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# The Relationship Between Health Misinformation Exposure and Adherence to Disease Prevention Programs: A Cross-Sectional Study in Indonesia

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**ABSTRACT**

*The rapid growth of digital technology has expanded access to health information but has also increased exposure to health misinformation, which may affect health-related behaviors. This study aimed to examine the relationship between exposure to health misinformation and adherence to disease prevention programs among adults in Palembang City, South Sumatra, Indonesia. A quantitative cross-sectional design was employed involving 120 respondents aged 18 years and above who actively accessed health information through digital media. Participants were selected using simple random sampling. Data were collected using a validated Likert-scale questionnaire and analyzed using descriptive statistics, Pearson correlation, and linear regression. The findings showed that exposure to health misinformation was moderately high (mean = 3.62), while adherence to disease prevention programs was at a moderate level (mean = 3.45). Pearson correlation analysis revealed a significant negative relationship between misinformation exposure and adherence ($r = -0.462$; $p < 0.05$). Linear regression analysis indicated that misinformation exposure significantly predicted adherence behavior ($B = -0.385$; $p < 0.001$), explaining 21.3% of the variance. The results suggest that health misinformation is an important factor influencing adherence to disease prevention programs. Enhancing digital health literacy, strengthening evidence-based health communication, and increasing public trust in health institutions are essential strategies to improve compliance with disease prevention measures and reduce the negative impact of misinformation.*

***Keywords:*** *Health Misinformation, Health Compliance, Disease Prevention, Digital Health Literacy, Health Behavior*


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## INTRODUCTION

The development of digital technology over the past two decades has brought about significant changes in the way people access health information, making the internet and social media the primary sources—fast, easily accessible and personalised. This has driven a shift away from traditional sources of information, such as healthcare professionals, towards digital platforms that often lack rigorous scientific validation mechanisms, thereby creating both opportunities and challenges for modern health communication systems (McKinley, 2025). This ease of access has also been accompanied by a massive increase in the volume of information circulating without scientific verification, triggering a state of information overload, in which individuals struggle to critically filter data. Furthermore, in the context of global health, this situation has evolved into the phenomenon of an infodemic—the excessive spread of information, both true and false—which ultimately makes it increasingly difficult for the public to find reliable sources of information (Nugrahani, 2022).

One serious implication of this digital transformation is the increased spread of health misinformation (inaccurate information without malicious intent) and disinformation (intentionally misleading information), both of which significantly impact public health by influencing individuals' perceptions, attitudes, and behaviors toward health issues (Terry, 2024). This misinformation takes various forms, ranging from health hoaxes and medical conspiracy theories to unscientific treatment claims, and its spread is amplified by social media characteristics that allow unvalidated content to go viral, alongside digital algorithms that reinforce belief-aligning echo chambers (Nugrahani, 2022). Furthermore, this issue is exacerbated by the community's low digital health literacy, which hinders the ability to distinguish valid from invalid information, as well as by cognitive biases like confirmation bias and the availability heuristic that strengthen the acceptance of misinformation, especially when it aligns with an individual's prior beliefs (Johnson, 2025).

Berikut adalah penggabungan ketiga paragraf tersebut menjadi satu paragraf utuh yang mengalir dengan lancar tanpa mengurangi inti maknanya:

The impact of health misinformation extends beyond cognitive aspects to directly affect health behaviors by eroding public trust in healthcare institutions and medical professionals, as research shows that perceptions of high levels of misinformation on social media correlate with decreased trust in the healthcare system (Stimpson et al., 2025). This decline in trust subsequently distorts individuals' perceptions of disease risk, causing those exposed to misinformation to underestimate disease severity or doubt the effectiveness of scientifically proven medical interventions, ultimately leading to irrational health decisions such as refusing vaccinations or choosing untested alternative treatments (McKinley, 2025). Empirically, various studies demonstrate that this misinformation contributes to low adherence to disease prevention programs; for instance, the spread of vaccine misinformation has been linked to decreased vaccination rates and the resurgence of previously controlled diseases, while also negatively impacting adherence to health protocols and the use of evidence-based therapies (Dhawan et al., 2021).

Theoretically, the relationship between exposure to misinformation and adherence behavior can be explained through several approaches. The Health Belief Model (HBM) explains that health

behavior is influenced by an individual's perception of disease susceptibility and severity, as well as the benefits and barriers of preventive measures. Misinformation can distort these perceptions, thereby reducing motivation to adhere to health programs.

