



## Cultural Mediation and Health Advocacy: Understanding Community Health Cadres' Roles in Indigenous Rural Outreach in Central Indonesia

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### ABSTRACT

Effective health communication in indigenous rural communities is shaped by cultural values, relational dynamics, and local trust structures. Community health cadres (kader) often serve as the primary bridge between biomedical systems and traditional belief frameworks. However, their nuanced roles remain underexplored in public health literature.

This study aims to explore how community health cadres experience, interpret, and perform their roles in delivering health education within indigenous rural contexts focusing on the cultural and emotional dimensions of their work.

Using an interpretative phenomenological approach, this qualitative study engaged nine experienced health cadres from indigenous rural communities in Central Indonesia. Data were collected through in-depth semi-structured interviews and analyzed thematically to uncover participants' lived experiences and meaning-making processes.

Four major themes emerged from the analysis: (1) navigating cultural boundaries, (2) building relational trust, (3) mediating institutional expectations, and (4) managing emotional labor. Participants described the ongoing tension between their institutional responsibilities and their embedded roles in local communities. They emphasized the importance of adapting health messages to align with cultural logics, while simultaneously sustaining legitimacy within both public health systems and community norms.

The findings highlight that successful health outreach in marginalized settings requires more than the transmission of technical knowledge—it demands cultural literacy, emotional resilience, and grassroots legitimacy. By portraying cadres as cultural mediators rather than passive conduits of biomedical information, this study offers new insights into culturally responsive health communication. These insights can inform policy and practice aimed at designing empathetic and inclusive health programs tailored to indigenous populations.



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### INTRODUCTION

Health education remains a fundamental pillar of public health systems, particularly in low-resource and rural settings where community-based approaches serve as a primary vehicle for health promotion (Kirmayer & Eric Jarvis, 2019; Li dkk., 2024). Within such frameworks, community health workers and cadres are often positioned as vital intermediaries, tasked with translating biomedical knowledge into culturally appropriate messages for the populations they serve (Lafferty dkk., 2023). Their roles become increasingly complex in indigenous or culturally distinct rural communities, where traditional beliefs, local health practices, and linguistic diversity intersect with national health agendas.

The effectiveness of health communication in these contexts is shaped not only by message content, but by the relational trust, cultural fluency, and emotional labor carried by the health cadres themselves (Amadu dkk., 2021). Previous studies have acknowledged the importance of cultural

competence and trust-building in community health initiatives (Leung dkk., 2019), yet the subjective experiences of those delivering such messages remain largely underexplored. Understanding how cadres make sense of their roles, navigate cultural boundaries, and respond to institutional expectations requires attention to their lived experiences within these unique socio-cultural contexts.

There is an urgent need to explore how community health cadres experience and interpret the act of health communication in indigenous communities—not simply as an intervention, but as a social and cultural negotiation. These experiences are imbued with personal meaning and emotional labor that often remain invisible in outcome-oriented evaluations. Phenomenology offers a valuable lens to uncover these deeper layers, enabling researchers to move beyond surface-level behavior and into the realm of meaning-making and identity formation (Lindberg dkk., 2023). By centering the subjective realities of community health actors, this study contributes to a more humanistic understanding of public health practices in marginalized and culturally diverse settings.

Research into the lived experiences of individuals involved in health promotion has gained growing attention in recent years, particularly within the domain of community-based health initiatives (Lafferty dkk., 2023; Wagner dkk., 2021). These studies underscore the significance of understanding how health workers perceive their roles, responsibilities, and challenges in delivering health education, especially in complex cultural environments. Community health cadres, operating at the frontline of health communication in indigenous settings, embody unique experiential knowledge that is often underrepresented in public health literature.

Despite the increasing recognition of these experiences, methodological challenges persist in capturing their full depth and complexity (Braganza dkk., 2022; Ganann dkk., 2022). Much of the existing research in this area remains dominated by quantitative approaches that prioritize measurable outcomes over subjective interpretation. While useful for assessing program efficacy, these methods often fail to illuminate the nuanced processes through which cadres internalize, negotiate, and perform their roles in culturally embedded ways (Morenz dkk., 2024). The reliance on standardized surveys and structured instruments leaves little room for the voices of health workers to emerge organically or for context-specific insights to be revealed.

