

Health provision for the poor

Islamic aid and the rise of charitable clinics in Indonesia

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Abstract: By exploring Islamic charitable clinics in Indonesia, this paper shows how community-based initiatives and *zakat* [Islamic charitable obligation] agencies have provided wider access to viable health services for destitute families in poor urban and rural areas. *Zakat* agencies, with their charitable clinics, have recently gained strong support from both society and the government. They have, for example, tried to bring a community response to the current social economic challenges through the revitalization of the *zakat* and Islamic charity practice. Low-priced, accessible and free medical assistance for poorer families and small economic enterprises provided by the *zakat* agencies reflect the endeavours of middle class Indonesian Muslims to translate Islamic discourse on social welfare in a more concrete way. The rise of Islamic charitable clinics, whose origins and motives can partly be linked to the Islamic discourse of the welfare of the *ummah* [the Islamic community], is without doubt a consequence of emerging interpretations of the meaning and function of Islamic aid in contemporary Indonesian Islam.

Keywords: health care; *zakat*; social work; charity; poverty; Muslim NGOs

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It has been argued in recent studies on Islam and welfare activism that religiously motivated charitable works have increasingly contributed to the social development process. This is marked partly by the proliferation of various Islamic voluntary welfare organizations whose major concerns include education, health and social service. In Indonesia, some Islamic voluntary organizations have generated their major resources from a public and domestic basis as they have also functioned as alms collectors. Since the start of the economic crisis in the late 1990s, the appearance of Islamic welfare organizations in the public sphere has become increasingly obvious, providing a range of charitable and development-oriented programmes in both poor urban and rural areas while enjoying popular support from the community. Interestingly, it was when the country's economy was in crisis, which in turn resulted in an increase in the rate of pauperism, that urban middle class Muslims endeavoured to adapt Islamic notions of social welfare to the current socioeconomic challenge by utilizing almsgiving and Islamic charitable works as a discursive focus.

This paper will shed some light on the rise of Islamic charitable clinics in contemporary Indonesia and the multiplicity of roles they have played, ranging from providing health assistance for disadvantaged segments of society to introducing Islamic notions of mutual help and social welfare systems. This topic is interesting to pursue, given that in the Indonesian context no comprehensive work, whether historical, sociological or otherwise, has, as far as I am aware, been written about the Islamic charitable clinics that have proliferated in recent years. Although many attempts have been made by scholars to present *zakat* movements in Indonesia, the works for the most part concentrate on the socioeconomic and political dimensions of *zakat* practice. Recent studies on almsgiving in Indonesia have, however, pointed to the following issues: first, there has been a clear shift in *zakat* practice, in line with the process of Islamization of the Indonesian political setting in which Islamic almsgiving has been seen as a socioeconomic/political system rather than financial worship.¹ The enactment of law on *zakat* administrations in certain provinces through the implementation of 'shari'a by-laws' whose objective is to forge compulsory – instead

¹ Jonathan Benthall (1999), 'Financial worship: the Quranic injunction to almsgiving', *Journal of the Royal Anthropological Institute*, Vol 5, No 1, pp 27–42; see also Arskal Salim (2008), *The Shift in Zakat Practice in Indonesia: From Piety to an Islamic Socio-Political-Economic System*, Asian Muslim Action Network and Silkworm Books, Chiangmai.

of voluntary – payment illustrates how *zakat* affairs have enjoyed political support from the government in the current Indonesian political landscape.² Under this *shari'a* by-law on *zakat*, local governments have attempted to levy *zakat* on salaries, particularly from Muslim civil servants. Second, there has been a transformation of religious charitable works into corporate culture, which has had a considerable impact upon the improvement of transparency in collecting and redistributing alms and on efficiency in carrying out sustained programmes.³ Studies on the *zakat* movement and social welfare activism also share a similar concern, linking the rise of charitable institutions with the inadequacy of the state in providing an adequate welfare system, which by definition should benefit people coming from deprived backgrounds.

Many scholars have conducted studies regarding charitable institutions and Islamic voluntary organizations. Focusing on the roles and networks of the middle class, Janine A. Clark, for example, describes factors that have contributed to a rise in Islamic social institutions (ISIs), which include Islamic charitable clinics, in Egypt. ISIs in particular flourished primarily at the end of the nineteenth century as a response to hardship in Egyptian society, as well as being part and parcel of an ‘anti-colonial struggle’.⁴ The widespread penetration

² Asep Saepuddin Jahar (2006), ‘The clash between Muslim and the state: Waqf and *Zakat* in post independent of Indonesia’, *Studia Islamika*, Vol 13, No 3, pp 353–396; Arskal Salim (2003), ‘*Zakat* administration in politics of Indonesia’, in Arskal Salim and Azyumardi Azra, eds, *Shari'a and Politics in Modern Indonesia*, ISEAS, Singapore; see also Michael Buehler (2008), ‘The rise of *shari'a* by-laws in Indonesian districts: an indication for changing patterns of power accumulation and political corruption’, *South East Asia Research*, Vol 16, No 2, pp 255–285; and Sirojudin Abbas (2005), ‘The struggle for recognition: embracing the Islamic welfare effort in the Indonesian welfare system’, *Studia Islamika*, Vol 12, No 1, pp 33–72.

³ For further discussion, see Haedar S. Bamuallim, *et al*, eds (2006), *Islamic Philanthropy & Social Development in Contemporary Indonesia*, Center for the Study of Islam and Culture, Jakarta; Zaim Saidi, *et al*, eds (2003), *Pola Penggalangan Dana Sosial di Indonesia: Pengalaman Delapan Belas Lembaga Sosial*, Piramedia, PIRAC & Ford Foundation, Jakarta; Idris Thaha, ed (2003), *Berderma untuk Semua: Wacana dan Praktik Filantropi Islam*, PBB & Teraju, Jakarta; Chaider S. Bamualim, ed (2005), *Studi Kasus dan Lembaga Wakaf dan Zakat di Indonesia*, PBB, Jakarta; Amelia Fauzia, ed (2006), *Filantropi Islam dan Keadilan Sosial: Studi tentang Potensi, Tradisi, dan Pemanfaatan Filantropi Islam di Indonesia*, CRSC, Jakarta.

⁴ Janine A. Clark (2004a), *Islam, Charity and Activism: Middle Class Networks and Social Welfare in Egypt, Jordan and Yemen*, Indiana University Press, Bloomington, IN, p 45; see also Clark (2004b), ‘Social movement theory and patron-clientelism: Islamic social institutions and the middle class in Egypt, Jordan and Yemen’, *Comparative Political Studies*, Vol 37, pp 941–968.

of Christian missionaries in poor urban and rural areas has become another major factor in generating the rise of ISIs. In the Egyptian context, the expansion of charitable clinics has, in short, much to do with the contested social, political, intellectual and religious identities of Egyptians. Compared with secular welfare organizations, Clark argues, Islamic charitable institutions 'are far more independent of state aid and other grants' due to their ability to carry out effective fundraising and mobilize popular endorsements from the community.⁵

Benoît Challand's studies on charitable organizations specializing in health in Palestine reveal that the appearance of Islamic charitable clinics is partly a manifestation of the opposition and resistance to the prevalent Western donors, which benefit secular and professional NGOs.⁶ The discourse evolving in Islamic health NGOs is therefore quite different from that of the professional 'secular' NGOs. According to Challand, the former NGOs, supported by almsgiving and charity funds, are inclined to work in the local community with a lower scale of impact. Challand argues that they recompense 'their institutional weakness through a closer relationship with deprived segments of the population,' as well as functioning as 'tangible and concrete examples for the population'.⁷ The secular NGOs seem to have been more popular in employing such vocabularies as 'civil society', 'development' and 'empowerment', but incapable of relating and responding to popular needs and inclined 'to follow priorities set by donors'.⁸

Discussing the movement of Sufi orders in the Sahara, Knut S. Vikor suggests that social bonding and brotherhood principles in the Sufi tradition constitute 'symbolic capital', enabling such a Sufi order as Sanusiyah to urge the community to set social changes in motion and to integrate their symbolic capital into piety in the social domain.⁹ For example, Sanusiyah Sufism in the Sahara has provided welfare activism for disadvantaged groups of the society. Likewise, Tijaniyah Sufism in Darfur City has set up social rehabilitation for street children, and Qadiriya Sufism in Sudan has offered Islam-based

⁵ Clark (2004a), *supra* note 4, at p 45.

⁶ Benoît Challand (2008), 'A *Nahda* of charitable organizations? Health service provision and the politics of aid in Palestine', *International Journal of Middle East Studies*, Vol 40, p 234.

⁷ Challand, *supra* note 6, at p 234.

⁸ Challand, *supra* note 6, at p 240.

⁹ Knut S. Vikor (2002), 'Sufism and social welfare in the Sahara', in Holger Weiss, ed, *Social Welfare in Muslim Societies in Africa*, Nordiska African Institute, Stockholm, pp 95–96.

alternative medicine.¹⁰ It is mentioned that their involvement in social welfare is nothing more than the fruit of the failure of the state in responding to social hardship in those countries. While the above findings share enriching information, this paper argues that there has been an increasing tendency within *zakat* agencies to include health provision for the poor as their major social programmes along with economic development-oriented programmes. Islamic charitable clinics set up by *zakat* agencies have functioned as a mechanism to redistribute alms to deserved beneficiaries, as an approach to translate religious notions of welfare within social and economic domains, and implicitly as a strategy to evaluate the weakness of state welfare provision in the arena of health care.

Islamic charitable clinics in Indonesia

It is necessary to clarify the meaning of Islamic charitable clinics as used in this paper. There are at least three main types of hospitals in Indonesia, according to ownership and the origin of their resources. The first constitutes public hospitals that have received a substantial government subsidy. These hospitals are governed by different state bodies such as the Ministry of Health, local governments (provincial and district), state-owned companies and the Indonesian National Army. The second constitutes private hospitals, both domestic and international, which have appeared as commercial enterprises.¹¹ The last constitutes 'non-commercial clinics' that are run by non-profit organizations, including *zakat* agencies and charitable associations, which have recently received widespread support from the community. Nor are charitable clinics a new phenomenon in Indonesia, or in other countries in South and South East Asia or the Middle East. Charitable

¹⁰ Rudiger Seesman (2002), 'Sufi leaders and social welfare: two example from contemporary Sudan', in Holger Weiss, ed, *Social Welfare in Muslim Societies in Africa*, Nordiska African Institute, Stockholm, pp 98–103.

¹¹ According to the 2007 Indonesian Health Profile, there are 1,033 public hospitals in Indonesia, 582 (56.34%) of which are government-owned and 451 (43.66%) of which are private hospitals. Both government and private institutions have also set up smaller special clinics and some kinds of community health centres [*puskesmas*] in order to reach patients in rural areas. There are 8,324 government-based community health centres operating across the regions. See Ministry of Health of the Republic of Indonesia (2008), *Indonesia Health Profile*, Ministry of Health, Jakarta, pp 101–202.

clinics arose especially in countries with a shortage of health services.¹² In Indonesia, the involvement of religious associations in welfare activism is prevalent and plays a dominant role in the establishment of health centres. Historically speaking, since the early nineteenth century, a number of religious groups, notably Christian and Muslim, have set up various kinds of health centres. Under the support of the Dutch colonial government, the Christian groups in the Netherlands East Indies, for example, enjoyed certain privileges, such as the political opportunity to adopt and develop a Western medical system. In subsequent years, this path has been followed by Muhammadiyah, a modernist Muslim association whose social activities have been overwhelmingly related to welfare issues.¹³ Muhammadiyah has recently become renowned as the largest Islamic association running hundreds of clinics, hospitals, plus nursing and medical schools in Indonesia.

In recent times, we have seen a pervasive involvement by Islamic associations in the establishment of clinics in Indonesia, which are not always charitable, but rather, commercial in character.¹⁴ Despite the preservation of Islamic identity, there is no particular distinction between Islamic clinics and other 'secular' private or government clinics. Yet the roles played by charitable clinics have distinguished them from both 'conventional' private and government clinics: charitable clinics simply attempt to serve particular segments of society such as poorer families. Various terms have been employed to signify charitable clinics that are supported by voluntary contribution. Among those terms are 'voluntary clinics', 'philanthropic clinics', 'community clinics' and 'non-profit clinics'.¹⁵

¹² Dar es Salaam Charitable General Hospital in Tanzania, SGL Charitable Hospital in Punjab, Dinbandhu Charitable Hospital in Gujarat, Makassed Islamic Charitable Hospital in Jerusalem, and Muslim Khatri Charitable Hospital in Karachi are among the non-profit hospitals set up by religious denominations that arose due to a shortage of facilities and poor health services in each region.

¹³ Founded in 1912 by a devoted Muslim cleric, Kyai Ahmad Dahlan, Muhammadiyah and its women's division, namely Aisyiyah, have recently operated 345 clinics and hospitals throughout Indonesia. For further information about Muhammadiyah hospitals, see Majelis Kesehatan dan Kesejahteraan Pimpinan Pusat Muhammadiyah (2005), *Profil dan Direktori Rumah Sakit Muhammadiyah-Aisyiyah 2005*, MKKM PP Muhammadiyah, Jakarta.

¹⁴ See Majelis Syuro Upaya Kesehatan Islam Seluruh Indonesia (2003), *Profil dan Direktori Rumah Sakit dan Lembaga Pendidikan Kesehatan Islam di Indonesia*, Mukisi, Jakarta.

