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Health Practices as a Sociocultural Process in Indonesia: Prevention, Illness Behavior, and the Role of the Sick

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ABSTRACT

This study aims to describe the dynamics of transitions between stages of health behavior as a social process occurring in the daily practices of Indonesians, while also exploring the mechanisms that most consistently explain these transitions based on the reviewed literature. Using a literature review and document analysis approach, various empirical findings regarding health practices were analyzed thematically. Stella Quah's conceptual framework was utilized to categorize the results into three main domains: preventive behavior, illness behavior, and sick-role behavior. The results indicate three recurring social mechanisms. First, the meaning of health, which is based on the ability to perform social functions, creates a certain threshold of seriousness, which influences decisions about when preventive action is deemed necessary and when symptoms are deemed to require further treatment. Second, the flow of knowledge circulating within families, community networks, and digital media acts as an interpretive filter in understanding symptoms and determining what steps are considered rational at the sick-role stage. Third, experiences interacting with health services and barriers to access contribute to shaping patterns of care-seeking at the sick-role stage, including the process of negotiating therapy within the context of medical pluralism. In some situations, religious practices serve as both emotional support and daily discipline, helping to stabilize treatment choices across these stages. This research is limited to consistent patterns within the analyzed corpus of literature and is not intended to be generalized to the entire Indonesian social context. This research expands the body of knowledge on the sociology of health in Indonesia by reformulating the linkages between the three stages of health behavior and recurring social mechanisms, and synthesizing the diverse health practices documented in the reviewed literature.

1. INTRODUCTION

Health practices in Indonesia do not always move linearly from medical knowledge to preventive or curative measures. In many situations, the decision to act is preceded by practical considerations rooted in bodily experiences and daily demands. A person often perceives themselves as healthy as long as they are still able to carry out social roles and routine activities without significant obstacles. Thus, the definition of health is not solely

determined by clinical indicators but is also shaped by work rhythms, family responsibilities, and social norms regarding when someone is considered ill. Within this framework, preventive measures and seeking medical attention tend to be postponed until symptoms significantly disrupt daily functioning (Widayanti et al., 2020). Consequently, symptoms are often only recognized as problematic when they have significantly impacted productivity and social relationships, at which point professional help is considered.

This phenomenon of delay is widely discussed in studies of non-communicable diseases, particularly chronic diseases. The slow-developing nature of chronic diseases and the often-asymptomatic nature of their symptoms make them easily normalized as part of the aging process or ordinary fatigue. Drawing on the literature on chronic diseases as a starting point for analysis, this study positions health practices and care-seeking as social processes interwoven into everyday life. The experience of living with diabetes, for example, demonstrates that disease management does not always follow clinical recommendations directly and consistently. Patients' practices are often guided by lay knowledge, family traditions, and pragmatic adjustments to economic and social needs. This is evident in dietary adjustments, the use of herbal remedies, self-care for wounds at home, and negotiations about insulin use (Sari et al., 2022). These findings demonstrate that health actions are not merely technical responses but are embedded in a complex network of social practices.

In this context, local categories play a crucial role as the initial mechanism guiding the process of symptom recognition, risk assessment, and decisions to act or delay. In some rural communities in Central Java, diabetes is understood through terms such as sugar disease and sweet pee disease (Pujilestari et al., 2014). Furthermore, there are classifications of wet and dry sugar, which influence how people assess the severity and consequences of the disease (Pujilestari et al., 2014; Sari et al., 2022). Assessments are often based on easily observable signs, such as urinary frequency or the presence of ants in the urine. In many cases, risk is perceived as more relevant to others than to oneself. This perception contributes to weak early prevention practices, as action is only considered when symptoms have disrupted daily activities (Pujilestari et al., 2014).

In the realm of services and information flows, Indonesians demonstrate flexible and adaptive navigational skills. Individuals can combine doctor consultations with non-medical therapies, utilize information from digital channels, and seek advice from religious authorities or local healers. This pattern is not limited to a specific region but is found across regions, with variations influenced by access, infrastructure, and service availability (Setianti et al., 2025). Medical pluralism is becoming common practice, not the exception. In this practice, individuals and families play an active role in developing care strategies that best align with their needs, values, and available resources.

Although the literature on health culture and practices in Indonesia continues to grow, many findings are still presented separately based on stages of health behavior. A number of studies provide in-depth descriptions of actions after a diagnosis or long-term disease management routines. However, research that explicitly links the phases of feeling well, the phase of symptom onset, and the phase of recognizing oneself as ill within a continuous social process is still relatively limited. As a result, the transition between phases is often not read as a complete dynamic (Widayanti et al., 2020). Similarly, findings regarding relational norms, lay categories, information authority, and medical pluralism often remain descriptive. These aspects have not been fully formulated as systematic explanatory mechanisms for when and why individuals move from delaying action to self-care to seeking competent care (Permana et al., 2019; Pujilestari et al., 2014; Sari et al., 2022).

