik University, East Java, Indonesia, 61153. E-mail: titik.suhartini-2024@fkip.unair.ac.id; <https://orcid.org/0009-0004-2927-9401>

elevating the probability of stroke, coronary artery disease, heart failure, and chronic kidney disease.² In Southeast Asia, pooled estimates indicate that hypertension prevalence in urban populations approaches 34%, reflecting a substantial public health burden in the region.³ Although effective pharmacological treatment and lifestyle-based management are available, blood pressure control remains inadequate in many populations. This is especially true in low- and middle-income countries, where health system problems and cultural factors come together.⁴

Standard treatment for high blood pressure includes taking medications, making lifestyle changes, and monitoring blood pressure regularly to lower the risk of heart disease.^{5,6} Sustained blood pressure control, therefore, depends not only on clinical prescriptions but also on patients' daily self-management practices. Self-care is very important for stopping the spread of disease and lowering the risk of heart disease.⁷ For people with high blood pressure, self-care usually means taking medicine, eating a healthy diet (especially cutting back on salt), getting regular exercise, monitoring weight and blood pressure, managing stress, and going to the doctor regularly.^{5,8} However, achieving consistent self-care requires not only individual motivation but also knowledge, beliefs, social support, health literacy, access to services, and other factors in one's environment.^{9,10}

Southeast Asia comprises diverse sociocultural contexts, including Indonesia, Malaysia, the Philippines, Thailand, Vietnam, Singapore, Brunei, Myanmar, Cambodia, Timor-Leste, and Laos, each with distinct cultural traditions, religious practices, and community structures. In many of these settings, health decisions are influenced by inherited beliefs, communal norms, and spiritual interpretations of illness. For instance, in Malaysia, some individuals prioritize natural remedies and spiritual practices over prescribed antihypertensive medications.^{11,12} In Indonesia, herbal rituals and spiritual healing may delay engagement with biomedical care,¹³ while in the Philippines, metaphors such as

malapot na dugo ("thick blood") influence treatment choices and perceptions of illness severity.¹⁴ Evidence from Thailand and Vietnam demonstrates culturally embedded practices such as group walking, meditation, herbal use, and massage that may complement biomedical treatment but may also substitute for it in certain contexts.^{8,15} In rural and underserved areas, limited access to formal healthcare services can further reinforce reliance on traditional medicine and non-biomedical explanatory models.^{14,16} These findings suggest that cultural meanings surrounding hypertension may shape self-care in Southeast Asia, functioning both as barriers to biomedical adherence and as potential entry points for culturally responsive interventions. Non-adherence to hypertension management is therefore not solely an individual behavioral issue but reflects complex interactions between cultural norms, sociodemographic factors, and health-system structures, including ethnicity, religion, education level, and household responsibilities.⁹

Several systematic reviews in Southeast Asia have examined the prevalence and burden of hypertension,^{3,17,18} as well as general determinants of hypertension management and control, while broader evidence syntheses have mapped self-care practices in the region.¹⁹ However, existing reviews have largely focused on epidemiological trends, general adherence patterns, or overall management strategies, and many remain country-specific or limited to isolated components of care. Consequently, there is a limited region-wide, study-level synthesis that clarifies how cultural beliefs and practices shape specific hypertension self-care behaviors across diverse Southeast Asian contexts. Although Irwan et al. conducted a scoping review that comprehensively maps hypertension self-care management in Southeast Asia,¹⁹ its primary objective is to describe the breadth of available evidence rather than to generate a focused thematic synthesis of culturally situated mechanisms influencing daily self-care practices. To our knowledge,

no systematic review has provided a region-wide, study-level thematic synthesis specifically examining how cultural views and habits influence hypertension self-care behaviors across selected Southeast Asia settings. Accordingly, the present review provides an integrated thematic framework, grounded in critical appraisal and systematic methods, to clarify culturally situated mechanisms and to inform culturally responsive self-care support and intervention design. To enhance interpretive depth beyond descriptive synthesis, we applied a conceptual lens focusing on explanatory models of illness, health system pluralism, and culturally safe communication, which guides the interpretation of how culturally shaped meanings of hypertension, pluralistic care practices, and sociocultural interaction patterns influence self-care and inform nursing practice in community and primary care contexts.

Literature and Conceptual Framework

Self-care refers to individuals' purposeful activities to maintain health, prevent complications, and manage chronic conditions in everyday life.²⁰ In chronic diseases, self-care is not limited to following clinical instructions but involves ongoing decision-making, problem-solving, and adaptation within one's social environment. In hypertension, self-care is commonly operationalized through medication-taking, dietary regulation (particularly sodium reduction), physical activity, weight management, self-monitoring of blood pressure, stress management, and regular engagement with healthcare services.^{5,8} However, due to limited healthcare access in many Southeast Asian settings, individuals may integrate biomedical care with traditional remedies and spiritual practices, which can shape treatment choices and introduce challenges for sustained self-care.¹³ Hypertension self-care presents distinct challenges due to the condition's frequent asymptomatic nature, which can diminish perceived urgency and make sustained self-care more reliant on beliefs, routines,

familial support, and access to care. Accordingly, understanding hypertension self-care requires attention not only to individual motivation and knowledge but also to the social and contextual conditions in which daily self-care takes place.¹⁶

To guide interpretation, this review adopted a culturally responsive lens that conceptualized hypertension self-care as embedded within sociocultural norms, family-community expectations, and pluralistic health systems.^{10,11} First, explanatory models were used to examine how local meanings, perceived causes, and culturally shaped interpretations of hypertension influence treatment seeking, medication-taking, and daily lifestyle practices. Second, health system pluralism was used to interpret how individuals navigate and negotiate biomedical care alongside traditional and spiritual practices, including patterns of complementarity and substitution.^{21,22} Third, culturally safe communication informed interpretation of how hierarchy, indirect communication, and perceived respect within healthcare encounters shaped trust, disclosure of non-biomedical practices, and sustained engagement with evidence-based recommendations. This conceptual framing supports the analysis of culturally situated mechanisms that shape self-care choices (e.g., medication use, dietary decisions, and engagement with biomedical care) and strengthens the translation of findings into community nursing practice, particularly through culturally safe assessment, respectful negotiation of health beliefs, and family-community engagement where appropriate.^{11,15}

Aim and Review Question

This review was undertaken to explore the extent to which cultural beliefs, values, and practices shape hypertension self-care behavior among adults in selected Southeast Asian countries. The review questions were framed using the PICOS framework. Accordingly, the review addressed the following questions:

1. How do cultural beliefs, values, and practices influence hypertension self-care behaviors among adults with hypertension in selected Southeast Asian countries?
2. What key sociocultural barriers and facilitators shape adherence to hypertension self-care in these settings?
3. What community-based approaches are reported in the literature to address cultural barriers and support hypertension self-care?

