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Family Health Literacy Strengthening through Kader Surabaya Hebat Mentoring Strategies

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Abstract

Background – Family health literacy refers to the ability of family members to access, understand, evaluate, and use health information in making appropriate decisions related to health, prevention, treatment, and the utilization of health services. In practice, families are increasingly exposed to diverse health information from health workers, social media, interpersonal networks, and digital platforms, creating challenges in determining which information is accurate, relevant, and applicable to their specific conditions.
Research Urgency – The complexity of health information indicates that improving family health literacy cannot rely solely on one-way information dissemination. Families require contextual assistance that helps them interpret information, assess its suitability, connect it with their actual circumstances, and translate it into feasible health-related actions.
Research Objectives – This study analyzes the mentoring strategies used by Kader Surabaya Hebat to strengthen family health literacy and identifies the supporting and inhibiting factors influencing their implementation in Simomulyo, Surabaya.
Research Method – This study employed a qualitative case study involving Kader Surabaya Hebat members, assisted families, a cadre coordinator, and community health center staff. Data were collected through in-depth interviews, non-participant observation, and documentation. Data analysis used an interactive model consisting of data condensation, data display, and conclusion drawing and verification. Data validity was ensured through source and technique triangulation.
Research Findings – The findings show that mentoring was implemented adaptively through needs identification, personal communication, simplification and clarification of information, monitoring, follow-up, and facilitation of access to services. These strategies helped families understand health information, assess its relevance to their conditions, and determine realistic actions. Implementation was supported by family openness, cadre experience and social rapport, inter-cadre coordination, and institutional support. However, administrative burdens, time constraints, differences in family capacities and responses, and inconsistent follow-up limited the continuity and depth of mentoring.
Research Conclusion – Strengthening family health literacy requires contextual, dialogic, and sustainable mentoring rather than one-way health information delivery.
Research Novelty/Contribution – This study conceptualizes Kader Surabaya Hebat mentoring as both health-literacy mediation and non-formal family learning, showing how community cadres connect health information, family circumstances, and health-service access through adaptive and continuous educational interactions.

Keywords: *family; health literacy; Kader Surabaya Hebat; mentoring strategy; public health*

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INTRODUCTION

Health literacy is an important determinant of individuals' and communities' ability to maintain health, prevent disease, use health services, and make informed decisions. Health literacy is not only related to the ability to read medical information, but also includes knowledge, motivation, and competence to access, understand, assess, and use health information in daily life. These abilities are influenced by experience, social interaction, resource availability, and characteristics of the health service system (Nutbeam & Lloyd, 2021; Stormacq et al., 2023). Thus, the limitations of health literacy cannot be seen solely as an individual weakness but also as related to the complexity of information and health services faced by the community.

Conceptually, health literacy includes functional, interactive, and critical levels. Functional health literacy concerns the basic ability to acquire and understand health information. Interactive literacy includes cognitive and social skills to communicate and act on information, while critical literacy deals with the ability to reflect on information and use it to improve control over health (Abel & Benkert, 2022; Nutbeam & Lloyd, 2021). Marcozzi et al. (2024) and Stormacq et al. (2023) formulate four main competencies of health literacy, namely accessing, understanding, assessing, and using health information. The framework shows that strengthening health literacy is not enough to be done through one-way information delivery, but requires a dialogical, contextual, and empowering process.

The family is the primary environment in which health information is obtained, discussed, interpreted, and applied. Food selection, medication use, hygiene and sanitation practices, care for family members, disease prevention, and the decision to seek medical help are influenced by family knowledge and considerations. Family health literacy therefore refers not only to the ability of one family member, but also to a shared process of seeking information, assessing the credibility of sources, discussing options, accessing services, and determining health measures. Limited health literacy is associated with low understanding of health information, difficulty following treatment instructions, inappropriate use of services, and unfavorable health outcomes (Goto et al., 2025; Nepps et al., 2023).

These challenges are increasingly complex as digital health information sources increase. The ease of obtaining information through social media, search engines, and conversational apps does not always come with the ability to assess its accuracy and relevance. Algifari et al. (2024), Rachmani et al. (2022), and Nugroho et al. (2024) show that digital access and literacy in community contexts still require competencies for evaluating and using information appropriately. This condition shows that the availability of information has not automatically resulted in proper understanding and action. Families still need assistance to help simplify, verify, and connect information to the health conditions they are facing.