As a result, prior studies have frequently overlooked the emotional labor, cultural translation, and identity work that shape the everyday realities of community health cadres (Dichter dkk., 2021; Leung dkk., 2019). These limitations constrain our understanding of the phenomenon and reduce the potential to inform more culturally responsive and person-centered health strategies. By adopting a phenomenological lens, particularly through Interpretative Phenomenological Analysis (IPA), this study seeks to address these gaps and generate a richer, more textured account of how cadres experience and assign meaning to their work within indigenous rural communities.

In the field of community health promotion, existing efforts to improve communication between health systems and indigenous communities have largely relied on standardized educational models and pragmatic interventions (Ayres dkk., 2021; Fong dkk., 2024). These typically include the dissemination of informational materials, structured training modules for health workers, and protocol-driven outreach activities aimed at enhancing message uptake. While these strategies may yield measurable outputs such as increased program coverage or attendance, they provide limited insight into the personal and cultural dimensions that shape the actual experiences of health cadres in the field.

Such practical approaches often fall short in capturing the deeply embedded, lived realities of cadres who function at the intersection of institutional expectations and local belief systems (Ashburn dkk., 2019; Dion dkk., 2021). The complexity of their roles—as cultural mediators, trusted community figures, and conveyors of biomedical knowledge—cannot be fully appreciated through outcome-driven frameworks alone. As (Opoku dkk., 2022) have noted, even when qualitative methods are employed, there is a tendency to summarize themes without engaging the interpretative depth necessary to uncover the core meanings of participants' experiences.

This underscores the need for a methodological shift toward phenomenology, which prioritizes the subjective and interpretive dimensions of human experience (Opoku dkk., 2022;

Ostojic dkk., 2025). By employing an interpretative phenomenological approach, it becomes possible to access the internal world of cadres—their sense-making processes, emotional labor, and cultural navigation—in ways that transcend superficial descriptions. Such an approach offers a more holistic and ethically grounded understanding of how health communication unfolds within culturally rich and often underserved communities.

Previous research has examined the role of community health workers in various settings, highlighting their importance in improving access to health education and services (Brown dkk., 2022; Kondrátová dkk., 2019). Studies such as (Ostojic dkk., 2025) have explored how these workers navigate cultural contexts, yet often stop short of capturing the deeper, lived meanings of their roles. Most of the literature emphasizes outcomes and behavioral change, but less attention is given to the subjective experiences of cadres in negotiating cultural expectations. This leaves a gap in understanding the internal processes and emotional complexities behind their efforts. Addressing this gap requires a more interpretive and context-sensitive approach.

This study applies an Interpretative Phenomenological Analysis (IPA) to explore the lived experiences of community health cadres who deliver health messages in indigenous rural communities (Feldman dkk., 2021; Lindberg dkk., 2023). The IPA approach is well-suited to uncover the nuanced ways in which participants make sense of their roles and challenges. It allows the research to move beyond what cadres do, and into how they feel, think, and construct meaning in their day-to-day practices. By using this method, the study responds directly to the knowledge gap by offering an in-depth, participant-centered understanding of health communication in culturally complex environments. This approach emphasizes empathy, reflexivity, and the co-construction of meaning between participant and researcher.

This article is structured into several key sections. The introduction presents the background and rationale for the study (Morenz dkk., 2024; Verbillis-Kolp dkk., 2024). The next section outlines the cultural and institutional context of community health work in indigenous regions. Following that, the methodological framework is described, including the data collection and analytic procedures (Verbillis-Kolp dkk., 2024). The results section presents the emergent themes, supported by narrative excerpts from participants. Finally, the discussion and conclusion reflect on the findings, their implications for health communication practice, and the theoretical contributions of the study.

