

INFORMATION LITERACY OF THE TUO LIMBUR VILLAGE COMMUNITYIN ADDRESSING COMMUNITY HEALTH ISSUES

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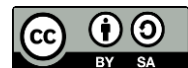
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Abstract

The development of information technology has influenced the way people search for and use health information. This study aims to describe the differences in information literacy among the people of Tuo Limbur village based on their level of education and the factors that influence them in dealing with health issues using The Big6TM information literacy model. The methods used were case studies with purposive sampling, in-depth interviews, observation, and documentation. Data analysis was conducted in three stages: each case, between strata, and across cases. The results showed that highly educated people were closer to the Big6TM stages that required information literacy skills, such as problem formulation, determining information search strategies, location and access, utilising information, identifying information, and evaluation, compared to less educated people who tended to rely more on indigenous communication. This study emphasises the importance of education, improving access to official information, and integrating local cultural approaches in improving the health information literacy of rural communities.

Keywords: Information Literacy, The Big6TM, Public Health, Indigenous Communication



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INTRODUCTION

Public health issues pose a serious challenge in this global era characterised by a rapid flow of digital information. Low levels of information literacy make it easy for people to fall prey to hoaxes, disinformation, or internet health rumours, especially those related to health issues. The COVID-19 pandemic a few years ago showed that people with low literacy tend to ignore health protocols, easily believe in conspiracy theories, and are reluctant to follow medical advice. A similar situation also occurs in rural areas, such as in Tuo Limbur, Jambi, where people still rely on traditional or indigenous communication to obtain information (Fitriyani & Rahma, 2023). Research by the National Library, revealed that the information literacy index in rural Jambi is relatively low, ranking 10th nationally (Sanjaya et al., 2025). When the information obtained is unverified, it becomes more difficult to prevent the spread of dangerous behaviour, so low information literacy in rural areas has the potential to worsen the situation. This condition affects social resilience, preparedness for epidemics, and the effectiveness of public health policies.

Previous literature reviews indicate that research on health information literacy in Indonesia generally focuses on urban communities with better digital access. Rachmawati and Agustine (2021), for example, emphasise the importance of digital health literacy among urban communities, who tend to find it easier to utilise information technology to search for and manage health information. Research on rural communities is still relatively scarce and more often focuses on aspects of technology accessibility rather than patterns of information search, evaluation, and use. The Economist Impact study also highlights digital literacy, but rarely highlights the local context, which is rich in traditional cultural values (Impact, 2025).. Similarly, other researchers have focused on studying the digital literacy movement in public primary and secondary schools in the city of Pontianak (Setiawan et al., 2023). On the other hand, tribal traditions in Gorontalo use traditional communication media in development in Titidu Village. The community uses traditional media as an intermediary to implement communication in Titidu Village, without considering the information literacy of the community (As'adi, 2020). Thus, there is a clear gap in the literature regarding an in-depth understanding of how rural communities manage health information and how socio-cultural factors influence their behaviour.

An evaluation of previous studies shows that information literacy frameworks such as The Big6TM, Seven Pillars, or Empowering Eight are more commonly used in formal education contexts and are rarely applied in rural contexts. In addition, previous studies have placed greater emphasis on digital literacy, even though indigenous communication factors still play an important role in rural areas. Research shows that low-educated rural communities tend to believe in mysticism and rely on traditional communication during the COVID-19 pandemic, thus tending to ignore health protocols (Rahayu, 2022). This reinforces the importance of research that not only assesses information literacy technically, but also pays attention to socio-cultural dimensions and local wisdom.

Based on this description, this study formulates two main questions, namely: (1) how do the information literacy levels of highly educated and less educated Tuo Limbur communities differ in terms of obtaining health information, and (2) what factors influence the process of searching for, receiving, and using health information in rural communities. This study hypothesises that highly educated communities tend to follow the Big6TM information literacy stages, while less educated communities rely more on indigenous communication. Thus, the objectives of this study are to describe the differences in information literacy among the Tuo Limbur community and to identify the educational, social, and cultural factors that influence their behaviour in accessing health information.