Methods

Study Design: The review procedures were organized in accordance with the PRISMA 2020 statement to ensure transparent identification, selection, appraisal, and synthesis of relevant studies (**Figure 1**). The review protocol was prospectively recorded in PROSPERO (CRD420250656487).

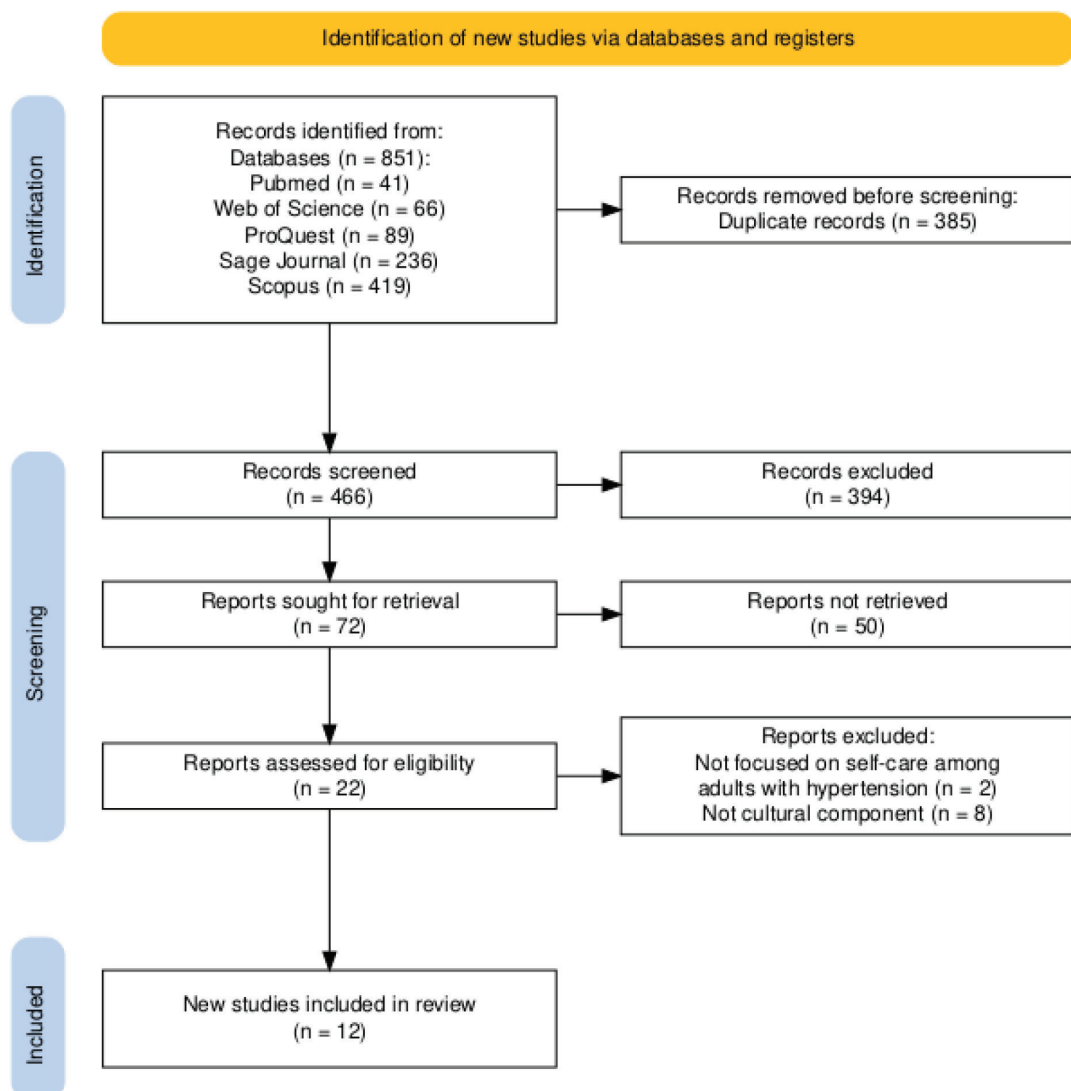


Figure 1. PRISMA flow diagram of the systematic review

Search Strategy: Relevant studies were identified through structured searches of five electronic databases: PubMed, Scopus, Web of Science, ProQuest, and SAGE Journals from February 14 to March 31, 2025. Database-specific strategies combined subject headings (e.g., MeSH in PubMed) and keywords for self-care, culture-related terms, and Southeast Asia (regional label and country names). We applied a publication-year filter of 1 January 2015–31 March 2025, language limits (English), and human-study filters at the database level where supported. Grey literature was not searched due to feasibility constraints and to prioritize peer-reviewed evidence with accessible methodological reporting. Only publications available in English were considered during screening and extraction; however, this decision may have limited the inclusion of potentially relevant studies reported in local Southeast Asian languages. Verbatim search strings (including field tags, truncation, adjacency operators, and limits) and run timestamps for each source are provided in **Appendix Table 1**.