## **RESEARCH METHODS**

### **Study Design**

This study adopted an interpretative phenomenological approach to explore the lived experiences of community health cadres in conveying health messages within indigenous rural communities (Mueller dkk., 2024; Perry, 2023). Interpretative Phenomenological Analysis (IPA) was selected due to its emphasis on understanding how individuals make sense of their personal and social worlds, particularly in relation to culturally embedded practices (Wagner dkk., 2021). This approach was deemed suitable for uncovering the nuanced meanings and contextual realities embedded in the participants' roles as mediators of health information. IPA's foundation in hermeneutic philosophy enabled a deeper interpretation of participants' experiences beyond surface-level description, aligning with the study's objective to reveal essential meanings through participants' narratives and reflections.

### **Participants**

Participants consisted of active community health cadres who had at least two years of experience working within indigenous or culturally distinct rural communities (Hammersley, 2003; McMahon & McGannon, 2024). Individuals were included based on their direct involvement in delivering health education, their fluency in both local and national languages, and their familiarity with local customs and beliefs. Exclusion criteria comprised cadres who had recently joined (less than 6 months) or who had not been directly involved in health education outreach. A purposive sampling approach was used to ensure the selection of participants with rich, experience-based insights related to the phenomenon under investigation (Adelia & Susanto, 2020). A total of nine participants (seven females and two males), aged between 28 and 52 years, were involved. . Most had completed

secondary education and had longstanding residence within the communities they served, which reinforced their cultural embeddedness and local credibility.

### **Data Collection**

Data were collected through in-depth, semi-structured interviews using an interview guide developed to elicit reflective and open-ended responses (Bednarek-Gilland, 2015; Gibton, 2015). Interviews were conducted face-to-face in locations chosen by participants, typically their homes or local community centers, to ensure a safe and familiar environment. Each session lasted between 45 and 75 minutes and was audio-recorded with consent. Field notes were also taken to capture contextual details and non-verbal cues. All interviews were conducted in Bahasa Indonesia, with occasional use of local dialects, and later transcribed verbatim. The data collection process was designed to foster rapport and trust, allowing participants to express their perspectives freely and authentically (Bandzuh dkk., 2022). No formal modifications were made to the interview guide, though flexibility was maintained to follow emergent topics of significance.

### **Data Analysis**

Data were analyzed using Interpretative Phenomenological Analysis (IPA), involving a series of systematic steps to identify essential themes (Ekadinata dkk., 2023). Transcribed data were first read multiple times to achieve immersion, followed by initial noting and coding of significant statements. These codes were then clustered into emergent themes through a process of interpretative abstraction. Patterns and divergences across cases were identified to develop superordinate themes that encapsulated shared meanings. The analysis emphasized participants' subjective interpretations and contextual factors influencing their experiences. NVivo 12 software was used to support data organization and coding, although analytical interpretations remained grounded in manual reflexive processes consistent with IPA methodology.

### **Ethical Considerations**

Ethical approval was obtained from the relevant institutional review board prior to the commencement of the study (Borcsa & Rober, 2015). All participants provided written informed consent after being informed about the purpose, procedures, risks, and benefits of the research (Cintyamena dkk., 2021). Anonymity was ensured by assigning pseudonyms to all participants, and identifiable information was removed during transcription. Confidentiality of the data was strictly maintained, with access limited to authorized personnel. The study adhered to the ethical standards outlined in the Declaration of Helsinki and complied with national ethical guidelines for research involving human participants.

## **RESULTS**

### **Navigating Cultural Boundaries in Health Communication**

Participants frequently described the challenge of bridging biomedical health concepts with the traditional worldviews of indigenous communities. Cadres often found themselves interpreting not only language but also values, belief systems, and attitudes towards health.

“Sometimes, I feel like I am not just translating words from the Puskesmas, but I’m also translating a whole different way of thinking. They ask, ‘Why take medicine when the forest provides us with healing?’” (Participant 3)

Cadres emphasized the importance of understanding indigenous cosmologies and health beliefs, which often conflicted with clinical advice. These cultural tensions required the cadres to adopt an intermediary role, reshaping messages to align with local logic without compromising health outcomes.

#### **How to effectively bridge cultural boundaries in health communication?**



### **Building Trust Through Relational Engagement**

Trust emerged as a foundational element in the communication process. Cadres emphasized that their acceptance within the community was not automatic but earned over time through relational consistency, cultural sensitivity, and presence.