LITERATURE REVIEW

Health Literacy

Health literacy is an individual's ability to obtain, understand, and utilise health information so that they can make appropriate decisions regarding self-care and disease prevention. Health literacy is a key factor in determining the health status of a community (Nutbeam, 2015). Health literacy is also an integral part of efforts to prevent and control infectious diseases, especially in emergency situations such as the COVID-19 pandemic (Organization, 2020). Health literacy is not limited to the ability to read medical brochures or follow doctors' instructions, but also includes communication skills, evaluation of information sources, and the application of knowledge in daily life. In rural contexts, health literacy plays a vital role because limited access to modern health facilities makes communities more vulnerable to misinformation and unsafe medical practices.

Conceptually, health literacy can be categorised into three levels: functional, interactive, and critical. Functional literacy encompasses basic skills in reading and understanding health information, interactive literacy includes the ability to communicate with health workers and use information in a social context, while critical literacy emphasises the ability to analyse health information in depth and make strategic decisions. However, research conducted by Kay shows that the health literacy of rural communities is still very low (Temple, 2017). This has an impact on low community compliance with health protocols and concern for maintaining health. Low health literacy makes rural communities more vulnerable to hoaxes, disinformation, and the influence of non-scientific opinions. In this study, health literacy is linked to information literacy, where the ability to assess the quality of health information is greatly influenced by an individual's level of information literacy. In other words, good information literacy is a prerequisite for achieving adequate health literacy.

Indigenous Communication

Indigenous communication is a traditional communication system that has developed based on the values, norms, and local culture of a community. This form of communication usually takes place through traditional gatherings, conversations between residents, communal prayers, or other social activities that have become part of everyday life. Indigenous communication in rural areas is still the main medium for shaping public perception of public issues, including health (Jamaludin, 2015). In the context of a pandemic, indigenous communication serves as a fast channel for disseminating information among residents, although the quality and accuracy of the information conveyed often cannot be verified. The Tuo Limbur community, for example, still conducts communal prayer rituals or pilgrimages as a response to disease outbreaks, a practice that reflects a blend of cultural beliefs and the need for health information. This shows that indigenous communication has an important position in the rural information ecology.

Although it has the power to strengthen social cohesion and preserve cultural values, indigenous communication also has a serious weakness, namely its vulnerability to becoming a channel for the spread of misinformation and disinformation. The community's trust in traditional communication often hinders the acceptance of modern health practices, such as vaccination or medical treatment (Fauzan & Nurul, 2025). In the case of the Tuo Limbur community, belief in mystical things has caused some residents to reject health protocols or the COVID-19 vaccine. However, indigenous communication can also be used positively when integrated with modern approaches.

RESEARCH METHOD

The issue of health information literacy was chosen for this study because of its high urgency in the context of community preparedness to face disease threats, both endemic and pandemic. In rural areas such as Tuo Limbur Village, the community still faces various

limitations, ranging from access to health facilities, low levels of education, to strong beliefs in traditional practices and indigenous communication. This makes health information literacy not only a technical issue, but also a complex socio-cultural one. Therefore, this study places information literacy as the main focus to understand the patterns of searching, receiving, and using health information. The type of research used is qualitative research with a case study approach, as this method allows researchers to explore the real experiences of the community in depth and comprehensively in the social, cultural, and educational context. The data used is primary and secondary, so that it can provide a comprehensive picture of the phenomenon being studied.

The data sources in this study were obtained from the community of Tuo Limbur Village, taking into account differences in educational strata, namely highly educated and low-educated communities, both those living in villages, working in villages, and those working in cities. Informants were selected using purposive sampling techniques to obtain representation from various categories relevant to the research objectives. Primary data were collected through in-depth interviews to explore personal experiences in obtaining health information, participatory observation to record the actual behaviour of the community in accessing and using information, and documentation in the form of records of community activities and village government archives. Secondary data were obtained from regional health reports, government policies, official WHO data, and relevant academic literature. This combination was used to strengthen the validity and reliability of the data. The triangulation technique was applied so that the validity of each piece of information obtained could be tested through the consistency between pieces of information.