In the Indonesian literature landscape, quantitative and qualitative approaches complement each other in describing health practices and care-seeking. Quantitative studies help map patterns and relationships between variables, for example, in the use of traditional medicine in populations with chronic diseases and its association with adherence to prescription medication (Pradipta et al., 2023). Other research shows that the use of traditional, modern, and transitional medicine systems is influenced by levels of knowledge, beliefs, and access factors such as facility distance, service costs, and insurance coverage (Febriyanti et al., 2024). Quantitative findings provide a sense of the scale of the phenomenon and general trends, but they cannot fully explain the social dynamics that occur at crucial moments.

These crucial moments include the initial assessment of symptoms, social validation of complaints, building trust in specific sources of information, and negotiating decisions within the household. It is at these points that social interactions, power relations, and meaning systems play a central role. A qualitative study of medication adherence in the elderly, for example, demonstrated the powerful influence of family and pro-herbal social networks in shaping daily practices (Widyakusuma et al., 2023). Other research confirms that family traditions, trusted sources of information, and everyday infrastructure contribute to maintaining the use of herbs as a complement to prescription drugs (Widayati et al., 2025). Through a qualitative approach, the dynamics of

negotiation and justification of health actions become more visible, including how individuals weigh the risks, benefits, and legitimacy of a therapeutic option.

Based on this explanation, this study poses a primary question: how does the transition between stages of health behavior occur as a social process in everyday practice in Indonesia? A follow-up question is what mechanisms most consistently explain this transition in the reviewed literature. This study argues that the transition between stages of health behavior is consistently shaped by cultural mechanisms operating in everyday practice. Referring to Stella Quah's framework, culture is understood as the context within which health behavior occurs (S. Quah, 2010). Operationally, referring to Talcott Parsons, as summarized by Quah, culture is understood as a system of learned and shared meanings and symbols that guide health judgments and actions (S. Quah, 2010). From this perspective, culture manifests itself in norms of appropriateness, authority relations, and therapeutic choices that are considered reasonable and legitimate in everyday life.

These meanings shape how individuals define health, interpret symptoms, believe or doubt information, and negotiate therapy among various actors: family, social networks, local healers, religious authorities, and health professionals. Thus, health actions cannot be understood solely as individual responses to biological symptoms, but as the result of interactions between meaning systems, social structures, and the material conditions surrounding a person's life. To explore the variation in health actions in the reviewed literature, this study uses three categories of health behaviors (S. Quah, 2010). First, preventive health behaviors, namely actions taken by individuals who feel healthy to prevent the onset of disease. Second, illness behaviors, namely actions when someone begins to feel unwell and tries to understand their symptoms and find solutions, ranging from self-medication, simple home care, to discussions with family or friends. Third, sick-role behaviors, namely actions when an individual recognizes themselves as sick with the aim of recovery, which is generally accompanied by seeking help from those considered experts, whether modern medical practitioners, traditional healers, or a combination of both. This framework allows for the reading of health measures as analytical stages that can be compared across studies, while also providing space for understanding the pluralism of routes of care as an integral part of everyday social practices.

The literature mapping conducted in this study led to the identification of three core mechanisms that consistently help explain transitions between stages of health behavior. The first mechanism is the circulation of knowledge and the formation of trust through family, social networks, and digital channels. This flow of information shapes how symptoms are interpreted and determines initial choices of action. The second mechanism relates to the negotiation of authority and legitimacy of action, both in social relationships and in clinical interactions. Norms of appropriateness, experiences communicating with health professionals, and determining who is considered authorized to provide health advice are important factors in this process. The third mechanism concerns structural opportunities and barriers that influence routes to care, including cost, distance, service availability, and health insurance, as well as the tendency to combine different forms of therapy. In addition to these three core mechanisms, additional mechanisms emerged more selectively and will be discussed further in the results and discussion sections. By positioning transitions between stages of health behavior as a social process influenced by cultural and structural mechanisms, this study seeks to enrich our understanding of health practices in Indonesia. This approach highlights not only what individuals do when faced with symptoms, but also how and why these actions are taken within the context of specific social relations, meaning systems, and material conditions. Through a synthesis of existing literature, this study contributes to the formulation of a more integrative analytical framework for understanding the dynamics of health behavior in Indonesian society.

