

Institutionalizing Humanitarian Jihad: Muhammadiyah's Public Ethics and Health Governance Narratives in Indonesia

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Abstract

This article examines how Muhammadiyah converts jihad from a general religious vocabulary into an institutional ethic of public health governance. It does not treat jihad primarily as armed struggle or private moral discipline, but as a contested language through which religious commitment is translated into organized care, professional service, scientific authority, and public accountability. Using qualitative comparative narrative analysis, the study compares three clusters of official Muhammadiyah discourse published up to 2023: the foundational narrative of al-Ma'un and Penolong Kesengsaraan Oemoem/Pembina Kesejahteraan Umat (PKO/PKU); the managerial narrative of hospitals and health institutions; and the crisis-governance narrative developed through the Muhammadiyah COVID-19 Command Center (MCCC). The analysis shows a patterned transformation. Foundational narratives moralize suffering and universalize service; institutional narratives proceduralize religious duty through standards, expertise, and organizational discipline; crisis narratives centralize coordination while legitimating biomedical knowledge, vaccination, and collective risk reduction. These narratives are mutually reinforcing but not identical. Professionalization expands institutional capacity while creating tensions involving bureaucratization, financial sustainability, and unequal organizational resources. The article argues that Muhammadiyah's distinctive contribution lies not merely in describing social service as jihad, but in institutionalizing humanitarian jihad as a repeatable governance practice. This formulation clarifies how a faith-based civil society organization can produce public ethics through infrastructures that operate across religious boundaries while retaining an explicitly Islamic moral grammar.

Keywords: Muhammadiyah; humanitarian jihad; public ethics; health governance; al-Ma'un.

INTRODUCTION

The public meaning of jihad remains politically and analytically unstable. In international debate, the term is frequently reduced to violent mobilization, while in Muslim ethical traditions it also denotes disciplined striving, moral responsibility, protection of life, intellectual effort, and service to others. The reduction of jihad to warfare obscures the institutional settings in which Muslims translate religious obligation into routine public action. Hospitals, clinics, disaster-response bodies, schools, charitable agencies, and professional associations are not peripheral to this translation. They are among the principal locations where religious concepts acquire administrative form, material resources, measurable outputs, and public consequences.

Muhammadiyah provides a particularly important case for examining this process. Founded in Yogyakarta in 1912, the organization developed a large network of educational, health, welfare, philanthropic, and humanitarian institutions. Its public identity has long been associated with reformist Islam, organizational modernism, and the establishment of social services. Scholarship has accordingly described

Muhammadiyah as a major component of Indonesian civil society and as a religious movement that combines doctrinal reform with institution building (Hefner, 2000; Nakamura, 2012; Peacock, 1978). Yet the ethical and political significance of its health institutions cannot be explained simply by counting hospitals or describing charitable activities. The more difficult question concerns the narrative work through which health service is rendered Islamic, public, professional, and universal at the same time.

The theology of al-Ma'un is central to Muhammadiyah's self-description. Derived from the Qur'anic chapter condemning those who neglect orphans and the poor while performing empty piety, al-Ma'un has been interpreted within Muhammadiyah as a demand to convert faith into organized social assistance. This interpretation has supported hospitals, orphanages, schools, disaster relief, and philanthropic programs. It also provides a moral language in which care for vulnerable people is not optional benevolence but evidence of religious truthfulness. The establishment of *Penolong Kesengsaraan Oemoem* (PKO) and the opening of an early Muhammadiyah clinic in 1923 are repeatedly narrated as institutional expressions of this ethic. By its centenary in 2023, PKU Muhammadiyah Yogyakarta was publicly represented not only as a hospital but as a historical embodiment of service across social and religious boundaries (Muhammadiyah, 2022a, 2023a).

The COVID-19 pandemic intensified the importance of this institutional tradition. Through the Muhammadiyah COVID-19 Command Center (MCCC), the organization coordinated hospitals, universities, regional branches, philanthropic bodies, religious authorities, volunteers, and communication networks. Muhammadiyah supported infection prevention, treatment, social assistance, public education, and vaccination. This response is analytically significant because it linked Islamic obligation with scientific knowledge and centralized coordination. It also demonstrated that humanitarian ethics are effective only when they can be activated through existing infrastructures. The pandemic therefore exposed the relationship between moral narrative and organizational capacity more clearly than ordinary periods of service delivery.

