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Pesantren Medical: Health Education Management for Santri Towards an Islamic and Healthy Lifestyle

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ABSTRACT

Islamic boarding schools (pesantren) often emphasize religious purity but lack integrated systems to promote hygienic practices. This study addresses the gap by exploring how health education can be managed effectively within a pesantren context to foster a healthy and Islamic lifestyle among santri (students). Using a qualitative case study approach, this research was conducted at Pesantren Nurul Qarnain in Jember, Indonesia. Data were collected through in-depth interviews, participatory observations, and document analysis. Thematic analysis was carried out using Miles and Huberman's interactive model, with triangulation ensuring credibility. The study identified three key components of successful health education management: (1) participative kyai leadership that models hygiene and spiritual discipline, (2) structured institutional systems including SOPs, hygiene evaluations, and collective routines, and (3) the role of *santri husada* as internal health cadres who provide peer-based education and monitoring. These elements facilitated the transformation of hygiene behaviors from externally enforced routines into internalized, community-driven habits grounded in Islamic values. The integration of leadership, institutional systems, and peer empowerment created a sustainable health culture. The "Pesantren Medical" model developed through this study offers a culturally embedded, replicable framework for other faith-based residential schools. It demonstrates how religious values, when operationalized through leadership and structure, can drive behavioral change and promote holistic well-being.

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1. INTRODUCTION

Islamic education promotes the development of holistic individuals (*kaffa*) by balancing physical and spiritual well-being, as reflected in values such as *thaharah* (cleanliness) and bodily care (Daulay, 2014; Arif, 2006). However, in many pesantren (Islamic boarding schools), these values are often treated rhetorically rather than operationalized in daily practices. Despite Islamic teachings emphasizing purity, many pesantren environments still lack access to clean water, sanitary toilets, and organized hygiene systems (Khobir, 2010). This indicates a disconnect between religious ideals and actual health practices on the ground, an issue that remains underexplored in educational management literature.

Recent studies have described various hygiene-related challenges in pesantren, including overcrowded dormitories, unsanitary food distribution, and poor waste disposal systems. The COVID-19 pandemic further exposed critical weaknesses in health education systems within pesantren, such as the absence of PHBS (Clean and Healthy Living Behavior) frameworks, limited hygiene infrastructure, and the lack of trained health cadres (*santri husada*). These deficiencies suggest that current health programs in pesantren are often fragmented, short-term, and overly reliant on external interventions, lacking deep cultural and spiritual integration.

While Nugraha and Syarifudin (2021) highlighted factors such as health facilities and cadre empowerment, they overlooked how spiritual values internalized through religious routines contribute to sustainable behavior change. Similarly, studies by Ramadhan et al. (2025), Apriliani et al. (2023), and Redjeki and Rahmawati (2023) demonstrated improvements in health awareness but offered minimal insight into long-term character transformation rooted in Islamic beliefs. These findings reflect a broader limitation in current PHBS frameworks, which tend to focus on technical compliance rather than embedding health education as a lived, value-based experience within the pesantren ecosystem.

To address this gap, this study introduces the *Pesantren Medical* model, an Islamic health education management approach that integrates *thaharah*, spiritual hygiene, worship discipline, and leadership by example (*uswah hasanah*) from the kyai. Unlike conventional health interventions, this model positions health as both a spiritual practice and a cultural norm.

This research specifically aims to develop and evaluate the implementation of the *Pesantren Medical* model at Pondok Pesantren Nurul Qarnain, focusing on hygiene routines, consumption patterns, environmental cleanliness, and the internalization of Islamic values in santri behavior. It seeks to provide a replicable framework for other faith-based boarding institutions, demonstrating how the synergy of spiritual leadership, institutional structure, and community-based empowerment can produce a sustainable health culture.

By reframing health education within pesantren as a spiritually grounded, community-driven system, this study fills a critical gap at the intersection of public health and Islamic education. It also contributes practically by offering a contextualized model for integrating health and religious values, particularly relevant in the post-pandemic era of educational transformation.

2. METHODS

This study employed a qualitative approach using an intrinsic case study design, focusing exclusively on Pondok Pesantren Nurul Qarnain due to its distinctive integration of Islamic values in health education management. The design was chosen to allow an in-depth and holistic exploration of health-related practices such as *thaharah* (ritual cleanliness), spiritual hygiene, kyai role modeling, and cleanliness traditions embedded in the daily routines of santri.

Fieldwork was conducted over a period of three months, from September to November 2024, involving weekly visits averaging three full days per week. This allowed the researcher to observe both routine and special activities, ensuring comprehensive data coverage across time and context.