¹⁵ Religious institutions have, in this respect, played pivotal roles in bringing back the voluntary character of hospitals in treating patients (needy, aged and the like) with-

There are two types of Islamic charitable clinic in Indonesia. The first consists of clinics that have become increasingly commercialized. Some Islamic clinics in Indonesia – to borrow Janine Clark’s distinction of Islamic social institutions (ISIs) in Middle Eastern countries – have become ‘Islamic commercial institutions’ (ICIs), signifying ‘those mostly private commercial (albeit non-profit) institutions that cater, as evidenced by their relatively high fees, to the middle class. . .’.¹⁶ In this respect, Muhammadiyah clinics can, to some extent, be included in this category. The second type is of clinics set up by *zakat* agencies and charitable institutions as a means of providing low-priced and free medical care to the poor. Islamic charitable clinics resemble Clark’s definition of Islamic welfare institutions (IWIs) whose overriding effort is to ‘cater to the welfare of the poor...provide financial aid to orphans and reduce-price medical service to the poor’.¹⁷ Therefore, the term ‘Islamic charitable clinics’ in this paper refers to community health centres/clinics set up by Islamic voluntary welfare associations, notably *zakat* agencies, whose overarching objective is to cater to particular disadvantaged groups of society as the legitimate beneficiaries of almsgiving.

Given that Islamic almsgiving has greatly underpinned charitable clinics, another point that must be made relates to the concepts of *zakat*, *infaq*, *sadaqa* and *waqf*. *Zakat* literally means ‘to increase’ or ‘to purify’. It is a normative ‘compulsory giving’ that every Muslim should pay. There are two main types of *zakat*. The first is *zakat al-fitr*, a tax on individuals. Whether one is male, female, child or adult, one must pay this tax, provided one has the ability to do so. In practice, the *zakat al-fitr* is paid by the heads of families on behalf on their family members at the end of Ramadhan month or before the Eid festival. The second type of *zakat* is *zakat al-mal*, an Islamic tax on wealth, through which Muslims with sufficient means are required to give alms to legitimate recipients, notably the poor. According to normative Islamic principles, the payment of *zakat* should be channelled to the rightful *zakat* committee/agency/body appointed by either the state or the community. This agency is responsible for the redistribution of the collected alms to legitimate recipients. *Infaq* etymologically means ‘to spend’. In the

out charge. The *Medical Dictionary* defines voluntary hospital as ‘a private, not-for-profit hospital that provides uncompensated care to the poor’; see Website: <http://medical-dictionary.thefreedictionary.com/voluntary+hospital> (accessed 20 June 2009).

¹⁶ Clark (2004a), *supra* note 4, at pp 35–36.

¹⁷ Clark (2004a), *supra* note 4, at pp 35–36.

context of the Islamic giving tradition, it can mean spending wealth for a specific purpose, notably for the good of society and in accordance with Islamic values. *Sadaqa* is a general form of giving by an individual or institution. It is not exclusively related to money or wealth. All good conduct, both moral and physical, which is both individually and collectively advantageous to society, can, according to Islam, be regarded as *sadaqa*. In short, *infaq* and *sadaqa* bear a resemblance to certain forms of altruism in the general discussion of philanthropy. The two terms also represent Islamic charitable and, in some cases, voluntary giving. Yet it should be noted that the term *sadaqa* is often employed in the Qur'an to denote *zakat*.¹⁸ The Quranic injunctions and prophetic narrations have prescribed how to pay alms, what wealth is subject to *zakat* law, and to which institution the *zakat* payment should be channelled. But there is no such prescription for *sadaqa* and *infaq*. It is also worth emphasizing that the use of *zakat* and *sadaqa* is different in character. *Zakat* funds, as far as the *zakat* agencies such as Dompot Dhuafa (DD) and Rumah Zakat Indonesia (RZI) are concerned, cannot, unlike *sadaqa*, be used to finance physical buildings such as schools or clinics.¹⁹ The *sadaqa* funds can be spent flexibly on everything acceptable according to Islam, such as matters of consumption, productive and important projects, or even physical infrastructure.²⁰

Although the nature of *zakat* is different from that of charitable giving, *zakat* payment in Indonesia remains voluntary in character.²¹ In spite of the implementation of a *shari'a* by-law on *zakat* in certain regions, in general, Indonesian Muslims practise *zakat* voluntarily. The

¹⁸ See, for example, Yusuf Qardhawi (1999), *Fiqh az-Zakat*, translated by Monzer Kahf, Dar Al-Taqwa, London.

¹⁹ The use of *zakat* funds for physical infrastructure has become the concern of traditionalist ulamas. The Nahdlatul 'Ulama in its first *Muktamar* [National Congress] conducted on 21 October 1926, had issued a *fatwa* emphasizing that *zakat* funds could not be used for financing mosques, madrasahs [Islamic schools] or dormitories; see K. H. A. Azis Mayshuri, ed (2004), *Masalah Keagamaan: Hasil Muktamar dan Munas Ulama Nahdlatul 'Ulama, Vol I*, Qultum Media, Jakarta, p 5. However, the Nahdlatul Ulama has given another opinion, as a result of the Munas Alim Ulama [National Meeting of Muslim Scholars] on 30 August 1981 in Kaliurang-Yogyakarta, mentioning that the use of *zakat* funds for physical infrastructures in support of da'wa in the way of God [*fi sabilillah*] was allowed [*boleh*]. *Ibid*, Vol II, at p 23.

²⁰ This is not to say that the redistribution of *zakat* funds among Indonesian Muslims is influenced by a single religious viewpoint. There are also communities and religious groups using *zakat* funds for physical infrastructure, such as building *madrasahs* [Islamic schools], mosques, public facilities and so forth.

²¹ Mohammed Ariff, ed (1991), *The Islamic Voluntary Sector in Southeast Asia*, ISEAS, Singapore.

Table 1. Zakat agencies and health programmes.

Zakat agency	Health provision					
	Provisional health service	Medical mobile service	Ambulance	Maternity clinics	Children's nutrients	Permanent clinic
Dompet Dhuafa/DD	Yes	Yes	Yes	Yes	Yes	Yes
Rumah Zakat Indonesia/RZI	Yes	Yes	Yes	Yes	Yes	Yes
YDSF	Yes	Yes	Yes	Yes	Yes	Yes
Lazis Muhammadiyah*	No	No	No	No	No	No
DPU Daarut Tauhid	Yes	No	Yes	No	No	No
Al-Azhar Peduli	Yes	No	No	No	No	No
Pos Keadilan Peduli Ummat	Yes	Yes	Yes	Yes	Yes	Yes
Portal Infak	Yes	No	Yes	No	No	No

Notes: The Muhammadiyah Zakat Board does not provide particular health services. This is partly because Muhammadiyah has run a number of hospitals and clinics throughout the regions of Indonesia.

payment of *zakat al-mal*, for example, is not obligatory in the sense of being enforced by the state, which is not an Islamic state. Many Indonesian Muslims feel more comfortable channelling their *zakat*, *infaq* and *sadaqa* directly to the poor among their closer relatives.²² Otherwise they tend to channel their contributions through their preferred institutions, such as temporary mosque-based *zakat* collectors, community-based *zakat* agencies (*Lembaga Amil Zakat/LAZ*), and the quasi-state *zakat* board (*Badan Amil Zakat/BAZ*). In reality, people tend not to make a distinction between *zakat* and *sadaqa* – except *zakat al-fitr* – when donating certain portions of their wealth. Likewise, *zakat* agencies do not make rigorous efforts to clarify the actual wealth of the *zakat* payers and whether or not their payment can appropriately be regarded as *zakat* instead of *sadaqa*. Due to the voluntary character of *zakat* practice in Indonesia, I use the term ‘Islamic charitable clinics’ to identify health centres funded by *zakat* agencies (See Table 1).

There are community-based *zakat* agencies (LAZ) that have expanded their scope of programmes by engaging in welfare issues since the late 1990s. Amongst dozens of *zakat* agencies specializing in health

²² See the result of the PIRAC survey on giving traditions in Indonesia in 2006–08.

provision, two main institutions have recently come to the fore, showing remarkable progress by serving thousands of poorer families. These two major institutions are Dompet Dhuafa Republika (DD), a philanthropic Islamic organization affiliated with the Muslim-based national daily newspaper *Republika*, and Rumah Zakat Indonesia (RZI), which literally means ‘Indonesian *Zakat* House’, a religious-gathering-based philanthropic organization founded in Bandung, West Java. To narrow this topic, I will compare the existing charitable institutions with Muhammadiyah hospitals. The way in which Muhammadiyah creates hospitals is rather different from the method of *zakat* agencies. The clients of Muhammadiyah hospitals come from various backgrounds, ranging from the wealthy middle class to low-income households. Some portions of the revenue obtained by Muhammadiyah hospitals are reinvested in social and economic enterprises. Therefore, Muhammadiyah missions and programmes no longer rely heavily upon almsgiving. In particular, I will also look at the social function of internal *zakat* bodies that exist in Muhammadiyah hospitals, especially with regard to financing patients from deprived economic backgrounds.

In order to obtain reliable data, I visited some *zakat* agencies, health NGOs, (private) Islamic hospitals and Islamic charitable hospitals operating in Jakarta, Bandung and Yogyakarta from 2007–09. It is worth emphasizing that the institutions in question (DD and RZI) are located in urban areas of Java. However, the beneficiaries of Islamic charitable clinics, as we will see in the following section, include people from both urban and rural areas. During the field research, I interviewed dozens of people, among them physicians, directors of clinics, nurses, directors of *zakat* agencies, administrative staff and patients/beneficiaries. From these people, I have learned how the *zakat* movement (1) has become a source of financing for Islamic charitable hospitals, (2) has much to do with Islamic views about poverty, social welfare, mutual help and Islamic community, and (3) has provided a bridge – through its intensified activities in the matter of health – between ‘the haves’ (individual or collective/corporation) and the ‘have nots’.

Why the rise of charitable clinics? The context

The following stories may reflect the experience of those coming from deprived backgrounds that are unreachable by the state health policy and who seek medical treatment at charitable clinics. A 60-year-old agricultural worker from a small village in the Pangalengan highlands

of Bandung came to the city escorting his pregnant 16-year-old daughter-in-law to deliver the baby in an Islamic charitable clinic. The clinic is located in the suburbs of Bandung, about 40 km from the Pangalengan highlands. As a farm labourer, he spends much of his time in the village with his wife taking care of cultivated areas belonging to his landlord. He entrusted his small farm near his house to his 18-year-old son, the husband of the pregnant young woman. The monthly income of this family of farm labourers is sufficient for their day-to-day living expenses, but does not cover education and health care expenditures. Therefore, the agricultural worker encourages his son to work on the farm instead of sending him to college. When one of the family members gets sick, the family attempts self-medication or, if necessary, looks for low-priced health services in the local health centre. Yet the situation is rather different when the family requires special but costly medication for a particular illness. The agricultural worker and his pregnant daughter-in-law's appearance at DD's charitable clinic in Bandung reflects their needs for appropriate and lower-cost maternity health treatment for one of the family members.

A similar case is illustrated by the experience of a 55-year-old farm labourer from the Cikalong Wetan subdistrict, about 45 km from the Bandung municipality, who escorted his wife (35 years old) for intensive medical care. They decided to visit this clinic because they were worried about medical costs, and wanted to avoid the unpleasant experiences that they might have faced in the conventional clinics due to their low economic status. This husband with four children (the elder son had just enrolled in high school, while the youngest was a three-year-old) used to work as a construction labourer in Jakarta. He went back to his village to work as a labourer on a tea farm. Although this family can afford daily expenditure and send their children to the schools available in the village, the additional cost for family health care is an exception. With a limited income, they have faced great difficulties in managing the health care of family members either by relying upon a self-pay approach or conventional medical insurance.²³ The above cases

²³ The 2007 'Indonesia Health Profile' (p 20) of the Ministry of Health of the Republic of Indonesia reported that the percentage of people who attempted self-help treatment was higher (65.01%) than those who achieved medical treatment (44.14%). While a comprehensive explanation of the factors motivating people to take self-help medication in Indonesia remains deficient, people's attitudes towards health seem to be in line with the pauperism rate that affects 37.17 million people, or 16.58% of the total population (225,642,124 people).

were related to me during my visit to the Free Maternity Clinics of Bandung, one type of Islamic charitable clinic established by *zakat* agencies. The two families are among those who are trying to seek alternative institutions for their medical treatment as they are not being reached by the current health care system of the Indonesian government.

The Indonesian government has launched various welfare programmes as a means of providing health care for uninsured poorer families. One related policy was the enactment of the Law of the National Social Security System [*Sistem Jaminan Sosial Nasional* – SJSN] No 40 in 2004,²⁴ which stated that every citizen, especially if poor, will be insured by the government for basic health services.²⁵ Other government health care schemes include *Kartu Gakin-Keluarga Miskin* [‘Poor Family Card’] and *Jamkesmas* [Social Security System] that allow destitute families to access low-cost or even free health provision. In reality, however, the implementation of the Law of the National Social Security System (SJSN) is by no means comprehensive. In fact, the above health care schemes cannot be accessed appropriately by the targeted segments at grass-roots level, especially among workers in the informal sectors.²⁶ This is due to: (1) the gap between the number of distributed health care cards [*kartu askes*] and the actual number of poorer families in the country; (2) the lack of an effective bureaucracy and administration system in both hospitals and local administrations;²⁷

²⁴ At the national level, for example, the Indonesian government has, via the Ministry of Health, created an insurance programme for the poor, namely *Askeskin*. By 2008, the state budget allocation for the *Askeskin* programme reached Rp4.6 trillion, to be accessed by approximately 76.4 million people. In managing this programme, the government appointed the state-owned health insurance firm, PT *Askes*, to be responsible for the claims submitted by hospitals that had treated those coming from deprived backgrounds.