This article asks: How does Muhammadiyah narratively construct jihad as an ethic of health governance, and how does that construction vary across foundational, institutional, and crisis contexts? The article develops three arguments. First, Muhammadiyah's health narratives transform jihad by connecting religious striving to the protection of life and the organized alleviation of suffering. Second, this ethical transformation is inseparable from professionalization. Compassion becomes administratively consequential through hospitals, expertise, budgets, standards, coordination, and reporting. Third, institutionalization generates tensions. The expansion of professional health services can distance organizations from their original egalitarian rhetoric, subject care to market pressures, and produce uneven capacities across regions. Humanitarian jihad should therefore be understood neither as mere rhetoric nor as an automatically coherent ethic, but as an ongoing process of aligning moral commitments with institutional practices.

The study is not a systematic literature review. It is a qualitative comparative narrative analysis of selected institutional discourses and historically relevant scholarship available up to 31 December 2023. The purpose is interpretive rather than exhaustive: to identify

recurring narrative structures, compare their governance implications, and explain how a religious moral vocabulary becomes embedded in public institutions. This approach enables the article to move beyond a celebratory institutional history while avoiding the opposite error of treating religious language as a decorative cover for organizational interests.

Jihad is a multivalent Islamic concept whose semantic field includes struggle, exertion, perseverance, defense, ethical self-formation, and collective action. Historical jurisprudence contains extensive discussion of warfare, but neither the Qur'anic vocabulary nor later Muslim usage is exhausted by military meaning. Modern Muslim movements have invoked jihad to describe education, anti-colonial resistance, economic development, disaster relief, social reform, and professional service. Analytically, the task is not to select one supposedly authentic meaning and exclude all others. It is to examine how actors authorize a particular meaning in a specific institutional field.

A public-ethics approach shifts attention from abstract definition to social consequences. Public ethics concerns the norms through which actors justify obligations toward strangers, distribute responsibilities, recognize vulnerability, and evaluate institutional conduct. When jihad is used in a health-governance narrative, it establishes a relationship among religious duty, human suffering, expertise, and collective organization. It can motivate sacrifice, intensify solidarity, and frame professional work as morally meaningful. It can also discipline members by presenting compliance with organizational coordination or public-health measures as an expression of religious responsibility.

This approach avoids two symmetrical errors. The first is securitization, in which jihad is read primarily through the possibility of violence. The second is romanticization, in which every peaceful use of jihad is assumed to be ethically unproblematic. A public-ethics analysis instead asks who is protected, which authorities are recognized, what kinds of knowledge are trusted, how resources are allocated, and whether universal claims are reflected in actual access to services.

Health governance extends beyond the state. It includes the institutions, networks, rules, professional communities, financing mechanisms, and public narratives through which health priorities are defined and services are delivered. In Indonesia, religious organizations have historically filled gaps in education, welfare, and health provision while also collaborating with public authorities. Their role cannot be reduced to subcontracting state functions. They generate social trust, mobilize volunteers, collect donations, form professional identities, and interpret public policy for religious constituencies.

Muhammadiyah illustrates the hybrid position of a faith-based governance actor. Its hospitals participate in regulated health markets and national insurance arrangements, employ biomedical professionals, and cooperate with ministries and international agencies. At the same time, they are described as *amal usaha*: organized endeavors through which the movement realizes its religious mission. This dual identity creates both capacity and tension. Religious legitimacy can mobilize resources and strengthen commitment, but professional institutions require financial stability, technical regulation,

managerial hierarchy, and quality assurance. The language of service must therefore mediate between prophetic moral claims and the institutional rationalities of modern healthcare.

The concept of institutionalization is used here to describe the conversion of a moral imperative into durable roles, organizations, procedures, and expectations. Institutionalization does not mean that the original ethic remains unchanged. On the contrary, it involves selection and translation. Certain dimensions of al-Ma'un—service, vulnerability, social usefulness, and opposition to empty ritual—become prominent. Other possible dimensions are subordinated to the operational requirements of hospitals and command structures. The result is a practical public theology whose meaning is produced through recurrent organizational action.

Al-Ma'un as a moral grammar of organized care

Within Muhammadiyah, al-Ma'un functions as more than a scriptural citation. It is a moral grammar that connects correct belief with the social visibility of care. Accounts of Ahmad Dahlan's teaching commonly emphasize his insistence that students repeatedly study the chapter until they translated it into assistance for poor and marginalized people. Whether narrated as historical memory, movement mythology, or ethical pedagogy, the story establishes a criterion of religious authenticity: recitation without organized action is inadequate.

