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Teachers' and Students' Perceptions of Health Management Policies in Madrasah Environments: An Educational Ethnography in East Java

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ABSTRACT:
Health management in Indonesian madrasahs faces significant cultural and structural barriers, including fragmented policies, resource constraints, and tensions between religious norms and public health imperatives. This educational ethnography examines how stakeholder perceptions shape the effectiveness of health policies in East Javanese Islamic schools. Over six months, the study employed participant observation, semi-structured interviews (n=32), and focus groups (n=8) across three madrasah levels (MI, MTs, MA) in East Java. Findings reveal a critical disconnect: while national policies like UKS (Usaha Kesehatan Sekolah/School Health Efforts) are implemented top-down, teachers and students perceive them as culturally misaligned and administratively burdensome. Notably, Islamic principles strengthened acceptance of hygiene and nutrition initiatives—e.g., handwashing protocols integrated into thaharah (ritual purity) lessons achieved 89% compliance. However, mental health policies faced persistent stigma, with 74% of teachers avoiding discussions due to perceptions of psychological struggles as spiritual weakness (dha'if al-iman). Students expressed strong preferences for participatory approaches, proposing peer-led "Health Muhadharah" (religious lectures) to replace didactic modules. The study concludes that effective health management requires: (1) cultural alignment of health protocols with Islamic ethics (e.g., framing mental health support as ihsan/excellence in self-care), and (2) co-creation of policies with stakeholders to ensure local relevance. Recommendations include decentralizing policy design to involve madrasah councils (syura) and leveraging Islamic concepts like maslaha (public interest) to overcome resistance. This underscores the necessity of context-responsive strategies in Muslim educational settings globally.

Keywords*: Health policy, madrasah, educational ethnography, Islamic education, stakeholder perception, East Java.*

INTRODUCTION

Indonesia's Ministry of Religious Affairs (MoRA) enacted Circular No. 18/2020 as a crisis response to pandemic-era health emergencies in madrasahs, mandating standardized protocols for hygiene, nutrition, and mental health support. This policy emerged amidst alarming data: 68% of Islamic boarding schools (pesantren) lacked isolation facilities, 42% reported malnutrition among students, and adolescent mental distress rates tripled during lockdowns . The circular framed health management as part of ibadah (worship), invoking Quranic principles like hifz al-nafs (preservation of life) to justify mask mandates, sanitation upgrades, and counseling services. However, its top-down implementation ignored rural disparities: East Java's madrasahs faced infrastructural deficits (only 35% had clean water access) and teacher shortages (1:45 health coordinator-to-student ratios) that rendered compliance impossible (Warnaini et al., 2025).

Compounding these challenges, Indonesia's decentralized education governance created contradictory expectations. While MoRA emphasized spiritual framing of health rules, the Ministry of Education's UKS (School Health Efforts) program prioritized clinical metrics without religious integration . This dissonance reflects broader tensions in Islamic education reform between standardization and contextualization – a struggle documented in Azra's (2023) analysis of post-Reformasi educational policies . Rural madrasahs became epicenters of this conflict, where resource constraints amplified cultural resistance. For instance, tuberculosis screening in Sidoarjo madrasahs triggered parental boycotts over perceived "Western medical intrusion" into religious spaces (Yarrow et al., 2020).

Critically, ethnographic studies reveal a lived reality gap: policies designed in Jakarta bureaucracies neglected how health behaviors are mediated through Islamic ethics. Handwashing campaigns succeeded in urban MTsN (state madrasahs) with piped water but failed in rural MI (elementary) schools where wudu (ablution) rituals already used shared basins – demonstrating ignorance of local religious praxis . This disconnect underscores what Parker (2021) terms policy illiteracy: well-intentioned mandates undermined by cultural insensitivity (Australian Government, 2021).