2. METHOD

This research uses a literature review approach combined with document analysis as the primary strategy for reviewing and synthesizing published empirical findings (J. David Creswell, n.d.). Literature review was chosen because it allows researchers to systematically explore, compare, and integrate previous research findings to build a more comprehensive analytical framework. Literature collection was conducted purposively through searches of various accessible academic databases and international journal publisher portals. Furthermore, a backward search technique was used to identify additional sources with thematic links to the study's focus (George, 2008). This strategy aims to ensure that the selected documents are not only topically relevant but also provide empirical depth and conceptual contributions to the discussion.

Inclusion criteria were clearly defined to maintain consistency and analytical rigor. Included studies were empirical research addressing health practices in Indonesia, specifically those reporting health behaviors, care-seeking processes, or the use of non-biomedical therapies. Furthermore, the documents must contain a

description or analysis of the socio-cultural context surrounding these health practices (Miles et al., 2014). Therefore, the selected literature is not limited to reports of behavioral patterns alone but also provides explanations of the social factors, cultural values, relationships, and structures that influence health decisions. This approach allows researchers to examine health practices as phenomena embedded in social life, not simply individual responses to biological symptoms. The selected documents were then analyzed using document analysis techniques. Document analysis is understood as a systematic procedure for reviewing, evaluating, and interpreting document content to gain meaningful and scientifically sound understanding (Bowen, 2009). In the context of this research, document analysis focuses not only on summarizing previous research findings but also on identifying patterns of argumentation, conceptual categories, and implicit and explicit social mechanisms within the empirical findings.

The analysis process was conducted in stages and iteratively. The first stage was a cursory reading to gain an overview of the focus, methods, and key findings of each study. This stage helped researchers identify the documents' relevance to the research question. The second stage involved in-depth reading, aimed at a detailed examination of the research context, the theoretical framework used, and the reported social dynamics. At this stage, researchers began initial coding of sections of text that demonstrated patterns of action, consideration, or decision-making processes in health practices. The third stage was interpretation, which attempted to link findings across documents to build a broader, more integrated understanding (Bowen, 2009). Coding was conducted thematically to identify recurring patterns and develop analytical themes that represented the dynamics of health behavior. The emerging themes were then mapped into three health behavior categories that served as the analytical framework for this study. This mapping allowed researchers to explore how preventive practices, responses to symptoms, and self-recognition of illness were described across studies. This process also identified consistent social mechanisms within the literature, such as the circulation of knowledge, the negotiation of authority, and the influence of access structures (Creswell, 2016). Through these steps, the analysis does not stop at describing the findings, but moves towards formulating patterns and mechanisms that help explain the movement between stages of health behavior in the Indonesian social context.

3. RESULTS AND DISCUSSION

Health Action as a Social Process

The reviewed literature reveals a recurring pattern in the trajectory of health actions across contexts. Typically, individuals begin with a sense of well-being, then confront vague or nonspecific complaints, progress to self-recognition of illness, and ultimately determine the appropriate path to help. However, this trajectory is neither linear nor automatic. The transition between stages is strongly influenced by how an individual interprets the severity of the symptoms, the extent to which they interfere with daily functioning, and how the social environment responds to the condition. Judgments about whether a symptom is serious enough to warrant further action are often formed through conversations with family members or close friends (Hilmi et al., 2024). Support, advice, or even denial from those around them can accelerate or delay the decision to seek help. Furthermore, individuals must determine which authorities are trustworthy, whether medical professionals, traditional healers, religious figures, or digital sources. This selection process reflects the fact that health actions are not solely a biological response but rather the result of complex social negotiations. This pattern is consistent across research designs and social settings, including reviewed studies on help-seeking behavior. Thus, health actions can be understood as a gradual, negotiated social process influenced by relationships, values, and everyday contexts (Widayanti et al., 2020), rural community FGDs (Pujilestari et al., 2014), ethnography of chronic disease patients (Sari et al., 2022), and multi-regional studies on health information and care beliefs (Setianti et al., 2025).

Preventive measures are often implemented as part of daily habits, rather than as a direct response to medically measurable clinical risk indicators. This means that people tend to maintain their health as long as it aligns with their routine lifestyle, rather than being compelled by a test result or professional advice. The transition from feeling well to being deemed in need of treatment is often determined by the disruption of daily functioning. Only when work, domestic responsibilities, or social rhythms begin to be disrupted are symptoms deemed serious enough to warrant attention (Simanjorang & Simanjuntak, 2024). In this context, preventive action is often delayed, even when information about the actual risk factors is readily available and accessible. As long as the body is still able to perform social roles relatively normally, the risk is perceived as less urgent. The situation changes when symptoms become more pronounced. The literature shows that a common initial response is self-care, such as adjusting diet, resting, or trying certain herbal remedies. Furthermore, individuals often undertake limited trials of therapies to monitor the progress of their condition. Before engaging further with formal health services, many

people first seek informal referrals. These sources can come from family, neighbors, friends, or digital sources. This process reflects a gradual process of seeking help, influenced by practical considerations and available social support (Setianti et al., 2025; Widayanti et al., 2020). During this phase, bodily experiences are also filtered by familiar community categories, such as the term sweet-pee disease or the wet/dry sugar classification, so that complaints are not always considered valid enough to be brought to the attention of clinical authorities (Pujilestari et al., 2014; Sari et al., 2022).