This grammar has three governance implications. First, it identifies suffering as a public claim rather than a private misfortune. Second, it places responsibility on an organized community, not only on individual donors. Third, it favors durable institutions over episodic charity. These implications distinguish Muhammadiyah's narrative from a purely voluntarist account of benevolence. Hospitals and clinics become technologies for stabilizing compassion across time, creating professional continuity, and widening the scale of service.

Yet al-Ma'un does not itself determine a single institutional model. It can support free services for the poor, subsidized cross-class provision, philanthropic fundraising, or commercially sustainable hospitals that allocate part of their capacity to social missions. The meaning of al-Ma'un is therefore continually negotiated within changing political economies of healthcare. This indeterminacy is not evidence of irrelevance. It is precisely why narrative analysis is necessary: the same moral symbol can legitimize different arrangements, and its critical force depends on how it is connected to access, accountability, and organizational priorities.

METHOD

This study uses qualitative comparative narrative analysis. Narrative is understood as an organized account that connects actors, moral problems, causal mechanisms, institutional responses, and desired outcomes. Institutional narratives do not merely describe events; they allocate responsibility, authorize expertise, create collective identity, and define legitimate action. Comparison is used to identify how the same moral vocabulary changes when it moves across historical and organizational settings.

The corpus was purposively constructed from materials available up to 31 December 2023. It includes official Muhammadiyah reports and website publications, organizational statements concerning COVID-19, public accounts of PKO/PKU history and the centenary of PKU Muhammadiyah Yogyakarta, statements on vaccination and health service, and secondary scholarship on Muhammadiyah, Islamic philanthropy, civil society, humanitarianism, and pandemic response. The selection does not claim exhaustive coverage. Documents were included when they contained explicit or implicit claims about religious obligation, service beneficiaries, professional authority, organizational coordination, public accountability, or the relationship between Islam and health.

The analysis compares three narrative clusters. The foundational cluster concerns al-Ma'un, Ahmad Dahlan, PKO, and the historical origins of PKU. The institutional cluster concerns hospitals, managerial responsibility, professional standards, collaboration, and the universal scope of service. The crisis cluster concerns MCCC, pandemic coordination, biomedical authority, prevention, treatment, vaccination, volunteerism, and social protection. Each cluster was coded according to five questions: What is the moral problem? Who is the responsible actor? Which knowledge is treated as authoritative? Through what organizational mechanism is action conducted? What tensions or exclusions are obscured by the narrative?

The comparative logic is interpretive. It does not measure the frequency of keywords or infer the attitudes of all Muhammadiyah members. Official discourse is treated as organizational self-representation: a source for understanding how the movement seeks to legitimate action and discipline its institutions. Such discourse may diverge from local practice. The article therefore distinguishes narrative claims from verified service outcomes and uses secondary studies to identify organizational challenges. This distinction prevents official statements from being treated as transparent evidence of performance.

The study is limited in three respects. First, it relies primarily on publicly accessible institutional materials and does not include interviews with hospital staff, patients, or MCCC volunteers. Second, the decentralized character of Muhammadiyah means that local institutions vary substantially, while central narratives often present a more coherent organizational image. Third, the cutoff at 2023 excludes subsequent developments. These limitations make the article a theory-building and interpretive contribution rather than a comprehensive evaluation of Muhammadiyah's health system.

Table 1. Comparative analytical framework

Narrative arena	Core moral problem	Governance mechanism	Primary tension
Foundational: al-Ma'un and PKO/PKU	Neglect of the poor and separation of worship from social responsibility	Organized charity, clinics, hospitals, and universal service	Mythic coherence versus historical and local variation

Institutional: hospitals and professional service	Need to sustain reliable, high-quality, accountable care	Professional expertise, standards, hierarchy, collaboration, financing	Mission drift, marketization, and unequal access
Crisis: MCCC and COVID-19	Collective threat, uncertainty, misinformation, and fragmented response	Central coordination, biomedical guidance, volunteers, hospitals, vaccination	Centralization versus decentralization; emergency solidarity versus durable reform

RESULTS AND DISCUSSION

1. The Foundational Narrative of Humanitarian Service

Muhammadiyah's foundational health narrative begins with a moral diagnosis: religious life becomes false when ritual observance is detached from responsibility toward people experiencing poverty, illness, and abandonment. Al-Ma'un supplies the scriptural form of this diagnosis. The chapter condemns those who deny moral accountability, repel orphans, fail to encourage feeding the poor, perform prayer carelessly, act for display, and withhold ordinary assistance. In Muhammadiyah's pedagogical memory, Ahmad Dahlan's repeated teaching of al-Ma'un transforms exegesis into an imperative for collective organization.