Data collection employed triangulated methods: (1) semi-structured interviews, (2) participant observation, and (3) document analysis. Interviews were conducted with key stakeholders, including the kyai, *santri husada* (student health cadres), regular santri, and community members. Observations took place during morning cleaning (*ro'an*), ablution practices, waste management, and mealtime routines. Documentation collected included SOPs from the *poskestren* (pesantren health post), cleaning duty schedules, sermon transcripts, and health inspection reports.

All participants were informed of the study's purpose and procedures. Informed consent was obtained from adult participants and the pesantren leadership. For underage santri, parental or guardian consent was secured through official permission letters facilitated by the pesantren administration. Anonymity and confidentiality were strictly maintained, and participation was entirely voluntary.

To ensure credibility and trustworthiness, the study applied data, method, and source triangulation following Denzin's (1978) and Patton's (1999) frameworks. An independent auditor was also engaged to review the research process and interpretations, thereby increasing dependability and confirmability.

Data analysis followed the Miles and Huberman (2014) interactive model, consisting of: (1) Data reduction, by identifying themes related to religious health values, institutional structures, and behavioral impacts; (2) Data display, through matrices, diagrams, and narrative synthesis to illustrate the Pesantren Medical model; (3) Conclusion drawing, supported by member checking and theoretical triangulation; (4) Verification, using repeated informant validation and focused thematic discussion.

Research instruments included: (1) An interview guide based on themes of leadership, hygiene, and behavior change; (2) An observation sheet aligned with PHBS indicators from the Jember District Health Office, and (3) A documentation checklist tailored to pesantren operational health systems.

Purposive sampling was used to select informants representing four key groups: (1) The kyai as spiritual and managerial leader; (2) Santri across educational levels (10–20 individuals); (3) Health cadres and administrators (5–8 individuals); and (4) Community members and alumni (5–10 individuals) for external triangulation.

3. FINDINGS AND DISCUSSION

3.1 Findings

3.1.1 The Role of the Kyai's Leadership in Cultivating a Healthy Culture

The leadership of the kyai at Pesantren Nurul Qarnain is not merely symbolic or administrative, but deeply embedded in everyday practices that directly shape the lives of the *santri*. The kyai's role is pivotal in creating a healthy environment (physically, socially, and spiritually). Within the pesantren's traditional, highly centralized leadership system, a healthy culture does not emerge by itself; instead, it is actively cultivated through the kyai's direct and indirect influence. Field findings indicate that the kyai's leadership serves both as a foundation and as the driving force behind establishing clean and healthy habits among the *santri*.

An interview with one of the caretakers revealed a recurring pattern in the kyai's involvement with hygiene activities: "*I wake up earlier to ensure the kyai joins the morning cleaning duty; santri feel both supervised and motivated*." (CaretakerKy, 2025)

This quote shows that the kyai does not simply issue instructions from afar but participates in the initial stages of cleaning activities. His physical presence at strategic times, such as morning duty or just before dawn prayer, psychologically energizes and raises awareness among the *santri*. This point is confirmed by a *santri* interview: "*When the kyai joins the cleaning at night, we feel ashamed to be lazy*." (Santri07, 2025)

This indicates a positive social pressure arising from the presence of an authoritative figure. The sense of shame provoked by the kyai's involvement becomes a highly effective informal social control mechanism. In other words, the kyai influences behavior not merely through rules but through mutual respect and a strong emotional bond. During Friday cleaning duty observations, the kyai was seen actively inspecting the grounds, engaging in conversation with *santri*, inquiring about cleanliness, and offering words of encouragement like "jazakumullah" ("May Allah reward you") or "good job, keep it up", forms of appreciation that reinforce student morale.

This direct engagement by the kyai acts as a powerful social instrument for instilling hygiene values. He doesn't function solely as a supervisor but as a living example. The *santri* witness him cleaning the environment, sorting trash, and reminding them to wash their hands—a concrete visualization of the values he espouses. Most *santri* stated that their motivation to maintain cleanliness stems not from fear of punishment but from respect and a desire to emulate the kyai.

Beyond leading by example, a second dimension emerged: empowerment. The kyai not only directs but also entrusts certain *santri* to coordinate cleaning duties or remind their peers. One senior *santri* shared: "*The kyai personally asked me to be the cleaning coordinator. He said I could be a good example for the younger ones*." (Santri14, 2025)

This indicates a tiered development model. The kyai selects influential *santri* and entrusts them with responsibility, not merely for logistical delegation, but as an acknowledgment of their capacity. These entrusted students experience greater moral responsibility and strive to act as role models. Observations show these coordinators using a small whistle to organize duty times and offering gentle evaluations to underperforming peers.