Eligibility Criteria: Study selection was guided by the PICOS framework. The population comprised adults (≥ 18 years) diagnosed with hypertension in Southeast Asia settings. The intervention/exposure of interest was cultural beliefs, values, traditions, social norms, and explanatory models influencing hypertension self-care behaviors. Comparison was not applicable. Outcomes were hypertension self-care behaviors, including medication adherence, dietary practices, physical activity, blood pressure monitoring, engagement with biomedical care, and use of traditional or spiritual practices. Eligible studies included qualitative, observational, quantitative, and mixed-methods research published in peer-reviewed journals between January 1, 2015, and March 31, 2025, with the final search completed on March 31, 2025. Only English-language articles were retained for inclusion. This review included qualitative and mixed-method studies because these methodologies are essential for understanding the subjective perceptions, cultural meanings, and complexities associated with hypertension self-care behaviors. These study designs offered

complementary perspectives on both measurable patterns of self-care and the contextual meanings, lived experiences, and cultural processes that shape hypertension management. Exclusion criteria encompassed studies focused exclusively on pregnancy-related hypertension, non-peer-reviewed materials, and records without accessible full text.

Study selection: After completing the literature search, all retrieved references were imported into Rayyan to facilitate independent, blinded screening and to manage the screening workflow. Rayyan's AI prioritisation feature was used only to assist the order of screening and did not replace reviewer judgement. Two reviewers (N.P.A.R.D. and K.A.N.P.) independently reviewed titles, abstracts, and full-text articles against the predefined inclusion criteria. When differences arose, they were resolved through discussion among reviewers; cases that remained uncertain were referred to a third reviewer (N). Of the 72 reports sought for full-text retrieval, 50 remained inaccessible after multiple retrieval attempts. We attempted full-text retrieval through institutional library subscriptions, alternative publisher platforms, Google Scholar, and manual searches of journal websites. We also explored available interlibrary access options where feasible. Despite these efforts, the full texts of 50 reports remained inaccessible within the review timeline and were therefore excluded from eligibility assessment. A total of 12 studies met the final inclusion criteria and were included in the synthesis.

Data extraction was carried out independently by two reviewers (N.P.A.R.D. and K.A.N.P.) using a structured review matrix. The extraction process captured publication details, study location, aims, methodological approach, participant profile, sample size, data collection methods, analytic procedures, and key findings related to cultural influences on hypertension self-care behaviors (**Table 1**). For this review, cultural influences were operationalized as beliefs, values, traditions, religious/spiritual practices, social norms, and explanatory models shaping hypertension self-care behaviors.

Table 1. Main study characteristics of all included studies (n = 12)

Author, year, country	Objectives	Design	Study participants	Data collection	Data analysis	Results
Wahab et al. (2021) ¹¹ Malaysia	Explore the roles of culture, religiosity, and spirituality on adherence to anti-hypertensive medications	A qualitative ethnographic	23 participants	Semi-structured interview with face-to-face or phone calls using audio-taped and notes	Thematic analysis approach using Atlas-ti	Cultural, religious and spiritual beliefs, together with indirect, non-confrontational communication and the notion that “natural is safe and negatively impacted adherence and contributed to hidden non-adherence.
Palileo Villanueva et al. (2022) ²² Malaysia and the Philippines	Examines the prevalence, determinants, and outcomes of traditional, complementary, and alternative medicine use for hypertension among low-income households	Cross-sectional	946 hypertensive adults (495 in Malaysia and 451 in the Philippines)	Structured questionnaire and blood pressure measurements	Descriptive and multilevel mixed-effects regression (logistic and linear)	TCAM use was higher in the Philippines (18.8%) than in Malaysia (8.8%). Cultural beliefs influenced TCAM use, mainly as a complement to conventional treatment.
Ningsih et al. (2020) ²⁷ Indonesia	Examines the effect of culture-based education in improving knowledge of hypertension patients in the Makassar Community	Quasi-experiment with pretest-posttest control group design	36 hypertensive patients (18 intervention, 18 control)	Questionnaire using culturally adapted hypertension education (CAHE) tool	Paired t-test and independent t-test	Culture-based hypertension education improved patients’ knowledge, beliefs and self-care practices, particularly in communities where local cultural values remained strong.
Lasco et al. (2020) ¹⁴ Philippines	Explore lay conceptions of hypertension and how cultural beliefs shape self-care practices	Qualitative study (grounded theory)	71 semi-structured interviews and 4 focus group discussions (FGDs) with hypertensive patients	Semi-structured interviews and FGDs	Grounded theory thematic analysis using NVivo	Cultural beliefs about “thick” and “hot” blood influenced perceptions of hypertension causes and self-care behaviors. Hypertension was viewed as a dynamic, non-chronic condition influenced by genetics, diet, heat, and stress.
Padmi et al. (2025) ²⁴ Indonesia	To explore the relationship between community cultural practices and the occurrence of hypertension	Cross-sectional	90 participants (hypertension patients aged 30–70 years)	Structured questionnaires on demographic data and community culture related to hypertension	Spearman Rank correlation analysis	Shared eating practices such as <i>megibung</i> , frequent consumption of salted fish, high consumption of alcohol (palm wine), fried foods and coconut-based dishes and social drinking were closely linked with poor dietary adherence and difficulties maintaining blood pressure control.

Table 1. Main study characteristics of all included studies (n = 12) (Cont.)

Author, year, country	Objectives	Design	Study participants	Data collection	Data analysis	Results
Kurnia et al. (2018) ²⁸ Indonesia	To explore the experiences of barriers to hypertension management among the Minangkabau ethnic group in Payakumbuh, Indonesia	Qualitative phenomenological study	12 participants	In-depth interviews	Colaizzi's phenomenological analysis method	Participation in high-salt communal eating and other cultural practices showed a positive association with the presence and severity of hypertension. Cultural dietary habits and family traditions were major obstacles to effective hypertension control.
Rahmawati & Bajorek (2017) ²⁵ Indonesia	Assessed medication adherence and hypertension knowledge, and their predictive factors, in people with hypertension, living in rural communities	Cross-sectional	384 participants from 8 rural villages	Structured questionnaire, MMAS-8, and knowledge survey	Descriptive statistics and multivariate analysis (logistic regression)	Only a minority had good knowledge and adherence; poor understanding, side-effect concerns and practical barriers were closely linked to non-adherence. Cultural beliefs and preference for traditional medicine were key reasons for nonadherence.
Yatim et al. (2019) ²⁹ Malaysia	Explore factors influencing hypertension self-management and sustainability of self-care practices among participants of a hypertension self-management education programme	Qualitative study with focus group discussions	3 focus groups involving 19 participants	Semi-structured focus group discussions	Thematic analysis using NVivo	Group education reduced isolation and enhanced peer learning; challenges to sustain self-care included family/social pressures, denial about illness, cultural food practices during events like Hari Raya Aidilfitri, and lack of self-discipline. Strategies included self-control, portion control during festivities, and ongoing monitoring.
Chantakeeree et al. (2021) ³⁰ Thailand	To examine older adults' views on health-promoting behaviors in the context of hypertension and to identify related influencing factors	Qualitative study	40 participants (urban and rural)	Semi-structured interviews	Thematic analysis (Braun & Clarke method) using NVivo	Five themes emerged: taking responsibility for BP control, achieving a healthier lifestyle, experiencing spiritual growth, building social relationships, and the influence of environmental factors. Cultural and spiritual practices played a major role in self-care.