Community-based assistance has the potential to bridge the gap between health information, service systems, and family life. Community-based interventions tend to be more meaningful when carried out interactively, use appropriate language, involve community mobilizers, and are tailored to the needs of the target group (Burns et al., 2021; Ekayani et al., 2025; Ahmed et al., 2022). In this context, cadres can function as health literacy mediators who help families find information, understand options, overcome barriers to service, and determine appropriate actions (Gonzalez et al., 2022; Spencer et al., 2021; Spencer et al., 2024). The mentoring strategy in this study is understood as a series of cadre actions to identify needs, adjust communication, simplify information, provide motivation, check understanding, monitor the application of information, and connect families with the necessary services.

Cadre mentoring also has a non-formal education dimension because it takes place outside the school system, is oriented to life problems, and utilizes family experiences as a source of learning. Through dialogue, example-making, practice, reinforcement, and follow-up, families not only become recipients of health messages, but are involved in the process of understanding problems and determining actions. Adult learning is part of lifelong learning that takes place through formal, non-formal, and informal pathways (Belete et al.,

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2022; Hamzah et al., 2024; Hayat et al., 2024; Rahim & Widodo, 2021; Setiyowati et al., 2025; Thwe & Kálmán, 2024). This perspective emphasizes that health assistance should be directed at strengthening family capabilities and independence, not just compliance with instructions.

The success of mentoring is not only determined by cadres' knowledge. Family trust is influenced by communication skills, quality of social relationships, suitability of messages with family conditions, and support of the health care system (Damayanti et al., 2023; Ismail et al., 2023). On the other hand, cadres can face many programs, a broad range of assisted areas, limited facilities, administrative burdens, and weak coaching and supervision. Family characteristics, motivation, self-efficacy, and communication skills of cadres also affect the mentoring process (Indrayani et al., 2024; Khonitatillah, 2024; Susanto et al., 2024). This means that the mentoring strategy is shaped through interactions among cadre competence, family acceptance, and institutional support.

In the city of Surabaya, various functions of community cadres are integrated through the *Kader Surabaya Hebat*. Based on Surabaya Mayor Regulation Number 15 of 2025 and Surabaya Mayor Regulation Number 78 of 2025, *Kader Surabaya Hebat* supports community services in the fields of health, welfare, family empowerment, environment, communication, information, and citizen data collection. The scope of the task provides opportunities for cadres to accompany their families comprehensively. In addition, it also requires the ability to balance administrative activities with a personalized and sustainable education and mentoring process.

In the context of Simomulyo, preliminary study results from observation and interviews show that cadres have carried out home visits, health education, family data collection, monitoring of at-risk families, or service facilitation. However, variations were found in the family's ability to understand health information, assess the correctness of information, follow medication use instructions, determine services that need to be accessed, or implement health recommendations. Cadres also face family rejection and differences in communication skills. The initial findings show that the research problem lies not only in the availability or absence of health information, but in how cadres help families process information into decisions and actions.

Previous research on *Kader Surabaya Hebat* can be grouped into three tendencies. First, research examines program implementation and cadre governance, highlighting policy standards, resources, coordination, and cadre performance (Rahadi et al., 2025). Second, health-oriented research explains cadres' contributions to clean and healthy living behaviors, family health, and community health programs (Fauzi & Suprobowati, 2023; Maharrani et al., 2024). Third, community health worker research emphasizes empowerment through training, continuing education, communication, and participation in service delivery (Schleiff et al., 2021). These studies show that cadres carry out their functions as educators, facilitators, motivators, companions, and service liaisons. However, previous research has identified more of the roles, activities, and contributions of cadres than it has described the strategies used in mentoring interactions.

This gap shows that the role of cadres as educators or facilitators has not sufficiently explained how families are helped to access, understand, assess, and use health information. Therefore, this study places the assistance of *Kader Surabaya Hebat* as a process of mediating health literacy as well as non-formal learning in the family. The analysis is directed at how cadres recognize needs, build trust, adjust language, simplify information, check understanding, help families consider options, monitor the implementation of recommendations, and facilitate access to services. Family characteristics, cadre workload, institutional support, and relationship with services were also analyzed as conditions that influenced the process. Based on this framework, this study aims to analyze the assistance strategy of the *Kader Surabaya Hebat* in strengthening family health literacy in Simomulyo, Surabaya, as well as identifying supporting and inhibiting factors for its implementation.

