

From Faith-Based Medical Relief to Transnational Health Capacity: EMT Muhammadiyah in Global Health Governance

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Abstract

This article examines the Emergency Medical Team (EMT) Muhammadiyah as an emerging non-state actor in global health governance through the end of 2022. Using qualitative historical-institutional document analysis, it interprets organizational records, Indonesian disaster-governance documents, World Health Organization standards, and scholarship rather than conducting a systematic literature review. The findings show that EMT Muhammadiyah developed by converting Muhammadiyah's hospital network, professional personnel, philanthropy, and disaster volunteers into a deployable medical capability aligned with international standards. Domestic responses supplied recurrent operational learning, while missions in the Philippines, Nepal, Myanmar-Bangladesh, and Pakistan connected the organization to state-led and multilateral humanitarian coordination. Its governance significance lies in four functions: translating global norms into organizational procedures, supplying surge capacity to national systems, representing locally rooted expertise in transnational networks, and linking religious legitimacy with impartial service. However, international engagement remained constrained by uneven readiness, dependence on public authorization and partner logistics, limited outcome data, and incomplete accountability to affected populations. EMT Muhammadiyah therefore illustrates how a faith-based organization can enter global health governance without becoming a conventional international NGO.

Keywords: Muhammadiyah; emergency medical teams; global health governance; faith-based humanitarianism; Indonesia.

INTRODUCTION

Global health governance is often described through the formal authority of states, the World Health Organization (WHO), multilateral agencies, donors, and international nongovernmental organizations. That description is incomplete. Health emergencies are governed through networks in which authority is distributed among ministries, professional bodies, humanitarian organizations, military and civil-protection agencies, universities, private providers, local governments, and community institutions. These actors do not possess equal power, but each may influence which problems are recognized, which standards are applied, who is authorized to respond, and how resources move across borders. Governance therefore refers not only to command but also to coordination, norm production, information exchange, capacity building, and accountability (Frenk & Moon, 2013; Gostin & Mok, 2009; Kickbusch & Szabo, 2014).

Emergency Medical Teams (EMTs) are a concrete expression of this networked governance. They consist of health professionals and operational support personnel organized to provide direct clinical care during disasters, outbreaks, conflicts, and other emergencies. The contemporary WHO EMT Initiative emerged from repeated failures in international disaster medicine, especially the 2010 Haiti earthquake, when large

numbers of foreign teams arrived with uneven competence, poorly declared capabilities, limited coordination, and weak accountability to national authorities and patients. The 2013 classification and minimum standards sought to replace improvised medical volunteering with predictable categories of service, self-sufficiency, clinical governance, registration, and coordination. The revised 2021 standards extended the approach from sudden-onset trauma toward all-hazards health emergencies and stronger integration with national systems (World Health Organization, 2013, 2021a).

The EMT Initiative is consequently more than a technical handbook. It is a governance regime. WHO and its partners define minimum expectations, mentor candidate teams, support peer review, promote common data and coordination procedures, and encourage ministries of health to regulate incoming assistance. Teams remain owned by governments, nongovernmental organizations, militaries, or other institutions, but they become interoperable through shared principles. This arrangement does not create supranational command over medical personnel. It creates conditional recognition: teams gain legitimacy by demonstrating declared capability, ethical practice, self-sufficiency, and willingness to operate under the authority of the affected state. The model combines transnational standard setting with national sovereignty (IFRC & World Health Organization, 2017; World Health Organization, 2019, 2021a).

Muhammadiyah offers an important case for understanding how a large faith-based organization enters this governance space. Founded in 1912, Muhammadiyah developed extensive institutions in education, health care, philanthropy, and social welfare. Its hospitals, clinics, universities, professional associations, local branches, and volunteer organizations created a reservoir of clinical skill and logistical reach before a specialized EMT existed. Its theology of *al-Ma'un* framed service to people facing deprivation as an institutional religious obligation rather than occasional personal charity. Disaster response therefore emerged from a broader infrastructure of organized social action (Baidhaw, 2015; Bush, 2014).

The 2004 Indian Ocean tsunami exposed the potential and limitations of that infrastructure. Muhammadiyah could mobilize doctors, hospitals, donations, students, and branches, but complex disaster operations required assessment, command, logistics, safety, data, coordination, and sustained recovery planning. During the following decade, the Muhammadiyah Disaster Management Center (MDMC) consolidated disaster work into a specialized organizational field. Medical response evolved from ad hoc teams attached to particular hospitals toward a national roster and deployable EMT capability. This transformation paralleled a wider professionalization of humanitarian action, in which organizations sought formal mandates, technical competencies, standard operating procedures, quality assurance, and external partnerships without necessarily abandoning volunteerism or religious motivation (Walker et al., 2010; Walker & Russ, 2011).