²⁵ In line with this, the 1945 Indonesian Constitution (Article 34) clearly emphasizes that: (1) ‘Impoverished persons and abandoned children shall be taken care of by the state’; (2) ‘The state shall develop a system of social security for all of the people and shall empower the inadequate and underprivileged in society in accordance with human dignity’; and (3) ‘The state shall have the obligation to provide sufficient medical and public service facilities’. See the 1945 Indonesian Constitution; also Sulastomo (2005), *Sistem Jaminan Sosial Nasional*, Yayasan Penerbitan Ikatan Dokter Indonesia, Jakarta, pp 54, 84.

²⁶ For further discussion of the social security system in Indonesia, see Michael Raper (2008), *Negara Tanpa Jaminan Sosial: Tiga Pilar Jaminan Sosial di Australia dan Indonesia*, TURC, Jakarta.

²⁷ See also Iranda Yudhatama (2007), *Demokrasi Overdosis: Menggugat Tanggungjawab Negara atas Jaminan Sosial dalam Sistem Demokrasi Liberal*, Pustaka Pelajar & Jangkep, Yogyakarta, pp 51–52.

and (3) the people's limited access to information about government health care insurance.²⁸ It is partly under these circumstances that certain poorer families in rural and urban areas seek alternative, more accessible, lower-cost and less bureaucratic health care outside the government health centres.

The growth in the number of charitable clinics is also influenced by the increase in Islamic aid and various social funds collected by *zakat* agencies. There has been a new trend within national and multinational corporations in Indonesia to channel their social funds to *zakat* agencies. In Indonesia, the concept of corporate social responsibility (CSR) was first introduced formally through the Ordinance on Corporation [UU *Perseroan Terbatas*] No 40 in 2007 and through the Ordinance on Capital Investment [UU *Penanaman Modal*] No 25, also in 2007. Since then, the government has attempted to impose the implementation of these laws on corporations and investments. Legitimized by the concept of CSR,²⁹ Muslim workers in large corporations are able to organize social funds derived from either employees' *zakat* payments or corporate social funds. Corporations are not in fact covered by the law (or shari'a by-laws) on almsgiving imposed at the provincial and district levels. Law and shari'a by-laws on almsgiving apparently remain restricted to Muslim civil servants and often overlook employees in the private sector. As *zakat* agencies have not much benefited directly from shari'a by-laws in respect of *zakat* payment, they have endeavoured to optimize corporate social funds as an alternative source. Research conducted by the Public Interest Research and Advocacy Centre (PIRAC), a Jakarta-based NGO, reveals that although corporate social funds are predominantly allocated for social services, religious activities and education, the allocation for health programmes remains a moderate 33%.³⁰

²⁸ *The Jakarta Post*, 21 February 2008; *Kompas*, 8 August 2007; in 2009, the health budget spend in this country was equivalent to 3.1% of its GDP; 55.5% of the Indonesian population is uninsured because health insurance from both government and private sectors has only reached 44.5% coverage. See Salut Muhidin and Jerico Fransiscus Pardosi (2009), 'Time to overhaul RI's public health system', *The Jakarta Post*, 23 June.

²⁹ See Ordinance No 40 on Corporation in 2007, especially Chapter V and article 74 that regulate corporate social responsibility and sustainable development. This act insists that every corporation should allocate some portion of its revenue for social purposes.

³⁰ The PIRAC study also explains that corporations attempt to avoid political issues in the channelling of their social fund. Therefore only a few of the companies supported law reform (3%) and advocacy programmes (12%); some encouraged activities

Unlike advocacy NGOs that are politically quite resistant to the government's unpopular policy on health, there is no strong discourse or movement within *zakat* agencies opposing the recent government policies on health and economics. Rather, *zakat* agencies seem to have built relations with government officials, in a partnership to foster social welfare in the country.³¹ Abu Sayuqi, the founder of RZI, for example, explains: 'We would like to show that NGOs could help society, and so would the government. I would not bother the government . . . but rather would like to help them.'³² It is also common for the inaugurations of Islamic charitable clinics to be attended by high-ranking government officials, ranging from the President to the Vice-President of the Republic of Indonesia, the Minister of Health and other politicians. In 2001, Vice-President Hamzah Haz visited Ciputat in Tangerang, on the outskirts of Jakarta, to inaugurate the free health services (LKC) of DD. Following this, on 14 September 2007, the President of the Republic of Indonesia, Susilo Bambang Yudoyono, together with Vice-President Muhammad Yusuf Kalla, was present at the inauguration of a health centre that was set up by the Semi-Government National *Zakat* Board (BAZNAS) inside the complex of the Sunda Kelapa Grand Mosque of Jakarta.³³

in arts and culture (30%), health (33%) and environment (38%); and the rest financed programmes on education (57%), religion (61%) and social services (82%). In line with this, the *Indonesia Zakat & Development Report 2009* explains that following the *Era Reformasi*, which is signified by the decline of the New Order, Indonesia entered two important phases: the institutionalization phase (1999–2000) and the capacity-building and synergy phase (2001 until the present). The former is indicated by the rise in political awareness among Indonesian Muslims to strengthen *zakat* institutions through the enactment of *zakat* ordinance; while the latter is marked by efforts to rejuvenate the function of *zakat* agencies in society and to create a more powerful impact for *zakat* funds by building synergism among the existing *zakat* agencies. See PEBS FE UI & CID (2009), *Indonesia Zakat & Development Report: Zakat dan Pembangunan [Era Baru Zakat Menuju Kesejahteraan Ummat]*, PEBS FE UI, CID, & DD, Jakarta, pp 8–10.

³¹ The political attitudes of *zakat* agencies are therefore rather dissimilar to other development and advocacy NGOs, as the former (*zakat* agencies) tend to work on service and development-oriented programmes rather than advocacy programmes in their dealings with poverty eradication. For the types of NGOs in Indonesia, see, for example, Bob Hadiwinata (1999), *The Politics of NGOs in Indonesia: Developing Democracy and Managing Movement*, RoutledgeCurzon, London.

³² Website: http://koran.republika.co.id/berita/61469/Abu_Syauqi_Style_Manajen_Kita_Mirip_Perusahaan (accessed 20 June 2009).

³³ The newly charitable health centre of the Sunda Kelapa Mosque comprises one general polyclinic, one dental clinic, one laboratory, one pharmacy and two ultrasonography units. It provides a 24-hour service for low-income households.

The presence of high-ranking government officials in the above-mentioned clinics points to the state's encouragement of communities to strengthen social cohesion. This encouragement arguably arises from the moderate contributions to the social development process, in accordance with government interest in the welfare of society.³⁴ More importantly, however, charitable services offered by *zakat* agencies are regarded by the state – to borrow an expression from Soheir A. Morsy – as 'a contribution towards placating the masses'.³⁵ Meanwhile, inviting government officials can be seen as a way in which *zakat* agencies remind the government to provide a viable health care service and increase the living standards of low-income households.³⁶

Charitable clinics: programmes, actors and beneficiaries

The Islamic charitable clinics created by Dompot Dhuafa (DD) and Rumah Zakat Indonesia (RZI) in part represent Muslim NGOs' attitudes towards the welfare of the community. In the following section, I discuss the profiles of two Islamic charitable clinics: their programmes, financial sources, actors and beneficiaries, as well as their roles in the community. I will also investigate further the limitations and potential of the existing health care scheme offered by *zakat* agencies from the perspective of mutual help among the poor.

Dompot Dhuafa: health care and community development

DD was originally part of *Republika*, a Muslim national daily newspaper. *Republika* was first established in 1992 by Yayasan Abdi Bangsa [the Abdi Bangsa Foundation], a foundation that has a close and direct link with ICMI, the 'government-sponsored' association of Indonesian Muslim Intellectuals. At that juncture, ICMI was a rather influential institution that enjoyed strong support from the New Order

³⁴ Free health care services have often become a political commodity during election time at both the national and regional (provincial and district) level.

³⁵ Soheir A. Morsy (1988), 'Islamic clinics in Egypt: the cultural elaboration of bio-medical hegemony', *Medical Anthropology Quarterly*, New Series, Vol 2, No 4, p 359.

³⁶ Board members of *zakat* agencies realized that the shortage of viable health care could not be solved by service-oriented programmes alone such as those offered by *zakat* agencies and their charitable works. However, they also believe that, for the time being, not only do poor people need advocacy from NGOs, but they also need direct service as an instantaneous solution to the symptoms of problems. Yet, according to the CEO of one *zakat* agency, a long-term advocacy programme remains important in order to address the cause of problems.

government. Observers have suggested that President Soeharto attempted, in his final years, to ally himself with the Islamic faction as a means of preserving his power.³⁷ By the time ICMI was founded, B.J. Habibie, the Vice-President, was installed as ICMI's Head of the Board of Trustees. The establishment of Muslim daily newspapers such as *Republika* in the latter years of the New Order therefore found no political barriers from the regime. Moreover, DD was founded by a number of devoted Muslim journalists and employees of *Republika*. Those journalists and workers witnessed social and economic disparities in society as they fulfilled their journalistic duties. Being aware of the potential social fund that could be gathered from Muslim communities, those journalists, led by Ari Sudewo, turned to Islamic aid derived from *zakat*, *infak*, *sadaqa* and *waqf* as an alternative means of bridging the gap between the rich and the poor.³⁸ In 1993, they began establishing a small *zakat* body to which Muslim journalists working at *Republika* channelled their *zakat* and *sadaqa*.

Supported by urban, middle class Muslims, especially professionals, educated people and celebrities who were very enthusiastic about bringing Islamic teachings into the social and economic domains, DD grew rapidly. Since 2001, it has operated independently from *Republika* and has been managed professionally. Known as a national *zakat* agency, DD has run various programmes under the concept of 'Social Asset Networks' – one of which deals with health care for the needy. On 6 November 2001, DD launched Free Health Services [*Layanan Kesehatan Cuma-Cuma – LKC*], only accessible to those in need. Allocating Rp2,804,740,088, DD established three *Gerai Sehat* [Health Outlets] in Ciputat and Cipulir in Jakarta, and Bekasi in West Java. Since then, these Health Outlets have catered to dozens of patients from low-income families. Furthermore, DD launched *Aksi Layanan Sehat* [Health Service Action] to reach poor areas (ghettos), and *SIGAP Bencana* [Disaster Preparedness] to operate in conflict- and disaster-affected regions.³⁹ Moreover, DD has developed and extended the scope of its

³⁷ See, for example, Robert W. Hefner (1997), 'Print Islam: mass media and ideological rivalries among Indonesian Muslims', *Indonesia*, Vol 64, *Language and Media*, p 95. On the birth of ICMI and the political dynamics during the New Order era, see Syafii Anwar (1995), *Pemikiran dan Aksi Islam Indonesia: Sebuah Kajian Politik tentang Cendekiawan Muslim Orde Baru*, Paramadina, Jakarta; also, Robert W. Hefner (1993), 'Islam, class and civil society: ICMI and the struggle for Indonesian middle class', *Indonesia*, Vol 56, pp 1–35.

³⁸ See Dompot Dhuafa, *Annual Report 2002 and 2003*.

³⁹ Dompot Dhuafa, *Annual Report 2004*.

Table 2. Zakat funds allocated for health by DD (1993–2002).

Year	Poor patient services/facilitation (Rp)	Clinic support (Rp)
1993	0	0
1994	25,711,585.00	10,000,000.00
1995	26,794,650.00	11,651,000.00
1996	29,497,000.00	2,800,000.00
1997	65,818,200.00	20,850,000.00
1998	101,687,500.00	8,300,000.00
1999	116,881,100.00	0
2000	207,834,700.00	0
2001	460,688,200.00	2,143,873,155.00
2002	356,101,700.00	2,325,025,900.00
Total	1,390,975,335.00	4,522,500,055.00
<i>Total</i>	<i>5,913,475,390.00</i>	

Note: The figures for 1993–2000 indicate the extent of the funds spent by DD before the establishment of LKC: the amount spent on clinic support increased suddenly after the operation of LKC – hence the clinic support figures for 2001 and 2002.

health care programme by revitalizing *Pos Pelayanan Terpadu* [POSYANDU – community health posts], the beneficiaries of which include housewives, housemaids and teenagers. In this respect, DD has been remarkably innovative, having incorporated income-generating projects with community health centres so that social and economic welfare could be run altogether. The ongoing and monumental project of DD concerning health has been named *Zona Madina Dompét Dhuafa* [‘zone-based Islamic integrated community development’], under which a more comprehensive Islamic charitable hospital, namely *Rumah Sehat Terpadu*, is currently being constructed. Launched on 7 January 2009, this new project is being funded partly by the community through ‘cash waqf’ [*wakaf tunai*] (see Table 2).⁴⁰

DD’s Maternity Clinic of Bandung (RBC)

One of DD’s branch offices is located in Bandung and was founded in 2002. It has become DD’s representative office in West Java. By renting one building in the city centre of Bandung, DD’s branch office is reachable by both donors and recipients; in everyday life, donors/*zakat* payers and *zakat* recipients enter and exit through these doors on a daily basis. The location of this office is only 300 metres from the

⁴⁰ See Dompét Dhuafa, *Newsletter Masa Kini*, No 0109 (Shafar 1430 H).

major public hospital in West Java, *Rumah Sakit Hasan Sadikin (RSHS)*, from which DD's office frequently receives uninsured patients from deprived backgrounds who need more assistance than they can obtain at the public hospital. Some need financial help to pay their prescription costs not covered by state insurance; others simply require administrative assistance to gain free basic medical care from the government. The most frequent cases that DD treats relate to maternity care, and DD is often called in by poorer families to finance the costs of maternity care. It works in cooperation with the Maternity Clinic Al-Islam Awi Bitung of Bandung, which bills the care of pregnant women to DD's office. DD's regular expenditure on this programme has increased along with the rising cost of maternity medical treatment, and thus the initiation of operating its own maternity care for low-income households was in place by 2004. The clinic is named the Free Maternity Clinic, or RBC [an acronym for *Rumah Bersalin Cuma-Cuma*] and provides health care for infants, children and women. DD's first maternity clinic was set up in Bandung, West Java; it has handled nearly 10,000 health-related cases to date.