“I had to join their ceremonies, eat their food, and sit with the elders many times before they would even listen to what I was saying about hygiene.” (Participant 1)

Trust-building was not limited to individual relationships; it extended to the cadres’ ability to embody community values while promoting new practices. Their social embeddedness enhanced the receptivity of health messages and was perceived as more authentic than messages delivered by external professionals.

### **Mediating Institutional Expectations and Local Realities**

Another central theme was the tension between formal institutional demands and the practical realities on the ground. Cadres expressed a sense of being “caught in-between”—expected to implement standardized public health campaigns that often disregarded local context.

“We are told to distribute leaflets and follow the campaign guidebook, but no one here reads those. I have to explain things using stories or draw things on the ground.” (Participant 6)

Participants reported modifying or supplementing official materials with culturally appropriate analogies, oral storytelling, or visual aids. These adaptations were often unrecognized by program administrators but critical for community comprehension.

### **Emotional Labor and the Invisible Work of Cadres**

The study also revealed the emotional burden experienced by cadres as they negotiated their dual identity: as agents of the health system and as members of the community. Many spoke of feelings of frustration, fatigue, and moral conflict when their efforts were dismissed or misunderstood.

“There are days when I feel like giving up. They think I’ve become part of the outside system and no longer one of them. But I still live here, I’m still one of them.” (Participant 2)

This theme underscores the often-invisible emotional labor required to maintain credibility, negotiate cultural tensions, and advocate for behavior change within a deeply relational and culturally embedded role.

The lived experiences of community health cadres in indigenous rural settings reveal a multifaceted process of cultural negotiation, trust-building, and adaptation. . These individuals operate at the intersection of formal health systems and local sociocultural structures, engaging in a complex form of communicative labor that transcends conventional public health messaging. The visual summary in Table 1 reinforces the thematic clarity of the findings and highlights the depth of interpretative insights gathered through phenomenological inquiry. Their narratives underscore the significance of culturally informed communication strategies grounded in empathy, trust, and contextual knowledge.

## **DISCUSSION**

The study revealed that community health cadres in indigenous rural settings experience their role as a complex process of cultural negotiation, emotional labor, and adaptive communication (Choi dkk., 2020; Hassan dkk., 2022). These cadres do not merely transmit health information; they embody the role of cultural mediators, building trust, navigating institutional constraints, and reshaping health messages to fit local belief systems—responding directly to the central research question regarding how they subjectively experience this role.

The findings provide a rich, interpretive answer to the research question by illustrating that cadres construct their identity and strategies through lived interaction with both institutional frameworks and community values (Blebu dkk., 2023). Their experience is defined by an ongoing balancing act: maintaining credibility within their own communities while aligning with external health policies. This phenomenological insight highlights that health communication is not only a procedural task but a deeply situated, meaning-making activity grounded in trust, empathy, and personal investment. The study's contribution lies in its uncovering of these layers of meaning, which are often invisible in traditional assessments of health program effectiveness.

These findings align with prior research emphasizing the cultural dimensions of health communication, such as (Faza dkk., 2022), who note the significance of relational trust in rural health delivery. However, this study goes further by employing IPA to uncover the interpretive processes through which cadres internalize and negotiate their roles. It expands upon (Ginting dkk., 2021), who discuss cultural competence in broad terms, by offering detailed accounts of how such competence is enacted through context-specific storytelling, symbolic presence, and participation in community rituals. Yet unlike some studies that treat cultural adaptation as a linear process of message translation (e.g., Lee dkk., 2018), the current findings highlight the recursive and emotionally taxing labor required to continually balance competing value systems.

Moreover, the study critically departs from the instrumentalist framing found in health promotion literature that views cadres primarily as agents for behavior change. For instance, mainstream frameworks such as the Health Belief Model or Theory of Planned Behavior tend to emphasize rational decision-making and message framing, often overlooking the affective and relational dimensions emphasized by participants in this study (Ajzen, 1991; Rosenstock, 1974). In contrast, this research reveals how health communication in indigenous settings is relationally negotiated, identity-laden, and emotionally embodied—dimensions which are often minimized or entirely excluded in behaviorist or positivist paradigms.