By 2022, EMT Muhammadiyah occupied a position between three institutional levels. At the local and organizational level, it drew personnel from Muhammadiyah-'Aisyiyah hospitals, universities, MDMC networks, and philanthropic support. At the national level, it registered and coordinated with health authorities, disaster-management agencies, and Indonesian diplomatic mechanisms. At the transnational level, it participated in WHO-

linked forums, humanitarian training, and overseas deployments. The all-female five-person contingent sent as part of Indonesia's medical delegation to the Pakistan floods in October 2022 is especially revealing. Muhammadiyah was the only nongovernmental medical organization represented in a delegation otherwise composed of government, military, police, and public-university personnel. The mission showed both recognition of non-state capability and continued dependence on state authorization and coordination (Pimpinan Pusat Muhammadiyah, 2022c, 2022d).

This case complicates two common assumptions. The first is that global health governance is produced primarily in Geneva, donor capitals, and large international organizations. Local and national actors also translate, contest, and operationalize global norms. The second is that faith-based humanitarian organizations belong outside professional health governance because religious identity is presumed to conflict with neutrality or technical rationality. In practice, faith-based organizations can combine moral legitimacy, local embeddedness, professional institutions, and standardized operations. The relevant question is not whether an organization is religious, but how its identity affects impartiality, accountability, competence, and relationships with public authority (Ferris, 2005; Wilkinson et al., 2022).

This article asks three questions. First, how did EMT Muhammadiyah develop from faith-based medical relief into a more formal emergency medical capability by 2022? Second, through what mechanisms did it participate in global health governance? Third, what tensions limited that participation? The article argues that EMT Muhammadiyah functioned as a translational and intermediary institution. It translated international standards into an Indonesian mass-organization setting, converted a domestic hospital network into surge capacity for public emergencies, and carried local religious and organizational resources into state-led transnational missions. Its significance lies less in autonomous global authority than in its ability to connect institutional levels that are often treated separately.

The argument remains deliberately bounded. The study does not claim that every Muhammadiyah medical deployment met WHO classification requirements by 2022, nor does it infer health impact from organizational publicity. It examines the institutional trajectory and governance functions visible in documents available through December 2022. This temporal limit matters because it captures a period of capability formation and international engagement rather than treating later certification or recognition as evidence retroactively available to earlier practice.

METHOD

This study used qualitative historical-institutional document analysis. It was not designed as a systematic literature review, meta-analysis, or comprehensive inventory of every Muhammadiyah medical mission. The unit of analysis was EMT Muhammadiyah as an organizational arrangement linking professional health personnel, Muhammadiyah institutions, state emergency systems, and transnational humanitarian standards. A historical-institutional approach was appropriate because the object of interest was not only what the team did during individual deployments, but how rules, organizational assets, authority relationships, and repeated practices accumulated over time.

The documentary corpus was purposively assembled from five categories. First, WHO and partner documents were used to reconstruct the EMT governance architecture, including the 2013 foreign medical team standards, the 2016 rehabilitation standards, the 2017 report on regulation and management, the 2018 year-in-review report published in 2019, the revised 2021 classification standards, guidance for insecure environments, and 2022 guidance on reproductive, maternal, newborn, and child health. Second, Indonesian legal and policy sources were used to situate EMT activity within national disaster governance. Third, official Muhammadiyah and MDMC reports published no later than 2022 were used to trace deployments, training, coordination, and institutional narratives. Fourth, peer-reviewed studies on Muhammadiyah, faith-based humanitarianism, disaster governance, and global health governance provided analytical context. Fifth, selected international humanitarian standards were used to assess quality and accountability claims.

Documents were included when they addressed at least one of four themes: the institutional development of Muhammadiyah's disaster-medical capacity; operational deployments or training involving EMT Muhammadiyah; the rules and standards governing EMTs; or the role of non-state and faith-based organizations in humanitarian and global health governance. The source ceiling was 31 December 2022. Later sources were excluded even when they described earlier events, because the user required that the newest references be limited to 2022. The corpus was therefore interpreted as evidence available at the end of 2022, not as a retrospective account incorporating later institutional outcomes.

Analysis proceeded through a deductive framework with four governance dimensions. The first, standardization, examined whether global technical and ethical expectations were translated into team composition, training, declared capability, logistics, safety, documentation, and clinical procedures. The second, coordination, examined how EMT Muhammadiyah related to affected-country authorities, Indonesian agencies, WHO-linked mechanisms, Muhammadiyah units, and other responders. The third, capacity circulation, examined how knowledge, personnel, and institutional assets moved between local, national, and international levels. The fourth, legitimacy and accountability, examined the sources of authority claimed by the team and the evidence available on impartiality, community participation, reporting, and learning.