Full- and part-time medical workers have been appointed to this maternity clinic, among them one gynaecology specialist, three physicians, five midwives and three nurses. There are also employees who work as administrative supervisors, financial supervisors, front office attendants and security guards. This clinic is open 24 hours a day for maternity care and its regular office hours are from 7.30 am to 5.00 pm. It provides antenatal care (ANC), intranatal care (INC) and post-partum or post-natal care for uninsured, disadvantaged groups. Its programmes include improvement in nutrition for children and pregnant women, pregnancy exercises, medical ultrasonography (USG), immunization and basic medical treatments. The RBC has also functioned as a medical adviser, able to recommend the needy with particular illnesses to a larger public or private hospital for more appropriate medical treatment.

Initially, the RBC was laid out in the form of a small health clinic in a rural area, occupying a small house in a suburb of Bandung. In its early years, the clinic had limited facilities and it could host only a few patients. In 2007, a new proposal came unexpectedly from the local people to set up a more permanent and representative clinic. Admiring DD's social activities, a local family wanted to endow [*waqf*] some of its land to DD for social purposes. An agreement was made between the two (the family and DD) whereby the family would provide the land

and DD would construct the building.⁴¹ It is worth mentioning that some *zakat* agencies, including DD, never use *zakat* funds to finance physical infrastructure projects as they believe that *zakat* funds can only be allocated directly to beneficiaries. Therefore, this *zakat* agency insists that intensive fundraising should be carried out in cases where funds are required specifically for building works and projects. Thus, with the support of the DD central office and the help of donors and corporations who were aware of the social roles of this institution, a permanent and better equipped maternity clinic was finally established.⁴² The RBC in Bandung received different kinds of endowments. Apart from land, for example, it also received endowments in the form of medical facilities and cash. The way in which the RBC attracted its donors is also interesting: DD distributed a list of required medical facilities – with the respective value attached to each – to potential donors so that donors could give according to their own personal preferences. Certain medical facilities in the RBC are therefore marked with a list of the donors' names.

Rumah Zakat Indonesia: social concern of an Islamic gathering group

RZI was originally named Dompok Sosial Ummul Qura (DSUQ) and founded in 1998. The initiation of this *zakat* agency cannot be detached from the cleric and social activist 'Abu Syauqi' (Deni Triesnahadi), who has led the *Majelis Ta'lim Ummul Qura*, a religious gathering group, for over two decades.⁴³ This *Majelis Ta'lim* was founded by Abu Syauqi in 1996 and initially facilitated religious gatherings and public sermons in which Abu Syauqi was a key figure. In the following years, the *Majelis Ta'lim*'s activities were broadened to engage with social activities. The first and foremost item on the agenda at that time was to help poor orphans living in the surrounding neighbourhood. As leader, Abu Syauqi began by compiling a proposal comprising the comprehensive files of 10 orphans. The proposal was then presented to the community. Gaining an enthusiastic response, Syauqi, who used to work as a

⁴¹ This is not to say that the process of endowing this land ran smoothly, because one of the family members later refused to endow the inherited land. RBC was in dispute with a family member of the *waqif* ['those who donate'] over the use of endowed land for social purposes.

⁴² In the case of RBC, Muslim Workers Union of PT. Indosat TBK, an Indonesian telecommunications company, is among the private institutions contributing significantly to the establishment of RBC.

⁴³ *Republika*, 22 October 2004.

physiological and religious counsellor in a private hospital in Bandung, presented a further 100 files regarding the orphans to the community and received similar passionate support. A number of people then encouraged him to extend his social activities by addressing not only orphans, but also poorer families in the neighbourhood. He then promoted his institution as a *zakat* agency to which Muslims could channel their *zakat*, *infak*, *sadaqa* and *waqf*.⁴⁴

This agency has in essence tried to redefine the concept of Islamic piety and to translate it into reality. It aims to become an intermediary between *muzakki* [the givers] and *mustahik* [recipients] in order to narrow the gap between prosperous [*aghniya*] and disadvantaged groups of society [*dhu'afa*]. Acting as a *zakat* collector, RZI has gained strong support from society, and since 2003 has been acknowledged as a national *zakat* agency by the Ministry of Religious Affairs. It is reported that by 2008, this *zakat* agency had been supported by 64,222 donors and had been able to operate 44 branch offices throughout Indonesia. To date, it has provided work for at least 700 employees.⁴⁵ RZI's social activities can be simply defined as populist and its programme nomenclatures include *Ecocare*, *Healthcare*, *Educare* and *Youthcare*. RZI won praise from the United Nations for its contribution to health and to the distribution of essential nutrients among poorer families. RZI is regarded as having been involved in the promotion of the United Nations' Millennium Development Goals (MDGs), especially in the fields of poverty eradication, education and infant and maternity mortality rate reduction.

RZI's health services and Integrated Community Development (ICD)

Integrated Community Development (ICD) is a subdistrict- or village-based community development programme implemented in certain regions. In order to be more effective in carrying out its activities in the community, RZI's functionaries, namely *mustahik relation officers* (MROs), or people who can regularly interact with *zakat* recipients

⁴⁴ It is worth mentioning that Abu Syauqi has close connections to, and has even been a part of, the Tarbiyah Movement in Indonesia. Even so, he chose to become a social activist rather than a politician, as he decided not to join any political party. However, in the election of the Mayor of Bandung Municipality, Abu Syauqi was nominated by the PKS as the Vice-Mayor of Bandung, assisting Taufiqurrahman, a candidate for Mayor of Bandung.

⁴⁵ Interview, *Republika*, 6 July 2009.

[*mustahik*], are appointed in the targeted locations. MROs act as RZI's representatives, responsible for the success of its missions, including micro-finance projects. The MROs are usually installed in a community, staying close to the people so that they can become acquainted with their societal needs. MROs' main duties are to assess the socioeconomic background of a community, to classify the targeted groups according to their average income, and to monitor RZI's ongoing economic development programmes in the given regions. In short, the MROs have functioned as motivators, coordinators and facilitators. RZI particularly selects young, dedicated and married men to be MROs. The MROs have become key sources in supplying information to RZI's office about the actual conditions in the field. It is interesting that the ICD programmes have also become a medium through which to recruit charitable clinic members.⁴⁶

RZI has allocated most of its collected funds to health programmes;⁴⁷ 12.5% of the total social fund is for the *zakat* administrator [*'amil*]; 10% is kept in reserve; and the remaining 77.5% is redistributed through various programmes. Seven Free Maternity Clinics (RBGs) have been established in certain regions of Indonesia, notably in major cities such as Bandung, Semarang, Jakarta, Yogyakarta, Medan, Pekanbaru and Surabaya. In other areas where the collected funds are insufficient for the regular expenditure of charitable clinics, RZI does not operate its own clinics. In order to compensate for the absence of clinics in certain regions due to a limited budget, RZI offers free maternity care [LBG – *Layanan Bersalin Gratis*] in cooperation with local hospitals and

⁴⁶ The target beneficiaries for ICD are poorer families (potential *zakat* recipients) who are considered eligible for both micro-finance (*Ecocare*) and free health provision (*Healthcare*). Interview with Hadiyani Nugraha, Manager of RZI's Charitable Maternity Clinic of Bandung 14 March 2009, in Bandung. The ICD also engages potential donors (*zakat* payers from wealthy families) in the given region as its partners. Up to March 2009, RZI had managed 227 ICDs with 4,062 families throughout Indonesia.

⁴⁷ *Zakat* agencies in Indonesia seem to agree that 12.5% of the collected fund is allocated for the *zakat* collector, with the rest to be distributed through various programmes on health, education, micro-finance, and so forth. It would appear that those programmes have been created to reach eight types of *zakat* recipients: namely *miskin* [the poor], *fuqara* [the needy], *muallaf qulubuhum* [those whose hearts are inclined to Islam], *riqab* [bond persons], *gharimin* [people in debt], *ibn sabil* [wayfarers], *'amil* [*zakat* administrators] and *fi sabilillah* [in the way of God]. It should be noted, however, that from the above-listed *zakat* recipients, *muallaf qulubuhum* [those whose hearts are inclined to Islam], *riqab* [bond persons] and *gharimin* [people in debt] are among those who are rarely reached by *zakat* agencies in comparison with other recipients. To me, this is simply because of the absence of effort among the existing *zakat* agencies to reinterpret the meaning of the above-listed *zakat* recipients.

maternity clinics. For example, in Banda Aceh, where RZI is still struggling with the problem of collecting social funds from local people, especially since the tsunami, health services are provided through local hospitals and clinics, with RZI footing the bill.⁴⁸

One of RZI's Free Maternity Clinics was set up near the centre of Bandung. Its location is close to the Central Office of RZI and surrounded by different buildings. To the right and left side of the clinic, there are small, higher-education institutions. Bandung Super Mall, the largest shopping mall in Bandung, is located only some 400 metres from the clinic. This area is far from the slums of Bandung. A house that functions as a clinic had been rented for a couple of years and then bought by RZI.⁴⁹ This clinic was built in order to cater for poorer families in the Bandung area. By the time I conducted my fieldwork, this clinic was being directed by a young physician who had been working there with RZI for six months. He decided to accept RZI's offer to become the manager of this clinic after serving as a junior physician in a public hospital in a suburb of Bandung. He told me that during his time with RZI, he had undergone a whole new experience thanks to RZI's status as a social institution that combines social and religious duties (see Table 3).

Interestingly, these DD and RZI clinics seem to be trying to develop a new brand, one that differs from state-owned and private hospitals and clinics. The term 'hospital' in English is equivalent to the phrase '*rumah sakit*' in Bahasa Indonesia (which literally means 'the house of the sick', comparable with *ziekenhuis* in Dutch). In order for a health centre or clinic to be described as '*rumah sakit*', it first must fulfil conditions set by the Ministry of Health. In Jakarta, for example, charitable clinics belonging to DD have been named *layanan kesehatan cuma-cuma* ['free health services'] and *rumah sehat Indonesia* ['Indonesian health houses'], rather than *rumah sakit*. In Bandung, RZI and DD use the phrases *rumah bersalin gratis* (RBG) and *rumah bersalin cuma-cuma* (RBC) respectively to identify their Free Maternity Clinics. Likewise, while the state-managed '*Pusat Kesehatan Masyarakat*' (PUSKEMAS) is the official name of the government's community health centre, DD uses the phrase '*Pondok Keluarga Masyarakat Sehat*' [Family Boarding for Community Health]. Not only

⁴⁸ Interview with Bukhari, Branch Manager of RZI in Nanggroe Aceh Darussalam, 26 November 2008, in Banda Aceh.

⁴⁹ It is said that the current maternity clinic is the place where Abu Syauqi, the founder of RZI, was born.

Table 3. The redistribution of Islamic aid, RZI, 2008.

Programme	Percentage	Activities
Ecocare	20	Micro-finance, cooperative, economic development.
ICD	5	Facilitating RZI's programme in the community.
National distribution	9	Supporting RZI branches throughout Indonesia.
Youthcare	10	Youth Camp, on-campus volunteer recruitment, training capacity building of volunteer (for community development and emergency rescue team), and Youth Development Centre.
Educare	22	'The Winner School' (scholarship for distinguished preliminary students), Kids Learning Centre (KLC), Centre for Kids' Potential Development, and Student Camp.
Healthcare	34	Free maternity clinics, free maternity service, free health service, ambulance, mobile clinics, immunization, etc.

Table 4. Charitable clinics operated by Islamic civil society organizations.

Institution	Types of clinic	Location	Description
Muhammadiyah/ Aisyiyah	345 clinics and hospitals	Throughout Indonesia	Semi-charitable and non-charitable
Dompot Dhuafa	3 health outlets; 2 RBC (maternity clinics), 3 LKC (community health centres); 2 polyclinics/hospitals; 1 lung specialist clinic; and 1 mental clinic	Jakarta (Ciputat & Sunda Kelapa), Bogor, Bekasi, Bandung, Palembang, Pontianak, Jambi, Bali, Northern Aceh	Charitable
Rumah Zakat Indonesia	7 clinics/maternity clinics	Bandung, Semarang, Jakarta, Yogyakarta, Medan, Pekanbaru and Surabaya	Charitable

does this DD brand represent the institution's function, but also its religious and social identity. The *zakat* agencies appear to have used particular brands in order to communicate more effectively with the public, the donors and the beneficiaries (see Table 4).