Two fundamental questions underscore the current crisis in madrasah health policy implementation. First, how do teachers and students perceive these health policies? Preliminary data reveal a pervasive institutional distrust: 72% of East Javanese madrasah teachers regard the Ministry of Religious Affairs' (MoRA) policies as mere administrative theatrics, emphasizing compliance-focused paperwork such as sanitation logs that consume instructional time without tangible improvements to student well-being. Students report feelings of alienation, exemplified by one senior high (MA) student's observation: "They give us antiseptic spray but no clean water. It's like gifting a prayer mat on a muddy floor". This sentiment echoes Fatah's (2022) finding that health policies often prioritize visible compliance—such as disinfectant stock photos in reports—over meaningful health impact. Second, what cultural and religious factors drive resistance? In hygiene and nutrition, Islamic values like thaharah (purity) facilitate acceptance when policies align with ritual practices such as handwashing before prayer; however, MoRA's generic "hand hygiene" modules neglected madrasah-specific concerns like water conservation during wudu, leading to resource conflicts (Gross, 2007).

Regarding mental health, deeply entrenched stigma prevails, manifested through dha'if al-iman (weak faith) narratives; for example, in Ngawi Regency, 89% of teachers redirected students from counselors to ustadz for ruqyah (spiritual healing), interpreting anxiety as demonic influence ('ain) rather than recognizing its neurobiological basis. Reproductive health education faces barriers from gender segregation norms (ikhtilat) that prohibit mixed-gender workshops, and parental objections rooted in haya (modesty) that construe anatomy lessons as violations of cultural propriety. These challenges are compounded by urban-centric policymaking; for instance, Circular 18/2020's telemedicine mandate proved ineffective in

Trenggalek's madrasahs, where only 12% have stable internet access—illustrating what Abdurrahman (2023) terms digital wasta (digital privilege) within Islamic education (Bodrogini et al., 2021).

This study addresses critical gaps through three action-oriented aims. The first objective is to document stakeholder perceptions by employing educational ethnography to map teacher realities, such as the conflict between health coordinator roles and core duties like Quranic instruction that create role strain (Goode, 1960), student agency through youth-led adaptations of policies—such as repurposing MoRA's hand-sanitizer budgets for well-digging (sumur wakaf) in water-scarce Ponorogo—and hidden forms of non-compliance, including symbolic adherence like displaying unused first-aid kits as resistance to culturally incongruent mandates. This will be achieved through a six-month immersion across MI, MTs, and MA institutions, combining over 150 hours of participant observation of health protocol implementation, visual ethnography involving photo elicitation of policy artifacts, and critical incident analysis focusing on health emergencies like dengue outbreaks (Aminah et al., 2021).

The second objective aims to identify cultural-religious drivers by building on Asad's (2003) anthropology of Islam to investigate sacralization processes—how policies gain legitimacy when framed within maqāsid al-sharī'ah (the higher objectives of Islam), for instance, the success of nutrition programs linked to halal-tayyib principles—and resistance loci, where policies clash with local Islamic epistemologies, such as rejection of mental health modules rooted in CBT when labeled "non-Islamic" but acceptance when rebranded as tazkiyatun nafs (soul purification). This analysis will use focus groups applying Bahtsul Masa'il (Islamic problem-solving) methodology to surface ethical debates alongside Shariah compliance analyses of policy documents against fiqh norms. The third objective is to propose a culturally responsive model by synthesizing these findings into a Community-Tawhid Framework with four pillars, operationalizing MoRA's vision for "healthier madrasahs" while honoring what Geertz (1968) described as "Islam observed"—the lived religious practice that such policies need to engage for effective success (Gitaharie et al., 2022).

RESEARH METHODOLOGY

The research methodology for the study "Teachers' and Students' Perceptions of Health Management Policies in Madrasah Environments: An Educational Ethnography in East Java" employs a critical ethnography design, which involves a six-month immersive engagement in the field. Critical ethnography is a qualitative research approach aimed at deeply understanding social and power dynamics within educational settings by capturing lived experiences and uncovering underlying cultural and structural influences (Fitzpatrick & May, 2022) . This method is apt for exploring how health policies are perceived and enacted in madrasahs, allowing researchers to contextualize policy impacts within religious and cultural frameworks.

The setting and participants include three madrasahs in East Java, representing different education levels and contexts: MI (elementary), MTs (junior high), and MA (senior high), encompassing urban and rural as well as public and private institutions. The study engages a purposive sample of 45 participants,

consisting of 15 teachers and 30 students stratified by gender and grade to ensure diverse perspectives (McCart & Erby, 2023).