Recognizing oneself as ill marks an expansion of the relational dimension in the healthcare process. At this stage, decisions are no longer individual, but increasingly involve family and close networks. Family members often play a role in providing advice, considering therapeutic options, and even determining when and where to seek help (Aji & Widodo, 2023). At the same time, patients begin to interact and negotiate with healthcare professionals regarding diagnoses, treatment options, and potential consequences. The route taken is also heavily influenced by previous experiences with healthcare services, including the quality of communication, comfort, and ease of access. Several studies have shown that in these situations, multiple therapies are often chosen as a practical strategy. Individuals and families seek to expand their therapeutic options to increase their sense of security and confidence in the healing process (Alden et al., 2018). The use of non-biomedical practices such as herbs, jamu, massage, or the assistance of local healers often coexists with formal medical services. This combination is generally not intended to reject biomedicine, but rather to complement and strengthen healing efforts. Thus, health practices at the illness recognition stage reflect adaptive strategies that simultaneously consider medical, social, and emotional aspects (Setianti et al., 2025; Widayanti et al., 2020). It's important to distinguish here that access determines possible choices, while culture filters those choices through norms of appropriateness, authority relations, and trusted categories of explanation. In this way, the shift from self-care to competent care is not only about symptom intensity but also about social legitimacy and perceived safety in a limited situation (Sari et al., 2022; Setianti et al., 2025).

Phases of Preventive Health Action, Illness, and the Role of Illness in Practice

The framework developed by Quah is utilized in this study as an analytical tool to organize and interpret findings from various studies in a more structured manner. The framework serves as a conceptual map that helps organize diverse research findings so they can be compared systematically, even though they originate from different contexts, methods, and focuses. By using this framework, findings that were initially scattered and seemingly disparate can be placed in a more coherent flow, making patterns of health behavior shift more easily identifiable (S.-H. Quah & Bishop, 1996). Three main categories are used as the basis for grouping. First, preventive health behavior, which is the action taken by individuals while still feeling healthy with the aim of maintaining their physical condition and preventing disease. Second, illness behavior, which refers to the response when someone begins to experience symptoms and attempts to understand and address these symptoms. This stage can include self-care, information seeking, and informal consultations. Third, sick-role behavior, which is the action when an individual acknowledges that they are ill and takes steps to achieve recovery, usually through engagement with those perceived as having authority or competence. Through these three categories, the dynamics of health behavior can be analyzed as a multistep, interconnected process (S. Quah, 2010).

Preventive behavior refers to various actions individuals take before they experience symptoms of illness or when attempting to prevent an existing condition from worsening. At this stage, a person typically still perceives themselves as healthy, so actions taken are more focused on maintaining their health, maintaining bodily balance, or avoiding risk factors perceived as potentially disruptive. These efforts can include regulating diet, adequate rest, physical activity, or other habits deemed supportive of daily functioning (Marshall & Wing, 1966). Meanwhile, illness behavior emerges when symptoms begin to be felt and recognized as different from normal. In this phase, individuals attempt to interpret the meaning of their symptoms, assess their seriousness, and attempt reasonable initial steps. These actions can include self-care, seeking information, discussing them with family, or attempting simple therapies to monitor the condition's progress (Greer & Weber, 1964). Sick role behavior occurs when an individual explicitly recognizes themselves as ill and feels the need for more targeted treatment. At this stage, individuals tend to seek help from those deemed competent, such as healthcare professionals or other trusted practitioners. This recognition is usually accompanied by changes in social roles and more intense involvement in the treatment process (S. Quah, 2010). With this map, the movement between categories is read as a social process that occurs through thresholds of legitimacy, trusted authority, and choices of actions deemed appropriate in everyday life.

In the literature reviewed, preventive behavior is largely influenced by an understanding of health that rests on the ability to perform daily functions. A person generally considers themselves healthy as long as they are able to work, manage a household, and participate in social activities without significant obstacles (Nutbeam, 1999). Based on this understanding, prevention is not always positioned as an obligation that must be carried out consistently and continuously. As long as the body is deemed to be functioning normally, the urge to take preventive action tends not to be urgent. Consequently, preventive practices are often situational and depend on the perception of early signs of impairment. Efforts to maintain health become more focused when symptoms or minor changes appear that begin to disrupt work productivity, domestic responsibilities, or the rhythm of social interactions (Ahlgren & Hammarström, 1999). At that point, individuals begin to consider steps to prevent worsening conditions, either through lifestyle adjustments or seeking additional information. Thus, preventive behavior is not solely driven by awareness of measurable medical risks, but rather by a practical evaluation of the ability to maintain social roles. This function-based definition of health shapes how people determine when prevention is necessary and when it can be postponed without directly perceived consequences (Widayanti et al., 2020).