In summary, the kyai's leadership style is unique and multifaceted. First, the kyai's physical presence and active involvement in the *santri*'s daily routines directly catalyze the formation of healthy habits. Second, the emotional bond between kyai and students fosters motivation based on respect rather than compliance. Third, empowerment strategies enhance internal management effectiveness and foster a sense of ownership among the *santri* for the healthy culture they uphold. The combination of modeling and delegation creates a leadership style highly effective in the pesantren context, where spiritual, moral, and social values are inseparable from everyday practice.

3.1.2 Structure and Implementation of a Healthy Culture

The healthy culture at Pesantren Nurul Qarnain does not emerge randomly or through individual habits alone; it is meticulously organized through measurable systems and structures. These systems feature written regulations, monitoring mechanisms, and social instruments like schedules, evaluation forms, and notice boards. This implementation exceeds mere cleaning activities; it reflects an institutional design that transforms hygiene into a collective value. Such structure is essential to ensure that cleanliness is not a temporary task, but a sustainable shared practice.

Reviewed documentation includes Standard Operating Procedures (SOPs) from the pesantren's health post (*Poskestren*), covering daily cleaning shifts, responsibilities of health cadre *santri husada*, and light disciplinary measures for those neglectful of hygiene duties. Additionally, each weekend administrators complete a hygiene evaluation form with indicators such as bathroom cleanliness, bed neatness, dining area sanitation, and waste management.

One administrator explained: "*Every week we fill in the cleanliness monitoring form, and then post the results on the mosque's announcement board. So everyone knows which room is the cleanest or the dirtiest*." (Administrator04, 2025)

In direct Friday morning observations, several students brought brooms and mops without prompting. They cleaned dormitory corridors and the mosque as part of the routine *ro'an* (pre-dawn communal work). The duty coordinators recorded attendance and participation.

Figure 1. Santri Ro'an Activity at the Pesantren

This implementation is systematic and structured. The formal SOP issued by *Poskestren* serves as a common reference for all community members: students, staff, and support personnel. In this context, documents are not mere administrative tools but behavioral management instruments with social effects. For instance, hygiene evaluation forms and posting hygiene scores on notice boards create public benchmarking: students compare room or group cleanliness openly.

This social practice fosters internal accountability, not primarily through penalties but via social recognition and peer pressure. Students feel ashamed if their room scores poorly, or proud if declared "cleanest room." This is collective social control that is more sustainable than individual oversight.

Moreover, students independently perform *ro'an* without reminders, evidence that consistent structures and flow of duties have internalized intrinsic awareness. They no longer view cleanliness as an extra task, but as an integral aspect of their identity. With continued enforcement, the culture of cleanliness evolves from administrative to communal habit rooted in pesantren life.

Thus, the structure of a healthy culture at Pesantren Nurul Qornain has progressed from a formal system to a lasting collective habit. Its success lies not in having documents per se, but in their internalization and consistent execution, with full participation from the entire pesantren community.

3.1.3 Habitual Healthy Behavior: Transformation at Both Individual and Collective Levels

A healthy culture in the pesantren does not form instantly or solely by top-down rules; it develops gradually through small, repeated practices. These habits serve as the bridge between written regulation and deep-rooted behavior change, both individually and collectively within the *santri* community. In this communal context, these habits do more than shape personal conduct; they establish a shared value system and social norms. This process illustrates that lasting health culture emerges not just from structural intervention, but from the *santri* themselves.

In-depth interviews revealed that new *santri* undergo a progressive behavioral transformation. One student explained: "*At first, we mixed all trash together and the wudu area was slippery, but after repeating it many times, now santri automatically separate wet and dry waste*." (Santri15, 2025)

This quote points to a progression from disorder to disciplined hygiene. The "repetition" mentioned refers to continuous reinforcement, through instruction, supervision, and environmental modeling.

Another *santri* added: "*If someone litters, another santri immediately criticizes them—sometimes harshly, sometimes just a look*." (Santri08, 2025)

This illustrates active peer control. When *santri* feel empowered to correct each other, hygiene becomes more than institutional order, it becomes collective consciousness. Responsibility for cleanliness shifts from formal authorities like the kyai or staff to the students themselves.

Observations support these accounts. In the mosque and dining area, *santri* automatically dispose of waste separately (organic vs. non-organic) without prompting. The wudu area shows orderly queues with no standing water or slipperiness. Dining tables are tidy afterward—the students themselves clear plates and clean surfaces.