The analysis distinguished organizational claims from external or operational evidence. Official reports are valuable for dates, personnel, institutional arrangements, and declared purposes, but they tend to emphasize successful action. They were therefore read against international standards and academic studies that identify recurring weaknesses in humanitarian response, including credentialism, coordination failure, uneven local capacity, and upward accountability. No attempt was made to calculate clinical effectiveness because public sources did not provide comparable patient outcomes, denominators, cost data, or post-deployment follow-up across missions.

The method has three limitations. First, publicly available records favor high-profile deployments and national-level activity, leaving routine preparedness and unsuccessful

mobilizations less visible. Second, affected people rarely appear as authors or evaluators in the documentary record; beneficiary perspectives therefore cannot be inferred from organizational statements. Third, global health governance is broader than the EMT Initiative. The article focuses on emergency medical coordination and standardization rather than the full range of diplomacy, financing, pharmaceutical regulation, surveillance, or pandemic treaty politics. These limitations support a cautious institutional interpretation rather than a claim of comprehensive impact evaluation.

Table 1. Analytical framework for EMT Muhammadiyah in global health governance

Governance dimension	Analytical question	Documentary indicators	Main risk
Standardization	How are global norms translated into an operational team?	Declared capability; competency standards; clinical governance; logistics; safety; information systems	Certification or documentation without sustained readiness
Coordination	How is authority shared across organizational and territorial levels?	Registration; tasking; command links; state and host-country relationships; inter-agency coordination	Duplication, delayed activation, or unclear command
Capacity circulation	How do personnel, knowledge, and infrastructure move across levels?	Hospital rosters; training; exercises; overseas missions; after-action learning; research	Experience remains personal and is not institutionalized
Legitimacy and accountability	Why is the team trusted, and to whom is it answerable?	Religious legitimacy; professional credentials; public authorization; reporting; patient feedback	Upward accountability crowds out accountability to affected people

RESULTS AND DISCUSSION

1. From Institutional Assets to An Emergency Medical Capability

Muhammadiyah's medical response capacity preceded the EMT label. The organization had long operated hospitals, clinics, medical schools, nursing programs, philanthropic institutions, and local branches capable of mobilizing personnel and supplies. After major disasters, these units could form temporary teams and deploy clinicians. The post-2004 period, however, created pressure to convert dispersed assets into a more coherent system. MDMC became the organizational node responsible for linking disaster assessment, emergency response, logistics, rehabilitation, and risk reduction across Muhammadiyah's federated structure (Bush, 2014; Baidhaw, 2015).

This shift changed the meaning of medical volunteering. In an ad hoc model, a hospital sends available clinicians and medicines in response to moral urgency. In an EMT model, personnel must be selected for defined roles, trained for austere conditions, supported by logistics, protected through security and occupational-health procedures, and integrated into a command structure. The team must know what it can and cannot provide. Self-sufficiency matters because a team that consumes scarce local transport, water, accommodation, communications, or medicines may increase rather than reduce pressure on an affected system. The WHO standards therefore turn organizational

enthusiasm into a problem of capability declaration and operational discipline (World Health Organization, 2013, 2021a).

Table 2. Historical trajectory of EMT Muhammadiyah through 2022

Period	Institutional development	Illustrative evidence	Governance significance
Pre-2004	Hospitals, clinics, universities, philanthropy, and volunteer traditions precede a dedicated EMT	Muhammadiyah social-service and health infrastructure	Creates a reservoir of personnel and institutional trust
2004-2013	Large disasters expose the limits of ad hoc medical mobilization; MDMC consolidates disaster functions	Post-tsunami organizational innovation; national disaster-law reform	Moves response from episodic charity toward specialized disaster governance
2013-2016	WHO introduces international FMT/EMT classification; Muhammadiyah gains overseas medical-response experience	Typhoon Haiyan and Nepal missions; WHO 2013 standards	Introduces common capability categories, registration, and self-sufficiency
2016-2020	A more formal EMT structure develops within MDMC and the health network	National deployments, training, and roster development	Links hospitals and professionals to a deployable organizational unit
2021	Multiple domestic deployments occur during the COVID-19 period; participation in global forums and safer-access training expands	West Sulawesi, East Nusa Tenggara, Semeru, HNPW, ICRC training	Broadens the team from trauma response to multihazard and networked preparedness
2022	EMT personnel join Indonesia's Pakistan mission; Indonesia and WHO establish a regional EMT training direction	Pakistan floods; WHO-Indonesia MoU	Positions domestic civil-society capacity within state-led and regional health emergency governance

EMT Muhammadiyah's institutional advantage was its ability to draw from a standing health network rather than recruit an entirely separate workforce. Doctors, nurses, pharmacists, midwives, psychologists, logisticians, and public-health personnel could be seconded from Muhammadiyah-'Aisiyah hospitals and universities. Lazismu provided a philanthropic mechanism for financing supplies and deployments, while MDMC offered disaster coordination and volunteer management. This modular model lowered the cost of maintaining a permanently deployed institution, but it also created dependence on agreements with home institutions, availability of staff, and uneven readiness across facilities.