This narrative does not portray the poor merely as recipients of individual alms. They appear as a test of the religious community's capacity to build institutions. The movement's early welfare initiatives, including PKO, are consequently remembered as evidence that Islam can generate modern public service. The shift is crucial: the moral unit is no longer a single act of giving but a continuously operating organization. Clinics require buildings, personnel, medicine, administration, and financing. Institutional durability becomes part of ethical seriousness.

The history of PKU Muhammadiyah Yogyakarta is repeatedly positioned within this sequence. Official centenary accounts describe the hospital as a heritage institution that originated in the movement's commitment to public health and helped stimulate the later growth of Muhammadiyah hospitals and clinics. In 2022, Muhammadiyah reported approximately 120 hospitals and around 400 Muhammadiyah-'Aisiyah clinics, while emphasizing collaboration among health and educational institutions (Muhammadiyah, 2022a). The figures are organizational claims rather than independently audited data in this study, but their narrative function is clear: scale is presented as accumulated proof that al-Ma'un can be reproduced institutionally.

The centenary discourse also emphasizes service without discrimination. At the 2023 commemoration, PKU Muhammadiyah Yogyakarta was described as having served society without distinguishing social or religious groups, and this universality was explicitly linked to the spirit of al-Ma'un (Muhammadiyah, 2023a). The claim matters because a faith-based institution can define its public in two different ways: as an internal constituency of believers or as a universal community of need. Muhammadiyah's health narrative selects the second. Islamic identity motivates service but does not formally restrict beneficiaries.

This universalism functions as public ethics in at least three ways. It identifies human vulnerability as morally prior to communal boundaries. It presents Islamic commitment as compatible with citizenship and national welfare. It also protects the movement's institutions from the accusation that religious service is merely a strategy of conversion or sectarian competition. Historical scholarship nevertheless shows that competition among religious organizations was part of the environment in which modern welfare institutions developed. The ethical significance of universal service therefore lies not in the absence of institutional interests, but in the norm by which those interests are publicly constrained.

The foundational narrative also contains a modernist theory of action. Suffering is not addressed only through prayer, patience, or spontaneous generosity. It is addressed through planned intervention. Peacock (1978) interpreted Muhammadiyah's reformism as an effort to make religious commitment socially effective through disciplined organization. Nakamura (2012) likewise documented the movement's embeddedness in local society and its capacity for institutional adaptation. Health service exemplifies this orientation: it combines scriptural motivation with practical knowledge, organizational routines, and the expectation of improvement.

Calling this orientation humanitarian jihad is analytically useful only when the phrase is precisely defined. The narrative does not eliminate every other meaning of jihad, nor does it require official documents to use the term continuously. Rather, it constructs a recognizable pattern of striving in God's path through the protection of life, relief of suffering, and mobilization of collective resources. Jihad becomes humanitarian when the object of struggle is preventable suffering and when the means are care, knowledge, institutional discipline, and solidarity.

At the same time, the foundational narrative can become too smooth. It can compress a century of organizational conflict, local initiative, financial difficulty, and political negotiation into a single line from scripture to hospital network. Such compression is typical of institutional memory: it provides coherence and transmits identity. A critical reading does not dismiss the narrative as invented. It asks what the narrative enables and what it hides. It enables members to interpret professional health work as religiously meaningful. It can hide the contingent choices through which specific hospitals balance charity, insurance reimbursement, investment, staff welfare, and competition.

The critical force of al-Ma'un therefore depends on its continued ability to question institutions, not merely celebrate them. If it becomes only a founding legend, it can legitimize organizational expansion without evaluating whether poor and marginalized groups actually gain access. If retained as a standard of judgment, it asks whether institutional success is being measured by buildings and revenue alone or by the reduction of avoidable suffering. This distinction becomes more important as Muhammadiyah's health institutions grow in technical complexity.

2. Amanah, Professionalism, and the Governance of Muhammadiyah Health Institutions

The institutional health narrative differs from the foundational narrative in vocabulary and emphasis. The moral drama of neglected suffering remains present, but the central

problem becomes reliability. A hospital cannot fulfill al-Ma'un through intention alone. It must ensure clinical competence, patient safety, financial continuity, regulatory compliance, staff coordination, and public trust. Consequently, the language of compassion is joined by the language of amanah, professionalism, quality, accountability, and organizational excellence.