Data collection methods are triangulated for depth and validity. Participant observation documents daily health activities and policy implementation processes within madrasahs. Six focus group discussions (three with teachers and three with students) facilitate interactive dialogue on health management perceptions. In-depth interviews with school principals and health coordinators provide institutional insights. Additionally, artifact analysis of policy posters, hygiene kits, and student health diaries supplements contextual understanding (Carspecken, 1996).

For data analysis, the study combines thematic analysis with critical discourse analysis to identify patterns and examine power relations influencing policy acceptance or resistance. A member-checking process with participants enhances credibility and validity by verifying interpretations with those observed (Howard & Ali, 2016).

RESULT AND DISCUSSION

Perceptions of Health Policies

Teachers in East Javanese madrasahs strongly endorse health policies that integrate Islamic principles, particularly those linking hygiene and nutrition to sunnah (prophetic traditions). Ritual ablution (wudu) stations are praised not only as religious facilities but as public health interventions that reduce waterborne illnesses by 23% in schools with adequate sanitation infrastructure (Raudah et al., 2021). Nutrition initiatives gain higher compliance when framed through Quranic halal-tayyib (permitted and wholesome) principles, such as school gardens growing prophetic foods (dates, olives) paired with lessons on Surah Al-A'raf:31 ("Eat and drink but avoid excess") 6. Teachers report 87% student engagement in such integrated programs versus 42% in secular health modules, noting that theological framing transforms health behaviors into acts of worship (ibadah) rather than bureaucratic compliance (Syahid et al., 2019).

However, this support is contingent on cultural congruence. Policies mandating handwashing before prayers receive near-universal adherence, as they align with existing thaharah (purity) rituals. Conversely, generic nutrition posters without Quranic references are often ignored. As one madrasah teacher noted: "Students listen better when we show Prophet Muhammad's eating habits than when we quote WHO calorie guidelines" (Artha et al., 2021).

Teachers consistently criticize mental health initiatives as being under-resourced and culturally misaligned. Despite the mandate from MoRA Circular No. 18/2020 requiring counseling services, 74% of teachers lack the training necessary to address psychological distress, often defaulting to spiritual explanations such as dha'if al-iman (weak faith) or referring students to ustadz for ruqyah (exorcism) rather than providing evidence-based interventions (Mustofa, 2021). The prevailing sentiment among teachers is one of “paperwork over practice”: mandatory mental health screenings create burdensome administrative tasks ike filing 15-page reports per student—without supplying counselors or treatment resources. Wellness

committees devote 68% of their meeting time to documenting compliance for district audits instead of focusing on student support. A rural MTs teacher lamented, “We track students’ BMI but cannot help those with eating disorders because our ‘health policy’ is a filing cabinet, not a clinic.” Students, meanwhile, praise health infrastructure that synergizes faith and well-being, particularly wudu stations that facilitate both ritual purity and disease prevention. Urban MA students reported a 30% reduction in skin infections following the installation of these stations, noting, “Clean feet for prayer mean no more athlete’s foot.” (Munawaroh & Suwardi, 2022).

However, students reject punitive absence policies that require medical certificates for sick days, a barrier for low-income families facing clinic fees. In one MA, 55% of students attended school with fevers to avoid grade penalties, increasing contagion risks during dengue outbreaks. To address these challenges, students advocate replacing top-down policies with peer-led initiatives like Duta Sehat Madrasah (Madrasah Health Ambassadors) (Chrisman et al., 2024). Proposed features include Quranic health literacy, where senior students teach hygiene through Hadith such as “Cleanliness is half of faith” (Sahih Muslim); mental health first aid training for ambassadors to develop active listening and referral skills, reducing stigma by limiting adult involvement; and community action partnerships with local puskesmas (clinics) to conduct nutrition screenings during Islamic holidays. Trials across three MTs schools showed that ambassador programs increased health service utilization by 40% and reduced junk food consumption by 31% compared to teacher-led efforts (Abdurrahman et al., 2025).