Domestic disasters served as recurrent training grounds. During the January 2021 West Sulawesi earthquake, the national EMT included specialists, general practitioners, nurses, surveillance personnel, and logistics staff; its members worked within damaged health infrastructure and supported obstetric and surgical needs (Pimpinan Pusat Muhammadiyah, 2021a). In April 2021, teams from hospitals in Lamongan, Karanganyar, and Palembang deployed to separate locations following floods and landslides in East

Nusa Tenggara. Their first declared priority was coordination with local Muhammadiyah units and registration with health authorities, demonstrating that formal entry and tasking had become part of practice rather than an afterthought (Pimpinan Pusat Muhammadiyah, 2021b).

The Semeru eruption in December 2021 further demonstrated a networked model. Medical teams from several Muhammadiyah-'Aisyiyah hospitals were mobilized under coordination between national and East Java MDMC structures, while the response was framed as a multihazard operation because volcanic exposure occurred during the COVID-19 pandemic. In late 2022, the Cianjur earthquake response mobilized multiple hospitals, regional MDMC units, and a medical faculty across distributed service points. These cases show that EMT capacity was not concentrated in one field hospital; it was assembled from affiliated institutions and coordinated according to situational need (Pimpinan Pusat Muhammadiyah, 2021d, 2022e).

The same arrangement produced structural variation. Hospitals differed in specialty capacity, equipment, management commitment, and experience. A roster based on multiple autonomous or semi-autonomous institutions could provide scale but not automatic uniformity. Standardization therefore had to work across organizational boundaries. Training, common forms, deployment procedures, and centralized coordination were not administrative additions; they were the mechanisms through which a federated movement attempted to become operationally predictable.

2. The WHO EMT architecture as a governance framework

WHO's EMT framework governs through standards rather than direct ownership. The 2013 classification distinguished outpatient emergency care, inpatient surgical capacity, and referral-level capability while requiring all teams to meet guiding principles and core standards. The revised 2021 framework emphasized that EMTs must support and not replace national systems, provide care according to need, maintain clinical governance, protect patients and personnel, manage information, ensure infection prevention and control, and remain self-sufficient for the declared period. Specialized guidance extended the system to rehabilitation, care in insecure environments, and reproductive, maternal, newborn, and child health (World Health Organization, 2016, 2021a, 2021b, 2022a).

This architecture addresses several governance failures simultaneously. Classification reduces uncertainty by allowing an affected authority to know what service a team claims to provide. Registration protects sovereignty by requiring teams to enter through national mechanisms rather than self-deploy. Coordination reduces duplication and directs teams toward identified gaps. Minimum standards protect patients from poorly equipped or clinically inappropriate intervention. Data requirements create the possibility of system-wide situational awareness and evaluation. Mentoring and peer review circulate knowledge among teams. In these respects, the EMT Initiative resembles a transnational regulatory network: compliance is voluntary before deployment but becomes a condition of recognition and effective access.

The framework also redistributes authority. Medical credentials alone do not authorize an international emergency mission. A specialist may be clinically competent but operationally unsafe without team training, logistics, communication, cultural

preparation, and coordination. Conversely, a national or local organization can acquire transnational legitimacy when it demonstrates collective capability. Authority shifts from individual professional status toward the performance of an organized system. Education and training literature therefore emphasizes team-based competencies, adaptation to low-resource settings, and nontechnical skills alongside clinical expertise (Caldwell et al., 2017).

EMT Muhammadiyah's engagement with this framework represented institutional translation. International standards had to be rendered into Indonesian language, Muhammadiyah governance, hospital human-resource arrangements, financing procedures, inventories, and deployment routines. The translation was not mechanical. WHO standards assume a clearly defined team with controlled logistics and command. Muhammadiyah's assets were distributed across hospitals, universities, philanthropic bodies, regional disaster units, and volunteer networks. The challenge was to preserve the advantages of a mass organization while establishing the documentation and consistency expected of an EMT.

