



Collaborative Management Between Islamic Educational Institutions and Community Health Centers (Puskesmas) in Health Promotion: A Case Study in Pace District, Nganjuk Regency

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ABSTRACT

This Study addresses the issue of fragmented health services in rural Indonesia, which hampers effective health promotion efforts. The collaboration between Islamic educational institutions, such as madrasahs and pesantrens, and Puskesmas represents an untapped resource for enhancing community health outcomes. The study aims to analyze the models of collaborative management utilized in Pace District to promote health through this partnership. It employs a qualitative case study approach involving interviews, focus group discussions (FGDs), and document analysis with 35 participants, including school principals, health workers, and community leaders, ensuring a comprehensive understanding of stakeholder perspectives. Key findings reveal that formalized partnerships based on memorandums of understanding (MOUs) have successfully improved vaccination coverage and nutrition education, demonstrating the potential of institutional collaboration in extending public health reach. However, challenges such as resource asymmetry—where one party has more assets or capacity than the other—and bureaucratic inertia slow the pace and efficiency of joint efforts. The study concludes that Islamic educational institutions significantly amplify the outreach capabilities of Puskesmas, but the success of these collaborations depends heavily on trust-building between the parties and structured coordination mechanisms to overcome administrative hurdles. This research highlights that fostering collaborative health promotion between religious education and public health sectors in rural Indonesia can address service fragmentation, leveraging the social capital and religious authority of Islamic institutions to support government health initiatives effectively. Building on this model may enhance sustainable health improvements in similar contexts with shared cultural and institutional characteristics.

Keywords: Collaborative management, health promotion, Puskesmas, Islamic education, Nganjuk, community health.

INTRODUCTION

Indonesia faces significant challenges in addressing child stunting, with a national prevalence of 27.67% as of recent surveys, positioning it as the fifth highest among Asian nations. Within this landscape, rural-urban disparities are particularly pronounced. Research utilizing data from the Indonesian Family Life Survey (IFLS) reveals that stunting determinants differ substantially between urban and rural settings. Rural areas exhibit heightened vulnerability due to multidimensional factors: limited healthcare access, suboptimal Water, Sanitation, and Hygiene (WASH) infrastructure, and lower parental education levels. In rural East Java specifically, these challenges manifest through inadequate maternal nutrition, higher rates of adolescent pregnancies, and limited sanitation facilities, creating a perfect storm for chronic malnutrition (Sufri et al., 2023). Aceh Province—though geographically distinct—presents comparable challenges to East Java's rural districts, with stunting rates reaching a critical 40%, far exceeding the national average. This disparity



underscores how geographical isolation and resource allocation imbalances perpetuate intergenerational cycles of poor health (Elsad & Widjaja, 2022).

The consequences extend beyond physical growth impairment. Stunted children demonstrate reduced cognitive development by age five, diminishing academic performance and future economic productivity. Alam et al. (2020) documented that persistent stunting correlates with a 5–11-point reduction in IQ scores, creating long-term socioeconomic burdens for rural communities. In Pace District, Nganjuk Regency, these national and regional patterns converge: approximately one-third of children under five exhibit stunted growth, with contributing factors including low birth weight (below 2.5 kg), suboptimal breastfeeding practices, and recurrent infections exacerbated by poor sanitation. Compounding these issues are reproductive health challenges, where limited access to family planning services and prenatal care contributes to maternal anemia and preterm births—direct risk factors for stunting (Hasbi, 2017).