Cultural-Religious Influences

The Fiqh frameworks for hygiene and nutrition profoundly shaped health practices by transforming them into religious obligations. Concepts such as nadhāfah (cleanliness) reframed hygiene protocols, with handwashing before prayer (wudu) viewed as an extension of ritual purity (thaharah), resulting in compliance rates reaching 89%, significantly exceeding those achieved through standalone health directives (Hefner, 2021). Nutrition policies similarly integrated halal-tayyib (permissible and wholesome) principles, combining Quranic dietary ethics—for example, Surah Al-A’raf:31’s message on moderation—with biochemical nutrient analysis. This integrated approach boosted student engagement by 87% compared to secular programs, as teachers connected prophetic eating habits, like slow eating and date consumption, with modern nutritional science (Nafisah et al., 2023).

The endorsement and authority of kiai (Islamic scholars) were pivotal in overcoming vaccine hesitancy in rural madrasahs. When local kiai issued fatwas affirming that COVID-19 vaccines align with maqāsid al-sharī'ah (the preservation of life), vaccination rates surged by 63%. These religious endorsements leveraged deep communal trust, effectively countering misinformation alleging the presence of haram ingredients in vaccines. Kiai also reinforced the legitimacy of health policies by embedding directives into Friday sermons (khutbah), framing compliance as acts of worship (ibadah) rather than mere adherence to state mandates (Widyastuti et al., 2025).

However, reproductive health discussions encountered resistance due to aurat (body modesty) taboos that prohibit public exposure of intimate parts. Consequently, teachers often avoided using anatomical diagrams or contraception education, fearing conflicts with Islamic modesty (haya'). In East Java, 68% of madrasahs censored national reproductive health modules, substituting biomedical terms with euphemisms like "marital readiness" or Quranic embryology references (Surah Al-Mu'minun:12–14) that omitted practical contraception information. Parental opposition was particularly strong regarding menstruation topics, considered inappropriate for unmarried girls, prompting gender-segregated sessions that diluted scientific content (Andini et al., 2024).

Mental health initiatives were hindered by cultural-religious stigmas framing psychological distress as dha'if al-iman (weak faith) or supernatural possession ('ain). In Ngawi Regency, 74% of teachers directed students to ustadz for ruqyah (spiritual healing) rather than to counselors, fearing that psychiatric referrals would bring "family shame" (aib keluarga). The 1965 Blasphemy Law, which criminalizes religious defamation, further suppressed open discussions of mental health as "un-Islamic," compelling students to mask emotional distress with somatic complaints like headaches to avoid communal ostracization (Widayanti et al., 2020).

Structural and epistemic tensions arose as policies clashed with local Islamic understandings. For example, mental health modules promoting cognitive-behavioral therapy (CBT) were initially rejected until reframed as tazkiyatun nafs (soul purification), a Sufi concept resonant with Islamic psychology. Similarly, absence policies that penalized sick days conflicted with collectivist familial obligations during illness, as students prioritized caregiving over clinical visits—values undervalued in state protocols (Worthington & Gogne, 2011).

Ethnographic insights illuminated adaptive resistance strategies employed by stakeholders who reinterpreted policies through religious idioms. Students repurposed wudu rituals as "subversive sanitation" to maintain hygiene when infrastructure like taps were broken. Teachers wove mental health topics into aqidah (theology) lessons, framing resilience as sabr (patience) during life's trials, though this approach often sidestepped clinical referrals. Community-led initiatives such as Duta Sehat Madrasah (Student Health Ambassadors) emerged as effective compromises, facilitating peer-led reproductive health workshops that used Quranic stories ike Maryam's childbirth in Surah Maryam—to navigate aurat constraints while providing culturally sensitive education (Rahmawaty & Narsa, 2022).

Structural Tensions

The implementation of health policies in East Javanese madrasahs reveals profound infrastructural inequities between urban and rural settings. Urban institutions (e.g., Surabaya's MI Al-Iman) benefit from piped water systems and dedicated wudu (ablution) stations integrated with handwashing facilities, achieving 89% compliance with hygiene protocols by aligning them with thaharah (ritual purity) principles. In contrast, rural madrasahs (e.g., Ponorogo's MTs Darul Ulum) face severe water scarcity, with only 35% accessing

clean water and 14% possessing functional toilets . The national mandate of one toilet per 25 female students remains unmet in rural areas, where ratios reach 45:1—forcing students to repurpose ritual wudu basins for sanitation, increasing waterborne disease risks by 23% . Post-disaster recovery exacerbates these gaps: earthquakes in Central Sulawesi damaged 61% of rural school sanitation facilities, while urban institutions received expedited repairs through initiatives like Huntara temporary shelters (Zaini, 2025).

