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Social Perceptions of Health in Urban and Rural Indonesia

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ABSTRACT

Differences in social, cultural, and service contexts between urban and rural areas in Indonesia shape variations in how health is socially perceived. This article aims to examine how social perceptions of health are constructed in urban and rural communities and to identify the factors influencing these differences. A qualitative approach employing a structured narrative literature review was applied to twenty scholarly articles published over the past decade, which were analyzed through thematic synthesis. The main findings indicate that urban communities tend to conceptualize health within a rational and biomedical, individual-oriented framework, whereas rural communities interpret health in a more communal and context-sensitive manner, influenced by cultural values, social relations, and local authority. Distinctions are also observed in access to health information, perceptions of disease risk, patterns of preventive behavior, and the strength of social norms. This study concludes that health perception is a socially constructed phenomenon shaped by the interaction of structural conditions, cultural orientations, and social capital. The findings imply that health promotion and intervention strategies should be context-sensitive and tailored to the social characteristics of each setting to achieve sustainable outcomes

Perbedaan konteks sosial, budaya, dan ketersediaan layanan antara wilayah perkotaan dan pedesaan di Indonesia membentuk variasi dalam cara masyarakat memaknai kesehatan. Artikel ini bertujuan untuk menganalisis secara komprehensif konstruksi persepsi sosial kesehatan pada masyarakat perkotaan dan pedesaan serta faktor-faktor yang memengaruhinya. Penelitian menggunakan pendekatan kualitatif dengan desain tinjauan literatur naratif-terstruktur terhadap dua puluh artikel ilmiah yang dipublikasikan dalam sepuluh tahun terakhir dan dianalisis melalui sintesis tematik. Temuan utama menunjukkan bahwa masyarakat perkotaan cenderung memahami kesehatan dalam kerangka rasional-medis dan berorientasi individual, sedangkan masyarakat pedesaan memaknainya secara lebih komunal, kontekstual, dan dipengaruhi oleh nilai budaya, relasi sosial, serta otoritas lokal. Perbedaan juga tampak pada akses informasi, persepsi risiko penyakit, pola perilaku pencegahan, serta kekuatan norma sosial. Kajian ini menyimpulkan bahwa persepsi kesehatan merupakan konstruksi sosial yang dibentuk oleh interaksi antara struktur, budaya, dan modal sosial. Implikasinya, strategi promosi dan intervensi kesehatan perlu dirancang secara kontekstual dengan mempertimbangkan karakteristik sosial wilayah agar lebih efektif dan berkelanjutan.

Keywords: social perceptions of health, urban, rural, Indonesia

Introduction

From a sociological perspective, health is not merely understood as a biological state but as a socially constructed phenomenon shaped by the dynamic interaction between individuals, social structures, cultural systems, and the physical environment in which people live (Megatsari et al., 2018; Setianti, 2025). Social perceptions of health emerge

through collective experiences, access to knowledge, socioeconomic positioning, and value systems that influence how individuals and communities define well-being, illness, vulnerability, and preventive action (Frankenberg & Jones, 2004; Maulana et al., 2018). In the Indonesian context, the contrasting social characteristics of urban and rural settings generate distinct patterns of health perception, reflected in differences in cognitive understanding, emotional response, and health-related behavior (Laksono, 2023; Wulandari et al., 2022).

Urban areas, characterized by high population density, social heterogeneity, intense mobility, and relatively advanced health infrastructure and information technology, tend to foster health perceptions grounded in scientific reasoning and preventive orientation (Sokang et al., 2019; Tejamaya, 2021). Conversely, rural communities, which are embedded in strong communal bonds, rely heavily on local resources and often face limited access to formal health facilities, are more likely to interpret health through collective experience, cultural beliefs, and the authority of local social actors (Suharmiati et al., 2023; Basrowi, 2024). Socioeconomic inequality and geographic isolation place rural populations in a structurally disadvantaged position, exposing them to higher levels of poverty, inadequate infrastructure, and shortages of health professionals, thereby widening the urban–rural health divide (Aurelia et al., 2025; Thamrin et al., 2025).

Although Indonesia's health sector reforms, particularly the expansion of the national health insurance system, have improved overall service coverage, substantial disparities in access and utilization persist, especially in rural and remote regions (Laksono, 2023; Rinasih, 2019). Unequal distribution of health personnel, limited local fiscal capacity, long travel distances, and inadequate transportation infrastructure constitute major structural barriers that restrict equitable access to care (Idris & Karimah, 2025; Wulandari et al., 2022). Within this context, telemedicine and other digital health innovations are increasingly regarded as strategic instruments to overcome spatial constraints and extend service reach, although their effectiveness remains contingent upon digital literacy and network availability in underserved areas (Mangoma & Sulistiadi, 2024).