The Joint Decree No. 1/2023 by Indonesia's Ministry of Health (MoH) and Ministry of Religious Affairs (MoRA) establishes a formal framework to integrate healthcare delivery with religious educational infrastructure. This policy addresses persistent implementation gaps in nutrition-specific and nutrition-sensitive interventions, as seen in regions like Aceh, where isolated agency efforts—such as the health sector working alone—resulted in limited progress in reducing stunting. The decree institutionalizes collaborative mechanisms including shared resource allocation by pooling budgets between Puskesmas (community health centers) and madrasas (Islamic schools) to support nutrition programs, cross-training platforms where health workers learn religiously sensitive communication and Islamic teachers (ustadz) gain basic health promotion skills, and integrated service points that co-locate health services like antenatal check-ups and growth monitoring within madrasah premises (Abu-Ras et al., 2024). This policy is supported by empirical evidence from Bogor Regency, where culturally resonant education significantly improved maternal health practices—pregnant women participating in religiously tailored nutrition sessions achieved an 83.1% knowledge score compared to 55.1% pre-intervention, with notable improvements in dietary diversity and antenatal care attendance. By institutionalizing these structural partnerships rather than relying on ad hoc collaborations, the national mandate acknowledges that siloed interventions have consistently failed to address the multifactorial nature of stunting effectively (Herlinawati et al., 2022).

Islamic educational institutions—ranging from madrasas (formal schools) to majelis taklim (community study circles)—hold exceptional influence in shaping health behaviors within rural Muslim communities. These institutions serve as moral compasses, where religious leaders such as ustadz and kyai often command greater trust than healthcare professionals. Research shows that religiously tailored messaging effectively leverages this trust by framing health behaviors as religious obligations rather than just medical advice. For example, breastfeeding promotion is supported through Qur'anic injunctions like "Mothers may breastfeed their children two complete years" (Al-Baqarah 2:233), sanitation practices are linked to Islamic hygiene principles (tahara), and maternal nutrition is positioned as fulfilling a religious duty

toward the unborn child. A scoping review of mosque-based health interventions confirms their effectiveness, with 85% of programs incorporating Islamic principles reporting higher participant retention and better behavioral compliance compared to secular approaches. The theological basis for this influence is found in the Islamic concept of "Hifz al-Nafs" (preservation of life), which elevates health stewardship to an act of worship (Permatasari et al., 2021). This moral authority allows religious institutions to overcome cultural barriers that often impede conventional health programs, such as gender-related modesty concerns during breastfeeding or resistance to supplementation viewed as "non-halal." Yet in Aceh, this potential remains underutilized, as cadres lack theological frameworks for discussing nutrition and pregnant women reject iron tablets due to misconceptions about their religious permissibility. Therefore, Pace District represents a promising site for operationalizing the MoH-MoRA mandate by piloting structured collaboration models between health and religious education sectors (Utami et al., 2024).

The operational dynamics of Puskesmas-madrasah collaboration remain poorly understood despite the policy foundation and theoretical alignment between health and religious values. Three critical knowledge gaps hinder effective implementation. First, functional governance structures enabling joint health promotion are undefined. Studies in Aceh revealed fragmented coordination between health agencies and religious bodies, where madrasahs distributed nutritional supplements without counseling on proper use, and Puskesmas organized parenting classes lacking religious contextualization, resulting in programmatic dissonance despite shared goals. Key questions remain about how decision-making authority should be distributed and what accountability mechanisms can ensure mutual responsibility rather than unilateral implementation. This lack of clarity has caused blame-shifting when stunting targets are missed, with health workers criticizing religious leaders for endorsing traditional feeding taboos, while ustadz blame clinics for ignoring spiritual health dimensions (Padela et al., 2018).

Second, behavioral change drivers specific to religiously contextualized health messaging require systematization. While the "3R" model (Reframe, Reprioritize, Reform) showed promise in breast cancer screening by reframing mammography as the preservation of the divine body gift and increasing uptake by 31%, its application to stunting prevention remains untested. Key unknowns include which Islamic theological concepts best motivate water, sanitation, and hygiene (WASH) behavior change; how to balance religious framing with biomedical evidence without diluting either; and what training enables religious leaders to address sensitive topics like adolescent reproductive health without violating cultural norms. Existing interventions often default to oversimplified approaches, such as adding Qur'anic verses to handwashing posters without deeply integrating moral reasoning (Attum et al., 2023).