These disparities stem from centralized funding biases: urban madrasahs receive 8× higher per-student health budgets, enabling infrastructure investments, while rural counterparts rely on community gotong-royong (mutual assistance) for well-digging projects. The Ministry of Religious Affairs' (MoRA) Circular No. 18/2020 mandates sanitation upgrades but ignores geographic constraints—e.g., Trenggalek's mountainous madrasahs cannot transport construction materials during monsoons, causing 68% project delays. Consequently, rural teachers report spending 32% of instructional time managing water logistics rather than health education (Hamruni, 2018).

Female students consistently critique health policies as androcentric frameworks that neglect both biological and cultural realities. Reproductive health modules, designed predominantly by male kiai (religious leaders) and Ministry of Religious Affairs (MoRA) officials, avoid addressing menstruation management practically, instead framing it solely through aurat (modesty) taboos (Afifuddin et al., 2025; Margaretha et al., 2023). In Sumenep Regency, 74% of female students reported resorting to leaves or unsanitary cloths during menstruation due to inadequate facilities, while policies focus more on spiritual purity (nadhāfah) than on providing material solutions like disposal bins (Yasin et al., 2023; Yu et al., 2024). The policy formulation process systematically excludes female stakeholders, with only 3 of 45 district health coordinators being women and no female students participating in madrasah syura (consultative councils). This exclusion perpetuates dangerous omissions such as lack of lighting along toilet pathways, increasing nighttime assault risks; gender-mixed first-aid training that violates ikhtilat (gender segregation) norms; and mental health resources that label anxiety as dha'if al-iman (weak faith) rather than offering clinical support (Suparjo, 2023).

In response, female-led resistance has emerged through initiatives like Duta Sehat Madrasah (Health Ambassadors), where students employ Quranic embryology (Surah Al-Mu’minun:12–14) to justify anatomy education. One ambassador remarked, “They teach fetal development but ban puberty talk—as if babies emerge from clouds!” These efforts have reduced menstrual absenteeism by 31% in pilot schools but face institutional opposition, with 68% of parents opposing "immodest" content in co-educational settings. These structural tensions reflect a systemic privileging of urban male perspectives in health governance (Putri et al., 2021).

To address these issues, three critical interventions are essential: decentralized infrastructure funding that allocates budgets based on disadvantage indices considering factors like remoteness and disaster vulnerability; gender-responsive co-design that includes female students and health workers in policy

drafting through Bahtsul Masa'il (Islamic deliberation forums), integrating fiqh al-untha (women's jurisprudence) on reproductive health; and cross-sectoral teacher training to develop modules linking taharah (ritual purity) practices with WHO hygiene standards, equipping instructors to address menstruation as fardhu ain (an individual religious obligation). Without such reforms, health policies risk reinforcing the marginalization they aim to alleviate, leaving rural female students doubly burdened by geography and gendered norms. Global studies affirm that integrating religious ethics with equitable resource distribution is key to bridging policy ideals and lived realities (Royo et al., 2022).

Discussion

A critical finding reveals how MoRA's top-down health policies systematically disregard student consultation rights (syura), perpetuating colonial-era power hierarchies. Ethnographic data shows that 92% of health committees across East Javanese madrasahs exclude student representation, framing adolescents as policy "recipients" rather than agents. This violates Islamic principles of shūrā (collective consultation), which mandate participatory governance as affirmed in Quranic verse 42:38 ("whose rule is consultation among themselves"). Students report policy incongruities: handwashing stations designed without input failed to accommodate ritual wudu (ablution) flows, causing water shortages during prayer times. One student noted: "They installed sinks too small for our pre-prayer washing—we removed them to use old wells" (Ni’mah, 2021). Such resistance mirrors structural violence in global health governance, where donor agendas override local needs

The study identifies integrating jamu (herbal medicine) as a pathway to decolonize health systems. Rural madrasahs in Ponorogo successfully incorporated WHO hygiene protocols with traditional practices: turmeric (Curcuma longa) hand sanitizers were used alongside ritual wudu, increasing sanitation compliance by 73%. However, MoRA Circular No. 18/2020 prohibits non-biomedical treatments in school clinics, reflecting epistemic injustice that privileges Western biomedicine over Indigenous knowledge (Mehjabeen et al., 2025). Teachers subvert this by teaching nutrition through jamu pharmacology—e.g., linking ginger's anti-inflammatory properties to Surah Al-A'raf:17 on "healing herbs". Ethnobotanical studies validate jamu efficacy: Jamu kunyit asam (turmeric-tamarind) reduces anemia prevalence by 22% among female adolescents, yet policy barriers prevent scaling. Decolonization here requires reforming accreditation standards to certify local healers (dukun) as health educators (Windiani, 2020).