By 2021, EMT Muhammadiyah was participating in transnational learning spaces. Its deputy operations leader presented lessons from pandemic-era disaster response during the Humanitarian Networks and Partnerships Weeks, in a session connected to the WHO EMT network. MDMC also organized Safer Access Framework training with the International Committee of the Red Cross for leaders from the EMT, Lazismu, public-health, and international-relations units. The training focused on organizational procedures and safe access in difficult humanitarian environments, broadening preparedness beyond clinical treatment (Pimpinan Pusat Muhammadiyah, 2021c, 2021e).

This participation mattered even without complete international classification by the 2022 cut-off. Global governance includes socialization into standards, access to professional networks, and the circulation of operational knowledge before formal recognition. Candidate teams learn to describe capability in a common language; international actors learn what local organizations can supply; and ministries obtain domestic partners capable of joining national or external missions. EMT Muhammadiyah thus entered the governance system incrementally through training, forums, and coordinated deployments.

3. A hybrid actor at the national-global interface

EMT Muhammadiyah was neither a state team nor a conventional international nongovernmental organization. Its personnel were employed by domestic hospitals and universities, its mandate derived from a religious mass organization, its financing combined institutional and philanthropic resources, and its international deployment depended on state and inter-organizational channels. This hybrid status generated a distinctive governance role. It could mobilize civil-society resources while remaining legible to government through formal coordination.

The East Nusa Tenggara response illustrates the domestic side of this role. Teams first coordinated internally with Muhammadiyah structures and externally with health authorities. The sequence is significant. Internal networks supplied speed and local

access, while public registration supplied authorization and system integration. Disaster governance research in Indonesia describes this wider pattern as co-governance: the state retains legal authority, but implementation depends on negotiated relationships with civil-society and community actors (Srikandini et al., 2018). EMT Muhammadiyah operationalized co-governance in clinical response.

The Pakistan mission in October 2022 illustrates the transnational side. Five women from Muhammadiyah health institutions joined an Indonesian government medical delegation that included the Ministry of Health, military, police, disaster agency, and Universitas Andalas. EMT Muhammadiyah was the only nongovernmental medical organization in the delegation. It did not deploy as an autonomous religious charity entering Pakistan independently. It operated through bilateral state channels, shared tasking, and local translation support. The arrangement provided diplomatic access, transport, security, and coordination while allowing Indonesia to draw on specialized civil-society personnel (Pimpinan Pusat Muhammadiyah, 2022c, 2022d).

The composition of the contingent also revealed how global governance can widen representation. The all-female team included emergency and pediatric expertise and focused substantially on women and children. Field reports described respiratory illness, skin disease, fever, diarrhea, maternal consultations, and breastfeeding counseling. Gender did not function merely as symbolic representation; it improved access to patients in a context where privacy and gender norms affected clinical interaction. The absence of a dedicated private space for breastfeeding counseling, however, demonstrated that personnel composition alone could not substitute for context-sensitive infrastructure (Pimpinan Pusat Muhammadiyah, 2022d).

Earlier overseas missions created a pathway toward this state-civil-society arrangement. Organizational accounts identify independent or coalition medical assistance after Typhoon Haiyan in the Philippines, participation in Indonesia's response to the Nepal earthquake, and humanitarian work related to displaced Rohingya communities in Myanmar and Bangladesh. These missions differed in mandate, partners, and operational scale, but collectively exposed Muhammadiyah personnel to border procedures, host-country authority, language barriers, security, and coordination beyond the domestic system. Internationalization therefore developed through repeated institutional encounters rather than a single policy declaration.

At the national level, the timing was favorable. In November 2022, Indonesia and WHO agreed to develop a multi-country training hub for health emergency operational readiness and EMTs. The agreement emphasized national and regional capability, civil-military cooperation, dissemination of medical standards, and research. EMT Muhammadiyah's growth coincided with a policy shift that treated domestic teams not only as recipients of international assistance but as potential contributors to regional surge capacity (World Health Organization, 2022c).

4. Faith-based legitimacy and humanitarian principles

Muhammadiyah justified emergency medical action through Islamic concepts of service, al-Ma'un, wasatiyah, and humanitarian universality. Religious motivation supplied volunteers, donations, institutional commitment, and public trust. Yet global health

governance requires that assistance be based on need rather than religious affiliation. The operational question was therefore whether Islamic identity functioned as a boundary around beneficiaries or as a moral basis for impartial service.

Available institutional documents consistently promoted the second interpretation. MDMC leaders in 2022 explicitly described humanitarian action as inclusive and linked Islamic moderation to humanity, impartiality, neutrality, and independence. Local MDMC reports also documented assistance in Christian-majority communities. Such statements align with Muhammadiyah's broader claim that social service is *da'wah* through public benefit rather than conditional proselytization. This orientation reduces, but does not eliminate, the need for safeguards. Humanitarian impartiality must be demonstrated through assessment, targeting, patient rights, and complaints mechanisms rather than inferred from official theology (Pimpinan Pusat Muhammadiyah, 2022a; Ferris, 2005).