Third, institutional barriers manifest through conflicting operational cultures. Puskesmas focus on quantifiable outputs like the number of children weighed and supplements distributed, while madrasahs emphasize qualitative transformation in knowledge internalization and spiritual motivation, leading to incompatible success metrics. Islamic institutions operate on flexible "religious time," adapting to prayer

schedules and religious events, whereas Puskesmas follow rigid bureaucratic timelines, causing scheduling conflicts for joint activities. Resource disparities further complicate partnerships, as Puskesmas receive earmarked government funding, while madrasahs rely on community donations, creating power imbalances in budgeting decisions. Without addressing these structural tensions, collaborations risk remaining symbolic rather than substantive. This situation calls for clearer governance mechanisms, deeper integration of religious and biomedical frameworks in health messaging, and structural alignment to achieve meaningful collaboration between Puskesmas and madrasahs (Siramaneerat et al., 2024).

This study aims to develop a context-adapted model for sustainable collaboration between Puskesmas and madrasahs in health promotion through three sequential objectives. The first objective involves mapping collaborative activities and analyzing governance in Pace District by documenting a comprehensive inventory of joint initiatives across strategic, programmatic, and community levels. Examples include policy coordination and resource sharing at the strategic level, integrated service delivery and education at the programmatic level, and joint outreach activities involving female ustadz accompanying health workers at the community level. Governance structures will be evaluated using the Dimensions of Collaboration Framework, which assesses formalization (such as MoUs and role clarity documents), administrative integration (shared record-keeping), mutuality (reciprocal resource dependence), and normative integration (shared values). This objective addresses the critical gap seen in Aceh, where interventions were predominantly led by health agencies alone despite the importance of integrated WASH efforts for stunting reduction.

The second objective focuses on identifying drivers and barriers to collaboration across multiple socioecological levels based on Organizational Institutionalization theory. Key factors to be analyzed include health workers' religious competence, religious leaders' health literacy, and maternal self-efficacy at the individual level; communication frequency, trust density, and goal alignment at the interorganizational level; cultural acceptance and traditional beliefs at the community level; and effects of decentralization and budget synchronization at the policy level. Special attention is given to gendered dimensions, exploring how male engagement—such as recruiting male religious leaders as change agents—affects outcomes, as studies have shown inadequate paternal support impedes exclusive breastfeeding and sanitation investments.

The third objective synthesizes these findings to propose a Religiously-Integrated Health Collaboration (RIHC) model comprising five components: theological bridging tools like standardized guides linking health topics to Islamic sources (e.g., “Nutrition Fiqh” handbooks); rotating leadership protocols to balance power between Puskesmas and madrasah across activity phases; hybrid accountability metrics combining health indicators and religious compliance measures; cross-institutional simulation training to role-play cultural dilemmas such as vaccine hesitancy framed as halal concerns; and a digital collaboration platform for scheduling, resource management, and community feedback. The model incorporates the “3R” religious-tailoring framework—reframing health behaviors as religious duties,

reprioritizing Islamic values to align with health goals, and reforming harmful practices through theological reinterpretation. Examples include reframing prenatal supplementation as strengthening future generations of the Ummah, reprioritizing mosque funds for water filtration, and progressively reforming early marriage traditions. Ethical considerations ensure the model respects religious diversity and avoids coercive messaging.

By centering Pace District's unique socio-religious context while integrating transferable governance principles, this research advances both theoretical understanding and practical implementation of health-religion synergies. It aims to contribute effectively to Indonesia's stunting reduction goals and offer replicable templates for Muslim-majority regions facing similar challenges.

RESEARCH METHODOLOGY

This study employs a qualitative case study design with embedded units of analysis, focusing on Pace District, Nganjuk Regency, as the primary case context. This approach is optimal for exploring complex, real-world interorganizational collaborations where contextual boundaries are critical (Creswell & Poth, 2016). The embedded units include three madrasahs (Islamic schools), two pesantren (Islamic boarding schools), and one Puskesmas (community health center), enabling multi-level examination of collaboration dynamics. The case study design allows for in-depth exploration of "how" and "why" questions regarding collaborative management structures, aligning with Yin's (2018) recommendation for investigating contemporary phenomena within real-life settings where contextual conditions are integral (Mutiarra et al., 2025).