The data analysis process was conducted in three stages. First, within-case analysis to understand the experiences of each individual or group based on their level of education. Second, cross-strata analysis, which aimed to identify differences and similarities in information literacy behaviour between highly educated and less educated communities. Third, cross-case analysis, which combines findings from various groups to find common patterns and significant differences. The Big6TM information literacy model framework was used as the main analytical tool, covering the stages of formulating problems, determining search strategies, accessing sources, evaluating information, using information, and storing information. These stages are combined with an analysis of indigenous communication dimensions to understand how traditional communication still plays a role in the health information management process. With this analysis, the study is expected to produce a deep understanding of the information literacy conditions of rural communities and the factors that influence them.

RESULTS

The results of the study show that there are significant differences between highly educated and low-educated Tuo Limbur communities in terms of obtaining, managing, and using health information. These differences are clearly evident when analysed using The Big6TM information literacy framework. Highly educated communities are generally able to go through almost all stages of The Big6TM, from formulating problems to storing information. Conversely, low-educated communities tend to skip important stages and rely more on indigenous communication as their main source of information. This condition indicates that education and access to technology are determining variables in the quality of health information literacy.

From interview and observation data, highly educated people are more proactive in seeking information from official sources, whether through mass media, social media, or government channels such as the Ministry of Health website. They also cross-check before using this information in their daily lives. Conversely, less educated individuals tend to be passive, accepting information at face value from everyday conversations, traditional activities,

or chats at local cafes, without double-checking it. This makes them more vulnerable to hoaxes, misinformation, and unsafe medical practices, such as relying on herbal remedies without medical basis. Table 1 below summarises the differences between highly educated and less educated communities based on the Big6TM stages of information literacy:

Table 1. Differences in Information Literacy among the Tuo Limbur Community Based on Education (The Big6TM Model)

Literacy Stages (The Big6 TM)		Higher Education	Low education
Formulating the problem	the	Conducted clearly, able to identify needs	Not practised, tend to accept information at face value
Determining search strategy	the	Using various official & digital sources	Not practised, rely solely on verbal communication
Accessing sources		Official media, government, digital	Conversation, indigenous communication, traditional rituals
Evaluating information		Conducted with cross-checking	Not practised, information is accepted at face value
Using information		Following modern health practices & protocols	More inclined towards traditional/herbal practices
Storing information		Mobile phones, social media, personal records	Not practised, rely on memory/word of mouth

Based on the Big Six (Big6TM) model of information literacy, there are striking differences between groups of people with high and low levels of education in their approach to information, particularly in the context of health. In the first stage, namely problem formulation, educated groups tend to be able to identify their information needs clearly and critically. Conversely, groups with low levels of education often do not practise this stage; they are more passive and tend to accept information at face value without questioning its accuracy or their basic needs.

This difference continues in the determination of search strategies. Educated people utilise various official and digital sources, such as academic journals, government websites, and reliable databases to collect data. On the other hand, less educated groups do not usually employ systematic search strategies. They rely more on verbal communication, such as direct conversations with neighbours or family, as their main source of information. In terms of accessing sources, the gap is even more apparent. Highly educated communities prioritise official media, government institutions and digital platforms. Meanwhile, less educated communities tend to rely more on informal conversations, indigenous communication (local traditions passed down from generation to generation) and even traditional rituals as a means of obtaining information, including about treatment or disease prevention.

The information evaluation stage also shows a significant contrast. Educated groups are accustomed to cross-checking the information they receive, verifying it from several sources before believing it. In contrast, among less educated groups, such evaluation practices are generally not carried out. Once received, information is immediately considered true without further verification. When it comes to the use of information, differences in behaviour emerge. Individuals with high literacy tend to follow modern health practices and protocols recommended by health authorities. Meanwhile, groups with low literacy lean more towards traditional practices or herbal medicine, which are often passed down from generation to generation, even though they may not be medically proven.