In the context of chronic illness, the line between maintaining health and managing the condition is often blurred. Daily practices such as dietary adjustments, regular physical activity, routine check-ups, and even herbal consumption can be interpreted simultaneously as strategies for maintaining balance in life and as a form of disease control to prevent it from worsening (Tristram, 1980). In other words, actions that appear preventive also function as part of ongoing illness management. For many individuals, these routines are not always understood as a response to illness alone, but rather as a way to maintain the ability to carry out social roles and daily activities. Diet and exercise, for example, are intended not only to reduce clinical indicators but also to ensure the body remains strong enough to cope with work and family responsibilities. Similarly, regular check-ups at a health facility can be seen as measures to maintain stability, not simply as follow-up to a diagnosis. The use of herbs or complementary therapies is also often framed within the framework of maintaining bodily balance to prevent deterioration. These practices demonstrate that in the experience of living with chronic illness, health and illness are not entirely separate states. Both exist on a spectrum negotiated through daily routines to maintain quality of life and prevent the condition from worsening (Sari et al., 2022; Widayanti et al., 2020; Widyakusuma et al., 2023). The threshold for moving to the next stage is usually not the knowledge of the risk itself, but rather the moment when symptoms or limitations begin to interfere with what is considered normal functioning.

Illness behavior is characterized by an interpretive process that allows bodily experiences to be understood and guides subsequent actions. When symptoms begin to be felt, individuals do not immediately seek formal medical treatment but first attempt to give meaning to the sensations they experience. This process involves categories, terms, and frameworks of understanding available in their social environment, allowing the body to be interpreted through language and knowledge familiar to everyday life (Ali & Cleland, 2005). In rural contexts such as Purworejo, diabetes is understood through local terms such as sugar disease and sweet-pee disease, which emphasize specific characteristics of the disease. Furthermore, the classification of wet sugar and dry sugar is used to differentiate the severity or type of condition experienced. These categories help communities simplify understanding of a clinically complex disease and serve as a basis for determining whether the situation is considered mild or requires further attention (Zwaanswijk et al., 2011). Symptom assessment is often based on readily observable signs, such as increased frequency of urination or the presence of ants visiting urine. These indicators are considered concrete and verifiable in everyday life. Through this interpretive work, bodily experiences are not only understood biologically, but also filtered through local frameworks of meaning that influence decisions about whether or not to seek further help (Pujilestari et al., 2014).

In an ethnographic study in Banyumas, the distinction between wet and dry sugar re-emerged as a local framework for understanding diabetes. This classification serves not only as a descriptive term but also as a tool for assessing risk levels, particularly regarding the likelihood of injury. Through these categories, people attempt to gauge whether their condition is considered safer or has the potential to cause serious complications (Deumert, 2010). On the one hand, this division helps alleviate anxiety by providing a sense of clarity and control over the situation. However, the use of this classification also has certain consequences. In some cases, the assumption that someone is experiencing a less serious form of diabetes can reduce awareness of early signs of injury or infection. A minor wound may be deemed less urgent to be examined because it is considered relatively mild. This assessment can influence the decision to delay visits to formal health services. Consequently, access to medical care is often only sought after when the condition has worsened or caused more significant impairment (Sampson & Gifford, 2010). Thus, these local classifications serve a dual role: on the one hand, they provide a reassuring framework for understanding, but on the other, they potentially delay responses to risks that actually require early attention (Sari et

al., 2022). Analytically, this pattern suggests lay categorizations serve as filters, through which symptoms are screened and tested through self-care and therapeutic experimentation before being deemed worthy of referral to clinical authorities (Widayanti et al., 2020). The shift toward the sick role occurs when these filters are no longer adequate, such as when symptoms persist, worsen, or begin to demand stronger validation.

Sick role behavior emphasizes the importance of legitimacy, social recognition, and the negotiation of authority in care practices. Once a person has recognized their illness, actions taken are aimed not only at physical healing but also at gaining social validation that the condition is real and worthy of treatment. At this stage, health decisions increasingly involve interactions with those perceived as having authority and competence. Various cross-regional studies have shown that physicians generally remain the primary source of definitive answers, primarily through clinical examination and diagnosis (Yamamoto-Honda et al., 2013). The diagnostic process provides clarity regarding the name of the disease, its severity, and the treatment plan, thereby strengthening the legitimacy of the illness in the eyes of the patient and their family. Thus, modern medical authority plays a crucial role in providing certainty and direction for action. However, at the same time, religious authority is also often present as part of the care process. Prayer, ritual, or spiritual advice may accompany the treatment process as a form of moral support and religious meaning for the experience of illness. The presence of these religious practices is generally not intended to replace the role of doctors as determinants of medical certainty, but rather to complement the healing process with spiritual and emotional dimensions that are considered important in everyday life (Setianti et al., 2025).