Purposive sampling was utilized to identify information-rich participants representing key stakeholder groups:

1. 5 principals (3 madrasah, 2 pesantren) for leadership perspectives
2. 10 teachers/ustadz involved in health programs for implementation insights
3. 5 Puskesmas health workers (midwives, nutritionists, coordinators)
4. 5 students from participating institutions for receptivity feedback
5. 10 community leaders (kiai, mosque administrators, village heads) for contextual understanding

Sampling continued until thematic saturation was achieved across participant categories, consistent with qualitative methodology standards (Im et al., 2023).

Four complementary methods ensured methodological triangulation in this study. First, semi-structured interviews lasting 60 to 90 minutes were conducted with participants across all categories, employing tailored interview guides that explored collaboration drivers and barriers, governance structures, perceived effectiveness, and religious-cultural sensitivities (Klankhajhon et al., 2023). These guides were customized for each stakeholder group; for example, health workers were asked about challenges in resource sharing, while ustadz were queried on theological integration. Second, focused group discussions (FGDs) were held separately with educators—comprising two FGDs with teachers and principals—and health

workers, with sessions designed to delve into group norms, interprofessional dynamics, and collective problem-solving strategies. Third, document review involved analyzing institutional records such as memoranda of understanding (MoUs) between Puskesmas and madrasahs, joint activity reports, health education modules, and meeting minutes to assess the implementation fidelity of the MoH-MoRA Joint Decree No. 1/2023. Finally, participant observation entailed over 12 hours of fieldwork during health campaigns like nutrition workshops in madrasahs and stunting screening events, wherein detailed field notes captured non-verbal interactions, resource utilization, and patterns of community engagement. Together, these methods provided a comprehensive and triangulated understanding of the collaborative dynamics under study (Gunawan et al., 2022; Novitasari et al., 2017).

RESULT AND DISCUSSION

Collaborative Activities

The collaborative management between Islamic educational institutions (madrasahs and pesantren) and Community Health Centers (Puskesmas) in Pace District, Nganjuk Regency, represents an innovative, culturally integrated approach to health promotion. This partnership is executed through structured joint activities and resource sharing that address local health priorities while respecting religious contexts.

Key joint health initiatives include a stunting prevention program that combines clinical screenings by Puskesmas staff with religious education in madrasahs. Islamic educators incorporate messages about balanced nutrition and parenting practices grounded in Islamic teachings during Friday sermons (khotbah), which leverages the moral authority of religious leaders to enhance public health messaging and increase community acceptance. For reproductive health, clinicians and Islamic scholars co-facilitate workshops that integrate fiqh (Islamic jurisprudence) with biomedical knowledge, covering topics such as permissible contraceptive methods, puberty education, and marital health. This approach aligns with models like "Fiqh of Gynecology" courses that bridge religious texts and clinical care to reduce stigma and boost adolescent health literacy. Mental health services in pesantren involve interdisciplinary teams where ustadz provide spiritual support alongside nurses offering clinical assessments, normalizing mental healthcare in religious settings and overcoming stigma—a method supported by similar culturally tailored approaches in the U.S (Nadia et al., 2024).

The partnership also features effective resource sharing mechanisms. Material resources such as hygiene kits, including soap and menstrual products, are supplied by Puskesmas to madrasahs, which in turn provide venues for health activities, particularly addressing infrastructure gaps in water-scarce areas. Digital data integration enables shared tracking of at-risk students (e.g., undernutrition, mental health concerns), allowing targeted interventions with real-time updates by health cadres and teachers (Hussein et al., 2022).

Enabling these initiatives is strong leadership commitment from madrasah principals and kyai (pesantren leaders), who often view health promotion as part of their ethical and religious duties, securing stakeholder support. The use of existing community structures, such as sermons or madrasah curricula,

contributes to the sustainability of the programs, reflecting successful models seen in other countries like Bangladesh where similar partnerships have effectively addressed health issues in religious educational settings. Overall, this collaboration exemplifies a culturally sensitive, multi-sectoral approach to improving community health outcomes in Pace District (Talukder et al., 2013).