Table 1. Main study characteristics of all included studies (n = 12) (Cont.)

Author, year, country	Objectives	Design	Study participants	Data collection	Data analysis	Results
Tan et al. (2022) ²³ Malaysia	Evaluate the factors predicting self-care behavior for hypertension prevention in a Malaysian community using the Health Belief Model	Cross-sectional design	238 participants	Online questionnaire based on HBM and HTN-SCP	Multiple linear regression and descriptive statistics	Cultural food preferences, low perceived risk and beliefs that check-ups are unnecessary without symptoms reduced engagement in recommended self-care behaviors.
Bujawati et al. (2024) ¹³ Indonesia	Explore cultural practices for preventing hypertension in the Ammatoa Kajang tribe	Qualitative study with ethnographic and phenomenological	9 participants (patients, families, health workers, and traditional leaders)	Observation and in-depth interviews	Thematic analysis using NVivo	Understanding of hypertension was limited; people relied on ancestral customs and preferred traditional healers to medical facilities unless the illness was severe.
Rahmawati & Bajorek (2018) ²⁶ Indonesia	To quantify the use of traditional medicines and identify factors associated with their use among people with hypertension in rural Yogyakarta, Indonesia	Cross-sectional	384 hypertension patients aged ≥ 45 years	The researchers administered structured questionnaires.	Descriptive statistics, Chi-square tests, and logistic regression	Traditional medicines were widely used, sometimes alone and sometimes with drugs; trust in “natural” remedies and limited healthcare access encouraged their use.

Quality Appraisal: To support the credibility of the review findings, each included study was appraised using the Joanna Briggs Institute (JBI) critical appraisal tools matched to the relevant study design. Two reviewers (N.P.A.R.D. and K.A.N.P.) independently reviewed each article and identified any potential bias in relevant areas. When reviewers reached different conclusions, a third person was asked to help them reach agreement. Of the 12 studies included in the review, ten were judged to be of high methodological quality, while two were considered moderate in quality. These moderate ratings^{23,24} were primarily attributable to incomplete reporting in analytical cross-sectional studies, especially regarding the use of objective, standardized criteria for measuring the condition and the identification and handling of confounding factors. Across the qualitative studies, lower item-level scores were mainly related to limited reporting of researcher positionality and reflexivity; however, all qualitative studies remained in the high-quality category. Full appraisal details are presented in **Appendix Table A2–A4**.

Ethical Considerations: This evidence synthesis was based entirely on previously published research and did not require direct participant involvement or access to identifiable individual data. In accordance with institutional and journal policies, formal ethics committee approval was not required.

Data Synthesis: Given the variation in study designs, methodological approaches, and reported outcomes, quantitative meta-analysis was not feasible. We performed a thematic narrative (integrative) synthesis across mixed study designs, coding qualitative findings and relevant quantitative results, and integrating them into overarching themes. Codes were iteratively grouped into themes based on study findings, and patterns and discrepancies were examined across countries and study types (**Table 1**).

Results

Study and participant characteristics

A total of 12 studies were included from an initial retrieval of 563 articles.^{11,13,14,22–30} Collectively,

the studies involved 2,252 participants, including adults with hypertension, selected family members, healthcare providers, and traditional leaders. The included studies were conducted in selected Southeast Asia countries, predominantly Indonesia (n = 6), followed by Malaysia (n = 3), the Philippines (n = 1), Thailand (n = 1), and one multi-country study involving Malaysia and the Philippines (n = 1). The study designs comprised five cross-sectional studies, six qualitative studies, and one quasi-experimental study. Among the cross-sectional studies, three used both univariate and multivariate analyses, one used bivariate analysis, and one used a combination of analyses. In the qualitative studies, four employed semi-structured interviews, while three used in-depth interviews.

Main findings

The synthesis identified five recurrent themes that describe how cultural beliefs and practices shape hypertension self-care across the included studies in selected Southeast Asia settings: 1) culturally embedded perceptions of hypertension as a non-chronic or episodic condition; 2) reliance on traditional medicine, shamans, and cultural rituals in hypertension self-care; 3) culturally embedded dietary practices; 4) cultural and communication barriers affecting engagement with biomedical treatment; and 5) community and culturally anchored approaches supporting hypertension self-care. These themes reflect culturally situated mechanisms influencing how individuals interpret hypertension, negotiate treatment choices, and engage with everyday self-care practices.

Theme 1: Culturally embedded perceptions of hypertension as a non-chronic or episodic condition

Across settings, hypertension was often understood as “high blood” or a temporary imbalance rather than a chronic condition.^{14,27,28} In the Philippines, it was linked to “boiling” or “thick” blood caused by emotions or heat, while in Indonesia, some participants attributed it to *nipitabai* (witchcraft), stress, or resentment.^{13,14} In Malaysia, spiritual and alternative explanations coexisted with biomedical understandings,

while in Thailand, religious beliefs supported acceptance of illness as part of the natural life cycle.^{22,25,26} These culturally shaped perceptions were commonly described alongside delayed care-seeking, intermittent engagement with biomedical treatment, and views that hypertension management was necessary primarily during symptomatic periods.^{23,25}

Theme 2: Reliance on traditional medicine, shamans, and cultural rituals in hypertension self-care