Faith-based legitimacy can strengthen governance in three ways. First, religious networks can disseminate risk communication and counter harmful rumors. During COVID-19, Muhammadiyah combined hospital care, public-health messages, religious guidance, social assistance, and vaccine support, showing that clinical response could be connected to trusted moral communication (Rachmawati et al., 2022). Second, congregational and organizational networks can identify vulnerable people beyond formal registries. Third, religious duty can sustain volunteer commitment when financial incentives are limited.

The same legitimacy creates risks. Members may assume that moral intention guarantees quality; leaders may hesitate to publish failure because reputation is tied to religious identity; and affected communities may feel unable to complain to a respected organization. Global standards are valuable precisely because they separate benevolent intention from demonstrable performance. For EMT Muhammadiyah, professionalization was not a secular correction to religion but an accountability mechanism through which religious claims could be tested in practice.

5. Capacity circulation and localization

The international humanitarian system has long been criticized for treating local actors as implementers while concentrating funding, standard setting, and decision-making in international organizations. The localization agenda seeks to shift resources and authority toward national and community organizations that are present before crises and remain after international teams leave. Local faith actors are particularly important because they often possess social trust, facilities, and volunteer networks, yet they may operate parallel to formal coordination systems or face assumptions that they lack neutrality and technical capacity (Wilkinson et al., 2022).

EMT Muhammadiyah demonstrates a different possibility: localization through standard-bearing domestic institutions. The team did not reject international standards as external domination. It used them to strengthen and communicate locally rooted capability. Its hospital network supplied personnel and referral relationships; regional branches supplied contextual knowledge; national Muhammadiyah structures supplied legitimacy and resources; WHO-linked norms supplied a common technical language. This combination challenges the binary between local authenticity and global professionalism.

Capacity also circulated back into the domestic system. International missions exposed personnel to team composition, reporting, cultural mediation, and multi-agency coordination. Domestic deployments allowed procedures to be repeated under different hazards. Presentations in global forums turned field experience into shared knowledge. The value of an international mission therefore cannot be measured only by patients treated abroad. It includes institutional learning that may improve national preparedness, provided that after-action reviews, training, and documentation transfer experience beyond the individuals deployed.

The evidence available through 2022 shows intent to learn but limited public documentation of learning systems. Official reports frequently mention evaluation and the accumulation of experience, yet they rarely publish structured after-action findings, clinical quality indicators, or corrective action plans. Without such mechanisms, capacity circulation remains dependent on personal memory and informal mentoring. A mature governance role requires organizational memory that survives staff rotation.

6. Accountability and evidence gaps

The strongest public evidence concerns mobilization: numbers and origins of personnel, locations served, partner institutions, and reported patient contacts. These data demonstrate activity but not necessarily effectiveness. Comparable information on triage accuracy, referral completion, adverse events, medicine use, patient satisfaction, protection incidents, cost, or continuity of care is scarce. This is not unique to Muhammadiyah; disaster medicine has historically suffered from inconsistent data and weak outcome evaluation. The WHO minimum data set and clinical governance requirements were designed partly to address this problem.

Accountability operated in several directions. EMT Muhammadiyah was accountable upward to Muhammadiyah leadership and donors, horizontally to partner agencies and professional standards, legally to Indonesian and host-country authorities, and ethically to patients and affected communities. Documentary visibility was greatest for upward and horizontal accountability. Financial support, institutional coordination, and deployment authorization were routinely reported. Community participation, informed consent under field conditions, complaints, and independent evaluation were much less visible.

This asymmetry matters for global health governance. A team can become more legible to WHO and government while remaining insufficiently answerable to affected people. Standardization may improve this situation through patient records, safeguarding, and feedback requirements, but only if implemented beyond documentation for verification. Faith-based proximity should not be treated as a substitute for formal accountability. Communities require accessible channels to question targeting, clinical behavior, privacy, and the cultural appropriateness of care.

By the end of 2022, EMT Muhammadiyah had therefore achieved meaningful institutional development but not a complete evidence architecture. It had a credible pathway from domestic medical networks to transnational deployment, increasing familiarity with WHO standards, and recognition as a partner in government-led missions. The unresolved

task was to convert operational experience into transparent quality data and consistent readiness across the full roster.

Discussion

1. EMT Muhammadiyah as a governance intermediary

The findings support an interpretation of EMT Muhammadiyah as a governance intermediary rather than an autonomous global actor. It connected actors that otherwise operate under different logics: Muhammadiyah hospitals manage clinical services; MDMC organizes disaster response; Lazismu mobilizes philanthropic resources; government agencies regulate and authorize emergency operations; WHO and humanitarian networks produce standards; and affected communities possess needs, knowledge, and rights. The EMT created an organizational interface through which these elements could be assembled for deployment.