METHODS

This study uses a qualitative approach with a case study to analyze the mentoring strategies of *Kader Surabaya Hebat* in supporting family health-literacy processes. A qualitative approach is used to understand informants' experiences, actions, interactions, and meanings in their natural context (Mtisi, 2022). Meanwhile, the case study design was chosen because the research focuses on the mentoring process that takes place in a system that is limited by specific locations, actors, activities, and contexts (Green et al., 2022). The research case was limited to mentoring interactions between the *Kader Surabaya Hebat* and the assisted family in Simomulyo sub-district, Surabaya.

This study examines how cadres identify family health needs, build communication and trust, simplify information, provide motivation, monitor the application of information, and connect families with health and social services. The research also identified factors that support and hinder the implementation of mentoring strategies. Researchers served as the main instrument for data collection, processing, and interpretation, supported by in-depth interview guidelines, observation sheets, recording tools, documentation, and field notes. The research was carried out in Simomulyo, Sukomanunggal, Surabaya. The location was chosen purposively because there was an implementation of family assistance by the *Kader Surabaya Hebat* which was relevant to the focus of the research. Selecting one sub-district is intended to provide clear case boundaries so that the mentoring process can be understood in depth based on the local social and institutional context. The research findings are not intended to represent the entire implementation of the *Kader Surabaya Hebat* program in the city of Surabaya, but rather to provide a contextual and analytical understanding of the cases studied.

The research data consists of primary data and secondary data. Primary data was obtained through in-depth interviews with *Kader Surabaya Hebat*, assisted families, cadre coordinators, and health promotion workers of the Simomulyo Health Center, as well as through observation of mentoring activities. Secondary data were obtained from regional profiles, records of cadre activities, family assistance data, health education materials, data collection formats, photos of activities, program reports, and policies related to *Kader Surabaya Hebat*.

Informants were selected using *purposive sampling* techniques based on knowledge, experience, and direct involvement in the mentoring process. The criteria for Surabaya Hebat Cadres include: (1) active status in Simomulyo sub-district; (2) have experience accompanying families; (3) have conducted health education, monitoring family conditions, or facilitated access to services; and (4) willing to provide information openly. The criteria for assisted families include: (1) domiciled in Simomulyo sub-district; (2) have or are receiving assistance from cadres; (3) have participated in the mentoring process more than once so that they have adequate experience; and (4) willing to be an informant. Cadre coordinators and health promotion personnel were chosen because they know the division of duties, coaching, coordination, and institutional support for cadre activities.

The study involved 12 informants consisting of five *Kader Surabaya Hebat* (KSH), five assisted family members, one KSH coordinator, and one health promotion staff member from the Simomulyo Health Center. The KSH informants were approximately 39–65 years old, had completed senior high school education, and had at least three years of experience as community cadres, with some having six years or more of experience. The assisted family members were approximately 40–45 years old and had educational backgrounds ranging from elementary to senior high school. The two institutional informants the KSH coordinator and the health promotion staff member were approximately 30–45 years old, with educational backgrounds ranging from senior high school to a bachelor's degree. They were selected based on their institutional roles and knowledge of cadre coordination, mentoring, and linkages with health services. This composition provided perspectives from cadres, assisted families, program coordination, and health-service personnel.

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Table 1. List of Informants

Informant Category	N	Code	Age Range	Educational Background	Experience/Role
Kader Surabaya Hebat	5	KSH	Approximately 39-65 years	Senior high school	At least 3 years of cadre experience; some had 6 years or more. Involved in family mentoring, health education, monitoring, and service facilitation
Assisted family members	5	KD	Approximately 40-45 years	Elementary to senior high school	Had participated in cadre mentoring more than once and had experience receiving health-related information and follow-up assistance
KSH coordinator	1	KK	30–45 years	Senior high school to bachelor's degree	Involved in task distribution, cadre coordination, mentoring, and follow-up of family cases
Health promotion staff member, Simomulyo Health Center	1	PKM	30–45 years	Senior high school to bachelor's degree	Provided information regarding cadre coordination, health education, and linkages with health services
Total	**12**				

These characteristics provided contextual information for interpreting the mentoring process. Cadres' familiarity with the community and their years of experience provided contextual knowledge of family circumstances and different ways of approaching residents. Differences in the educational backgrounds and experiences of informants also provided diverse perspectives on how health information was communicated, interpreted, and followed up within families. These characteristics were treated as contextual information rather than as variables for comparing the effectiveness of individual cadres or families.