Adherence to treatment and complementary therapy are often seen as part of hypertension management, but they are also integral to the broader concept of self-care, especially in Southeast Asia, where cultural influences play a significant role. Adherence to medication and complementary therapies, such as herbal remedies and spiritual practices, often reflects patients' beliefs about their health, their trust in biomedical care, and their cultural preferences.²² These factors shape how individuals engage with self-care behaviors and influence their decisions regarding treatment adherence and the use of complementary therapies. Cultural beliefs and traditional practices were prominent in studies related to hypertension self-care. For instance, in Indonesia, many individuals relied on herbal medicine, shamans, and local health rituals before seeking biomedical treatment, typically reserved for more severe symptoms.^{13,28,29} In Malaysia and the Philippines, traditional, complementary, and alternative medicine were widely used, driven by the belief that "natural is safe" and the familiarity and accessibility of cultural practices.^{11,22} This reliance on complementary therapy illustrates how deeply culture shapes self-care behaviors. Additionally, structural factors such as time constraints, limited access to healthy foods, and low motivation were frequently mentioned in relation to biomedical self-care practices, while in Thailand, older adults combined spiritual practices, community support, and culturally valued physical activities with prescribed treatments.^{23,30}

Theme 3: Culturally embedded dietary practices: high salt intake, food preservation, and flavour preferences

Culturally embedded dietary habits were commonly reported in relation to blood pressure management. High-fat, high-salt dishes consumed at communal events in Indonesia, as well as everyday oily and salty foods in rural Yogyakarta, were commonly reported.^{25,28} In Bali, *megibung* promotes shared meals of salted fish, fried foods, and coconut-based sauces, with *tuak* (palm wine) commonly consumed.²⁴ In the Philippines, beliefs about "thick blood" influenced food choices, with some foods viewed as therapeutic.¹⁴ Fermented and salty condiments remained staples in Malaysia and the Philippines, and in Thailand, preserved and salty foods continued to be preferred despite medical advice, particularly among older adults.^{23,30}

Theme 4: Cultural and communication barriers affecting engagement with biomedical treatment

Cultural values, communication norms, and structural limitations were commonly described as factors affecting engagement with biomedical treatment. In Indonesia, distrust of biomedical care and parallel use of traditional remedies undermined consistent adherence, while in the Ammatoa Kajang community, restrictions on modern technology limited access to health information and delayed biomedical care until traditional healers were no longer effective.¹³ In Malaysia, indirect ways of talking between patients and healthcare providers was said to make it hard to talk openly about taking medicine, side effects, and not following the rules.¹¹ The difficulty of adhering to prescribed medication is influenced by cultural and contextual factors, including perceptions of the efficacy and safety of biomedical treatments, necessitating a more comprehensive contextual understanding.

Theme 5: Community and culturally anchored approaches supporting hypertension self-care

Several studies described community-based practices that were culturally anchored and aligned with local social structures for hypertension self-care. One study from Indonesia reported blood

pressure-related findings within communities characterized by health-supportive cultural practices.²⁴ Studies from Indonesia described community-based education tailored to local norms, alongside engagement in hypertension self-care activities, while studies from Malaysia reported changes in knowledge and adherence related to group-based hypertension self-management education.^{27,29} Studies from Thailand described the incorporation of spiritual practices, social connectedness, and culturally valued physical activities into routine care in relation to older adults' daily lives and participation in hypertension management activities.^{23,30} Across the included studies, community involvement, social relationships, and cultural alignment were recurrent features of practices described in relation to hypertension self-care.

Discussion

The findings of this review consolidate evidence on the influence of cultural beliefs and practices on hypertension self-care behaviors in specific contexts in Southeast Asia. In alignment with the review objective, the included studies elucidated the cultural significance of hypertension, including individuals' conceptualizations of the condition and their decisions regarding treatment-seeking, dietary practices, and adherence to biomedical recommendations.^{13,27} Interpreted through the conceptual lens used in this review, explanatory models of illness, health system pluralism, and culturally safe communication, these findings suggest that hypertension self-care is not best understood as an individual behavioral choice alone. Instead, self-care behaviors are socially negotiated and enacted within collective values, spiritual worldviews, and community norms that shape what is perceived as appropriate, feasible, and culturally legitimate.

In the included studies, high blood pressure was often described as episodic or temporary, rather than as a long-term illness that needs constant

management. When viewed through explanatory models, culturally shaped interpretations such as *malapot na dugo* ("thick" or "boiling" blood) in the Philippines and spiritual or supernatural attributions reported in parts of Indonesia affect how people think about the cause, severity, and the right way to respond.^{14,25,26} When hypertension is understood as a fluctuating imbalance or spiritually mediated condition, intermittent medication use and delayed engagement with biomedical care become intelligible within the individual's meaning system, rather than simply reflecting lack of motivation or knowledge.^{13,24} Similar patterns have been reported in other Southeast Asia contexts, where chronic conditions are often interpreted through holistic and non-biomedical frameworks.¹⁹ This interpretation strengthens nursing implications. Culturally responsive assessment should explicitly elicit patients' meanings and perceived causes of hypertension, then align education and care planning with these interpretations, while clarifying the rationale for ongoing management even in the absence of symptoms.

Cultural practices related to daily living were also described in relation to hypertension self-care behaviors in ways characteristic of Southeast Asian settings. The reviewed studies reported integrating traditional medicine, spiritual practices, and community rituals into self-care routines, reflecting a pluralistic health-care orientation in which biomedical and non-biomedical practices coexist.^{11,13} From a health system pluralism perspective, individuals may integrate or alternate between biomedical care and traditional or spiritual practices depending on perceived effectiveness, accessibility, and cultural acceptability, including patterns of complementarity and substitution.²¹ Importantly, pluralistic practices should not be interpreted solely as resistance to biomedical advice; they may serve as culturally legitimate strategies for coping, meaning-making, and accessing support. For community nursing practice, the key implication is to move beyond a dichotomy

of “adherence versus non-adherence” and toward negotiated, safe integration, assessing what practices are used, their intent, potential risks (including interactions with antihypertensive medications), and collaboratively identifying non-negotiable biomedical elements (e.g., ongoing antihypertensive therapy and routine monitoring) while respecting culturally valued practices.