The way people play the sick role is also shaped by relational norms that govern appropriate interactions. For diabetic patients in Yogyakarta, tepo seliro (a sense of mutual respect) can lead patients to withhold questions to avoid disturbing others waiting, resulting in brief consultations and limited space for clarification (Permana et al., 2019). In the realm of medicine, medical pluralism emerges as a common practice after someone admits they are ill. Individuals and families rarely rely on a single therapeutic system but instead tend to combine various options that are considered complementary. The use of herbs and jamu, for example, is often implemented alongside prescription medication. Similarly, massage, acupuncture, or the assistance of local healers are often part of a range of recovery efforts. The presence of these diverse forms of therapy does not necessarily reflect a distrust of formal medical services. Rather, this combination is usually understood as a strategy to expand the chances of recovery and increase a sense of security (Riumallo-Herl et al., 2014). Formal services are still accessed for diagnosis and monitoring, while non-biomedical therapies are used to support recovery, reduce symptoms, or strengthen the immune system. These coexisting practices demonstrate that in everyday experience, the boundaries between modern and traditional medical systems are fluid and negotiated according to patients' needs, beliefs, and access (Febriyanti et al., 2024; Setianti et al., 2025; Widayanti et al., 2020). This pattern demonstrates that the route to care is not simply a clinical choice, but also the result of a negotiation between trusted authorities, norms of appropriateness, and the availability of options deemed safe.

Mechanisms Connecting Culture and Health Action

This review demonstrates that culture plays a significant role in shaping health behavior, particularly through mechanisms that determine the threshold for transition between stages of action. The transition from feeling well to reading and interpreting symptoms, and from there to seeking competent care, does not depend solely on the intensity or severity of symptoms. The intensity of symptoms does influence, but it is not the sole determinant of decision-making. More crucial is how individuals assess their bodily functions in relation to daily activities. As long as the body is still considered capable of carrying out social roles and routine responsibilities, symptoms tend to be normalized (Lexchin, 2012). Furthermore, the process of selecting trusted sources of knowledge, whether family, health professionals, religious leaders, or digital channels, also shapes the course of action. Decisions are also influenced by how individuals navigate their route to care within the constraints of available access, such as distance to services, cost, and prior experience. Three key mechanisms identified in the literature consistently explain these transition patterns. These mechanisms not only help understand the types of actions taken but also explain why transitions between stages occur at specific moments in daily life, when considerations of function, trust, and access are intertwined.

The understanding of health, which rests on the ability to perform daily functions, serves as a threshold for seriousness in determining when action is necessary. Within this framework, prevention is only considered relevant when signs begin to disrupt routine activities. Thus, the severity of a condition is not primarily based on clinical indicators, but rather on its impact on work, domestic responsibilities, and social participation. Several reviews of help-seeking behavior indicate that disruption to daily activities is often a key indicator rather than

medical examination results or biological parameters (Proctor et al., 2011). When a person is still able to work, care for a family, and maintain a social rhythm, complaints tend to be viewed as less urgent. In such situations, preventive action is often deferred even though the individual has knowledge of risk factors or potential complications. Consequently, available medical information is not always immediately translated into action. As long as bodily function is deemed adequate, risks are viewed as possibilities that do not yet require an immediate response. This function-based threshold explains why prevention is often only activated when impairments become apparent and directly impact daily social roles (Widayanti et al., 2020).

This function-based threshold mechanism helps explain why, in the context of chronic illness, actions medically categorized as prevention are not always understood as stand-alone efforts. For many people, practices such as adjusting their diet, exercising moderately, taking medication regularly, or undergoing regular check-ups are more understood as ways to maintain a stable condition so that daily life can continue without significant disruption. The focus is not on prevention in the abstract, but rather on the continuity of function. In the experience of living with chronic illness, health and illness often exist on an interconnected spectrum. Therefore, actions clinically referred to as secondary prevention or risk factor management are not always perceived as separate "health programs"(Kelly et al., 2015). Instead, they are integrated into daily routines and considered part of strategies to maintain the ability to work, care for family, and fulfill social roles. As such, these practices are not always seen as a commitment to a healthy lifestyle isolated from the context, but rather as practical adjustments to avoid deterioration. This perspective helps understand why adherence to medical advice is often negotiated: as long as the condition is perceived as stable and functioning is not impaired, preventive measures are maintained to the extent that they support continued activity, not solely because of their medical label (Widyakusuma et al., 2023). Consequently, the transition from the preventive stage to the stage where complaints begin to be perceived as needing treatment typically occurs when social functioning is impaired, not when the risk is first recognized.