Data were collected through in-depth interviews, non-participatory observations, and documentation. In-depth interviews were conducted in a semi-structured manner so that the researcher had a set of questions aligned with the research focus while allowing informants to explain their experiences, views, and meanings openly. Interviews with cadres explored the process of identifying family needs, building communication and trust, delivering and simplifying information, providing motivation, monitoring, follow-up, service facilitation, and obstacles faced. Interviews with families explore the experience of receiving assistance, ease of understanding and assessing information, trust in cadres, involvement in decision-making, and the application of health information. Interviews with cadre coordinators and health promotion personnel were used to obtain information on coaching, coordination, division of duties, institutional support, and the relationship between cadres and health services.

Non-participatory observation was carried out by observing mentoring activities without being directly involved in the delivery of information or family decision-making. The aspects observed included the way cadres opened communication, explored needs, used language, explained information, responded to questions, involved family members, provided motivation, and arranged follow-ups. The observation results were recorded in observation sheets and field notes. Documentation is carried out by examining activity records, educational materials, mentoring data, activity photos, program reports, and other relevant documents. With the informant's consent, the interview is recorded and transcribed verbatim to maintain data accuracy.

The validity of the data was checked through source triangulation and triangulation techniques. Source triangulation was carried out by comparing information from *Kader Surabaya Hebat*, assisted families, cadre coordinators, and health promotion workers. Triangulation was carried out by comparing the results of in-depth interviews, observations, and documentation. Information that differs between sources or between techniques is not immediately eliminated but is retraced to understand the context and reasons for the differences (Adler, 2022).

The data were analyzed using an interactive model that included data condensation, data presentation, and conclusion drawing and verification (Indarthi et al., 2025). The analysis was carried out interactively from the time the data collection began until a stable conclusion was obtained. At the data condensation stage, interview transcripts, observation notes, and documents are read repeatedly and coded based on actions, experiences, responses, and obstacles relevant to the research focus. The analysis uses a combination of deductive and inductive coding. Deductive coding refers to the four competencies of health literacy, namely accessing, understanding, assessing, and using health information, as well as assistance strategies such as identifying needs, communication, simplifying information, motivation, monitoring, follow-up, and service facilitation. Inductive coding is used to identify new categories and themes that emerge from field data.

At the data presentation stage, the coding results are compiled into narrative descriptions, inter-informant comparison matrices, and inter-category relationship tables. Data from cadres were compared with family experiences, observation results, supporting documents, and information from related parties. Next, conclusions are drawn by identifying patterns, relationships, similarities, differences, and findings that do not match general trends. Conclusions were verified through re-examination of transcripts, field notes, documentation, and triangulation results.

The research is carried out by paying attention to ethical principles. The informant is provided with an explanation of the purpose and procedure of the research, the confidentiality of the data, and the right to refuse or terminate involvement. Participation is voluntary after the informant gives consent. The informant's identity is disguised using a code, while recordings, transcripts, and research documents are kept on a limited basis to protect the informant's privacy.

RESULTS AND DISCUSSION

The results of the study show that the assistance strategy of the *Kader Surabaya Hebat* in Simomulyo sub-district does not use a uniform pattern, but is adjusted to the needs, characteristics, and responses of each family. Cadres start mentoring by recognizing the family's condition through direct conversations, home visits, family integrated health service post activities, environmental monitoring, and data obtained from citizen monitoring. The initial approach does not always directly talk about health issues because some families need time to open up. Cadres generally start a conversation by asking about the state of family members, daily activities, and the development of conditions that have been conveyed before.