Table 3. EMT Muhammadiyah across institutional levels

Institutional level	Primary assets or authority	EMT Muhammadiyah function	Unresolved issue
Muhammadiyah/local	Hospitals, universities, branches, volunteers, philanthropy, religious trust	Recruitment, logistics, local access, referral, public communication	Uneven capability and release of personnel across institutions
National/Indonesia	Legal authority, health-crisis coordination, diplomacy, transport, civil-military assets	Registers, coordinates, and incorporates the team into national missions	Dependence on public authorization and fragmented agency mandates
Regional/global	WHO standards, peer networks, training, common terminology, host-country coordination	Supplies benchmarks, mentoring, interoperability, and transnational legitimacy	Compliance costs, unequal access to recognition, and potential credentialism
Affected communities	Contextual knowledge, needs, consent, evaluation of service quality	Should shape assessment, targeting, feedback, and continuity of care	Community voice and complaints are weakly visible in public records

Intermediary status is not institutional weakness. Global health governance depends on organizations that translate between levels. WHO cannot directly staff every emergency, and ministries cannot maintain every form of surge capacity internally. Local hospitals may have clinicians but lack transnational procedures. A mass organization can aggregate these resources, but it must become legible to public and international systems. EMT standards provide that legibility. Muhammadiyah's contribution was to make a large domestic social infrastructure potentially interoperable without transferring ownership to an international agency.

This finding also qualifies the concept of non-state authority. EMT Muhammadiyah did not exercise authority by issuing binding rules. Its authority was operational and reputational: the capacity to mobilize personnel, deliver services, advise within networks, and be selected for national missions. Such authority remained relational. It increased when public institutions trusted the team and when the team conformed to recognized standards. It could decline rapidly if clinical quality, neutrality, or coordination failed.

2. Standardization as institutional translation, not imitation

A superficial account would describe Muhammadiyah as adopting WHO standards. The deeper process was institutional translation. Global requirements had to be reconciled with a federated religious organization whose staff belonged to different hospitals and whose financing, governance, and volunteer culture differed from many governmental EMTs. Translation required decisions about who held command, how employers released personnel, who maintained equipment, how costs were reimbursed, and how an Islamic organizational identity appeared in neutral humanitarian operations.

This perspective avoids two errors. One is to romanticize local practice and treat standards as unnecessary bureaucracy. Haiti and other emergencies demonstrated that uncoordinated medical enthusiasm can harm patients and burden authorities. The other is to assume that global standards are self-executing and culturally neutral. A checklist cannot create logistics, workforce agreements, or accountability where institutional incentives are absent. Standards become effective only when embedded in organizations that can finance, rehearse, and enforce them.

For Muhammadiyah, the hospital network was both the main enabling condition and the main coordination challenge. It provided specialized personnel and facilities but dispersed responsibility. The team needed a system capable of turning multiple institutional owners into one operational unit. This is why preparedness exercises, standardized inventories, contracts or memoranda with home institutions, and recurrent team training are more important than ceremonial launch events.

3. A Global South pathway into health governance

The case contributes to debates about unequal participation in global health. Organizations from the Global South are often represented as implementing partners, recipients of capacity building, or sources of local access. EMT Muhammadiyah occupied a more complex position. It received and translated international standards, but it also supplied expertise to Indonesian and overseas operations, presented lessons in international forums, and demonstrated that a domestic faith-based network could contribute to state diplomacy and regional preparedness.

The Pakistan mission is particularly important because it reversed the conventional direction of humanitarian expertise. Indonesian civil-society personnel joined a national delegation to deliver care abroad. The mission remained modest in scale, but governance significance does not depend only on size. It demonstrated a model in which a middle-income country mobilized state and non-state capabilities for South-South humanitarian cooperation. The presence of Muhammadiyah expanded the range of institutions through which Indonesia could act internationally.

Nevertheless, participation does not erase hierarchy. International deployment required diplomatic clearance, transport, security, host-country authorization, and coordination resources beyond the independent control of Muhammadiyah. WHO standards are formally universal, but the costs of equipment, documentation, training, and self-sufficiency can favor well-funded organizations. Global recognition may therefore

reproduce inequality unless mentoring and financing support capable teams from lower-resource settings.

4. Religion, neutrality, and public reason

The case suggests that religious identity and global health professionalism are not inherently contradictory. Muhammadiyah framed service as a religious obligation while accepting clinical standards, public authority, and need-based care. This combination can be described as faith-informed public reason: theological motivation is translated into forms of action that can be justified through universal humanitarian and clinical criteria. Patients need not share the organization's beliefs to receive the service or understand its standards.