Amanah is especially important because it links theological obligation with delegated responsibility. Resources, authority, professional knowledge, and patient trust are treated as things held in trust rather than possessed without constraint. In governance terms, amanah can support transparency, careful stewardship, and answerability. It can also strengthen internal discipline by framing negligence as both professional failure and moral breach. The concept therefore helps translate religious ethics into expectations concerning management.

Professionalism introduces another form of authority. Foundational narratives authorize action through scripture and the example of Ahmad Dahlan. Hospital narratives must additionally recognize medical science, accreditation, licensure, and specialized expertise. This does not necessarily secularize the institution. Instead, scientific competence is incorporated into religious responsibility. A clinician's expertise becomes one means through which the protection of life is pursued. The relevant contrast is not faith versus science, but responsible faith allied with verifiable knowledge versus piety detached from competence.

The centenary slogan 'Lintasi Zaman, Sehatkan Bangsa'—crossing eras, making the nation healthy—illustrates this temporal and public orientation. It presents institutional endurance as a moral achievement while linking hospital service to national welfare. The institution is not represented as serving only Muhammadiyah members. Nor is it framed solely as a private healthcare provider. It is positioned as a religiously animated component of public infrastructure.

Collaboration is another recurring element. Muhammadiyah hospitals are embedded in a wider ecosystem of universities, medical schools, philanthropic bodies, women's organizations, disaster-management institutions, and territorial branches. Official accounts of PKU's centenary emphasized cooperation with other Muhammadiyah enterprises, especially in education (Muhammadiyah, 2022a). In governance terms, this network can support workforce development, research, referrals, public education, and emergency mobilization. The movement's institutional density is therefore not merely a collection of separate organizations; it can function as an infrastructure of coordination.

Nevertheless, networked governance is uneven. Muhammadiyah is decentralized, and local institutions vary in financial resources, managerial quality, professional staffing, and regional demand. A strong central narrative can imply uniformity that does not exist in practice. Some hospitals may be advanced referral institutions, while others face severe constraints. Institutionalizing humanitarian jihad thus requires more than naming every health enterprise as an expression of al-Ma'un. It requires mechanisms for redistributing expertise and resources across the network.

Financial sustainability presents the sharpest tension. Modern healthcare is costly, and hospitals operate within insurance systems, labor markets, pharmaceutical supply chains,

and competitive service environments. Charging fees or pursuing efficiency does not automatically contradict humanitarian ethics. Without stable revenue, an institution cannot retain staff, maintain equipment, or serve patients over time. The ethical question is how financial rationality is subordinated to, balanced with, or allowed to displace the mission of equitable care.

This tension can be expressed as a distinction between commercialization and sustainability. Sustainability uses financial discipline to preserve the institution's capacity to serve. Commercialization redefines service primarily according to revenue and market position. In practice the boundary is not self-evident. A premium service may cross-subsidize care for poorer patients, but it may also redirect attention toward profitable groups. A hospital may adopt efficiency standards that reduce waste, or it may use them to normalize understaffing. Religious vocabulary cannot resolve these questions by itself. It must be connected to transparent indicators of access, quality, staff conditions, and social benefit.

The narrative of professional excellence can similarly produce ambivalent effects. It challenges the assumption that faith-based care may rely on goodwill while accepting low quality. It insists that religious commitment requires competent service. Yet excellence can become a prestige project centered on buildings, technology, rankings, and organizational visibility. Al-Ma'un provides a counter-principle: excellence should be evaluated by its contribution to vulnerable people, not only by institutional distinction.

Muhammadiyah's public ethics therefore emerges through a double movement. Religious language humanizes administration by insisting that patients are moral subjects rather than service units. Administrative rationality disciplines religious aspiration by requiring procedures, competence, and accountability. The institutionalization of humanitarian jihad occurs in this interaction. It fails when either side dominates completely: moral rhetoric without capable systems produces unreliable care, while systems without moral scrutiny can reproduce exclusion efficiently.

3. Faith, Science, and Coordinated Action during the COVID-19 Crisis

The COVID-19 pandemic created a different narrative environment. In ordinary health governance, hospitals treat individual patients within established routines. A pandemic turns health into a problem of collective risk, uncertain knowledge, behavioral coordination, and institutional surge capacity. Religious gatherings, burial practices, mobility, misinformation, and vaccine acceptance become part of health governance. The responsible actor is no longer the hospital alone but a distributed organization capable of influencing public conduct.