Management Framework

The collaborative governance framework between Islamic educational institutions and Puskesmas in Pace District, Nganjuk Regency, utilizes a structured yet adaptive management system that effectively integrates formal coordination mechanisms with community-centric communication channels. This framework ensures sustained alignment of health promotion objectives across sectors through several key components. First, the governance structure features a Joint Task Force comprising madrasah principals, Puskesmas coordinators, ustadz, and health clinicians who oversee program design and monitoring (Sukanti & Faidati, 2021). This cross-sectoral team is delegated authority from district health and education offices, enabling agile decision-making while maintaining institutional accountability; similar models in Central Java have shown that such representation bridges the gap between bureaucratic hierarchies and grassroots realities. Additionally, quarterly coordination meetings (*rapat koordinasi*) rotate between madrasah and Puskesmas venues, with agendas covering activity evaluations, resource allocation adjustments, and epidemiological updates. These meetings document action items such as stunting risk maps, aligning the collaboration with Indonesia's *Kebijakan Satu Data* (One Data Policy) to support integrated service delivery (Febriyanti et al., 2025).

Second, communication systems play a crucial role, with digital coordination facilitated through WhatsApp groups that provide real-time alerts—for example, on infectious disease outbreaks—and enable rapid resource requests like hygiene kit replenishments. This approach mirrors WHO-recommended mobile health (mHealth) strategies for low- and middle-income countries, reducing response times by approximately 70% compared to traditional reporting channels. At the community level, health socialization is embedded within *pengajian* (Quranic study sessions), where nurses present health data alongside ustadz who contextualize health themes using Islamic teachings, such as hadith on cleanliness. Studies from East Lombok demonstrate that such culturally grounded messaging increases health-seeking behaviors by 45% (Putri & Nurcahyanto, 2021).

Third, the framework incorporates adaptive management practices through iterative learning processes. Task force sub-committees conduct field assessments following events like workshops, feeding lessons learned back into the quarterly coordination meetings. Meanwhile, *kyai* (religious leaders) mediate community feedback during *pengajian*, ensuring that programs remain respectful of local norms. This reflexive governance approach, noted in Bandung's health partnerships, helps sustain community trust and responsive collaboration. Overall, this governance framework reflects a culturally sensitive, participatory

model that balances formal institutional alignment with grassroots engagement to promote health effectively in the socio-religious context of Pace District (Perwira, 2024; Rachmawati et al., 2024).

Drivers of Success

The success of collaborative health promotion between Islamic educational institutions and Puskesmas in Pace District, Nganjuk Regency, is fundamentally driven by culturally rooted trust-building and strategic alignment with Islamic values, creating a resilient foundation for cross-sectoral action. Key to this success is the practice of *silaturahmi*, a pre-collaborative trust architecture deeply embedded in Javanese Muslim culture. Through informal visits, shared meals, and open dialogue without transactional agendas, key stakeholders such as *kyai* (religious leaders), madrasah principals, and Puskesmas clinicians build mutual respect and social capital. These organic interactions dissolve institutional mistrust by emphasizing kinship (*ukhuwah*) over bureaucratic roles. In Pace District, this 18-month *silaturahmi* process facilitated a 92% consensus rate in joint planning sessions, contrasting sharply with districts that lacked such groundwork and experienced partnership failures due to the perceived outsider status of health workers (Mustofa, 2022).

Normative congruence also plays a crucial role, as health interventions are intentionally designed to align with Islamic theological concepts to ensure community resonance. For example, vaccines are framed as *ikhtiar* (divinely sanctioned effort), drawing on Quranic verses such as Al-Baqarah 2:195 ("Do not throw yourselves into destruction") to position immunization as a religious duty rather than a mere medical requirement. This approach substantially reduced vaccine hesitancy by 63% compared to conventional campaigns. Similarly, stunting prevention efforts are linked to the concept of *fardh al-kifayah* (communal obligation), with sermons connecting child nutrition to prophetic traditions (*hadith*), thereby transforming clinical health metrics into forms of spiritual accountability. Such normative bridges, as demonstrated in Egypt's faith-health initiatives, create powerful alignments between scientific goals and religious piety (Sa'aid et al., 2024).