Clinic membership: medical and financial reasons

There are two types of beneficiaries: members and non-members. Members are those from low-income households who are entitled to free medical care once they have been approved for either in DD or RZI clinic membership, upon completion of an application form. The applicants enclose some specific documents to be approved, such as an ID card, family certificate (showing the numbers of family members), marriage certificate and a letter from the local administration certifying their economic status. The decision on membership is made by a small team that verifies the applicants' actual economic condition. Often the applicants are visited by the team to ensure that they are suitable for free health provision. During the visit, the team will interview the applicants and observe their dwellings, number of family members, types of occupation, etc. If necessary, the team will also consult with local leaders who are well acquainted with the applicants' socioeconomic background. Yet consultation with local leaders is often overlooked. The team often gives approval during the first visit whenever the team deems appropriate. It has been reported that, up until 2008, the membership of DD's RBC was in excess of 1,130 (see Tables 5 & 6 and Figures 1–3).

This membership system does not, however, prevent poor, non-member families from gaining access to health services. Some patients are simply granted membership after receiving health assistance from the clinic. In the case of DD's clinics, the membership system has functioned as a mechanism to control a clinic's annual expenditure and to manage patients' medical records. For example, in 2008 the RBC had a very limited budget, amounting to Rp600 million, provided by Dompot Dhuafa of Bandung to cover its annual expenditure, including utilities and salaries. The number of members has certainly shaped the budget proposal put forward by this clinic. The *zakat* fund can only be given to rightful types of beneficiaries, notably the poor and the needy. To sum up, clinic membership has functioned as a mechanism to prevent the mishandling of *zakat* funds.

Charitable clinics also present prospective members to donors for financial support. In RZI's clinic in Bandung, for example, the clinic's beneficiaries can be grouped into three categories. The first is 'prospective members', consisting of groups of people who have been profiled and surveyed by the clinic. They are conditionally regarded as members until the required funds to support their health care costs

Table 5. Numbers of patients and services, DD maternity clinic (RBC) in Bandung (up to 2008).

No	Types of activities	Number of individual beneficiaries
1	Registered beneficiaries	1,645
2	Members	1,130
3	Baby delivery	915
4	Family planning programme	2,492
5	Outpatients	2,942
6	Immunization	4,217
7	Antenatal programme	5,574

Table 6. Incidental health service activities of RZI in 2008.

	Cataract surgery	Harelip surgery	Hernia surgery	Male circumcision*	Siaga Sehat
Frequency/year	6	4	10	3	13
Target of beneficiaries	71	4	18	80	3,350
Registered beneficiaries	205	19	123	85	3,169
Served beneficiaries	45	4	18	79	2,664

* Islamic associations often conduct *Sunatan Massal*, an occasion that enables boys from low-income households to participate collectively in one of the Prophet's traditions, circumcision. Yet at present, female circumcision is rarely practised in Islamic medical clinics. In certain cases, in the interests of tradition, a family may make a request to the clinic for female circumcision. In order to provide 'customer satisfaction', the physician attempts to clean smoothly – not to cut – the skin around the baby girl's clitoris, using a particular physiological fluid. For further discussion of the circumcision tradition in Indonesia, see Nico Kaptein (1995), 'Circumcision in Indonesia: Muslim or not?' in Jan Platvoet and Karel van der Toorn, eds, *Pluralism and Identity: Studies in Ritual Behaviour*, Brill, Leiden, pp 285–302; Andrée Feillard and Lies Marcoes (1998), 'Female circumcision in Indonesia: to "Islamize" in ceremony or secrecy', *Archipel*, Vol 56, pp 337–367.

become available. In 2008, for example, RZI surveyed as many as 419 poor families. The second category is of 'members without financial support', comprising groups of people (about 210 poor families) who have been surveyed and approved for membership, but not channelled to particular donors. This highlights the fact that, due to a limited budget, not all members approved by the clinic automatically receive free health care services. It is thus in order to overcome this financial problem that RZI presents the profile of the approved members to certain donors. RZI often holds fundraising and social events attended by wealthy people and various companies, during which the profiled members are 'advertised' and then 'auctioned' to the donors. The last type is

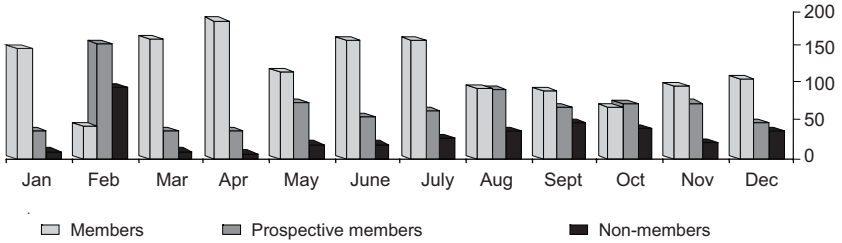


Figure 1. Basic and regular maternity services at RBG (January–December 2008).

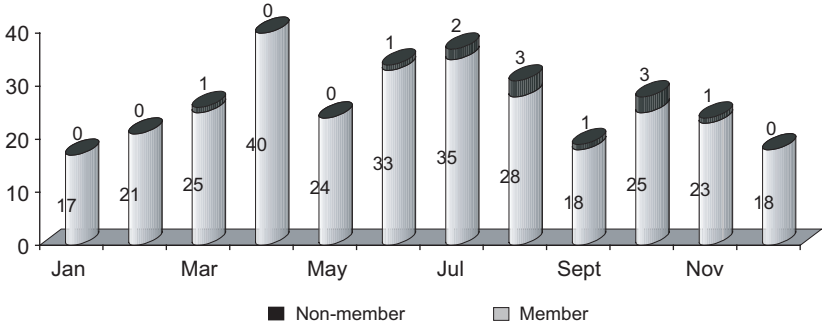


Figure 2. Maternity services (baby deliveries) at RBG (January–December 2008).

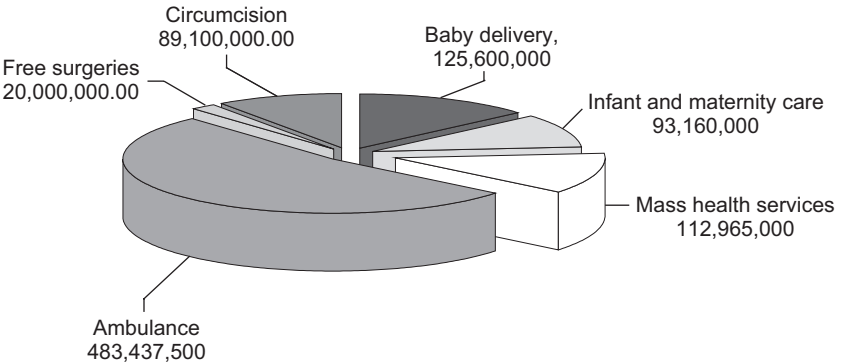


Figure 3. RZI expenditure on health (as at August 2008).

'members with financial support'. These people (116 families) are able to access health care, as they are being funded by particular donors. Bearing the above system in mind, it can be said that the source of funds coming into clinics does not necessarily originate from *zakat*, but rather from *sadaqa* and *infak*.

In addition to the availability of funds, the issue of membership is closely related to professionalism in providing medical services. Clinic membership has helped medical workers to become more acquainted with the clients'/patients' medical records so that the physicians can ascertain the appropriate antenatal and post-natal treatments. Nevertheless, charitable clinics often face a great number of difficulties, especially in dealing with non-member patients who require specialist treatment. It is reported by DD's clinic that its physicians found patients with serious diseases such as cardiomyopathy (a heart muscle disease), sub-arachnoid haemorrhage (bleeding surrounding the brain) and malnutrition, which require intensive medical treatment. In facing this kind of problem, the clinic can often do nothing because of budget constraints. Declining patients then becomes the clinic's final option, or, if it is possible, the clinic will carry out special fundraising to overcome a particular financial problem.

Although membership in the clinics of RZI and DD is valid for one year only, these two clinics have different policies on providing free maternity services for their clients. In DD's clinic, for example, each family can have only one opportunity to have a baby delivered. This policy acts to educate poorer families about family planning, sexual and reproductive health, as well as to diminish their dependency on charitable clinics. By contrast, membership of RZI's clinic is renewable. The clients/patients can have more than one period of membership as long as their membership is renewed before or during the second pregnancy. There has, however, been no such case so far. This may be because, as one physician at RZI's clinic has described, the poorer families are hesitant about coming back to the clinic for a second pregnancy. Special medical treatments are also provided, but very rarely. It depends on the type of disease and the availability of funds. In order to overcome serious cases, such as those requiring surgery, serious bronchitis, recto-vaginal fistulas, etc, the clinics 'advertise' the clients' profiles on their Website and send proposals for donations to prospective donors, be they individuals or corporations.

Why maternity care and nutrition?

Infant and maternal mortality rates in Indonesia remain higher than those in other South East Asian countries such as Malaysia, Thailand and the Philippines.⁵⁰ This has inspired *zakat* agencies such as DD and RZI to pay much more attention to maternity care and improvements in nutrition. Luthfi Affandi, the General Manager of Dompot Dhuafa in Bandung, suggests that poorer families in urban and rural areas are actually vulnerable to infant and maternal mortality as a result of three factors: (1) they do not have sufficient resources to be able to afford their health expenditures, especially to have regular medical check-ups during pregnancy; in some cases, and especially in rural areas, patients obtain the minimum treatment from a traditional midwife [*paraji*]; (2) lack of knowledge and information about health care is another major problem: the absence of intensive care from a local health centre may result in a high-risk pregnancy that requires special medical treatment (vacuum extraction or Caesarean section); (3) overdue intensive maternity care as a result of long distances between the patient's residence and maternity clinics, as well as the patient's hesitation about going regularly to maternity clinics, are two major related factors. It is worth noting that the problem arises because pregnancy is beyond the coverage of the state's health insurance.⁵¹ According to a report of the World Bank in 2009, infant mortality rates (IMR) in Indonesia have actually decreased by 50% since the 1990s, but since 2002 the decline has been slower. More importantly, Indonesia's maternal mortality ratio (MMR) in 2009 reached 420 deaths in every 100,000 births, one of the highest rates in East Asia.⁵² It is under these circumstances that clinic membership can reduce high-risk pregnancy among low-income households.

⁵⁰ See the 2007 Indonesian Health Profile, pp 139–142. It should be noted that the method employed by the Ministry of Health to measure infant and maternal mortality was based on hospital reports, excluding numbers from the community, which have not yet been researched.

⁵¹ Interview with Luthfi Afandi, General Manager of Dompot Dhuafa, Bandung Branch Office, 24 September 2008; interview with Head of Administrative staff of DD's Charitable Maternity Clinic, 29 September 2009. See also Luthfi Afandi and Hendi Suhendi (2008), 'Riak Kecil di Tengah Arus Besar: Studi Kasus Optimalisasi Dana Ziswaf DD Bandung', in Arifin Purwakanta, *et al.*, eds, *Gerakan Zakat untuk Indonesia*, KB Press and Dompot Dhuafa, Jakarta, pp 37–57.

⁵² *The Jakarta Post*, 29 May 2009. The above numbers on IMR and MMR are higher than those in 2007. Demographic and Health Survey has reported that in 2007, Indonesia's IMR was 34 per 1,000 live births, while its MMR was 228 per 100,000

Islamic charitable clinics belonging to DD and RZI can only accept as their members mothers who are up to seven months pregnant. Babies born in Islamic charitable clinics are eligible to receive further provisions from the clinics, such as routine health care and nutritional improvement. Furthermore, a manager of RZI's maternity clinic in Bandung suggests that, based on the pooling conducted by RZI in 2007, health services (notably free ambulance and maternity clinics) are among the most preferred programmes by beneficiaries. Therefore, RZI has upgraded its basic provision of health to maternity clinics. The manager also emphasizes that RZI's maternity clinics have played a pivotal role in decreasing infant and maternal mortality rates in Indonesia, or at least in the regions where RZI's clinics have been operating.⁵³ The establishment of maternity clinics is closely related to the *zakat* agencies' perspective on the future of the community. Eri Taufiq, the former Director of DD in Bandung, for example, explains: 'It is probably from the wombs of poor mothers that those children who may become future leaders may be born. Therefore, we assisted them from the antenatal phase. We do hope that a better and appropriate baby delivery process will result in the rise of leading generations.'⁵⁴ In the wider context, the above statement also reflects people's awareness of the necessity to increase the quality of families in a developing country such as Indonesia. Along with this, the issues of family planning are often promoted during antenatal and post-natal services.

The health programmes offered by both RBC (DD) and RBG (RZI) are relatively similar. Catering to women, infants and children has become the major concern of the two institutions, and therefore they have set up similar kinds of clinics. If we look further at the clinics, there are very obvious resemblances between RBG and RBC in terms of mission, objectives, organizational structures, policies, financial sources and beneficiaries. The clinics of the two agencies have even employed a very similar brand that might be confusing to both donors and beneficiaries. As previously mentioned, RBC and RBG are abbreviations of *rumah bersalin cuma-cuma* and *rumah bersalin gratis* respectively. In Bahasa Indonesia, the words '*gratis*' and '*cuma-cuma*' have a similar meaning, but express two different psychological senses.

live births. The increase in the infant mortality rate in Indonesia is, according to some experts, due to the economic crisis. See *The Jakarta Post*, 17 April 2003.