One of the cadres explained that initial information about the family was not enough to obtain through administrative data. Cadres need to speak directly to understand the problems that the family is facing. *"From that data, we only know that there are toddlers, the elderly, or families who need to be monitored. But when he came home, he saw what his needs were. So, we don't give advice right away. Usually, we ask first how the condition is, whether there are complaints or not, and what we have done so far." (KSH-2).* This information is in line with the experience of one assisted family, which felt more comfortable when the cadres did not directly blame the family's habits. *"Mrs. cadres usually ask first, not immediately say this is wrong or it is wrong. We told him about his condition, then he explained. So, we don't feel scolded. If something is not clear, we are also more courageous to ask." (KD-1).*

The results of the observation show that at the beginning of the cadre visit, they did not immediately ask about the family's health. Cadres first asked about the development of family members' conditions and listened to the answers without interrupting the conversation. When the family conveyed the difficulty of carrying out the previous recommendations, the cadres asked several questions to find out the cause. Cadres then adjusted the explanation to economic conditions, habits, and the support of other family members. The recognition of needs is also carried out through family integrated health service post activities. In this activity, cadres observe the condition of family members, ask about health developments, and record needs that require explanation or follow-up.

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Meanwhile, during home visits, cadres also observed the cleanliness of the environment and places that have the potential to become mosquito breeding sites. Larval examination does not stop at recording the condition; it is accompanied by an explanation of the parts that need to be cleaned and the preventive measures the family can take. The record shows that the identification of needs is not only in the form of data collection, but also an initial strategy to determine the content, methods, and intensity of assistance that is in accordance with family conditions.

Figure 1. Cadres visit and explore family needs

The findings show that the need recognition strategy is implemented through open interpersonal communication. Information about family health issues cannot always be obtained through formal questions. Openness develops when the family feels listened to and not judged. Therefore, the way cadres open conversations, listen, and respond to family experiences is part of a mentoring strategy, not just a form of social closeness (Purnomo et al., 2024). This condition is in line with the explanation that cadres' closeness to the community has not automatically made the information conveyed trustworthy. Public acceptance is also influenced by communication, the quality of social relationships, the suitability of messages with family situations, and the support of the health service system.

Family integrated health service posts and larval monitoring are part of the implementation of needs identification strategies, health communication, and follow-up. Through the family integrated health service post, cadres obtain information about the health condition of family members through monitoring child growth and development, monitoring the health conditions of mothers and pregnant women, and conversations about family health complaints or needs. Findings during the activity were used to determine the need for explanation, follow-up monitoring, or family connection with health workers. Meanwhile, larval monitoring allows cadres to link health information to real conditions in the home environment. Cadres showed places that have the potential to be mosquito breeding places, discussed preventive measures with their families, and provided education on clean and healthy living behaviors. In this way, health information is conveyed contextually and directed to actions that can be taken directly.

After the family's needs are identified, cadres convey information in simpler language and relate it to daily activities. Cadres avoid using health terms that are considered difficult to understand and provide examples of actions that can be taken using the resources available at home. In families that need further explanation, information is conveyed gradually and repeated at the next visit or communication. Adjusting language, examples, and stages of delivery shows communication strategies that are adaptive to each family's abilities.

A cadre described the method as follows: *"If you use the term from the community health center, sometimes residents do not necessarily understand it immediately. So, we explain it in colloquial terms. For example, not only do we have to maintain a diet, but we give examples of what foods need to be reduced and what can be chosen according to the family's conditions" (KSH-4).* The assisted family also stated that cadres' explanations are easier to apply when accompanied by concrete examples. *"If we only say that we have to live*

a healthy life, we sometimes get confused about where to start. Mrs. Cadre explained one by one, for example, what can be done first at home. So, it is easier because not immediately much has to be changed" (KD-3).

In the observation of mentoring activities, cadres were seen explaining information in short sentences and providing examples that were close to family routines. After explaining, the cadre asked again what steps the family would take. When the family's answer is not appropriate, the cadre repeats the explanation with different examples. Cadres also give other family members opportunities to ask questions so that decisions are not imposed on one person. This practice shows that the strategy of conveying information does not stop at giving messages but continues with an examination of family understanding. This process primarily supports the family's ability to understand health information. This is in line with research by Jamiliyati et al. (2025), Lima et al. (2025), and van Swol & Chang (2023), which explains that available information is not beneficial if the individual is not able to understand its meaning, purpose, and relationship to the conditions faced. Therefore, the use of simple language, concrete examples, repetition, and comprehension checks is an important part of the mentoring strategy.