Finally, in terms of information storage, highly educated communities utilise technologies such as smartphones, social media, and personal notes to document important

information. Conversely, in communities with low levels of education, written or digital storage practices are rarely used. They rely more on memory and word of mouth from generation to generation, which poses a risk to the accuracy and preservation of such information.

DISCUSSION

Based on The Big6TM information literacy framework, this study reveals crucial findings that educational attainment is a determining variable that creates a significant gap in how the Tuo Limbur community obtains, manages, and uses health information (Andiwijaya et al., 2022; Kurniasih & Pradana, 2019). Highly educated communities demonstrate the ability to systematically execute all stages of Big6TM (Sudirtha, 2017), starting from critically formulating health problems (Nugroho, 2015), determining search strategies through official and digital sources, conducting evaluations through cross-checking, to storing information digitally, which ultimately encourages the implementation of modern evidence-based health protocols. Conversely, low-educated communities tend to skip fundamental stages in Big6TM by passively accepting information without verification, relying on indigenous communication and oral traditions as primary sources, and preferring medically untested herbal remedies, making them more vulnerable to misinformation and risky health practices.

The logical relationship between the research results and research questions in this study is confirmatory, where the findings directly and consistently prove the initial argument that education level is a determining factor in health information literacy (Jariyah et al., 2024). The research results not only confirm the existence of differences, but further explain the mechanism of these differences through The Big6TM framework, showing that highly educated people are able to carry out all stages of literacy, from formulating problems to storing information procedurally and critically (Rezeki et al., 2024). Conversely, the findings prove that low-educated communities tend to neglect critical stages such as evaluation and storage, and rely on indigenous communication, which makes them vulnerable to misinformation and unsafe health practices. Thus, these results not only answer the research question of how these differences occur, but also reinforce the argument that education and access to technology are key variables that shape the quality of health information literacy in the Tuo Limbur community.

The logical relationship between the results of this study and the spatial and temporal context is dialectical, in that the results of the study can not only be explained by the spatial and temporal context of the Tuo Limbur community, but also explain the social situation they are currently experiencing. The findings on the information literacy gap between highly educated and low-educated groups (Kusnanto et al., 2024) directly reflect the socio-cultural reality of the Tuo Limbur community in a specific space and time, where technology-based modernity confronts traditions that still rely on indigenous communication (Nikou et al., 2022). The geographical context, level of access to formal education, and penetration of digital technology (Diana & Sari, 2024) in the Tuo Limbur community's living space are the main explanations for why these differences emerge. While on the other hand, the results of this study reveal how the context of space and time manifests itself in the form of vulnerability to health misinformation and the continued practice of traditional medicine (Sa'ad, 2020). Thus, the context of space and time is not only a passive background to the research findings, but an active variable that shapes and is explained by the observed patterns of information literacy behaviour.

Based on the findings of research in the Tuo Limbur community, there is significant consistency with previous studies confirming that education level is a determining factor in information literacy (Irfan et al., 2025), where highly educated groups do demonstrate more systematic and critical information search, evaluation, and utilisation skills, while less educated groups rely more on informal sources and traditional knowledge. However, this study also

reveals an important inconsistency with several studies in urban communities, which found that access to technology can moderate the impact of formal education. This inconsistency is strongly suspected to be caused by differences in the physical and social context of the Tuo Limbur community, which is rural and traditional, making access to technology not necessarily changing mindsets and beliefs about indigenous communication, unlike in urban contexts where technology plays a greater role as an agent of change. To enrich the field of study, this research adds the dimensions of indigenous communication and traditional rituals as channels of access to information that are equivalent to digital sources, and integrates them into the Big6TM model that is usually applied in modern academic contexts. The unique contribution (strength) that distinguishes this research is its ability to reveal how the modern information literacy framework (Big6TM) interacts with local knowledge systems in context.