⁵³ Interview with Hadiyani Nugraha, Manager of RZI's Charitable Maternity Clinic of Bandung, 14 March 2009.

⁵⁴ *Republika*, 22 October 2004.

The word *gratis*, which is a loanword from Dutch/English, has a more definite meaning: free! *Cuma-cuma* is often used by DD in order to obscure the word ‘free’ as a means of ‘respecting’ and ‘not disgracing’ the poorer families. DD’s experience suggests that even poorer families do not want to be directly referred to as such.⁵⁵

‘Health for all’: how to reach the targeted beneficiaries

Whether or not the existing charitable clinics can provide wider access to viable health provisions for poorer families can be seen in the way in which they reach – or are willing to be reached by – the beneficiaries. Despite the fact that most charitable clinics are not located in the slums of cities, they publicize themselves by advertising through the local radio and newspapers, as well as putting pamphlets and posters at the crossroads surrounding the clinics. This means that not all people, especially those living in rural areas, are reached by the publicity. A patient who had attended a charitable clinic told me that he had obtained information about the clinic from well educated people among his relatives and neighbours who lived and worked in the city where charitable clinics operate. For example, the experiences of patients who come from the Pangalengan highlands and the Cikalong Wetan subdistrict, as described above, suggest that they are informed about the clinics by their relatives and neighbours. This is because their areas are not reached by clinic advertisements. A family from the Pangalengan highlands was informed by some relatives working in the city of Bandung, while a family from Cikalong Wetan was brought to the clinic by neighbours who run DD’s economic development projects in a village near the Cikalong Wetan subdistrict.

Because access to information among poor villagers and poor urbanites is very limited, ‘person-to-person’ contact has greatly contributed to the circulation of information about the clinics. Those who have already accessed medical and health services from charitable clinics seem to inform their neighbours or relatives, who may have the same medical and financial problems, about their experiences. Therefore, it

⁵⁵ In 2005, when the price of oil and the cost of public transport in Indonesia both rose, DD took the initiative by introducing free public transportation. DD operated four buses around Jakarta city from 6.00 am to 6.00 pm. Each bus was labelled ‘*Bus Gratis Subsidi Dana Zakat, Infak, dan Sedekah*’ [Free Bus Subsidized by Zakat, Infak and Sadaqa Funds]. The results suggest that only a few people wanted to use the charity buses because they felt embarrassed riding such transportation with such an obvious message to the public as ‘free’.

is very common to find many patients residing in the same region and even the same village. This means that the existing system of advertisement, which has not reached potential patients, has caused villagers and urbanites to establish their own 'network' in order to access health services. Meanwhile, this situation provides an opportunity, notably for *zakat* agencies, to set up new clinics or to intensify the campaign for health in the area from which most patients come.

Beyond charitable health services

Religious and economic activities

Like other Islamic social institutions in many Muslim countries, Islamic charitable clinics in Indonesia attempt to be involved in poverty alleviation as well as economic stress reduction by creating income-generating projects for poor families. While the patients are receiving charitable services from the clinics, they are encouraged to become involved in other programmes. No less important is the fact that patronage has often characterized charitable works carried out by religious associations.⁵⁶ In this respect, Islamic *da'wa* is integrated into the clinics' social missions. Clinic staff, for example, distribute Indonesian-style Islamic veils to women members and clients as an encouragement to follow a proper Islamic dress code. The types of veils that are distributed are common in Indonesia; much simpler than a long *hijab* and *niqab* in Middle Eastern societies. While messages on Islam and advice on health are apparently delivered by physicians during medical check-ups and consultations, the patients and clients are also often invited to attend monthly religious gatherings held in the clinics. Doctors, nurses, administrative staff, security guards and other clinic stakeholders attended these gatherings. Most patients who attend

⁵⁶ Egbert Harmsen and Zami Zubaida's studies on Muslim voluntary organizations and Islamic civil society organizations in the Middle East, for example, reveal that both horizontal and vertical patronages have characterized the relationship between the providers and users of Islamic social institutions. See Egbert Harmsen (2008), *Islam, Civil Society and Social Work: Muslim Voluntary Welfare Society Associations in Jordan: Between Patronage and Empowerment*, Amsterdam University Press, Amsterdam, and ISIM, Leiden; Sami Zubaida (2001), 'Civil society, community and democracy in the Middle East', in Sudipta Kaviraj and Sunil Khilnani, eds, *Civil Society: History and Possibilities*, Cambridge University Press, Cambridge, pp 232–249.

regular religious gatherings are active members of the clinics who still expect further services from charitable clinics. These gatherings, according to one member of staff at a DD clinic, have functioned as a motivational forum that aims to strengthen cohesion among patients and DD's staff. It is also because the income-generating projects are based on group work, not individual work, that these gatherings are important. In the same way, RZI's clinic keeps in close contact with its clients through the *mustahik relation officers* (MROs) installed in the midst of communities. The task of the MRO is greater than simply acting as RZI's representative; he may monitor the religious attitudes of RZI's patients to assess whether they are willing to perform their religious obligations in daily life, and are therefore eligible for further economic support.

Islamic charitable clinics do not cater exclusively to 'good Muslims'. They are basically inclusive of poor families, regardless of their quality of religious life. Yet they seem to give privilege and priority to poorer Muslim families because of their understanding of the use of *zakat* funds and of the types of beneficiaries coming to the clinics.⁵⁷ During my research, I did not find any information that revealed non-Muslims having access to free health provision. It is not because the clinics reject non-Muslim patients, but rather because non-Muslims do not come to the clinics for medical services. As a matter of fact, Christian churches in Indonesia, especially in Java, have more sophisticated health programmes for Christian families – including the poor – than Muslim organizations. It is worth emphasizing that in the case of RZI's clinics, the pivotal role played by MROs in the recruitment of potential members may have unintentionally prevented non-Muslims from having the opportunity to receive free health services. The profiles of patients who become members of RZI's clinics vary, but they still represent mainly low-income households. Their occupations include farmers, construction labourers, *becak* [a modified bicycle] drivers, part-time labourers [*pekerja serabutan*], small merchants and of course the unemployed. These

⁵⁷ Among the eight types of *zakat* recipients according to Quranic injunction, only two can be classified as Muslim recipients: that is, '*amilin* [*zakat* collectors] and *fi sabilillah* [those who are in the way of God]. Meanwhile, other beneficiaries include the poor [*miskin*], the needy [*fuqara*], *muallaf qulubuhum* [those whose hearts are made to incline to the truth], *riqab*, *gharimin* [the bankrupt] and *ibn sabil* [travellers]. One *zakat* collector told me that the Qur'an does not make a clear distinction between the poorer families based upon their religious affiliation. However, because the majority of the Indonesian population is Muslim, the majority of poorer families are also Muslim.

people, as far as their outward appearances are concerned, are not always identifiable as so-called 'devoted Islamists'.

Income-generating projects created by *zakat* agencies are basically aimed at enabling unemployed couples to earn extra income. It seems to me that women have become their main targets. Cake baking, cooking, embroidering and sewing are among the kinds of 'ordinary' skills provided in the training. There is no particular training provided for the husbands, but in some cases, especially in rural areas, the *zakat* agencies have managed income-generating projects through, for example, home industry and animal husbandry. Should the families live in regions where the economic development programmes of *zakat* agencies do not exist, they cannot enjoy such income-generating projects. It is the case, however, that there are families who are not – or are not willing to be – involved in income-generating projects even after enjoying health provisions from charitable clinics. There have been very rare success stories of economic development projects that have been set up as a continuation of the health provision programmes.

From the 'haves' to the 'have nots': the failure of mutual help among the poor

The very short duration of membership seems to restrict the *zakat* agencies and prevent them from creating a more comprehensive scheme of mutual aid among the poor. The poorer families, including clinic members, do not engage in the health schemes provided by Islamic charitable institutions. *Zakat* agencies merely act as an intermediary between the 'haves' and the 'have nots'. Health programmes provided by *zakat* agencies are therefore merely a form of direct aid from the wealthy to the poor. The poor families in this respect are recipients, albeit members of the clinics. There has so far been no particular effort made by *zakat* agencies to create a health insurance system for the poor that, for example, involves them in the system while the *zakat* agencies act as facilitators. The patients/beneficiaries come and go without having any obligation to participate further in the system.⁵⁸ The existing health services are, therefore, undoubtedly characterized by an

⁵⁸ Lack of participation among the poor in a health care system in which charitable clinics are embedded has characterized the relationships between patients/beneficiaries and clinics. Saad Eddin Ibrahim's study on *Grassroots Participation in the Development of Egypt*, as cited by Janine Clark, confirms that 'the poor are largely excluded from PVO activity except as mere recipients of benefits', Clark (2004a), *supra* note 4, at p 65.

absence of mutual help from the poor to the poor through which patients are actually able to share solutions to similar problems.⁵⁹ In other words, there is a top-down relationship from the 'haves' to the 'have nots'. Due to a lack of participation among clinic members, we can assume that the principle of equity between the givers and the recipients in creating a health care scheme disappears as the members merely become 'passive objects' rather than at least 'partial subjects'. As a passive object, accessing health services is absolutely contingent upon the health providers' approval. While charitable clinics may have reduced the level of stress among poorer families, insecurity about serious illness remains high. The position of the poorer families, even the members of charitable clinics, remains vulnerable. Overall, this demonstrates the failure of the existing institutions to provide a more reliable health care system in which the poor can participate in so-called 'mutual help'. This does not mean, however, that patients with serious diseases are losing their chance of receiving treatment because *zakat* agencies have established strong partnerships with private sector organizations. Nevertheless, seen from a broader perspective, the lack of effort to draw low-income households into the system has in part also produced short-term improvement in health in the areas where charitable clinics operate. Charitable health care, with its limited capacities, has not yet been designated as a community-based health care system that can provide long-term health improvement for low-income households as a whole.⁶⁰

Financing Islamic charitable clinics

What is remarkable about the existing *zakat* agencies as voluntary sector organizations in Indonesia is that they emerged in a situation during which the private organizations sector began entering social domains to implement corporate social responsibility programmes. In our case, permanent Islamic charitable clinics were financed by different parties, ranging from community to commercial corporations. Charitable

⁵⁹ By the 1970s and 1980s, some Christian NGOs such as YAKKUM and YIS offered a form of community-based health insurance, namely '*dana sehat*'. Despite providing health services, this scheme allows the community to participate by contributing about 0.5% of average household income. See David Morley, Jon Rohde, and Glen Williams (1983), 'The ant and the elephant: voluntary agencies and government health programmes in Indonesia', in *Practising Health for All*, Oxford Medical Publications, Oxford, pp 168–189.

⁶⁰ There has been no adequate study of the impact of charitable clinics, notably maternity clinics, on the decrease in infant mortality in both regional and national contexts.

clinics, like other voluntary works, represent third-sector associations, which are located between the state and the market. However, this does not mean that charitable works and philanthropic activism, according to Thomas Adam, 'exist outside both'. Nor does it indicate, as Adam goes on to comment, that they are 'not influenced or regulated by both – the state provides the legal framework, and some philanthropic enterprises produce a profit which is either distributed among the philanthropists or reinvested in the enterprise'. Adam also concludes that philanthropic activism represents 'a mixed economy of welfare,' as 'the dividing lines between cooperation and philanthropy are not always precise'.⁶¹ In the discussion that follows, I demonstrate how private sector associations contribute to, or at least impact upon – but do not always regulate – charitable actions carried out by *zakat* agencies.

Collaboration with the private sector

Zakat agencies such as Dompot Dhuafa (DD) and the Rumah Zakat Indonesia (RZI) do not, as previously explained, use *zakat* funds to pay for physical infrastructure. The task of the *zakat* agencies is to redistribute *zakat* funds directly to beneficiaries through charitable and development-oriented programmes. Given that developing infrastructure is not an appropriate project for *zakat* funds, the existing *zakat* agencies have searched for new strategies to finance charitable clinics. They have, for example, built partnerships with private sector organizations, both national and multinational. I would like to emphasize that 'corporate social funds' are not necessarily derived from 'Islamic sources' such as *zakat*, *infaq*, *sadaqa* and *waqf* in the Islamic sense, but are also provided by companies that are not always 'religious' in nature. For example, some very well known multinational oil companies and state-owned corporations have been involved in the establishment of charitable clinics and in aiding special health provisions. The profiles of companies involved in DD's charitable projects illustrated in Table 7 imply that not all resources and social corporate funds are derived from religiously motivated giving. Some sources of Islamic aid have, in fact, even had 'secular roots', which have subsequently been 'Islamized' through *zakat* agencies. The intermediary role played by *zakat* agencies has bridged the gap between the needy with limited access to health, and social funds provided by wealthy corporations (see Figure 4).

⁶¹ Thomas Adam, ed (2004), *Philanthropy, Patronage and Civil Society: Experiences from Germany, Great Britain, and North America*, Indiana University Press, Bloomington, IN, p 4.

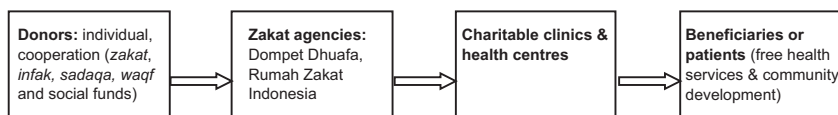
Table 7. Partners of DD clinics.