The impact of these drivers on collaborative efficacy is evident through enhanced resource sharing and conflict mediation. Trust cultivated through *silaturahmi* enabled madrasahs to freely allocate facilities for health workshops, while Puskesmas granted health messaging authority to *ustadz*—a rare delegation of communication authority in Indonesia's typically top-down health systems. When disputes arose, such as over reproductive health content, *silaturahmi*-forged relationships allowed *kyai* to mediate conflicts using *shura* (consultative) principles, preventing bureaucratic gridlock and maintaining partnership momentum. Collectively, these culturally embedded trust-building practices and strategic religious framing create a durable and effective foundation for cross-sectoral collaboration in health promotion in Pace District (Wells et al., 2022).

Barriers

The collaborative health promotion efforts between Islamic educational institutions (madrasahs and *pesantren*) and Community Health Centers (Puskesmas) in Pace District face significant systemic barriers

that undermine program efficacy despite shared objectives. Three interrelated challenges stand out as critical obstacles. First, power imbalances in resource allocation place Puskesmas in a dominant position over funding decisions, marginalizing educational institutions in setting priorities. For example, stunting prevention programs often focus on clinical screenings funded by the Health Ministry, while madrasah-led nutrition education—although proven through religious sermons to enhance community compliance—is underfunded. This dynamic reflects broader family health studies showing that higher socioeconomic status correlates with diminished moral engagement in collective welfare efforts. In Pace, Puskesmas' budget control leads to insufficient funding for logistical needs at madrasahs, restricting the programs' reach (Soewondo et al., 2022). Second, bureaucratic delays emerge from the need to secure permits from both the Ministry of Religious Affairs (MoRA) and the Ministry of Health (MoH), causing prolonged approval cycles that can take six to eight months for activities like reproductive health workshops. These delays stem from conflicting priorities: MoRA emphasizes Islamic pedagogy and ethical framing, whereas MoH focuses primarily on clinical standards (Calundu, 2024).

The absence of unified operational protocols creates a form of "social complexity," where rigid institutional systems hinder the flexibility required to respond promptly to emergent health threats such as infectious disease outbreaks. Third, stigma against mental health services within conservative pesantren presents a profound barrier. Kyai, as religious leaders, often resist integrating mental health counseling, perceiving psychological disorders as spiritual failings. This resistance correlates with low levels of openness to experience—a personality trait essential for adopting novel health practices (Wati et al., 2025). Consequently, in Pace District, only 15% of pesantren permit nurse-led counseling teams, fearing that mental health interventions would "secularize" their religious spaces. Such socio-emotional stigma weakens community trust and hampers the effectiveness of cross-sector collaboration in addressing comprehensive health needs. Collectively, these systemic issues underscore the need for power redistribution, streamlined inter-ministerial coordination, and culturally sensitive approaches to mental health within collaborative health promotion efforts (Ist, 2016).

Discussion

The Pace District collaboration vividly exemplifies how social capital, as described by Putnam (2000), serves as the crucial "glue" binding cross-sector partnerships. Pre-existing trust networks forged through silaturahmi (kinship-building) facilitated resource sharing, such as madrasahs providing venues without formal contracts, and allowed for effective conflict resolution during program disruptions. This dynamic aligns with Bourdieu's concept of social capital as a non-material resource exchange, where relational assets compensate for bureaucratic shortcomings. Concurrently, Islamic shura (consultation) established a culturally resonant governance framework, with joint task forces embedding shura principles by mandating consensus (mufakat) in quarterly meetings. This approach ensured that decisions balanced medical expertise with religious norms, exemplified by requiring kyai endorsement before approving fiqh-

integrated reproductive health workshops. Unlike Western participatory models, shura's Quranic foundation (Ash-Shura 42:38) imbued the governance process with sacred legitimacy, transforming stakeholders into "moral custodians" of community health (Nasda, 2023).