The circulation of knowledge within close social circles plays a significant role in shaping the authority of information individuals use to understand symptoms and determine appropriate action. Health referral sources come not only from medical professionals or formal service facilities but are also generated, reinterpreted, and disseminated within households, communities, and through digital media. In these spaces, personal experiences, others' stories, and practical advice form an important basis for assessing the body's condition. Health knowledge is thus dialogic and continuously updated through daily interactions. Discussions with family members, conversations with neighbors, and exposure to information on social media can influence how a person interprets a complaint, determines its seriousness, and chooses a therapy. The authority of information is not singular but rather dispersed and negotiated among various sources deemed relevant. In an ethnography of diabetes patients in Banyumas, for example, the use of herbal concoctions is learned through family traditions passed down from generation to generation (Kelly et al., 2015). Practices do not always follow standard dosages but are flexibly adjusted based on bodily sensations and daily experiences. This adjustment shows that therapeutic decisions are not only based on formal prescriptions, but also on embodied knowledge that develops in social relations and everyday practices (Sari et al., 2022).

In a survey of herbal use in primary care, family heritage and everyday sources of information supported the use of herbs as a complement to prescription medications, supported by routine infrastructure such as traditional markets and home gardens (Widayati et al., 2025). In a multi-regional study, informants assessed symptoms through Google, TikTok, or health apps, then combined these with advice from friends perceived as competent in their networks (Setianti et al., 2025). These findings suggest that information authority is multi-layered and competitive. Therefore, the transition from illness behavior to sick role behavior does not simply follow a single hierarchy of knowledge, but rather follows societal beliefs about who has the authority to validate symptoms as requiring clinical treatment.

Care pathways are shaped by service experiences and access conditions, and then implemented through the practice of medical pluralism. Barriers such as distance, availability of personnel, frequent medication out-of-stocks, cost, and transportation force people to choose realistic routes, particularly in rural or remote areas (Setianti et al., 2025). In the case of diabetes in Banyumas, limited monitoring tools add to uncertainty, so visits to formal care tend to occur only when the condition is already considered severe (Sari et al., 2022). Nationally, the use of traditional medicine among chronic disease populations is quite high and, in some groups, is associated with low adherence to prescription medications (Pradipta et al., 2023). These associations cannot be interpreted causally, but they suggest that in some patients, traditional medicine use may coexist with poorly coordinated medical practices. In the Sundanese context, the use of traditional, modern, and transitional systems is influenced

by knowledge and beliefs, but is also strongly influenced by access factors such as proximity to facilities, cost, and insurance (Febriyanti et al., 2024). This set of findings can be interpreted as a pathway to help, where access to and experience of services shape the need for alternatives, while medical pluralism provides a repertoire of actions that make these pathways feasible. In this way, medical pluralism appears as a practical strategy for seeking security and continuity of care within available opportunities, not simply a cultural preference (Setianti et al., 2025; Widayanti et al., 2020).

Beyond the three main mechanisms identified, religiosity does not appear as a standalone mechanism, but rather functions as a reinforcement that influences how all three operate. Religious values and practices play a role in shaping emotional regulation, psychological resilience, and discipline in carrying out daily routines. Thus, religiosity operates subtly by strengthening how individuals assess the seriousness of their condition, choose sources of authority, and establish channels for help. In an ethnography of diabetes patients in Banyumas, for example, the kersane gusti framework, understanding that their condition is part of God's will, helps individuals accept their illness without becoming overwhelmed by excessive anxiety. Sincerity and patience are not only expressions of spirituality but also strategies for reducing stress that can worsen physical conditions. These values support consistency in daily management, allowing religiosity to function as a moral and emotional resource in daily health practices (Sari et al., 2022). Among diabetes patients in Surabaya, spirituality and acceptance were reported as prominent coping mechanisms to reduce the distress often associated with medication routines and stigma (Arifin et al., 2020). In Padangsidimpuan, religiosity organizes routines and self-control in diet and activities, while also providing meaning that treatment is carried out to maintain capacity (Aziz et al., 2024). For kidney failure patients in Makassar, prayer with a partner and herbal consumption coexist with dialysis, strongly influenced by the advice of local networks and the authority of traditional healers (Komariah et al., 2023). Interpretatively, religiosity functions as a stabilizing device that can strengthen resilience to routines or shift the path to help, depending on the accompanying social relationships and available access.