Furthermore, the Theory of Planned Behavior (TPB) emphasizes that behavior is influenced by attitudes, subjective norms, and perceived control. Exposure to misinformation can shape negative attitudes toward health interventions and create social norms that discourage preventative behavior. Meanwhile, Information Processing Theory explains how individuals process and evaluate information, which in a digital context is often influenced by speed and emotion rather than rationality (Keikha et al., 2025).

Although research on health misinformation has expanded considerably, most previous studies have primarily focused on knowledge, attitudes, risk perceptions, and vaccine-related outcomes. Empirical evidence examining the direct relationship between health misinformation exposure and adherence to broader disease prevention programs remains limited, particularly in developing countries such as Indonesia. Furthermore, recent studies have highlighted the growing role of digital health literacy and public trust in health institutions in shaping responses to misinformation within increasingly complex digital information ecosystems. Therefore, this study aims to analyze the relationship between exposure to health misinformation and adherence to disease prevention programs among the community in Palembang City. The findings are expected to contribute to evidence-based health communication strategies, strengthen digital health literacy interventions, and support policies aimed at improving public compliance with disease prevention programs.

## METHODS

This study used a quantitative approach with a cross-sectional study design. The aim was to analyze the relationship between exposure to health misinformation and adherence to disease prevention programs. A quantitative approach was chosen because it allows for objective and measurable testing of relationships between variables through inferential statistical analysis. The cross-sectional design was used because data collection was conducted at a specific point in time to simultaneously describe the condition of the study variables within the population.

This research was conducted in Palembang City, South Sumatra with a data collection period of 3 months, namely in October - December 2025. The research location was chosen based on the high level of use of digital media and social media as a source of health information, so it is relevant to the research focus related to exposure to health misinformation.

The sample was selected using a simple random sampling technique, whereby each eligible member of the population had an equal opportunity to participate in the study. Eligibility criteria included individuals aged 18 years and above who actively used digital media and had accessed health information through the internet or social media during the previous six months. The minimum sample size was calculated using the Slovin formula with a 5% margin of error, resulting in a required sample of 120 respondents (Hair et al., 2021).

The variables in this study consist of independent, dependent, and additional variables. The independent variable is exposure to misinformation on health, measured by the frequency, source, and level of trust in information received from digital media. The dependent variable is the level of compliance with disease prevention programs, which includes behaviors such as vaccination, health screenings, and the implementation of clean and healthy living behaviors. Furthermore, this study also considers moderator or mediator variables, such as digital health literacy and level of trust in health institutions, which are suspected to influence the relationship between the independent and dependent variables.

Data collection was conducted using a questionnaire instrument structured on a five-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). The research instrument was developed based on indicators used in relevant previous research and has been tested for validity and reliability (Dhawan et al., 2021). Furthermore, a literature review was conducted to strengthen the theoretical foundation and ensure the indicators' alignment with the research concept.

Before being used in the main study, the questionnaire instrument was tested for validity and reliability. Validity testing was conducted using the Corrected Item-Total Correlation method, with the criterion of a correlation value greater than the table's r value, thus declaring the item valid. Reliability testing was conducted using the Cronbach's Alpha coefficient, with a threshold value of ≥0.70, indicating good internal consistency of the instrument (Hair et al., 2021).

Data analysis in this study was conducted in stages using statistical software such as SPSS or SmartPLS. Descriptive analysis was used to describe the characteristics of respondents and the distribution of data for each variable. Next, inferential analysis was conducted to test the research hypotheses, including a Pearson correlation test to determine the relationship between variables and a linear regression analysis to examine the effect of exposure to misinformation on compliance levels. If mediator or moderator variables are involved, the analysis can be further developed using a Structural Equation Modeling approach based on Partial Least Squares (SEM-PLS) to examine more complex relationships between variables (Hair et al., 2021).

This study received ethical approval from the Health Research Ethics Committee of Universitas Fort De Kock under Ethical Clearance Number: 111/KEPK/VII/2026. All respondents provided written informed consent prior to participation. Confidentiality and anonymity were ensured throughout data collection, analysis, and reporting processes.

This study also adhered to ethical aspects of research by ensuring that all respondents provided informed consent before participating. Confidentiality of respondent data was maintained by not including personal identification in data processing and reporting. All data obtained was used solely for academic and research purposes.