Figure 2. Monitoring of child growth by Cadres as part of health communication and family assistance

This finding also shows the dimension of non-formal education in cadre assistance. Interaction between cadres and families takes place through dialogue, exchange of experiences, giving examples, and gradual reinforcement. Families not only receive information but are given space to relate it to their experiences and abilities. The process is in line with the view Chen et al. (2025), Sykes & Jenkins (2023), and Yanagi et al. (2024) that health literacy needs to develop from functional skills to interactive and critical skills. One-way messaging may help families recognize basic information, but it's not enough to encourage families to discuss, consider options, and determine actions independently. Thus, the dialogical element in mentoring is a strategy to increase family involvement in processing health information.

In addition to helping them understand information, cadres are also dealing with various health information that has previously been received by their families from social media, chain messages, neighbors, or the experiences of other family members. Cadres do not always immediately state that the information is false. Cadres first ask the source of information, the context of its use, and the condition of the family members who will apply it. If the problem is beyond the cadres' authority, the family is directed to get an explanation from the health worker. This action indicates an information clarification strategy carried out by examining sources, considering suitability, and determining the need for further consultation.

One of the cadres said: *"Now residents often get information from WhatsApp groups or social media. Sometimes they immediately believe it because someone sent it. We asked first where the source came from. If we are not sure, we do not dare to justify it. Usually, we recommend asking the community health center s so that it is not wrong" (KSH-1).* One of the assisted families also admitted that previously the family tended to

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follow information shared by the closest people without checking its suitability. *"In the past, if someone sent health information, I thought it could be tried immediately. After being explained by the cadres, now I ask more questions first. The problem is that what is suitable for others is not necessarily suitable for our family conditions" (KD-4).* At the time of observation, the family showed a health message received through a conversation app. The cadre read the contents of the message, then asked if the family knew the source. The cadre did not give a medical decision but explained that the recommendation was not necessarily suitable for everyone and advised families to consult with the community health center officer. The cadre then helped the family determine whom to ask.

Figure 3. Family **integrated health service post** activities as a means of recognizing needs, health monitoring, and health communication with families

These findings suggest that clarification strategies help families assess health information before using it, rather than just receiving or disseminating it. Information assessment includes examining its source, relevance, benefits, risks, and suitability to family circumstances. In the process, cadres help families navigate the complexity of information and identify reliable follow-up sources. Tunç et al. (2025) explained that health literacy mediators can help people understand choices and navigate services, but their success is influenced by trust, clarity of action boundaries, and connectedness to the health system.

Nevertheless, the information clarification strategy is still carried out within the limits of the cadres' authority. Cadres do not replace health workers in providing diagnoses or determining medical actions. If the information or problem found requires professional competence, the strategy used is to direct the family to the right source or service. Thus, the introduction of the limits of authority and the decision to refer are part of the accuracy of the mentoring strategy, not the weakness of the cadres.

The next mentoring strategy is carried out through monitoring and follow-up after information is provided. Cadres contacted the family again to find out whether the agreed action had been taken, whether there was any progress, and whether the family experienced obstacles. Follow-up is carried out through repeat visits, meetings in community activities, phone calls, or text messages. For families who need further services, cadres provide information about the place, schedule, and service procedures. The selection of follow-up forms is adjusted to the level of family needs and the communication possibilities that can be carried out. A cadre

explained: *"If you only explain once, sometimes after that you forget or have not had time to do it. So, we asked again. If we meet in the neighborhood or via WhatsApp, we ask about the development. If it really must be checked, we remind the schedule or we connect with the officers" (KSH-3).*

The assisted family feels that follow-up communication makes them more motivated to carry out the actions that have been discussed. *"After being given an explanation, a few days later he was asked again whether it had been done or not. Not forced, but reminding. If not, ask what the obstacles are. It makes us feel cared for" (KD-2).* The results of observations during the follow-up visit showed that the cadres opened the conversation by asking about the actions that had been agreed upon at the previous meeting. The family said that some of the recommendations had been carried out but still had difficulties in certain parts. The cadres did not repeat all the explanations from the beginning but focused on the obstacles and agreed on more feasible steps. At the end of the visit, the cadre said that the family's development would be asked again.