Some even initiated their own efforts: "*Me and my friends created a small group to take turns guarding the back dorm area, it's often messy there*." (Santri11, 2025)

This signals a grassroots cleanliness movement. When *santri* initiate hygiene efforts independently, it demonstrates that a healthy culture has assimilated into their social and cognitive frameworks.

Habit formation is key to changing behavior among *santri*. Initially, healthy behaviors require repeated instruction and perhaps intensive oversight. However, over time these repetitions automate actions, like sorting waste, orderly queuing, and cleanliness of shared spaces. These actions then become internal norms, not requiring strict external monitoring. Peer feedback is a highly effective form of social control, often stronger than formal sanctions, since it is internal to the group. A simple glance can correct deviant behavior.

This suggests that consistent habit habits can establish a self-sustaining culture of health, without ongoing formal enforcement. The transformation occurs at both individual levels, for example, awareness and established hygiene habits, and communal levels, where *santri* collectively uphold these norms.

Active student involvement in maintaining their environment points to the emergence of a sense of ownership. When *santri* feel responsibility over their pesantren environment, cleanliness becomes part of collective pride, not just compliance. Visitors see that they care not because they must, but because they want to protect their shared space. Habitual practices at Pesantren Nurul Qornain thus serve not just as behavior-change tools, but as mechanisms for instilling new value systems and social structures that are deeply rooted in daily life.

3.1.4 The Role of Santri Husada as Change Agents

In the hierarchical system of the pesantren, *santri husada* (student health cadres) occupy a strategic role as bridges between structural policies set by the kyai and administrators and everyday *santri* practices. Their position is unique, they operate within formal structures while also being part of the general *santri* community, providing them social and emotional proximity advantages. They're not merely technical implementers but behavioral models for their peers. *Santri husada* serve in an intermediary role, between modeling and monitoring, between education and discipline. Within the pesantren ecosystem, they extend health messages downward for greater acceptance and upward when implementation issues arise.

Interviews with several health cadres revealed the weight of their responsibility. One explained: "*We have a set schedule: we give morning health talks, check the environment, and help those struggling with thaharah practice. But we try to communicate so it doesn't seem preachy*." (Husada02, 2025)

Another added a social dimension: "*When someone has stomach issues or a mild fever, they come to us before going to poskestren. So we act as an initial filter*." (Husada05, 2025)

These responses demonstrate that their responsibilities extend beyond formal health education, they include preventative care and peer support. They act as the starting point in the pesantren's health system: giving first aid, detecting issues early, and even advising informally.

Observations show *santri husada* actively monitoring wudu areas, checking trash cans, and greeting *santri* who deviate, without harsh reprimands, but with light, friendly reminders. In one instance, a cadre gently advised a peer during wudu: "*Bro, you didn't use enough soap, try again for better cleanliness*," while smiling and demonstrating proper technique.

They also documented minor health cases (like colds, cuts, or digestive problems) and reported to *poskestren* administrators. This documentation not only serves administrative purposes but also informs higher-level decision-making.

These findings suggest *santri husada* play a vital intermediary role. They bridge structural systems and the *santri* community, making them essential links in building a healthy culture. Their dual role (as monitors and peers) makes their approach more accepted than instructions from administrators or the kyai, as they communicate on equal social footing.

Their presence also confirms that cultural change is not only top-down but grows from within the community (bottom-up). With similar ages and experiences, health cadres excel at horizontal communication, making health messaging more digestible. Trust built through proximity transforms them into peer models, a powerful dynamic in community-based nonformal education.

It is important to note that *santri husada* do not treat *santri* merely as policy targets but engage them as active learners. They participate in creating, implementing, and evolving the healthy culture. This is a key element of cultural transformation: change results not from imposition or surveillance but from active community participation. *Santri husada* embody that participatory spirit.

Beyond technical duties, they bridge social and psychological gaps between formal rules and actual behavior in the field. Their presence enriches the pesantren health ecosystem by providing informal, flexible, and human-centered education. Over the long term, their role builds an internal cadre system that preserves the healthy culture even amid leadership changes.

Overall, this study demonstrates that participative kyai leadership, formal health culture structures, group-based habit formation, and strategically positioned *santri husada* together create an ecosystem that shapes *santri* into physically, mentally, and spiritually healthy individuals. Each element, leadership, structure, habits, and internal cadres, reinforces the others, forming an authentic implementation of the Pesantren Medical model.