## RESULTS

### 1. Respondent Characteristics

**Table 1. Distribution of Respondent Characteristics (n = 120)**

| Characteristics | Frequency (n) | Percentage (%) |
|---|---|---|
| **Gender** | | |

| | | |
|---|---|---|
| Man | 52 | 43.3 |
| Woman | 68 | 56.7 |
| **Age** | | |
| 18–25 years | 48 | 40.0 |
| 26–35 years | 42 | 35.0 |
| >35 years | 30 | 25.0 |
| **Education** | | |
| Senior High School | 50 | 41.7 |
| Diploma/Bachelor's Degree | 60 | 50.0 |
| Postgraduate | 10 | 8.3 |

Respondents were predominantly female (56.7%) and largely represented young adults aged 18–25 years (40.0%). Most participants had attained diploma or bachelor's level education (50.0%), indicating a relatively educated population with substantial access to digital information sources. These characteristics suggest that the study population is highly relevant for examining exposure to health misinformation in digital environments.

**2. Descriptive Statistics of Research Variables**

**Table 2. Descriptive Statistics of Main Variables**

| Variables | Mean | Standard Deviation | Min | Max |
|---|---|---|---|---|
| Exposure to Health Misinformation | 3.62 | 0.71 | 2.1 | 4.8 |
| Disease Prevention Program Compliance | 3.45 | 0.65 | 2.0 | 4.7 |
| Digital Health Literacy | 3.58 | 0.68 | 2.2 | 4.9 |
| Trust in Health Institutions | 3.40 | 0.73 | 1.9 | 4.8 |

Descriptive analysis showed that exposure to health misinformation had the highest mean score (3.62 ± 0.71), indicating relatively frequent exposure among respondents. Adherence to disease prevention programs remained at a moderate level (3.45 ± 0.65), suggesting room for behavioral improvement. Digital health literacy and trust in health institutions also demonstrated moderate scores, highlighting the potential role of these factors in influencing responses to health information.

## 3. Distribution of Variable Categories

**Table 3. Misinformation Exposure Categories**

| Category | Frequency | Percentage (%) |
|---|---|---|
| Low | 20 | 16.7 |
| Moderate | 60 | 50.0 |
| High | 40 | 33.3 |

More than four-fifths of respondents were categorized as having moderate to high exposure to health misinformation (83.3%). This finding demonstrates that misinformation has become a prominent component of the digital information environment experienced by the study population.

**Table 4. Compliance Categories**

| Category | Frequency | Percentage (%) |
|---|---|---|
| Low | 25 | 20.8 |
| Moderate | 70 | 58.3 |
| High | 25 | 20.8 |

Most respondents demonstrated moderate adherence to disease prevention programs (58.3%), while only one-fifth achieved high adherence levels. This pattern indicates that preventive health behaviors have not yet been optimally adopted across the population.

**4. Pearson Correlation Analysis**

**Table 5. Correlation Test**

| Variables | r | p-value |
|---|---|---|
| Exposure to Misinformation vs. Compliance | -0.462 | 0.000 |

Pearson correlation analysis identified a statistically significant negative association between exposure to health misinformation and adherence to disease prevention programs ($r = -0.462$; $p < 0.000$). The moderate correlation coefficient suggests that increased exposure to misinformation is consistently associated with reduced compliance with preventive health recommendations.

**5. Linear Regression Analysis**

**Table 6. Linear Regression Test Results**

| Independent Variables | B | t | Sig. |
|---|---|---|---|
| Exposure to Misinformation | -0.385 | -5,120 | 0.000 |

**| *R Square* | = *0.213* |**

Linear regression analysis confirmed that exposure to health misinformation significantly predicted adherence behavior ($B = -0.385$; $p < 0.000$). The coefficient of determination ($R^2 = 0.213$) indicates that misinformation exposure accounted for 21.3% of the variation in adherence levels, demonstrating a meaningful contribution while also suggesting the influence of additional behavioral and contextual factors.

## DISCUSSION

**1. Exposure to Misinformation, Digital Health Literacy, and Trust in Healthcare Institutions**

The research findings indicate that exposure to health misinformation remains a prevalent phenomenon among digital media users. This suggests that the public still faces challenges in filtering health information circulating across various digital platforms. According to the Health Belief Model (HBM), the information individuals receive can influence their perceptions of disease risk, the benefits of preventive measures, and the perceived barriers to adopting healthy behaviours.

These findings align with the research by Gaysynsky et al. (2024), which highlights the high levels of exposure to misleading health information among social media users. Furthermore, Southwell et al. (2022) emphasise that low digital information evaluation skills increase individuals'

vulnerability to health misinformation. In the context of this study, the fact that levels of digital health literacy and trust in health institutions remain in the moderate category indicates that the public does not yet fully possess the optimal capacity to identify and verify the health information they receive.

The findings suggest that improving digital health literacy and strengthening trust in health institutions are key components in mitigating the negative impact of misinformation on public health behaviour.