Muhammadiyah responded by establishing the Muhammadiyah COVID-19 Command Center. An official account states that MCCC was formed through a Central Board directive to coordinate programs and actions in response to COVID-19 (Muhammadiyah, 2021a). The command-center form is significant. It centralizes information and strategic direction while activating hospitals, universities, regional organizations, volunteers, philanthropic agencies, and communication channels. The narrative of jihad in this setting shifts from the historical creation of institutions to the rapid coordination of existing ones.

Crisis discourse also reconfigured religious authority. Decisions concerning congregational worship, infection prevention, and vaccination required Muhammadiyah leaders to relate Islamic jurisprudence to epidemiological evidence. The organization publicly encouraged its leaders at all levels to provide clear explanations of vaccination and mobilize organizational structures in support of public understanding (Muhammadiyah, 2021b). This stance treated biomedical knowledge as compatible with religious duty and presented vaccination as collective protection rather than an alien intervention.

The ethical object of action was not only the infected patient. It included healthcare workers, families, vulnerable households, people exposed to misinformation, and communities at risk of transmission. MCCC-related initiatives encompassed treatment, volunteer training, food assistance, prevention campaigns, and vaccination. Studies of Muhammadiyah's pandemic response describe the organization's ability to mobilize a pre-existing institutional network, while also noting problems of coordination, resource limitation, and the unprecedented scale of the crisis (Humaidi et al., 2022).

The pandemic narrative has a strong solidaristic structure. First, it defines COVID-19 as a shared threat that cannot be addressed through individual piety alone. Second, it frames compliance with health measures as responsibility toward others. Third, it authorizes expertise and organizational coordination as religiously legitimate. This structure counters a privatized understanding of faith in which personal confidence in divine protection displaces measures to reduce harm to strangers.

Jihad as public ethics becomes particularly visible here. Healthcare workers' endurance, volunteers' service, institutional expenditure, and organizational compliance can be narrated as forms of strenuous moral action. The point is not to glorify suffering or demand limitless sacrifice from staff. A responsible jihad narrative should not make burnout, unsafe working conditions, or inadequate protection morally invisible. Rather, it should distribute responsibility upward as well as downward: leaders and institutions are obligated to provide equipment, support, reliable information, and fair coordination.

The crisis also demonstrates the value of organizational memory. MCCC did not emerge from nothing. Muhammadiyah already possessed hospitals, universities, branches, philanthropic channels, and experience in disaster response. The command center could therefore connect religious legitimacy with operational capacity. This supports a broader proposition: public ethics becomes resilient when it is infrastructural. Moral commitment that exists only at the level of discourse must improvise during crisis; moral commitment embedded in institutions can be activated at scale.

Yet centralization creates its own tensions. Command narratives may understate the autonomy of local branches and the practical knowledge of frontline workers. They can also present a coherent national response despite significant variation in regional capacity. Effective crisis governance requires standardized direction, but it also requires feedback and adaptation. In Muhammadiyah's decentralized structure, the challenge is not choosing between central command and local initiative. It is creating accountable coordination between them.

A further tension concerns the temporality of emergency solidarity. Crises generate exceptional donations, volunteerism, and institutional cooperation. These may decline when public attention moves elsewhere. The ethical test is whether emergency innovations produce durable improvements in surveillance, infection control, occupational protection, community health communication, and inter-institutional coordination. Humanitarian jihad is institutionalized most fully when exceptional mobilization leaves behind stronger routine systems.

By 2023, Muhammadiyah continued to participate in vaccination initiatives, including collaboration supporting vaccination across numerous districts and cities during the transition toward endemic management (Muhammadiyah, 2023b). Such activity shows the extension of crisis governance beyond the initial emergency. It also illustrates how partnerships with government and international development actors are incorporated into Muhammadiyah's moral narrative. Collaboration is not represented as a loss of religious identity, but as a means of expanding public benefit.

4. Comparing Muhammadiyah's Health Governance Narratives

Comparison reveals both continuity and transformation. The three narrative arenas share a basic ethical structure: suffering is morally significant; religious commitment must become socially effective; organization is necessary; and service should extend beyond narrow communal boundaries. The object, actor, knowledge base, and mechanism of responsibility nevertheless change across arenas.

In the foundational narrative, the central moral failure is indifference. The paradigmatic subjects are the orphan, the poor, and the sick person abandoned by ritualistic society. Ahmad Dahlan and the early movement appear as moral entrepreneurs who expose the inadequacy of performative piety. Scripture is the primary authority, and the organizational solution is the creation of welfare institutions. The narrative's power comes from its simplicity: authentic faith produces care.