Theoretical Implications

Quah's framework provides a phase distinction that facilitates the interpretation of the variation in health actions in the reviewed literature (S. Quah, 2010). Through this analytical distinction, findings from various studies can be more systematically placed into three main phases: preventive, illness behavior, and sick role behavior. This grouping allows transitions between phases to be read not as discrete leaps, but as a series of decisions occurring in everyday practice. Thus, the dynamics of health actions can be analyzed as a gradual process influenced by social context and life experiences. The reviewed literature reveals a relatively consistent pattern. In the preventive phase, health-maintaining actions are generally embedded in efforts to maintain daily functions and routines. Prevention is not always understood as a specific program, but rather embedded in habits that support ongoing activities. In the illness behavior phase, responses to symptoms are largely guided by lay categorizations and trials of therapies deemed reasonable based on local knowledge and experiences. Individuals interpret complaints through familiar terms and test various measures before deciding on further action. Meanwhile, in the sick role behavior phase, the process moves through the search for social legitimacy, interactions with health services, and the selection of often pluralistic treatment pathways. The combination of various therapeutic systems reflects negotiations between medical authority, social values, and available access in everyday life (Pujilestari et al., 2014; Setianti et al., 2025; Widayanti et al., 2020). Thus, the focus of analysis does not stop at a list of actions, but rather on the conditions that lead people to transition through stages.

Findings in the Indonesian context emphasize the importance of considering the mechanisms that shape the legitimacy of actions and determine the pathways to care. The decision to access healthcare services is influenced not only by medical need but also by social norms governing relationships between individuals. In many situations, considerations of appropriateness, discomfort, and efforts to maintain social balance influence how individuals perform their roles as patients. Relational norms such as reluctance and the drive to maintain harmony can limit the intensity of healthcare service use. Patients may be reluctant to openly ask questions, express dissatisfaction, or request further explanations for fear of being perceived as impolite or overly demanding. These attitudes often impact the quality of communication during medical consultations. Furthermore, these norms can shape how individuals exercise their rights to care, including in the context of insurance or public facilities. Rather than demanding optimal access, some patients choose a passive stance to maintain good relationships with healthcare providers. Thus, the legitimacy of actions and pathways to care are determined not only by the service structure but also by the relational ethics that exist within society (Permana et al., 2019; Widyakusuma et al., 2023). pluralism can be seen as a practical strategy supported by the circulation of family knowledge, media, and daily

social functions, rather than as a position at odds with biomedicine (Febriyanti et al., 2024; Pradipta et al., 2023; Widayanti et al., 2020). Religious practice and authority can serve as emotional regulation, self-discipline, and meaning-making tools for therapy, thus influencing adherence and how people explain illness and healing (Arifin et al., 2020; Ichwan et al., 2024). Emphasizing these aspects positions culture as part of the mechanisms at work shaping decision-making.

4. CONCLUSION

This study demonstrates that health behavior in the Indonesian literature reviewed can be understood as a series of interconnected actions, starting with a state of feeling healthy, continuing through the process of interpreting complaints, and finally admitting illness and seeking help. Using Quah's framework, the findings are organized into three analytical categories: preventive behavior, illness behavior, and sick-role behavior. This grouping demonstrates that transitions between phases are not discrete events, but rather iterative processes influenced by specific social mechanisms. In the analyzed corpus, transitions between phases are consistently guided by three main mechanisms. First, there is a threshold of seriousness based on daily functioning. Individuals tend to judge the need for action based on the extent to which complaints interfere with their activities and social roles. Second, there is a process of filtering and competition for information authority that occurs through family, social networks, and digital channels. At this stage, various sources of knowledge interact and shape action preferences. Third, there is the arrangement of therapeutic pathways within the context of medical pluralism, which is influenced by experiences interacting with health services and access constraints such as cost and availability of facilities. Because this research is based on a literature review, the conclusions drawn are limited to recurring patterns in the reviewed studies and are not intended to be generalized across the diverse Indonesian context. The governance implications drawn from this reading emphasize the importance of targeting these social mechanisms, rather than simply expanding health information channels. Prevention messages, for example, will be more effective if formulated in functional language, emphasizing the importance of maintaining the ability to function and preventing disruption to social roles, thus aligning with how communities determine the urgency of action. At the clinical service level, improving communication quality should focus on the moment of treatment decision-making and clarifying concerns about side effects, as this is where misunderstandings easily amplify and spread through social networks. Strengthening civil society is also crucial, including by supporting patient groups and religious communities as spaces for sharing experiences, providing emotional support, and filtering practical information. For scientific development, future research is recommended to explore phase transitions in more depth through longitudinal or ethnographic approaches, as well as comparing regional contexts and service access, to understand how the legitimacy of health decisions is shaped and what factors accelerate or delay the transition between phases.

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