Dietary traditions, particularly communal eating practices and the cultural significance of high-sodium foods during social and ceremonial events, were frequently noted in relation to dietary self-care, highlighting how food practices are embedded within social obligation and cultural identity rather than individual dietary choice alone.^{24,28} Family and community customs, including shared meals and collective decision-making, were also frequently described in relation to self-care behaviors, reflecting the collectivist social orientation that characterizes much of the region.^{30,31} Conceptually, these patterns suggest that adherence is often negotiated within family and community routines. Family involvement can strengthen self-care through reminders and practical support, yet communal norms may constrain dietary change when social obligations compete with recommended restrictions.³² This implies that dietary counseling focused exclusively on individual restriction may be insufficient in collectivist settings; more feasible approaches may include family- and community-oriented strategies such as negotiating portion size, preparation methods, and lower-sodium alternatives within communal meals so that behavior change remains compatible with shared routines.

The interaction between culture and health-system factors was also discussed across the reviewed studies. Indirect communication styles, hierarchical relationships between patients and providers, and limited access to consistent health information were described as contextual features shaping how biomedical advice was interpreted and enacted.¹¹ In several Southeast Asian contexts, where respect for authority and avoidance of direct confrontation are culturally valued, these

communication norms were described in relation to patient-provider interactions and to constrained discussion of medication use or non-adherence.^{23,29,33} Interpreted through a culturally safe communication lens, these findings highlight how trust, hierarchy, and perceived respect in clinical encounters can shape patient willingness to disclose non-biomedical practices or difficulties with medication-taking. These patterns underscore the importance of culturally safe communication strategies in community nursing, including nonjudgmental inquiry about traditional/spiritual practices, checking understanding using patient-preferred language, and creating space for patients and families to discuss barriers without fear of blame.

Across the reviewed studies, community-based and culturally anchored practices were frequently described in relation to hypertension self-care. The prominence of community involvement, peer support, spiritual activities, and locally valued social structures reflects the central role of collectivism and community authority in Southeast Asian societies.^{27,34} These findings suggest that community authority and collective participation can serve as implementation pathways for culturally responsive self-care support, particularly where community norms strongly shape daily behaviors. For nursing practice, this means that hypertension self-management support may be more acceptable and sustainable when delivered through socially familiar platforms such as neighborhood associations, faith-linked gatherings, or peer-support groups, so long as these strategies reinforce, rather than displace, evidence-based biomedical care.

Applicability and transferability of these findings should be considered in light of contextual differences across countries and study designs. Eligible studies were identified from a limited subset of Southeast Asia settings, and cultural patterns may vary across countries not represented, as well as across urban-rural contexts and across religious and ethnic groups.¹⁴ The restriction to English-language publications and the absence of grey literature searching may have reduced cultural representation and may preferentially capture evidence

from settings more likely to publish in English-indexed outlets. In addition, heterogeneity in qualitative, observational, and mixed-method designs supports thematic interpretation rather than effect estimation; accordingly, conclusions are best applied as context-sensitive guidance for culturally responsive nursing assessment and intervention design, rather than as uniform generalizations across Southeast Asia.

Overall, this review highlights the culturally situated nature of hypertension self-care in selected settings in Southeast Asia. By integrating explanatory models, health system pluralism, and culturally safe communication as interpretive lenses, the synthesis advances nursing knowledge by clarifying mechanisms through which culturally shaped meanings, pluralistic care practices, and sociocultural interaction patterns influence everyday self-care behaviors. These insights support community nursing approaches that elicit patients' meanings of hypertension, engage families and communities where appropriate, and negotiate culturally valued practices alongside non-negotiable evidence-based elements of hypertension management.

Limitations

This review should be interpreted in light of several important limitations. The included studies varied in design, context, and methodological rigor, and most relied on qualitative or observational approaches. Although region-wide search terms were applied, eligible studies were identified from a limited number of Southeast Asia countries, which may underrepresent other cultural contexts within the region. There may also be publication or indexing bias in the uneven distribution of studies across countries, which could affect the regional balance of the synthesized evidence. The review was limited to English-language publications, potentially diminishing cultural representation by failing to capture country-specific evidence published in local languages. Additionally, grey literature was not examined, potentially heightening the risk of selective evidence inclusion.

Conclusion and Implications for Nursing Practice

This systematic review synthesized evidence on culturally situated hypertension self-care across Southeast Asia and organized the findings into five themes: illness perceptions, traditional and spiritual self-care practices, dietary traditions, sociocultural barriers to engagement with biomedical care, and community-based approaches. In the included studies, hypertension self-care was often discussed within pluralistic health frameworks, in which biomedical practices are used alongside traditional remedies, spiritual beliefs, and community norms. Culturally specific practices identified in this review included episodic or imbalance-based understandings of hypertension (e.g., *malapot na dugo* in the Philippines and spiritual attributions in Indonesia), the routine use of herbal and traditional remedies alongside prescribed treatment, and the central role of communal eating practices and sodium-rich foods in daily and ceremonial contexts. Across the included studies, self-care was often described as being negotiated within family, peer, and community leadership structures, reflecting the collectivist nature of many Southeast Asian societies. These findings suggest the need to acknowledge culturally specific interpretations and social contexts when analyzing hypertension self-care in Southeast Asia. Future research may further elucidate culturally grounded self-care practices among underrepresented populations and settings in the region, enhancing contextual understanding of hypertension management.

Author Contributions

Conceptualization, Formal analysis, Visualization, Writing—original draft: N.P.A.R.D.
Supervision, Methodological review, Consensus resolution, Writing—review and editing: N.

Supervision, Interpretation of findings, Writing–review and editing: S.

Validation, Formal analysis, Writing–review and editing: K.A.N.P.

Resources, Data curation, Writing–review and editing: T.S.

All authors read and approved the final manuscript.

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Conflict of Interest

The authors have no competing interests to disclose.