No Partner	Description	Contribution
1 PT Adhimix Precast Indonesia	A large corporation with four major business units (Readymix concrete, Precast concrete, Construction and Property).	Financing patients with special diseases.
2 BI	The Central Bank of the Republic of Indonesia.	Donating ambulances.
3 KFC (Kentucky Fried Chicken)	KFC Corporation is a chicken restaurant chain based in Louisville, Kentucky.	Donating ambulance and medical facilities: USG & sterilization.
4 P&G (Procter & Gamble)	A multinational company that produces health products: cosmetics, soap, drugs, nutrition items, papers, etc.	Donating ambulance and building LKC clinic in Bekasi, West Java.
5 AN TV	Indonesian private TV station.	Through <i>ANTV Peduli</i> , one of the social programmes of ANTV, this TV station ran various fundraising activities in support of DD's clinic.
6 Indosat	Indonesian telecommunication company.	Donating mobile health clinic and offering financial support for regular charitable health services and circumcision in Banten province.
7 Adira Finance	The largest multi-brand automotive financing company in Indonesia.	Participating in the establishment of ' <i>Rumah Sehat Terpadu</i> ' of DD in Bogor.
8 Inreso Foundation	A foundation established by the Workers' Union of PT Adira Dinamika Multi Finance. Its activities include financing health projects for the poor.	Financing LKC's patients with special diseases [or conditions] such as hernia, hydrocephalus, cancer, etc.
9 PT PPA	A government-owned asset management company. The objective of the PPA is to save, protect and manage national assets (banks and government-owned companies).	Financing irregular health services among villagers, circumcision, and patients with special diseases.
10 The Global Fund	A public-private partnership that aims to fight AIDS, tuberculosis and malaria throughout the world.	Actively engaging DD in the supervision and campaign against tuberculosis.

Table 7 continued.

No Partner	Description	Contribution
11 DKM At-Taqwa PT Denso	PT Denso is one of largest companies in the business of manufacturing automotive components. At-Taqwa is a Mosque set up by the company to facilitate Islamic activities among Muslim workers.	Financing patients with special diseases among the clinic's members.
12 Exxon Mobile Corporation	A US-based multinational oil and gas company.	Actively joining DD programme on health and community development in disaster and poor areas. This includes the establishment of clinics.
13 UPZ BNI Syariah	A Zakat Agency of BNI Syari'ah Bank.	Donating ambulance.

Islamic charitable clinics



The Muhammadiyah clinics

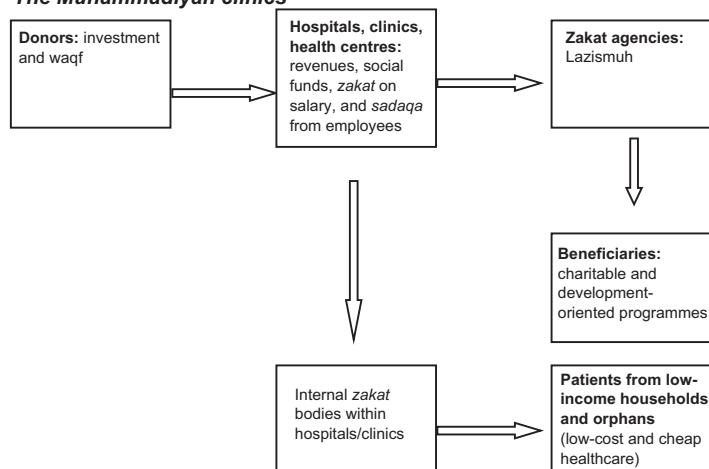


Figure 4. Sources and redistribution of Zakat for charitable works.

Partnership among Muslim voluntary organizations

The location of certain Islamic charitable clinics is often contingent upon the availability of land. While some *zakat* agencies, such as DD and RZI, have enjoyed significant support from big corporations, others have installed their clinics in areas near mosques. In urban areas, a large mosque can function not only as a place where Islamic worship is practised, but also as a spot where people can gather for social and economic purposes. During Friday prayers, for example, hundreds of small traders [*pedagang kaki lima*] display and sell their products, while beggars and poor families line up, awaiting people's generosity. Of greater relevance to the concerns of this paper, mosque-based *zakat* collectors are among the most preferred agencies to which the majority of Indonesian Muslims channel their giving. For that reason, the Indonesian *Zakat* Board (BAZNAS) took the initiative to cooperate with the Grand Mosque of Sunda Kelapa to set up a clinic. Occupying 9,920 m², this mosque was built in 1971. What is interesting is that the Grand Mosque of Sunda Kelapa is set amidst the upper middle class dwellings of the Jakarta subdistrict of Menteng. During Friday prayers, thousands of Muslims, notably those residing and working in surrounding areas come to this mosque for worship, given that it is located near to business centres and government offices.

In Indonesia, as in other Muslim countries, many Islamic charitable institutions are located in upper middle class areas.⁶² At least three factors determine the location of a charitable clinic in areas such as Menteng. The first factor relates to the availability of human resources. Many physicians, medical specialists and professionals attend weekly religious gatherings held in the Grand Mosque of Sunda Kelapa. Their involvement in such gatherings strengthens a form of social capital, which is then projected into collective action. These upper middle class, professional Muslims endeavour to contribute their skills as physicians and managers to charitable projects such as clinics. The second factor relates directly to donors rather than to beneficiaries. In this case, charitable clinics in urban areas have become a medium for *zakat* agencies to communicate first of all with donors and prospective donors. It is expected that the donors will continuously make

⁶² Janine Clark's studies confirm that the location of clinics has shaped their type, size and quality. Islamic clinics that are set up to cater to poor families and are located in poor, urban areas are relatively smaller and less well equipped than the clinics in surrounding wealthy neighbourhoods. See Clark (2004a), *supra* note 4, at pp 67–69.

contributions through *zakat* agencies after having witnessed that their funds are being used and redistributed appropriately through a charitable clinic. In other words, charitable clinics in urban areas have functioned as a medium to demonstrate how people's donations are redistributed to the right recipients.⁶³ The last factor is that poor families in need of assistance from *zakat* agencies reside not only in rural, but also in urban areas. In a developing country such as Indonesia, it is commonplace for elite housing complexes to be surrounded by numerous small slums. The above three factors provide answers to the question of why permanent charitable clinics operate predominantly in urban rather than rural areas. In rural areas, *zakat* agencies, like other social institutions, mainly carry out direct and short-term basic health services.

While the above narrative defines how a partnership has been established between Islamic voluntary organizations, mosque committees and other Muslim social institutions, cooperation among Islamic voluntary organizations such as DD, RZI, PKPU and DPU-DT cannot easily be established. This is partly shaped by differences in ideological background and political orientation as well as by rivalries in gaining support from the community, private sector organizations and the government. However, as is so often emphasized by their representatives, these Islamic voluntary associations expect to build synergies between them and to create a more comprehensive system of community-based health care in the future.

Support from local initiatives and innovation in waqf practice

Community participation is another key factor in determining the location of charitable clinics. Some are in fact supported by endowments from wealthy families. In the case of land *waqf*, the initiative usually comes from an individual or family, known as *waqif* ['those who donate']. The *waqif* offer land to be used for social or religious purposes to the existing social institutions, known as *nazir* ['people or institution assigned to manage *waqf*']. After having made an agreement, the *nazir* has the right to set up infrastructure on the given land. This was the experience of DD's maternity clinic in Bandung, which occupies 1,400 metres of land. It should be noted, however, that, as far as the experience of *zakat* agencies is concerned, land *waqf* is very rare. Because of this, they vigorously promote other types of *waqf* as an

⁶³ *Suara Merdeka*, 6 October 2006.

alternative means of financing social enterprises, including charitable clinics.

Cash *waqf* [*waqf al-nuqud*, or charitable endowments established with cash capital] seem to have been predominantly practised in order to finance Islamic clinics. The practice of cash *waqf* has a long historical record within Islamic society as a whole,⁶⁴ but it has been developed and promoted only recently in Indonesia. The Indonesian Ulama Council, or Majelis Ulama Indonesia (MUI) issued a *fatwa* [a religious opinion on the matter of Islamic law given by Muslim scholars] on cash *waqf* in May 2002, according to which donating money as *waqf* (instead of using the general term of *sadaqa*) is permitted as long as the use of *waqf* funds does not violate *shari'a* principles. The practice of cash *waqf* in Indonesia is also confirmed in the Ordinance on Endowment Administration, which was legalized as late as 2004.⁶⁵ Despite the fact that in Indonesia cash *waqf* has attracted debates among Muslims,⁶⁶ some institutions have moved forward by optimizing cash *waqf*. For instance, Islamic civil society organizations such as Muhammadiyah and professional *zakat* agencies such as DD and RZI have turned to cash *waqf* to promote their social, cultural and economic enterprises. In a country such as Singapore, the innovation of land and cash *waqf* has made a significant contribution to economic development processes within Muslim communities.⁶⁷

As mentioned previously, the establishment of charitable clinics has been much supported by cash *waqf*, as the *zakat* agencies will not make use of *zakat* funds for physical infrastructure. *Zakat* agencies have earned quite significant amounts of cash *waqf* from donors, surpassing that of land *waqf*. To mobilize cash *waqf*, DD issued the Cash *Waqf* Certificate

⁶⁴ For further discussion, see Murat Cizakca (2000), *A History of Philanthropic Foundations: The Islamic World from the Seventh Century to the Present*, Bogazici University Press, Istanbul, pp 27–69.

⁶⁵ The Ministry of Religious Affairs (2008), *Strategi Pengembangan Wakaf Tunai di Indonesia*, Direktorat Pemberdayaan Wakaf, Jakarta, p 8.

⁶⁶ While most 'ulam'a agree with new developments in *waqf* practice, such as in cash *waqf*, some remain reluctant to give precise opinions on the invested *waqf* funds within financial institutions such as banks and Bait al-Mal wa al-Tamwil. For examples of cash *waqf* practice in Indonesia, see Dian Masyita and Eri Febrian (2004), 'The role of BRI in the Indonesian cash *waqf* house's system', paper submitted to BRI International Seminar on *Developing Microbanking: Creating Opportunities for the Poor through Innovation*, 1–2 December, Bali, Indonesia.

⁶⁷ See for example, Rajeswary Ampalavanar Brown (2008), 'Islamic endowments in the land economy in Singapore: the genesis of an ethical capitalism 1830–2007', *South East Asia Research*, Vol 16, No 3, pp 343–403.

to be given to *waqif* whose donations amount to Rp 1 million or more. Within four months, from January to March 2009, for example, DD had issued 245 certificates with a total value of Rp2 billion.⁶⁸ This phenomenon of mobilizing cash *waqf* represents a new development by *zakat* agencies operating in urban areas. It is shaped by the fact that land in urban areas is very expensive, and at the same time, wealth circulated among the urbanites tends to be in the form of cash, not physical property. This trend of charitable endowment cannot be separated from the tendency of Indonesian people to channel *waqf* land to mosques and Islamic civil society organizations that manage Islamic schools, clinics, hospitals and orphanages, whereas channelling *waqf* land to *zakat* agencies remains rare. Moreover, the notion of cash *waqf* also allows for corporate spheres in particular to participate in Islamic charitable works and social practices. It is worth emphasizing that the improved management and advertisement of *zakat* by professional *zakat* agencies such as DD and RZI encouraged people to channel their *zakat* and *sadaqa* funds to the above agencies rather than to Islamic civil society organizations.⁶⁹ The amount of *zakat* funds collected by professional *zakat* agencies over the last five years has in fact been higher than that collected by civil society associations such as Muhammadiyah, Persatuan Islam and Nahdlatul Ulama.⁷⁰ Despite *zakat* agencies having increased in number and having played a greater role in urban areas, *kyai* [Islamic clerics] in rural areas still enjoy significant prestige in the communities, and in certain areas of East Java, for example, villagers still channel their *zakat al-fitr* to local *kyai* as a means of showing their admiration for the *kyai*'s dedication to the community.

Muhammadiyah hospitals: from charitable to economic enterprise

As previously discussed, Muhammadiyah is the largest Muslim association in Indonesia, managing hundreds of hospitals and clinics throughout the country. Unlike *zakat*-based charitable clinics, which

⁶⁸ Website: http://www.republika.co.id/berita/54672/Wakaf_Tunai_untuk_Kesehatan_Dhuafa (accessed 27 July 2009); also interview with Arifin Purwakananta, Programme Director, Dompot Dhuafa, 25 February 2009.

⁶⁹ The term 'Islamic civil society organization' is used here to distinguish between multipurpose organizations such as Muhammadiyah and Nahdlatul Ulama and charitable associations specializing in managing *zakat*, *sadaqa* and some kinds of Islamic social funds.