In the institutional narrative, the central failure is unreliability or mission drift. The relevant subjects include patients, staff, managers, regulators, and organizational leaders. Authority becomes plural: scripture, movement tradition, professional expertise, law, accreditation, and managerial knowledge all matter. The solution is not merely to establish institutions but to govern them well. The ethical question shifts from whether care exists to how care is organized, financed, monitored, and distributed.

In the crisis narrative, the central failure is fragmentation under collective threat. The subjects include entire populations linked through transmission risk. Epidemiological and clinical knowledge become especially authoritative, while religious leadership translates that knowledge into norms for worship and public behavior. The solution is coordinated mobilization through MCCC and the wider Muhammadiyah network. The ethical question is how quickly a decentralized movement can act collectively without suppressing local information or overburdening frontline workers.

These shifts can be described as moralization, proceduralization, and coordination. Al-Ma'un moralizes suffering by making neglect evidence of religious failure. Hospital governance proceduralizes the response by embedding duty in professional and

administrative systems. MCCC coordinates those systems under emergency conditions. Humanitarian jihad is not located in one stage alone. It is the narrative thread that links them: strenuous service moves from moral awakening to institutional routine and then to crisis mobilization.

The comparison also identifies a change in the imagined public. Foundational discourse emphasizes identifiable vulnerable groups. Institutional discourse imagines a broad patient public receiving universal and professional service. Crisis discourse imagines an interdependent population whose members can harm or protect one another through behavior. This expanding public is politically important. It enables an Islamic organization to articulate responsibilities that resemble public-health citizenship without abandoning religious language.

Another continuity is the rejection of a strict sacred-secular divide. Scripture motivates the establishment of clinics; professional medicine realizes the protection of life; organizational coordination becomes a form of religious responsibility. Muhammadiyah's narrative does not resolve every tension between revelation and expertise, but it normalizes their cooperation. During COVID-19 this cooperation became explicit because religious practice itself required adjustment in response to scientific assessment of risk.

The principal discontinuity concerns scale and abstraction. The al-Ma'un narrative is morally vivid because it begins with direct suffering. Large hospital networks and command centers operate through aggregate data, budgets, protocols, and population categories. These tools are indispensable, but they can distance decision-makers from lived vulnerability. The ethical role of foundational narrative is therefore not to replace administration but to keep administration answerable to persons who are least able to convert need into purchasing power or organizational influence.

Table 2. Narrative transformation across governance contexts

Dimension	Foundational narrative	Institutional narrative	Crisis narrative
Primary ethical failure	Indifference and empty ritual	Unreliable care and mission drift	Fragmentation, misinformation, and delayed response
Authoritative knowledge	Qur'anic ethics and movement memory	Religious values, professional medicine, regulation, management	Epidemiology, clinical science, religious guidance, crisis data
Organizational form	PKO/PKU and durable welfare institutions	Hospitals, clinics, universities, standards, partnerships	MCCC, coordinated networks, volunteers, vaccination programs
Imagined public	Poor, sick, orphaned, and marginalized people	Universal patient and national public	Interdependent population exposed to collective risk
Form of jihad	Service and institution building	Competent, accountable professional work	Coordinated protection, endurance, and risk reduction

Discussion

The findings support a conception of public religion that focuses on institutions rather than visibility alone. Religion enters the public sphere not only through political statements, symbols, elections, or legal demands. It also enters through the production of schools, hospitals, welfare systems, professional identities, and emergency infrastructures. Muhammadiyah's health governance narratives demonstrate how religious concepts can become socially consequential through organizational design.

The article's first theoretical contribution is to distinguish ethical reinterpretation from institutionalization. Many accounts note that jihad can mean peaceful striving or social service. That observation is necessary but insufficient. A concept becomes public ethics when it shapes durable expectations about who must act, through which institutions, using what knowledge, and under what standards of accountability. Muhammadiyah institutionalizes humanitarian jihad by connecting moral striving to hospitals, trained professionals, organizational budgets, command structures, and partnerships.

The second contribution concerns the relationship between faith and expertise. Modern health governance often assumes that religious authority and scientific authority are separate or competing. Muhammadiyah's narratives show a different configuration. Biomedical competence is incorporated into the moral obligation to protect life. During the pandemic, organizational leaders did not merely endorse science from outside; they used religious and organizational authority to make scientific guidance actionable within a mass constituency. This does not eliminate disagreement, but it creates a normative bridge between evidence and compliance.