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Appendix

Appendix Table A 1. Search term and algorithm for databases

Database	Search syntax strategy
PubMed	(“Hypertension”[Mesh] OR hypertens*[tiab] OR “high blood pressure”[tiab]) AND (“Self Care”[Mesh] OR self-care[tiab] OR “self care”[tiab] OR self-management[tiab] OR “self management”[tiab] OR adherence[tiab] OR “self monitoring”[tiab] OR “self-efficacy”[tiab]) AND (cultur*[tiab] OR sociocultural[tiab] OR “cultural factor*”[tiab] OR “cultural influenc*”[tiab] OR “traditional belief*”[tiab] OR “social norm*”[tiab] OR spiritual[tiab]) AND (“Southeastern Asia”[Mesh] OR “Southeast Asia”[tiab] OR Brunei[tiab] OR Cambodia[tiab] OR “Timor-Leste”[tiab] OR Indonesia[tiab] OR Laos[tiab] OR Malaysia[tiab] OR Myanmar [tiab] OR Philippines[tiab] OR Singapore[tiab] OR Thailand[tiab] OR Vietnam[tiab])
Web of Science	ts=(hypertens* OR “high blood pressure”) AND ts=(“self care” OR “self-care” OR “self management” OR “self-management” OR adherence OR “self efficacy” OR “self-efficacy” OR “self monitoring”) AND ts= (cultur* OR sociocultural OR “traditional belief*” OR (“social” NEAR/2 norm*) OR spiritual) AND ts=(“Southeast Asia” OR Brunei OR Cambodia OR “Timor-Leste” OR Indonesia OR Laos OR Malaysia OR Myanmar OR Philippines OR Singapore OR Thailand OR Vietnam)
Proquest	ti,ab(hypertens* OR “high blood pressure”) AND ti,ab(“self care” OR “self-care” OR “self management” OR “self-management” OR adherence OR “self efficacy” OR “self-efficacy” OR “self monitoring”) AND ti,ab(cultur* OR sociocultural OR “traditional belief*” OR spiritual OR (“social” NEAR/2 norm*)) AND ti,ab(“Southeast Asia” OR Brunei OR Cambodia OR “Timor-Leste” OR Indonesia OR Laos OR Malaysia OR Myanmar OR Philippines OR Singapore OR Thailand OR Vietnam)
Sage journals	(“hypertension” OR “high blood pressure” OR hypertens*) AND (“self care” OR “self-care” OR “self management” OR “self-management” OR adherence OR “self efficacy” OR “self-efficacy” OR “self monitoring”) AND (cultur* OR sociocultural OR “traditional belief*” OR spiritual OR (“social” NEAR/2 norm*)) AND (“Southeast Asia” OR Brunei OR Cambodia OR “Timor-Leste” OR Indonesia OR Laos OR Malaysia OR Myanmar OR Philippines OR Singapore OR Thailand OR Vietnam)
Scopus	(hypertens* OR “high blood pressure”) AND (“self care” OR “self-care” OR “self management” OR “self-management” OR adherence OR “self efficacy” OR “self-efficacy” OR “self monitoring”) AND (cultur* OR sociocultural OR “traditional belief*” OR spiritual OR (social W/2 norm*)) AND (“Southeast Asia” OR Brunei OR Cambodia OR “Timor-Leste” OR Indonesia OR Laos OR Malaysia OR Myanmar OR Philippines OR Singapore OR Thailand OR Vietnam) AND (LIMIT-TO (LANGUAGE, “English”)) AND (LIMIT-TO (DOCTYPE, “ar”))

Appendix Table A2. Critical appraisal of the eligible cross-sectional studies with JBI critical appraisal checklist for analytical cross-sectional studies

Question	Study					Total (n)	Total (%)
	Rahmawati & Bajorek 2017	Tan et al., 2022	Padmi et al., 2025	Palileo-Villanueva et al., 2022	Rahmawati & Bajorek, 2018		
Q1 Were the criteria for inclusion in the sample clearly defined?	Y	Y	Y	Y	Y	5	100%
Q2 Were the study subjects and the setting described in detail?	Y	Y	Y	Y	Y	5	100%
Q3 Was the exposure measured in a valid and reliable way?	Y	Y	Y	Y	Y	5	100%
Q4 Were objective, standard criteria used for measurement of the condition?	N	N	N	Y	N	1	20%
Q5 Were confounding factors identified?	Y	N	N	N	Y	2	40%
Q6 Were strategies to deal with confounding factors stated?	Y	N	N	Y	Y	3	60%
Q7 Were the outcomes measured in a valid and reliable way?	Y	Y	Y	Y	Y	5	100%
Q8 Was appropriate statistical analysis used?	Y	Y	Y	Y	Y	5	100%
Total score (n)	7	5	5	7	7		
Total score (%)	87.5%	62.5%	62.5%	87.5%	87.5%		
Quality	H	M	M	H	H		

Note. H = High, M = Moderate, N = no, Y = yes

Appendix Table A3. Critical appraisal of the eligible qualitative with JBI critical appraisal checklist for analytical qualitative research

	Question	Study					Total (n)	Total (%)
		Kurnia et al., 2018	Yatim et al., 2019	Lasco et al., 2020	Wahab et al., 2021	Bujawati et al., 2024	Chantakeeree et al., 2021	
Q1	Is there congruity between the stated philosophical perspective and the research methodology?	Y	Y	Y	Y	Y	Y	6 100%
Q2	Is there congruity between the research methodology and the research question or objectives?	Y	Y	Y	Y	Y	Y	6 100%
Q3	Is there congruity between the research methodology and the methods used to collect data?	Y	Y	Y	Y	Y	Y	6 100%
Q4	Is there congruity between the research methodology and the representation and analysis of data?	Y	Y	Y	Y	Y	Y	6 100%
Q5	Is there congruity between the research methodology and the interpretation of results?	Y	Y	Y	Y	Y	Y	6 100%
Q6	Is there a statement locating the researcher culturally or theoretically?	N	N	Y	N	N	Y	2 33.3%
Q7	Is the influence of the researcher on the research, and vice- versa, addressed?	Y	N	Y	N	N	Y	3 50%
Q8	Are participants, and their voices, adequately represented?	Y	Y	Y	Y	Y	Y	6 100%
Q9	Is the research ethical according to current criteria, or for recent studies, and is there evidence of ethical approval by an appropriate body?	Y	Y	Y	Y	Y	Y	6 100%
Q10	Do the conclusions drawn in the research report flow from the analysis or interpretation of the data?	Y	Y	Y	Y	Y	Y	6 100%
Total score (n)		9	8	10	8	8	10	
Total score (%)		90%	80%	100%	80%	80%	100%	
Quality		H	H	H	H	H	H	