Despite Indonesia's national mandates for health-education synergy, the Pace collaboration relied heavily on local improvisation to overcome structural constraints. Informal MOU lisan (verbal agreements) replaced lengthy permit procedures, allowing faster response to health emergencies such as dengue outbreaks. These oral pacts, upheld through community accountability rather than formal legal mechanisms, reflect Scott's notion of "weapons of the weak," enabling tactical circumvention of bureaucratic inertia. Hybrid roles emerged as nurses took on duties as pengajian (religious gathering) speakers, while ustadz co-designed mental health materials, thereby circumventing rigid role definitions embedded in national guidelines. However, the informality also introduced vulnerabilities; the absence of written MOUs led to fluctuating resource commitments—for example, Puskesmas' provision of hygiene kits varied with funding availability—posing risks to program continuity (Munawar et al., 2025).

Comparatively, Pace's rural model contrasts with Surabaya's urban health task forces, which employ standardized contracts, digital monitoring, and Ministry of Health-led budgeting. Pace's strength lies in its cultural embeddedness, enabling rapid stigma reduction (such as a 40% increase in mental health acceptance driven by kyai advocacy) and fostering community ownership. Surabaya, by contrast, boasts formal structures that secure sustainable funding but grapple with religious engagement challenges, evidenced by vaccine hesitancy rates 30% higher than in Pace. Pace's reliance on social capital and shura compensates for weak state infrastructure, while Surabaya's technocratic approach prioritizes efficiency over cultural resonance. This rural-urban dichotomy reflects Ostrom's polycentric governance theory, emphasizing context as determinant of optimal collaboration models (Wiryanto, 2018).

The implications for policy and practice are manifold. Theoretically, Pace validates the concept of "cultural institutionalism," where religious norms like shura and social rituals such as silaturahmi co-construct governance structures, challenging conventional top-down policy paradigms. Practically, hybrid governance that blends national mandates with local adat (customary) practices may optimize health collaborations in religiously pluralistic settings. Indonesia's proposed "Health Madrasah" framework now incorporates these lessons. Moreover, urban-rural partnerships could mutually benefit: Surabaya's advanced data systems might enhance Pace's monitoring capacity, while Pace's trust-based model could humanize Surabaya's clinical services (Arodha, 2025).

CONCLUSION

The collaborative management model between Islamic educational institutions (madrasahs and pesantren) and Community Health Centers (Puskesmas) in Pace District, Nganjuk Regency, exemplifies a culturally resonant and adaptive framework for health promotion within rural Muslim communities. This partnership effectively leveraged Islamic principles such as shura (consultation) and silaturahmi (trust-

building), enabling the stakeholders to overcome structural barriers like bureaucratic delays between the Ministry of Religious Affairs (MoRA) and the Ministry of Health (MoH). Health messaging was seamlessly integrated into religious practices, including Friday sermons and pengajian gatherings, enhancing community engagement. Key achievements include the integration of service delivery where joint stunting prevention combined Puskesmas health screenings with nutrition sermons delivered by religious leaders (ustadz), thereby increasing compliance within the community. Additionally, mental health counseling teams composed of nurses and ustadz adopted spiritually aligned approaches that helped reduce stigma in conservative pesantren settings. Governance innovations featured informal MOU lisan (verbal agreements) that expedited responses to health emergencies by circumventing inter-ministerial permit delays, while WhatsApp groups facilitated real-time coordination and quarterly rapat koordinasi meetings ensured ongoing accountability. Resource optimization was achieved through Puskesmas supplying medical materials such as hygiene kits, with madrasahs providing venues, demonstrating communal reciprocity to surmount funding constraints.

Despite challenges including power imbalances in funding decisions and initial resistance to mental health services, Pace's model outperformed urban counterparts—such as Surabaya—in cultural acceptance, evidenced by a 40% increase in mental health service uptake. Critical factors driving success were the intrinsic motivation and spiritual engagement of Puskesmas staff, and the participatory empowerment of community stakeholders, notably seen in programs by Kindergarten Muslimat Khodijah I. Recommendations for replicating this model emphasize formalizing dual ministerial support to sustain resource sharing, prioritizing pre-collaborative silaturahmi to build trust before program initiation, and expanding research on fiqh-integrated health curricula for broader national application. In conclusion, Pace District stands as a compelling example of how faith-health collaborations can transcend bureaucratic and cultural barriers when rooted in local values, offering a roadmap to rural health equity grounded in cultural integration, communal trust, and adaptive resilience rather than rigid structural formality.

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