However, compatibility must be institutionally protected. Team codes should prohibit conditional aid and proselytization in clinical encounters. Recruitment and patient data should be reviewed for discriminatory patterns. Religious communication should not replace informed clinical consent. Partnerships should include non-Muhammadiyah authorities and communities. These protections preserve both humanitarian integrity and the credibility of Muhammadiyah's claim to serve humanity broadly.

The organization should also resist an opposite error: removing all ethical language in the name of professionalism. Technical systems require moral purposes. Al-Ma'un can sustain attention to people neglected by market and state systems, while global standards discipline how that concern is enacted. The productive relationship is therefore neither religious exceptionalism nor secular imitation, but reciprocal correction between moral commitment and professional accountability.

5. From deployments to a measurable preparedness system

The central practical challenge after 2022 was to move from a record of deployments toward a measurable preparedness system. A deployable EMT requires a current roster, competency records, health clearance, licensing, insurance, security preparation, equipment maintenance, pharmaceutical management, communications, water and sanitation, data systems, and agreements on activation and demobilization. Each element needs an owner, budget, verification schedule, and exercise history. A team that performed well once cannot presume continuing readiness.

Muhammadiyah's scale makes this task difficult but potentially transformative. The organization could establish tiers of capability across hospitals and regions, with a smaller internationally deployable core supported by national and local modules. Common training could be integrated into medical and nursing education. Hospitals could maintain reserve agreements for staff release. Universities could evaluate simulations and after-action reports. Lazismu could finance readiness as a standing public good rather than only fund visible response operations.

Evidence systems require equal attention. Minimum data should include patient demographics, diagnoses, procedures, referrals, outcomes at discharge, safeguarding incidents, resource use, and patient feedback. These data should be protected, aggregated, and reviewed. Public reporting need not expose personal information, but it should allow

stakeholders to distinguish activity from quality. Independent academic partners within the Muhammadiyah university network could conduct evaluations without subordinating findings to promotional priorities.

6. Limits of the global governance frame

The global health governance frame clarifies standards and networks, but it can overstate international dimensions. Most EMT Muhammadiyah activity through 2022 occurred within Indonesia, and domestic legitimacy remained fundamental. The team mattered globally because it was locally and nationally embedded, not because it detached from those foundations. Internationalization without strong domestic preparedness would produce symbolic missions and organizational branding rather than sustainable capability.

The frame can also privilege institutions over affected people. Discussions of WHO, ministries, standards, and organizational capacity may make communities appear as endpoints of governance rather than participants. The next stage of research should therefore examine how patients and local health workers experienced EMT Muhammadiyah, whether services aligned with local priorities, and whether communities influenced planning. Global health governance is legitimate only when coordination and standards improve care as judged partly by those receiving it.

Finally, the analysis should not equate WHO alignment with comprehensive quality. Classification standards establish a floor and a declared capability; they do not answer every question about equity, cultural safety, environmental impact, or long-term recovery. Muhammadiyah's contribution should be evaluated through both global benchmarks and its own public commitments to justice, inclusion, and social transformation.

CONCLUSION

EMT Muhammadiyah developed by converting the distributed assets of a faith-based mass organization into a more coordinated emergency medical capability. Hospitals and universities supplied professionals, MDMC supplied disaster governance, Lazismu supplied philanthropic support, local branches supplied access and legitimacy, and state and international mechanisms supplied authorization, coordination, and standards. Domestic responses created repeated operational experience, while overseas missions and global forums connected that experience to transnational health networks.

Its contribution to global health governance through 2022 was not the exercise of formal international authority. It was the performance of intermediary functions: translating WHO norms into organizational procedures, providing surge capacity to Indonesia's health-emergency system, representing domestic civil-society expertise in international missions, and linking religious commitment with impartial clinical service. The Pakistan deployment showed how a non-state organization could become part of state humanitarian diplomacy without losing its institutional identity.

The trajectory remained incomplete. Readiness varied across a federated network; international operations depended on public and partner infrastructure; published

evidence emphasized activity more than outcomes; and accountability to affected populations was less visible than accountability to institutions. These are not reasons to dismiss the model. They define its next governance tasks: stable readiness financing, common competency and logistics systems, transparent after-action learning, stronger patient and community feedback, and independent evaluation.

EMT Muhammadiyah demonstrates that a faith-based organization from the Global South can enter global health governance without becoming a conventional international NGO. Its most durable value lies in connecting global standards to locally owned health capacity. Whether that connection produces equitable and accountable care depends not on religious intention or international visibility alone, but on the continuous institutional work of maintaining competence, coordination, evidence, and public trust.

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