The third contribution concerns infrastructure. Humanitarianism is frequently imagined as spontaneous compassion during exceptional suffering. Muhammadiyah's experience suggests that compassion becomes scalable when it is stored in institutions. Hospitals preserve clinical capacity; universities preserve expertise; branches preserve local reach; philanthropic agencies preserve funding channels; and command centers connect these resources during crisis. Infrastructure is therefore an ethical achievement, not only a technical asset.

This argument should not be converted into institutional triumphalism. Organizations can use moral narratives to defend authority, suppress criticism, or equate expansion with success. A hospital network may be large while access remains unequal. Central leaders may invoke coordination while local workers carry disproportionate burdens. Partnerships may increase capacity while creating donor dependence or programmatic priorities determined from outside. Public ethics requires institutional reflexivity: the capacity to evaluate whether governance practices reproduce the vulnerability they claim to address.

Three accountability tests follow from the analysis. The first is the access test: do poor, remote, disabled, stigmatized, or otherwise marginalized groups receive meaningful care? The second is the labor test: are health workers and volunteers protected, fairly treated, and allowed to raise concerns? The third is the transparency test: can stakeholders evaluate how resources are allocated, how priorities are set, and how religious mission

affects operational decisions? Without these tests, humanitarian jihad risks becoming a legitimating label.

The relationship with the state also requires careful interpretation. Muhammadiyah's health institutions supplement, collaborate with, and sometimes compensate for weaknesses in public provision. This can strengthen national health capacity and civic participation. It can also allow the state to rely on religious organizations without addressing structural inequalities. Civil society service should therefore not be romanticized as a substitute for universal public responsibility. The strongest governance model is complementary: religious organizations contribute trust, innovation, and reach while the state retains responsibility for equitable systems, regulation, and financing.

The universalism of Muhammadiyah's service narrative deserves particular emphasis. The organization grounds action in Islam while describing beneficiaries in non-sectarian terms. This combination offers an alternative to two common models: privatized religion with little public consequence, and politicized religion focused on coercive control of the public sphere. Institutional humanitarianism produces public presence through service. Its legitimacy depends less on enforcing religious identity than on demonstrating social usefulness and ethical reliability.

Yet universalism must be evaluated in practice. Formal openness does not automatically eliminate barriers created by cost, geography, gender, disability, bureaucracy, or social stigma. Future research should therefore compare organizational narrative with patient experience and service data. It should also investigate whether different Muhammadiyah hospitals operationalize social mission through cross-subsidies, charitable funds, insurance participation, outreach, or other mechanisms, and with what distributional effects.

Finally, the term jihad adds analytical value because it captures effort, discipline, and moral struggle, but it also carries political risks. Organizations must clarify that humanitarian jihad is not a euphemism designed merely to improve the public image of Islam. Its credibility depends on institutional evidence: protected lives, reduced suffering, competent services, accountable leadership, and cooperation across boundaries. The narrative is strongest when it remains open to criticism from its own ethical source. Al-Ma'un condemns performative piety; by extension, it can condemn performative humanitarianism.

CONCLUSION

Muhammadiyah's health governance narratives demonstrate that jihad can function as a public ethic when it is translated into durable institutions and accountable practices. Across the foundational narrative of al-Ma'un and PKO/PKU, the institutional narrative of professional hospital governance, and the crisis narrative of MCCC, religious striving is associated with the protection of life, alleviation of suffering, scientific competence, organizational discipline, and universal service.

The comparison reveals a cumulative process. Al-Ma'un turns social neglect into a religious problem. PKO/PKU turns that problem into an organizational mission. Hospitals turn mission into professional routines. MCCC reorganizes the network for collective

crisis response. The distinctive contribution of Muhammadiyah is therefore not simply a peaceful interpretation of jihad. It is the attempt to make humanitarian striving reproducible through infrastructure.

Institutionalization, however, is neither complete nor automatically virtuous. Professionalization can strengthen quality while increasing bureaucratic distance. Financial discipline can sustain institutions while encouraging market-oriented mission drift. Central coordination can accelerate action while obscuring local inequality and frontline burden. Humanitarian jihad remains credible only when organizational growth is subjected to tests of access, labor protection, transparency, and responsiveness to vulnerable groups.

This study has interpreted official discourse rather than measured outcomes. Further research should combine narrative analysis with interviews, comparative hospital case studies, financial and service-access data, and the experiences of patients and workers. Such research would clarify when Muhammadiyah's moral vocabulary functions as an effective governance resource and when it becomes mainly symbolic. The broader implication is that public ethics should be studied not only in texts and declarations but also in the institutions through which moral claims acquire budgets, procedures, professional roles, and consequences for human life.

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