This contrast challenges the assumption that fidelity to health protocols ensures efficacy, suggesting instead that locally trusted, emotionally attuned engagement may hold greater weight in influencing health outcomes, especially in culturally distinct environments.

### **Implications of the Findings**

The findings of this study carry significant practical and theoretical implications for the development of culturally responsive health communication strategies (Ginting dkk., 2021; Rinawan dkk., 2021). At a practical level, the insights underscore the need for health institutions to move beyond standardized messaging and engage more deeply with the lived realities of community health cadres, particularly in indigenous contexts. Cadres' ability to serve as cultural translators and relational bridges highlights the importance of embedding local knowledge, trust-building, and emotional resilience into the design and implementation of health promotion initiatives. From a socio-cultural perspective, the experiences of these cadres reveal the complex negotiations between traditional values and biomedical paradigms, suggesting that effective health communication must be co-constructed with respect to local epistemologies. These findings are particularly relevant for health systems in multicultural and underserved settings, where top-down interventions often fail to resonate without such cultural mediation.

### **Study Limitations**

Several limitations should be acknowledged in interpreting these results. First, the study was conducted within a specific cultural and geographic context, which may limit the transferability of findings to other settings (Zid dkk., 2020). The use of purposive sampling, while appropriate for phenomenological inquiry, may also restrict the diversity of experiences represented, as only cadres with established experience and community integration were included. Furthermore, although Interpretative Phenomenological Analysis enables deep insight into participants' lived experiences, it does not aim for generalizability in the conventional sense. The findings are therefore best understood as contextually rich accounts that illuminate rather than predict broader patterns. These limitations provide valuable boundaries within which the results should be interpreted and suggest caution against overextending the conclusions beyond the immediate context.

### **Future Research Directions**

Future studies could expand on these findings by exploring how community health cadres' experiences evolve over time in response to changes in policy, community dynamics, or health crises. Comparative research across different cultural or national settings could also deepen understanding of how contextual variables shape the roles and perceptions of health communicators (Has dkk., 2024). Additionally, integrating phenomenological insights with participatory action research may empower cadres to contribute directly to the design of health education programs that reflect their experiential knowledge. Such future inquiry would further bridge the gap between practice and policy, offering grounded strategies for culturally sensitive and sustainable health promotion. This line of research holds strong potential to enrich the broader discourse on equity, trust, and local agency in global health systems.

### **CONCLUSION**

This study explored the lived experiences of community health cadres in delivering health messages within indigenous rural communities, focusing on how they navigate cultural complexities and institutional expectations. The findings revealed that cadres act not only as health educators but also as cultural mediators who build trust, adapt communication strategies, and negotiate dual identities. These insights provide a deeper understanding of the subjective realities and emotional labor involved in community-based health promotion. The study addresses existing gaps by offering interpretive evidence that complements and enriches prior outcome-driven research. Importantly, these findings align with and expand the goals outlined in the World Health Organization's Framework on Integrated People-Centred Health Services (IPCHS), which emphasizes the role of local actors in delivering culturally responsive care. By illuminating how cadres mediate between national health agendas and local belief systems, this study underscores the need to position community health workers not as passive implementers, but as co-designers of health strategies—an approach echoed in the WHO's 2023 Operational Framework for Primary Health Care.

At the policy level, this study suggests that global health interventions must move beyond technical training and include capacity-building initiatives that acknowledge the emotional, cultural, and identity-related dimensions of frontline health work. Such recognition is essential for achieving Sustainable Development Goal 3 (Good Health and Well-being), particularly in marginalized and indigenous populations where trust and cultural relevance are foundational to healthcare delivery.

Thus, the study contributes not only to local public health practice, but also to global health discourse by offering empirical insights that support a paradigm shift toward equity-driven, culturally embedded health systems. It highlights the need for culturally grounded health programs that recognize and support the experiential knowledge of local health actors. Future research may expand this work by comparing experiences across cultural settings, mapping them onto international health systems, or integrating participatory approaches that elevate cadres' voices in shaping public health policy. Bridging phenomenological insights with global policy frameworks holds potential to foster more inclusive, responsive, and sustainable health interventions worldwide.

## CONFLICT OF INTEREST

The authors declare that there is no conflict of interest regarding the publication of this article.

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