Figure 4. Monitoring the condition of the home environment as part of the follow-up of family assistance

Monitoring and follow-up showed that the mentoring strategy did not end when the family received or understood the information but continued until the family was able to use it in action. Families can understand information, but they are not necessarily able to apply it immediately because habits, family member support, economic conditions, time, and ease of access to services influence them. The dimensions of accessing, understanding, assessing, and using health information do not always occur linearly. When families experience obstacles in implementation, cadres can return to provide explanations, help consider options, or connect families with needed services. The mentoring strategy is thus cyclical and can return to the previous stage according to the family's development and needs.

The implementation of the mentoring strategy is supported by family openness, cadre experience, closeness with the community, coordination between cadres, and support from the sub-district and community health center. Cadres who have lived in the neighborhood for a long time tend to understand better residents' character, acceptable ways of communicating, and parties who can be involved when problems arise. Experience also helps cadres determine whether families need re-explanations, follow-up visits, or referrals to health workers. These factors expand the choice of strategies that can be used and make it easier to adapt them to family conditions. A cadre stated: *"The character of the residents is different. Some can be talked to directly; some must be slow. Having been in the neighborhood for a long time, we know how to approach him. If there is a problem that we cannot handle, we coordinate with the coordinator or the Health Center" (KSH-5).* The cadre coordinator explained that coordination is needed because not all family problems can be solved by one cadre. *"The cadre said that there are families who need further attention. We will see the needs first. When it comes to health services, we continue and communicate with the Health Center. So, cadres do not work alone" (KK-1).*

Personnel of the community health center also emphasized that cadres have an important position in conveying family conditions that are not always seen when residents come to health facilities. *"Cadres are closer to their families and know their daily circumstances. Information from cadres helps us understand the conditions on the ground. However, cadres also need to coordinate immediately if they find something that*

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requires examination or handling by health workers" (PKM-1). Observations at the coordination meeting showed that cadres conveyed the progress of several families and discussed follow-up steps. The information discussed is not only related to health conditions, but also family barriers in accessing services. The coordinator then divides the tasks and determines the problems that need to be communicated to the community health center. Thus, coordination is not only a form of institutional support, but a strategy to ensure that the needs of families that exceed the ability of cadres get the right follow-up.

In addition to these supporting factors, the implementation of the mentoring strategy faces administrative obstacles and time constraints. Cadres must divide their time between data collection, reporting, integrated health service post activities, family visits, work, and domestic responsibilities. Administration is needed to map residents' conditions and document activities. However, when the number of tasks is quite large and must be completed in almost the same time, cadres have more limited space to implement mentoring strategies in depth and continuously.

One of the cadres revealed: *"What feels difficult is that data collection and activities come at the same time. We must fill in the data, participate in activities, and then there are still families to visit. Sometimes the visit is still carried out, but the time cannot be long because there are still reports to be completed" (KSH-2).* Observation records also show that after the service activities are completed, cadres are still recording and matching residents' data. At the same time, some families ask for further explanation. The cadres continued to respond, but the conversation was brief, and a follow-up was scheduled at the next opportunity. This situation shows that the administrative problem does not lie in the existence of records, but in the influence of administrative demands on time, depth of communication, and continuity of mentoring strategies.

The findings are in line with Nida et al. (2024), which shows that health cadres in Indonesia can face several programs, the breadth of tasks, limited facilities, and the need for supervision. This burden has the potential to reduce time and energy to interact deeply with the community. Therefore, simplifying reporting and using data more integrally is needed so that recording becomes a part that supports the determination of mentoring strategies, not shifting cadres' attention from the family.