Discussion

Findings indicate that the kyai plays a dual role: monitoring cleanliness (task-oriented) and fostering the emotional spirit of the santri (human-relation-oriented). This aligns with Keating (1986), who divides leadership styles into these two orientations. When the kyai directly participates in cleaning duties and gives instructions, he demonstrates a task-oriented approach, providing guidance and supervision. However, when he offers appreciation and instills positive shame, he prioritizes relationship orientation, coaching and supportive behavior.

This pattern is consistent with Sailin et al. (2024), who emphasize the effectiveness of situational leadership in pesantren contexts, leaders who are able to alternate between directive and supportive roles depending on the maturity and readiness of their followers. At Nurul Qarnain, the kyai exhibits both leadership modes by actively initiating hygiene practices and empowering student leaders, which reflects the situational leadership theory of Blanchard (1992).

The successful cultivation of a healthy culture in this pesantren is not solely based on top-down directives but is rooted in the kyai's embodiment of transformational and servant leadership. Muhammad & Sari (2021) have noted that such leadership fosters moral development and institutional productivity in Islamic schools. In this study, the kyai's hands-on involvement, such as sorting trash, leading cleaning routines, and offering moral reinforcement, illustrates this dual framework in practice.

According to Tasmuji (2011) and Koentjaraningrat (1993), culture is not merely behavior but a system of inherited meanings and symbols. Hygiene practices at Nurul Qarnain, such as the use of SOPs, hygiene evaluation forms, and public accountability boards, reflect a system where health behaviors are internalized as collective values. Actions like waste sorting or orderly ablution become normative—not enforced, but voluntarily practiced, indicating successful cultural internalization.

This process echoes the concept of moral habituation emphasized by Muhibbin Syah (2000) and Abuddin Nata (1999), who argue that repetition leads to the formation of moral character. The routine

nature of cleanliness at Nurul Qarnain, reinforced through role models, peer control, and structured routines, shows how repetition transforms behavior into identity.

The integration of leadership, structural routines, and behavioral habituation reflects an ecosystem of mutual reinforcement, where top-down guidance meets bottom-up participation. These findings resonate with Arifin et al. (2024), who argue that modern pesantren leadership is not only about authority but also about mobilizing community engagement toward shared goals.

In contrast to many secular school health programs, which often rely on externally driven interventions such as school-based campaigns, nurse-led sessions, or periodic health screenings, the *Pesantren Medical* model represents a more internally embedded and culturally-driven system. In secular contexts, health education often suffers from a lack of integration into daily routines and tends to emphasize short-term behavioral change without sufficient emotional or moral anchoring. While initiatives like the UKS (Usaha Kesehatan Sekolah) in Indonesian public schools provide valuable resources, they frequently lack the social cohesion and spiritual reinforcement found in pesantren.

For example, a study by Andriyani et al. (2022) on health programs in public junior high schools showed improvement in hygiene knowledge but reported low levels of consistent student participation due to weak role modeling and absence of peer-led mechanisms. By comparison, the success of health culture in Nurul Qarnain pesantren lies in its integration of kyai authority, peer monitoring through *santri husada*, and the embedding of cleanliness into religious routines, offering a model that combines structural, relational, and spiritual dimensions.

Thus, this study contributes not only to pesantren literature but also offers insights for broader health education settings. Secular and faith-based institutions alike can benefit from approaches that build internal ownership, social reinforcement, and leader role-modeling rather than relying solely on external incentives or campaigns.

In summary, the *Pesantren Medical* model is not merely a management system but a lived cultural framework where leadership, institutional routines, and internal agents of change co-create a sustainable health environment. This study broadens the discourse on health education by showing that behavior change is more enduring when grounded in spiritual values, community norms, and participatory leadership, principles that are transferable beyond pesantren contexts to other residential or values-based learning environments.

4. CONCLUSION

This study finds that the cultivation of a healthy culture at Pesantren Nurul Qarnain is primarily driven by the kyai's transformative and participative leadership, which integrates direct role modeling with emotional and moral guidance. Rather than coercion, the kyai inspires hygiene practices through respect and emulation, supported by structured systems such as SOPs, routine evaluations, and accountability mechanisms. Health behaviors among santri become internalized through repetition and peer reinforcement, with santri husada acting as health agents who bridge institutional policies and daily practices. These findings suggest that effective health education in pesantren relies not only on infrastructure but also on the synergy of spiritual leadership, social control, and culturally grounded behavioral habituation. The study introduces the Pesantren Medical model—a contextual framework integrating religious valuess with health education—that holds promise for replication in similar educational settings. However, the study's scope is limited to a single pesantren, which may affect the generalizability of the findings. Future research should explore the implementation and adaptation of this model in diverse pesantren environments to assess its broader applicability and long-term impact.

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