**2. High Exposure to Health Misinformation Among Digital Media Users**

The majority of respondents fell into the moderate to high misinformation exposure category, indicating that unverified health information remains easily accessible to the public. This phenomenon can be explained by the concepts of the 'echo chamber' and 'algorithmic amplification', which enable users to continually receive information that aligns with their existing preferences and beliefs.

These findings are consistent with the research by Kbaier et al. (2022), which shows that social media is one of the main channels for the spread of health misinformation. Research by Nowak et al. (2021) also found that exposure to inaccurate information is associated with increased information confusion and low compliance with health recommendations.

The findings suggest that high exposure to misinformation is influenced not only by the characteristics of digital platforms but also by individuals' ability to evaluate the credibility of information sources. Therefore, digital literacy-based interventions are a crucial strategy for addressing health communication challenges in the digital age.

**3. Level of Compliance with Disease Prevention Programmes**

The majority of respondents demonstrated a level of compliance falling within the moderate category. These findings suggest that disease prevention behaviours have not yet been fully and consistently adopted by the public. According to the Theory of Planned Behaviour (TPB), compliance with health behaviours is influenced by an individual's attitudes, subjective norms, and perceived behavioural control.

These research findings are consistent with those of Hartmann and Muller (2022), who found that trust in inaccurate information can reduce compliance with various health prevention measures. Research by Li et al. (2022) also shows that perceptions of benefits and barriers formed through the information received play a significant role in determining an individual's decision to follow health recommendations.

The findings indicate that adherence to disease prevention programmes is influenced not only by health knowledge but also by the quality of information received by the public. Therefore, the provision of accurate and easily understandable health information needs to form part of strategies to improve public adherence.

**4. The relationship Between Exposure to Misinformation and Adherence to Disease Prevention Programmes**

Correlation analysis revealed a significant negative relationship between exposure to health misinformation and levels of adherence to disease prevention programmes. These findings suggest that increased exposure to inaccurate information tends to be followed by a decline in adherence to various health recommendations.

Theoretically, these results can be explained by the Health Belief Model, which states that the information received by individuals influences their perceptions of the benefits and risks of a health-related action. Misinformation has the potential to create doubt regarding the effectiveness of health interventions, thereby reducing motivation to follow disease prevention programmes. The Theory of Planned Behaviour also explains that incorrect information can foster negative attitudes and social norms that do not support healthy behaviour.

These findings are consistent with those of Kisa and Kisa (2024), Nowak et al. (2021), and Hartmann and Muller (2022), who reported that exposure to misinformation is associated with low adherence to various health prevention measures. The findings indicate that health misinformation is a factor contributing to changes in public health behaviour and warrants attention in the planning of health promotion programmes.

**5. The Effect of Exposure to Misinformation on Compliance with Disease Prevention Programmes**

Regression analysis indicates that exposure to health misinformation has a significant influence on levels of public compliance. These findings confirm that misinformation is not only linked to changes in knowledge and perceptions, but also contributes to actual health behaviours.

The results of this study support the Health Belief Model, which explains that information plays a role in shaping individuals' perceptions of disease threats and the benefits of preventive measures. When the information received is inaccurate, the health decision-making process can be disrupted, thereby reducing the tendency to adhere to health recommendations. Furthermore, Information Processing Theory explains that individuals often use rapid and heuristic information processing in information-dense digital environments, making them more susceptible to accepting misleading information.

These findings are consistent with Ishizumi et al. (2024), who state that the impact of misinformation on health behaviour is multidimensional and involves various individual and environmental factors. The findings suggest that efforts to combat misinformation need to be integrated with improvements in digital health literacy, strengthening trust in health institutions, and the development of evidence-based health communication strategies to enhance the effectiveness of disease prevention programmes in a sustainable manner.

## CONCLUSIONS

This study demonstrates that exposure to health misinformation is significantly associated with lower adherence to disease prevention programs among adults in Palembang City.

Respondents experienced relatively high levels of misinformation exposure, while adherence to preventive health behaviors remained moderate. Statistical analyses confirmed that misinformation exposure negatively influenced adherence and contributed substantially to variations in compliance behavior.

These findings highlight the importance of strengthening digital health literacy, improving access to credible health information, and enhancing public trust in health institutions as part of disease prevention strategies. From a policy perspective, government agencies, public health institutions, and digital platform providers should collaborate to develop evidence-based health communication programs and misinformation mitigation initiatives.

Future research should incorporate additional determinants such as digital health literacy, institutional trust, social support, and access to healthcare services using multivariate or structural equation modeling approaches. Longitudinal studies are also recommended to better understand the causal mechanisms linking health misinformation exposure and adherence behavior over time.

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