Cultural values and social relations further shape how health is perceived and acted upon. In metropolitan settings such as Jakarta, health is commonly conceptualized in a holistic manner that encompasses physical, psychological, and spiritual dimensions, reflecting the integration of modern biomedical discourse with religious and cultural traditions (Sokang et al., 2019). At the community level, social solidarity and mutual cooperation function as forms of social capital that strengthen support networks, influence health-seeking behavior, and reinforce compliance with collectively shared norms (Cipta et al., 2024). Among adolescents, perceptual differences are also evident, as urban youth demonstrate greater awareness of the benefits of physical activity than their rural counterparts, although both groups exhibit limited understanding of recommended

activity duration, underscoring the need for context-sensitive and developmentally appropriate health promotion strategies (Syaukani et al., 2024; Yusuf et al., 2021).

Despite the growing body of research addressing urban–rural disparities in health service access, preventive practices, and acceptance of medical interventions (Fitria, 2024; Fitria et al., 2025; Hardhantyo & Chuang, 2021; Kelana et al., 2022), comprehensive syntheses that explicitly frame these findings within the concept of social perceptions of health and integrate social, cultural, and structural dimensions remain limited (Mentari, 2022; Setianti, 2025). Accordingly, the present study seeks to analyze social perceptions of health in urban and rural Indonesia through a literature review, examining how socioeconomic conditions, cultural contexts, infrastructural arrangements, and social capital interact to shape meanings of health, preventive behavior, and experiences of health service access, thereby providing an analytical foundation for more contextualized, adaptive, and equitable health policies.

Methods

This study employed a qualitative approach using a structured narrative literature review design to examine social perceptions of health in urban and rural areas of Indonesia. This design was selected because it enables an in-depth synthesis of empirical and theoretical findings while situating them within the conceptual framework of the sociology of health (Creswell & Poth, 2018; Snyder, 2019). A literature review approach is particularly appropriate for integrating diverse sources of evidence, identifying conceptual patterns, and developing a comprehensive understanding of how socioeconomic, cultural, and structural factors shape health perceptions across different social contexts (Petticrew & Roberts, 2006).

The literature search was conducted through national and international academic databases, including Google Scholar, Scopus, PubMed, and accredited Indonesian journal portals, using keywords such as “health perception,” “urban,” “rural,” “urban–rural disparities,” and “sociology of health.” The inclusion criteria comprised: (1) peer-reviewed journal articles published within the last ten years, (2) studies focusing on the Indonesian context or offering strong conceptual relevance to urban–rural comparisons, (3) publications addressing perceptions, behaviors, or access to health services, and (4) availability of full-text articles. Exclusion criteria included non-scholarly publications, duplicated records, and studies that did not explicitly engage with social or perceptual dimensions of health. The selection process was carried out through a stepwise screening of titles, abstracts, and full texts to ensure methodological and thematic relevance (Creswell, 2014; Booth, Sutton, & Papaioannou, 2016).

The selected studies were analyzed using thematic analysis, whereby key findings were coded and organized into major thematic categories, such as risk perception, trust in health services, cultural beliefs, social capital, and urban–rural disparities in access. Cross-study comparison was conducted to identify convergent and divergent patterns,

followed by conceptual interpretation within the theoretical lens of health sociology (Braun & Clarke, 2006; Creswell & Poth, 2018). This analytical strategy allowed the study not only to summarize existing evidence but also to develop a critical and integrative interpretation of how social, economic, and cultural contexts interact in shaping health perceptions among urban and rural communities in Indonesia.

Result

Based on a systematic search of national and international academic databases, including Google Scholar, Scopus, PubMed, and accredited Indonesian journal portals, a total of twenty peer-reviewed articles published within the last ten years were identified as relevant to the topic of social perceptions of health in urban and rural communities in Indonesia. These studies encompass empirical investigations and conceptual analyses addressing differences in access to health information, risk perception, preventive behavior, and the role of social norms in shaping how health is understood and practiced across spatial contexts. To synthesize the evidence comparatively and thematically, the selected studies were organized into the following thematic matrix

Table 1. Thematic Matrix of Social Perceptions of Health in Urban and Rural Indonesia (2015–2025)