Note. H = High, M = Moderate, N=no, Y=yes

Appendix Table A4. Critical appraisal of the eligible quasi-experimental studies with JBI critical appraisal checklist for quasi-experimental studies

Question	Study	Total (n)	Total (%)
	Ningsih et al., 2020		
Q1 Is it clear in the study what is the ‘cause’ and what is the ‘effect’ (i.e. there is no confusion about which variable comes first)?	Y	1	100%
Q2 Were the participants included in any similar comparisons?	Y	1	100%
Q3 Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	Y	1	100%
Q4 Was there a control group?	Y	1	100%
Q5 Were there multiple measurements of the outcome both pre and post the intervention/ exposure?	Y	1	100%
Q6 Was the follow-up complete, and if not, were the differences between groups in terms of their follow-up adequately described and analyzed?	N	0	0%
Q7 Were the outcomes of participants included in any comparisons measured in the same way?	Y	1	100%
Q8 Were outcomes measured in a reliable way?	Y	1	100%
Q9 Was an appropriate statistical analysis used?	Y	1	100%
Total score (n)	8		
Total score (%)	88.9%		
Quality	H		

Note. H = High, M = Moderate, N = no; Y = yes

อิทธิพลทางวัฒนธรรมต่อการดูแลตนเองของผู้ป่วยโรคความดันโลหิตสูง ในเอเชียตะวันออกเฉียงใต้ : การทบทวนวรรณกรรมอย่างเป็นระบบ

Ni Putu Ayu Ratna Dewi, Nursalam,* Sriyono, Komang Ardidhana Nugraha Putra, Titik Suhartini

บทคัดย่อ:งานวิจัยนี้เป็นการทบทวนวรรณกรรมอย่างเป็นระบบเพื่อศึกษาอิทธิพลของปัจจัยทางวัฒนธรรมที่มีต่อพฤติกรรมการดูแลตนเองของผู้ป่วยโรคความดันโลหิตสูงในภูมิภาคเอเชียตะวันออกเฉียงใต้ ซึ่งถือเป็นภาระทางสาธารณสุขที่สำคัญ โดยผู้วิจัยได้สืบค้นข้อมูลจากฐานข้อมูลอิเล็กทรอนิกส์ 5 แห่งในช่วงปี 2015 ถึง 2025 และคัดเลือกการศึกษาที่เกี่ยวข้องจำนวน 12 ฉบับ รวมกลุ่มตัวอย่างทั้งหมด 2,252 คน ผลการสังเคราะห์ข้อมูลเชิงบรรยายพบประเด็นสำคัญ 5 ประการ ได้แก่ การรับรู้เกี่ยวกับความเจ็บป่วย การดูแลตนเองตามความเชื่อทางจิตวิญญาณ และดั้งเดิม ประเพณีด้านอาหาร อุปสรรคทางสังคมและวัฒนธรรมต่อการเข้าถึงการแพทย์สมัยใหม่ และแนวทางการดูแลโดยอาศัยชุมชนเป็นฐาน ตัวอย่างที่เด่นชัด คือ ความนิยมในการใช้สมุนไพรและพิธีกรรมทางศาสนาในประเทศมาเลเซียและอินโดนีเซีย ซึ่งบางครั้งส่งผลให้การรักษาทงการแพทย์ล่าช้า รวมถึงความเชื่อเรื่อง "เลือดขุ่น" ในฟิลิปปินส์ที่ส่งผลต่อการตัดสินใจเลือกวิธีการรักษา นอกจากนี้ วัฒนธรรมการรับประทานอาหารร่วมกันและการตัดสินใจร่วมกันของครอบครัวยังมีบทบาทสำคัญต่อการปรับเปลี่ยนพฤติกรรมสุขภาพ งานวิจัยสรุปว่าพฤติกรรมการดูแลตนเองในภูมิภาคนี้มีความยึดโยงกับบริบททางสังคมแบบสะสมนิยม ดังนั้น การพยาบาลชุมชนจึงจำเป็นต้องใช้การประเมินและการสื่อสารที่สอดคล้องกับวัฒนธรรม รวมถึงการดึงครอบครัวและชุมชนเข้ามามีส่วนร่วมเพื่อส่งเสริมการปฏิบัติตัวของผู้ป่วยอย่างยั่งยืน โดยควรมีนโยบายที่สนับสนุนระบบบริการสุขภาพที่ปลอดภัยทางวัฒนธรรมและขยายผลงานวิจัยในพื้นที่ที่ยังขาดแคลนข้อมูลต่อไป

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Ni Putu Ayu Ratna Dewi, MNurs, RN, Faculty of Nursing, Airlangga University, Surabaya, Indonesia, 60115, Faculty of Health, Institute of Technology and Health Bali, Bali, Indonesia, 80227.

E-mail: ayuratna622@gmail.com/ni.putu.ayu-2024@fkip.unair.ac.id; <https://orcid.org/0000-0002-6840-4234>

Correspondence to: Nursalam, * PhD, MNurs (Hons), Faculty of Nursing, Airlangga University, Jl. Dr. Ir. H. Soekarno, Mulyorejo, Surabaya 60115, Indonesia. E-mail: nursalam@fkip.unair.ac.id; <https://orcid.org/0000-0002-9052-6983>

Sriyono, PhD, MNurs, CNS, RN, Faculty of Nursing, Airlangga University, Surabaya, Indonesia, 60115. E-mail: sriyono@fkip.unair.ac.id; <https://orcid.org/0000-0002-6533-1973>

Komang Ardidhana Nugraha Putra, MNurs, RN, Faculty of Health, Institute of Technology and Health Bali, Bali, Indonesia, 80227.

E-mail: ardidhana.itekesbali@gmail.com; <https://orcid.org/0000-0001-6598-6841>

Titik Suhartini, MNurs, RN, Faculty of Health and Natural Sciences, Sunan Gresik University, East Java, Indonesia, 61153.

E-mail: titik.suhartini-2024@fkip.unair.ac.id; <https://orcid.org/0009-0004-2927-9401>