The next obstacle comes from differences in family abilities and responses. Not all families have the same readiness to receive and apply information. Some families are easy to open and take action immediately, while others require repetition, an approach through a specific family member, or a longer time. Economic barriers, busy work, old habits, and previous experiences with health services also affect family responses. This diversity requires cadres to adjust the content, intensity, time, and parties involved in mentoring. One cadre explained: *"There are families who, after being explained immediately do it, but there are also those who have to be reminded several times. Sometimes it's not because they don't want to, but the person is working, there are other needs, or their family members have not been supportive. Thus, the approach cannot be equalized" (KSH-4).* The assisted family reinforced the statement: *"We actually understand what is being conveyed, but sometimes the implementation is delayed because of the time or having to wait for other family members. So, it is not disbelief, but there are circumstances at home that need to be considered" (KD-5).*

These findings show that the ability to use information is not only determined by knowledge. Families may have understood the recommendations, but have not had the time, resources, support, or access to implement them. Therefore, the family's response is inappropriate if it is immediately assessed as a lack of awareness. Mentoring strategies need to consider structural barriers and focus on choosing the most realistic course of action for the family. Consistent follow-up in the whole family is also an obstacle. Cadres tend to prioritize families with conditions that are considered more urgent. Prioritization is a strategy to deal with time and resource constraints, but it can cause other families to receive monitoring only through brief communication or routine activities. *"We are trying to monitor everything, but of course we can't do it with the same intensity. The condition is more urgent for us first. We usually ask other families when we meet or through messages. If there are new developments, then we will schedule another visit" (KSH-1).*

The difference in follow-up intensity does not fully indicate the limitations of the cadres' capabilities, but is also related to the breadth of responsibility, the number of families to be cared for, and the limitations

of monitoring mechanisms. Prioritization is a strategy to deal with time and resource constraints, but its implementation needs to be supported by clear priority criteria. Strengthening the mentoring strategy therefore requires a proportional division of assisted families, structured monitoring mechanisms, and simple and easy-to-use follow-up recording. Based on the overall results of interviews, observations, and documentation, the synthesis of mentoring strategies and their supporting and inhibiting factors is presented in Table 2.

Table 2. Synthesis of Findings and Implications of Strengthening Mentoring Strategies

Aspect	Key Findings	Implications of Reinforcement
Mentoring strategy	Recognition of needs, adaptive communication, simplification and clarification of information, monitoring, follow-up, and service facilitation	Strengthening adaptive communication skills and follow-up mechanisms
Supporting factors	Openness and trust of the family, experience and closeness of cadres, coordination between cadres, and support from the sub-district and the health center	Strengthening coordination and institutional support for mentoring
Inhibiting factors	Administrative burden, time constraints, diversity of family abilities and responses, and inconsistent follow-up	Simplification of administration, prioritization, and proportional division of assisted families

Overall, strengthening family health literacy does not take place only through the delivery of information, but through adaptive and sustainable mentoring strategies. The strategy helps families recognize needs, understand information, assess their suitability, and determine actionable actions. This series supports families' ability to access, understand, assess, and use health information as formulated by Rosano et al. (2022) and Stormacq et al. (2023). The strength of the mentoring strategy lies in adjusting communication methods, information content, and follow-up forms to the needs, obstacles, and conditions of each family.

The implementation of the strategy is strengthened by family trust, experience and communication skills of cadres, coordination between cadres, and support from sub-district and health centers. On the other hand, administrative burdens, time constraints, diversity of family responses, and inconsistent follow-ups can reduce the depth and continuity of mentoring. These findings align with those emphasizing the importance of social connections, communication, and health system support, and show that the breadth of tasks and workload can affect the implementation of cadre activities. Program strengthening therefore needs to be directed at developing adaptive communication, balancing administrative tasks with direct interaction, and strengthening coordination and follow-up mechanisms.

CONCLUSION

Assistance for *Kader Surabaya Hebat* in Simomulyo is carried out adaptively through the introduction of family needs, open communication, simplification of information, and monitoring and follow-up. Home visits and personal communication make mentoring not only about delivering health messages but also a dialogical process that helps families access the information they need, understand recommendations, assess their suitability for the family's condition, and determine possible actions to take. The set of strategies reflects the four dimensions of health literacy and shows that contextual approaches, trusting relationships, and ongoing interactions support its strengthening at the family level.

The implementation of the mentoring strategy is supported by family openness, cadres' experience and social closeness, coordination between cadres, and support from districts and health centers. Obstacles include administrative burdens, time constraints, differences in family abilities and responses, and inconsistent follow-ups. The findings confirm that the strength of the mentoring strategy lies not only in cadres' mastery of health information, but also in their ability to adjust communication, translate information, and help families choose actions that suit their needs and situations.

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