No	Author (Year)	Context	Access to Information	Risk Perception	Preventive Behavior	Social Norms	Key Findings
1	Megatsari et al. (2018)	Urban–Rural	Urban: formal media and health facilities; Rural: primary care and local leaders	Urban: medical-scientific; Rural: experience-based	Urban: screening and service use; Rural: reactive	Rural: strong community control	Disparities in access shape different meanings of health and illness.
2	Wulandari et al. (2022)	Urban–Rural	Urban: digital platforms and hospitals; Rural: field health workers	Urban: individual risk; Rural: environment-based	Urban: high utilization; Rural: delayed use	Rural: collective compliance	Spatial context influences health service utilization.
3	Laksono (2023)	Urban–Rural	Urban: multiple information sources; Rural: limited networks	Urban: clinical interpretation; Rural: geographical factors	Urban: preventive orientation; Rural: curative focus	Village norms influential	Regional structure shapes perceived health needs.
4	Hardhantyo & Chuang (2021)	Urban–Rural	Urban: immunization education; Rural: community health volunteers	Urban: scientific risk perception; Rural: pragmatic	Urban: higher coverage	Influence of local figures	Social factors determine immunization compliance.

5	Siramaneerat (2021)	National	Urban: national campaigns; Rural: restricted access	Urban: medical framing	Urban: systematic prevention	Collective village norms	Regional inequality affects awareness of immunization.
6	Tejamaya (2021)	National	Urban: mass media; Rural: interpersonal communication	Urban: high perceived COVID-19 risk; Rural: moderate	Urban: varied; Rural: authority-driven compliance	Strong rural norms	Information sources shape risk perception.
7	Simanjorang (2022)	Rural	Religious and health leaders	Socially constructed vaccine risk	High compliance when collective	Strong communal control	Community trust determines vaccine acceptance.
8	Idris & Karimah (2025)	Urban–Rural	Urban: easy ANC access; Rural: limited facilities	Urban: clinical understanding	Urban: routine visits; Rural: inconsistent	Role of family and tradition	Structural access shapes perception of maternal health needs.
9	Suharmiati et al. (2023)	Urban–Rural	Urban: biomedical services; Rural: traditional medicine	Urban: scientific; Rural: holistic	Rural: pluralistic practices	Strong cultural norms	Medical pluralism shapes health meanings.
10	Suyanto & Sari (2024)	Rural	Health centers and village authorities	Experience-based risk	Dependent on local campaigns	Community control dominant	Local trust structures guide health behavior.
11	Kelana et al. (2022)	Urban–Rural	Urban: media; Rural: village officials	Urban: scientific risk; Rural: experiential	Rural: strong collective compliance	High social control	Communal norms reinforce protocol adherence.
12	Arsiazi (2022)	Urban–Rural	Urban: digital sources; Rural: religious leaders	Urban: biomedical framing	Rural: religion-based practices	Dominant religious norms	Cultural values shape perceptions of death-related risks.
13	Fitria (2024)	Urban–Rural	Urban: social media; Rural: local outreach	Urban: scientific understanding	Rural: leader-guided compliance	Community influence strong	Social trust determines vaccine acceptance.
14	Fitria et al. (2025)	Urban–Rural	Urban: extensive information; Rural: limited channels	Urban: rational evaluation; Rural: belief-based	Urban: selective; Rural: collective	Strong village norms	Social structure differentiates vaccination response.

15	Harahap (2021)	Urban	Hospitals and mass media	Clinically oriented risk	Individual preventive action	Weak social control	Urban health perception is rational-individual.
16	Basrowi (2024)	Rural	Posyandu and community cadres	Maternal-child risk based on experience	Program-oriented prevention	Strong social support	Social capital strengthens service utilization.
17	Syaukani et al. (2024)	Rural	Community health education	Holistic perception among elderly	Communal physical activity	Gotong royong norms	Local culture shapes meanings of healthy ageing.
18	Setianti (2025)	National	Formal media and institutions	Socio-cultural construction of risk	Belief-influenced prevention	Norm-mediated behavior	Health perception is socially constructed.
19	Widiarti (2022)	Urban–Rural	Urban: insurance information; Rural: limited awareness	Urban: financial risk awareness	Rural: collective decision-making	Strong family role	Social status affects access to health insurance.
20	Mentari (2022)	National	Unequal information distribution	Structurally determined risk	Access-dependent prevention	Local normative influence	Social inequality drives health disparities.