Based on the findings of this study, the necessary response is to design and implement a Culture-Based Health Information Literacy Intervention Programme that specifically targets low-educated communities (Kualitas et al., 2025), particularly in the Tuo Limbur community, using a multi-dimensional technical approach. This programme should begin with contextualised practical training, namely simplifying the Big6TM model into three easy-to-remember steps ("Search-Check -Use") integrated with indigenous communication channels they already trust, such as training traditional leaders and local health cadres to become 'information verification agents' capable of accessing and explaining information from official sources such as the Ministry of Health website or WhatsApp infographics during rituals or traditional meetings. In parallel, it is necessary to build inclusive digital access infrastructure (Haniko et al., 2023), by establishing digital health posts containing tablet computers and illustrated posters that guide the steps for verifying information, as well as creating a special communication channel in the form of a WhatsApp group managed by the community health centre with audio content (voice messages) in the local language to reach those who are illiterate. For information storage, a simple documentation system was introduced using illustrated notebooks and message storage features on basic mobile phones, supported by the creation of physical information boards at health posts that record important health protocols. All of these interventions must be evaluated periodically through behavioural surveys and monitoring of participation in the programme, with measurable targets such as a significant reduction in the use of non-scientific medical practices and an increase in the community's ability to cite official sources when conveying health information to their neighbours.

CONCLUSION

Based on research conducted in the Tuo Limbur community, a critical finding that also provides food for thought in efforts to solve public health issues is that the absolute dependence of low-educated groups on indigenous communication such as informal conversations, traditional rituals, and collective memory has formed a complete and functional, yet highly vulnerable, 'alternative information system' that effectively replaces all stages of modern information literacy in The Big6TM model. While educated groups proactively formulate problems, evaluate and store information through official and digital sources, low-educated groups skip these critical stages and rely entirely on their cultural systems, which depend on the taken-for-granted acceptance of information without verification. This condition not only widens the information gap but also creates high vulnerability to misinformation and untested traditional medicine practices, thus demanding a health intervention approach that not only conveys medical facts but also builds an 'information bridge' by utilising and empowering trusted indigenous communication channels to convey accurate and safe health messages.

The results of this study make a substantial contribution to the development of health communication and information literacy by demonstrating the application of The Big6TM framework as an effective diagnostic tool for mapping health literacy gaps between highly educated and low-educated communities in specific cultural settings. The findings not only

reinforce innovation diffusion theory by confirming the central role of indigenous communication and interpersonal channels for low-educated groups, but also give rise to a new conceptual model that links education and technology access variables with abilities through stages of information literacy that culminate in quality health behaviour. Furthermore, this research opens up a critical future research agenda, including questions about the design of effective literacy interventions for marginalised groups, the potential for hybrid models that integrate traditional practices with modern medical protocols, and the role of technology as a bridge for the storage and dissemination of health information that is adaptive to the characteristics of low-educated communities.

Based on the findings, this study has several limitations that require further study for a more comprehensive understanding. In terms of focus and concept, the study only highlights formal education as a determining variable, thereby ignoring more complex socio-cultural dimensions such as the influence of age, economic status, or the level of trust in modern institutions versus traditional leaders, which could explain why low-educated communities choose traditional sources of information not simply as a result of limited access, but perhaps because of their functional value and integration with local culture. Methodologically, reliance on interviews and observations has the potential to introduce social desirability bias and is unable to capture the internal logic and unspoken decision-making processes of low-educated communities, thus requiring a more in-depth and longitudinal ethnographic approach to understand the dynamics of literacy change more authentically. Furthermore, the Big6TM framework, which tends to be linear and academic, may not be entirely suitable for evaluating collective and contextual information literacy practices, while the generalisation of dichotomous findings also needs to be expanded by investigating a more diverse spectrum of literacy and the existence of individuals or sub-groups that deviate from the general pattern.

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