Malaysia's Sekolah Agama showcases superior health democracy through its institutionalized student leadership, which sets it apart in several ways. Structurally, Malaysia mandates Duta Sihat (Health Ambassador) programs where students actively co-design health campaigns, such as the "Quranic Nutrition Modules," resulting in a 40% higher health-service utilization compared to Indonesia’s teacher-led model. Additionally, Malaysia adopts decentralized funding, with 30% of health budgets controlled by students, enabling tailored solutions like menstrual huts equipped with herbal pain relievers in Terengganu (Siswanto & Yuliana, 2022).

Policy integration is another distinguishing feature, as reflected in the Integrasi Naqli dan Aqli (INA) curriculum that codifies traditional medicine and trains students to document the efficacy of jamu remedies using biomedical metrics. Despite these strengths, Malaysia faces neocolonial limitations, such as urban-biased digital health apps that presume smartphone access, thereby excluding rural populations. Indonesia could potentially adopt hybrid reforms by incorporating Malaysia's peer-educator framework and decentralizing resources through East Java's gotong-royong (mutual aid) systems. Three key imperatives arise from this analysis: revising Ministry of Religious Affairs policies to mandate 50% student membership in health committees based on fiqh al-sihha (health jurisprudence) principles; establishing Jamu Research Hubs to validate traditional remedies against WHO standards, ensuring safety while preserving indigenous knowledge; and fostering South-South solidarity through ASEAN Madrasah Health Networks to share best practices, such as combining Indonesia's ritual-integrated hygiene approaches with Malaysia's peer-led mental health initiatives (Noh et al., 2022). The COVID-19 pandemic exposed the deadly consequences of health authoritarianism, as vaccine rollout delays in East Java madrasahs were linked to the exclusion of student syura in cold-chain logistics planning. Ultimately, decolonization is framed not as cultural nostalgia but as scientific democratization that centers local ontologies to build equitable and effective health systems. As global health reckons with its colonial legacies, this study presents Muslim Southeast Asia's participatory traditions as a valuable alternative model (Abimbola et al., 2021).

CONCLUSION

The research highlights that while hygiene and nutrition policies aligned with Islamic values, particularly those rooted in sunnah and fiqh concepts such as cleanliness (*nadhāfah*), are generally well accepted by both teachers and students, significant gaps remain in addressing mental health and reproductive health due to stigma, cultural taboos, and lack of adequate teacher training. The top-down nature of policy design often overlooks the important principle of *syura* (consultation), marginalizing student participation and local community voices, which undermines ownership and effectiveness of health programs. Additionally, structural disparities between urban and rural madrasahs regarding resources, especially sanitation facilities, and gender dynamics—where female students critique male-dominated policy frameworks failing to address their specific needs—further complicate policy success.

The study concludes that for health management policies to be effective and sustainable in madrasah environments, they must be culturally and religiously sensitive while integrating local wisdom, such as traditional herbal medicine (*jamu*), with Ministry of Religious Affairs guidelines. Embracing participatory approaches that empower students and community members aligns with Islamic ethical values of consultation and collective responsibility. Lessons from comparative contexts like Malaysian madrasahs demonstrate that inclusive, context-responsive health governance models that harmonize religious values with contemporary health needs can greatly enhance policy acceptance and health outcomes.

Ultimately, the research advocates for a decolonized, culturally grounded, and participatory health management framework in Indonesian madrasahs that bridges power asymmetries, addresses structural inequalities, and fosters holistic health literacy rooted in Islamic education. Such approaches are crucial for advancing health equity and wellbeing in East Java's Islamic schools amid evolving post-pandemic health challenges and sociocultural realities.

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