Discussion

Based on the synthesis of the twenty reviewed studies, it is evident that social perceptions of health in urban and rural communities in Indonesia are shaped by distinct social configurations, particularly in terms of access to information, risk perception, trust in health-care systems, and patterns of preventive behavior. These findings indicate that the meaning of "health" is neither neutral nor uniform, but socially constructed through context-specific experiences. In urban settings, health is predominantly understood within a rational and biomedical framework that emphasizes clinical measurement, technological prevention, and individual responsibility. In contrast, rural communities tend to interpret health more holistically, as a state of balance involving the body, the natural environment, social relations, and spiritual values. This pattern supports the arguments of Megatsari et al. (2018) and Suharmiati et al. (2023) that social and cultural contexts fundamentally shape how people define illness and well-being.

These differences are particularly apparent in relation to access to and sources of health information. Urban populations benefit from extensive exposure to digital media, professional health workers, and modern health facilities; however, the plurality of information channels often leads to heterogeneous interpretations and does not necessarily translate into consistent behavior. Rural populations, by contrast, rely more heavily on interpersonal sources that possess strong social legitimacy, such as religious

leaders, village authorities, and local health workers. In this context, health information functions not merely as technical knowledge but as socially binding guidance. This interpretation is consistent with the findings of Tejamaya (2021) and Simanjorang (2022), who emphasized that trust in information sources is more influential than the sheer availability of media in shaping the acceptance of health messages.

With regard to risk perception and vulnerability, the reviewed literature suggests that urban communities tend to interpret health risks through medical indicators, statistical reasoning, and probabilistic thinking, framing disease as an individual condition that can be managed through early detection and preventive intervention. Rural communities, on the other hand, more often construct risk through collective experience, shared narratives of past outbreaks, and environmental conditions, resulting in a contextual and socially grounded understanding of vulnerability. This pattern reinforces the arguments of Kelana et al. (2022) and Arsiazi (2022) that risk is not merely an epidemiological fact, but also a cultural and social construction shaped by collective memory and lived experience.

These contrasting interpretations of risk have direct implications for preventive behavior. Although urban residents generally display higher levels of formal health literacy and greater exposure to preventive campaigns, their compliance tends to be more variable, as health decisions are framed primarily as individual choices and are less strongly reinforced by social norms. In rural communities, preventive practices are often more stable when they are legitimized by local authority and embedded in communal norms and informal social control. This finding is in line with Syaukani et al. 2024) and Basrowi (2024), who highlighted the role of community-based regulation and moral obligation in shaping health-related behavior. Differences are also evident in patterns of trust toward health-care systems. Urban populations tend to place greater confidence in formal medical services and modern technologies, whereas rural communities frequently exhibit medical pluralism, combining biomedical treatment with traditional and herbal practices. Such patterns of trust are not solely the result of limited access, but are closely linked to social proximity, intergenerational experience, and cultural compatibility. This suggests that choices regarding treatment are embedded in socio-cultural relationships rather than determined exclusively by biomedical rationality, as also indicated by Suharmiati et al. (2023) and Setianti (Setianti, 2025).

Overall, this discussion demonstrates that social perceptions of health in Indonesia are produced through the interaction of structural conditions, cultural values, and social relations, and that urban–rural differences cannot be reduced to disparities in infrastructure alone. The main contribution of this study lies in reinforcing a sociological perspective that views health perceptions and practices as socially constructed and normatively regulated. Nevertheless, the study is limited by its reliance on secondary literature and therefore does not capture micro-level dynamics and recent transformations in everyday health experience. Future research is encouraged to

integrate ethnographic approaches, comparative surveys, and spatial analysis to further explore how health meanings are negotiated in diverse local contexts. From a practical standpoint, the findings suggest that health policies and promotion strategies should be context-sensitive, strengthening community-based networks and local leadership in rural areas while enhancing critical health literacy and social cohesion in urban settings, in order to ensure that interventions are not only informative but also socially effective and sustainable.

Conclusion

This study concludes that social perceptions of health in Indonesia are not formed in a uniform manner, but are strongly shaped by the distinct social contexts of urban and rural settings. The main findings reveal that urban communities tend to interpret health through a rational and biomedical lens emphasizing individual responsibility, whereas rural communities understand health as a socially embedded condition shaped by communal relations, shared experiences, and local cultural values. In this regard, the research objective of explaining the influence of social context on health perception has been successfully addressed. The contribution of this study lies in advancing a sociological perspective on health by demonstrating that health perceptions and practices emerge from the interaction of social structure, culture, and normative systems rather than from medical knowledge alone. From a practical standpoint, the findings highlight the importance of context-sensitive health promotion and intervention strategies, encouraging the integration of community-based approaches in rural areas and the strengthening of critical health literacy in urban environments, while also suggesting directions for future empirical research to further explore the dynamics of health perception through comparative field-based studies

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