⁷⁰ PEBS FE UI & CID, *Indonesia Zakat & Development Report*, p 19.

merely cater to poorer families, Muhammadiyah clinics have been transformed from their charitable status into ‘private commercial clinics’ whose clients range from the well-off to the underprivileged. On the other hand, ‘social entrepreneurship’ has so far characterized Muhammadiyah clinics, the origin of which can be traced back to an early twentieth century relief mission. In response to deteriorating social conditions and to the specific hardship caused by the eruption of Mount Kelud, Muhammadiyah organized a medium-scale relief action by setting up an independent emergency rescue unit, namely *Penolong Kesengsaraan Oemoem* (PKO). Having carried out various relief services in urban, rural and disaster-affected areas, this unit then set up a polyclinic on 15 February 1923.⁷¹ In the mid-1960s, PKO was renamed PKU to signify the Muhammadiyah specialization in health and social services, namely *Majelis PKU*. Following Muhammadiyah’s National Congress [*Muktamar*] in 2005, this *Majelis* was renamed *Majelis Kesehatan Masyarakat* [Council of Community Health Care]. Even though most Muhammadiyah hospitals have been named *RS PKU Muhammadiyah*, others are referred to as *RS PKU Aisyiyah* due to the pivotal roles played by Aisyiyah, a women’s division of Muhammadiyah, in the establishment of maternity clinics. In some cases, Muhammadiyah hospitals have their roots in the small polyclinics and maternity clinics of Aisyiyah. Other Muhammadiyah hospitals are simply named ‘Islamic Hospitals’ [*rumah sakit Islam*].

Like other Islamic organizations, Muhammadiyah has long administered *zakat*. Scholars even suggest that one of the ideas of Islamic reform introduced by this association in the early twentieth century concerned *zakat* practice, particularly a reform of the mechanism of redistribution of alms.⁷² In recent times, while operating *zakat* agencies at different levels of leadership ranging from the Central Board Office [*pimpinan pusat*] to the branch offices at district [*pimpinan*

⁷¹ For further information about the objective of the PKO, see *Reglement Moehammadiyah Bahagian Penolong Kesengsaraan Oemoem Hindia Timur di Djokjakarta*, Pertjetakan Persatoen, Yogyakarta; also *Buah Hasil Konperensi PKU (Penolong Kesengsaraan Umum) Muhammadiyah Seluruh Indonesia: 20–22 Mei 1961 di Jakarta*; see Panitia HUT RSU PKU (1988), *Memperingati Milad ke 65 SRU PKU Muhammadiyah Yogyakarta*, RSU PKU Muhammadiyah, Yogyakarta, p 14; also H.S. Prodjokusumo (1995), *Menelusuri dan Napak Tilas Perjalanan Muhammadiyah: 85 Tahun Perjuangan dan Pengorbanan Para Anggota dan Pimpinan*, Yayasan Amal Bakti Masyarakat, Jakarta, p 39.

⁷² Mitsuo Nakamura (1993), *The Crescent Arises over the Banyan Tree: A Study of the Muhammadiyah Movement in a Central Javanese Town*, Gadjah Mada University Press, Yogyakarta, p 285.

daerah] and subdistrict [*pimpinan cabang*] levels, Muhammadiyah social institutions such as hospitals, orphanages, schools, universities and cooperatives have also managed autonomous *zakat* bodies. In this respect, my findings suggest that the way in which *zakat* agencies operate in Muhammadiyah is ‘decentralized’ and *thus* rather different from other community-based *zakat* agencies discussed above, such as DD and RZI. The Central Board Office of Muhammadiyah allows all levels of leadership, from the national to the subdistrict level, to collect *zakat* funds and redistribute them to legitimate recipients.

Interestingly, Muhammadiyah also allows its hospitals, universities and schools to operate their own *zakat* agencies. It is therefore not surprising that while the Islamic charitable clinics of DD and RZI become the ‘agents’ through which to distribute *zakat*, *infak* and *sadaqa* funds to the legitimate beneficiaries, Muhammadiyah hospitals rather take the opposite role. They generate revenue, some portions of which are to be donated through Muhammadiyah’s *zakat* agencies. This means that as commercial enterprises, Muhammadiyah clinics can reinvest the earned profits and revenues into some kind of social enterprise, including social, religious [*da’wa*] and charitable activities. In fact, one Jakarta-based *zakat* agency of Muhammadiyah, Lazismuh, has received large-scale contributions from Muhammadiyah hospitals, either in the form of *zakat* funds or ‘corporate social funds’. The acting Director of Lazismuh, for example, explains that his *zakat* agency has received a significant amount of money from Muhammadiyah hospitals operating in Jakarta (the Islamic Hospital of Pondok Kopi, the Islamic Hospital of Cempaka Putih and the Islamic Hospital of Sukapura), Malang (the Islamic Hospital of Aisyiyah) and Yogyakarta (PKU Muhammadiyah of Yogyakarta). Those funds are allocated to support income-generating projects and entrepreneurship training in certain regions of Java, as well as *dakwa* activities in the outer islands⁷³ (see Figure 4).

Figure 4 clearly illustrates that the operational budgets of Muhammadiyah hospitals do not derive from significant donations or other forms of giving. Instead, as increasingly commercialized institutions, Muhammadiyah hospitals with their revenues can contribute to *zakat* agencies and support charitable works in other

⁷³ Yet it also should be noted that this network has not been set up with all Muhammadiyah *zakat* agencies. Until now, Lazismuh has been struggling to disseminate its ideas to the hundreds of Muhammadiyah *zakat* agencies sporadically operating over the regions.

Muhammadiyah social institutions.⁷⁴ Unlike Muhammadiyah orphanages and elderly care homes, which are charitable in nature, there has not been a Muhammadiyah hospital or clinic that can be purely categorized as a charitable institution particularly catering to the poorer families. That is not to say, however, that charitable activism is not to be found in Muhammadiyah hospitals. In the case below, for example, a sort of ‘internal *zakat* committee’ in the hospitals of Muhammadiyah, with its low-scale impact and capacity, allows a limited number of poorer households access to free or at least low-cost health services.

PKU Muhammadiyah: how poorer families are served

The first and oldest hospital founded by Muhammadiyah is located in Yogyakarta, just behind the Government Palace of Yogyakarta, and recently renamed as K.H. Ahmad Dahlan. This hospital is now located near *Kampung Kauman*, a village where Ahmad Dahlan, the founder of Muhammadiyah, grew up.⁷⁵ The older Muhammadiyah Central Board Office lies about 300 metres from the hospital. The PKU can, by definition, no longer be graded as a clinic, since it provides more comprehensive facilities. As in other government and private hospitals, the patients may choose their preferred rooms, either in first, second or third class, depending on their financial capacity.

All physicians, nurses and administrative staff working in this hospital are Muslims. Some are Muhammadiyah activists and the rest have simply become formal Muhammadiyah members. There are part-time physicians who already have permanent positions in government hospitals. Despite the fact that medical schools at the state universities remain the dominant source of physicians in this hospital, the number of physicians and nurses who have graduated from Muhammadiyah universities and are employed in this hospital continues to increase. It has also become a teaching hospital [*rumah sakit pendidikan*] for medical students at the Muhammadiyah University of Yogyakarta. Likewise, the Aisyiyah nursing school has greatly contributed to this hospital in providing human resources.

⁷⁴ The term ‘*amal usaha*’ used in Muhammadiyah is equivalent to social institutions that can be either charitable or commercial in character. It comprises hospitals, schools, orphanages, mosques and other Muhammadiyah productive assets.

⁷⁵ Marcel Bonneff (1985), ‘Le Kauman de Yogyakarta. Des fonctionnaires religieux convertis au réformisme et à l’esprit d’entreprise’, *Archipel*, Vol 30, pp 175–205; Ahmad Adaby Darban (2000), *Sejarah Kauman: Mengungkap Identitas Muhammadiyah*, Tarawang, Yogyakarta.

The extent to which Muhammadiyah hospitals serve poorer families can be seen from the roles played by their internal *zakat* committees. Many low-income households take medication in the PKU. Some can afford this expenditure; others cannot. Catering for poorer families is not the main objective of the PKU, as the distinction between patients coming from poor and well-off families is not precisely defined. In some cases, when it is necessary, the patients are required to show acceptable evidence to prove their economic position, while the hospital will make its decision based on the availability of its 'charity funds'. It is commonplace that, for basic health care, an internal *zakat* committee under the Islamic Counselling Division's supervision of the hospital, may foot the bill in order to help patients from deprived backgrounds.⁷⁶ But for serious illnesses, this hospital, like others (charitable, private and government) can often do nothing except leave the patients to find their own way to overcome their problems. The position of PKU as an Islam-based commercial hospital means that it is very often faced with similar moral and professional dilemmas.

The PKU Hospital also cooperates with other Muhammadiyah charitable institutions, notably orphanages. In Yogyakarta, where the first and oldest Muhammadiyah orphanages and hospitals are located, an effort to bridge charitable institutions (orphanages) and commercial institutions (hospitals) began some decades ago. The orphans from Muhammadiyah orphanages are given the 'privilege' of very cheap or even free health care services. Yet the cooperation between the two is not an instant result of their similarities in ideology and 'historical roots', because not all orphans that are raised in Muhammadiyah orphanages receive similar treatment. The existing relationship between hospital and orphanage rather resembles a formal cooperation between two different institutions. For example, it is usually the 'weaker institution' (orphanage) that initiates cooperation with the 'stronger institution' (hospital).

Aisiyah maternity clinics, nurses and health programmes

As an autonomous association of Muhammadiyah, the role of Aisiyah in the development of health centres, notably maternity clinics, throughout Indonesia is vital to Muhammadiyah. Some maternity clinics belonging to Aisiyah have become Muhammadiyah's hospitals, for example, the

⁷⁶ Interview with Wasid Ridlo, Counselling Division, RSU PKU Muhammadiyah, in Yogyakarta, May 2007.

PKU Hospital of Bantul Regency in Yogyakarta, which originated as a maternity clinic set up by Aisyiyah. This has been taken over by Muhammadiyah since the clinic became a hospital in 2002.⁷⁷

Founded on 19 May 1917 in Yogyakarta, Aisyiyah has paid much attention to the issues of women and children, as well as coping with such issues as reproductive health, nutrition and family planning. Despite the fact that the number of Aisyiyah maternity clinics increases every year, Aisyiyah's approach to health issues is not restricted to this area alone. Aisyiyah bears a resemblance to NGOs specializing in women's issues as it is acquainted with such terms as the empowerment of women, children's advocacy, a watch on trafficking, and civil society; and yet, Muhammadiyah and Aisyiyah are beyond – to borrow the term used by Janine A. Clark – 'Islamic charitable institutions' (ISIs)⁷⁸ and even larger than Benoît Challand's definition of 'Health NGOs'⁷⁹ because each institution can more appropriately be defined – according to Egbert Harmsen's term for a welfare association – as a 'multi-purpose association' differing from 'specialized associations'.⁸⁰

Due to the pervasive role of Aisyiyah in society, this association endeavours to involve itself in the welfare development process of health care in society through charitable and non-charitable services. Its concerns are disseminated through its extensive organizational structure, reaching even remote areas, from the community in urban areas to small villages. Its movement in part focuses on *keluarga sakinah* [the welfare of the family] and *qaryah thayyibah* [the well-being of the community]. Unlike other health NGOs, Aisyiyah materializes its ideal of society, which is framed within the concept of *qaryah thayyibah*, through religious gatherings.⁸¹ This is because religious gatherings can

⁷⁷ Interview with Siti Chamamah Soeratno, the President of Aisyiyah, 19 January 2009, in Yogyakarta; for another case, see, for example, Muhammad Fuad (2002), 'Civil society in Indonesia: the limit and potential of Muhammadiyah', *Sojourn*, Vol 17, No 2, p 141.

⁷⁸ Janine A. Clark (2004), 'Islamic association and the middle class', *ISIM Newsletter*, 14 June, p 5; also Clark (2004a), *supra* note 4, at p 35.

⁷⁹ Challand, *supra* note 6, at p 230.

⁸⁰ Harmsen, *supra* note 56, at pp 168–169.

⁸¹ In the last 10 years, Aisyiyah, in cooperation with both government and international NGOs, has actively promoted family planning and reproductive health by targeting teenagers and the elderly. It has established *posyandu lansia* [health centre for the elderly] and revitalized youth activities in the community. Interview with Triyas Setiawati, 14 January 2009, in Yogyakarta. Triyas Setiawati is the former President of Nasyiatul Aisyiyah [Muhammadiyah Young Women's Association] and has recently been appointed General Secretary of Aisyiyah.

be an effective forum by which to disseminate information to targeted segments of society, especially women. *Qaryah thayyibah*, which literally means ‘good community’, is a generic term used to signify community development programmes and the welfare of the community.⁸² In order to implement the two main programmes of *keluarga sakinah* and *qaryah thayyibah*, Aisyiyah has revitalized the function of female religious gathering. Chamamah Soeratno, the President of Aisyiyah, suggests that female religious gathering constitutes potential social capital, as women perhaps attend religious gatherings more than men.⁸³ For females in rural and even in urban areas, attending religious gatherings tends to be a matter of routine.⁸⁴ Finally, Aisyiyah’s concern for health and welfare is characterized by its training of professional nurses and midwives. As part of its non-charitable programmes on health, Aisyiyah considers the supply of qualified nurses [*perawat*] and midwives [*bidan*] as complementary to Muhammadiyah welfare activism on health. As mentioned above, Aisyiyah nursing schools have supplied human resources underpinning hospitals and clinics belonging to both Muhammadiyah and Aisyiyah throughout the country.

In 1990, with the support of BKKBN (The National Coordinator for Family Planning – *Badan Koordinasi Keluarga Berencana Nasional*), Aisyiyah launched a family welfare programme, the *Program Keluarga Sakinah Aisyiyah* (PKSA), under which it optimized the functions of its 135 community health centres across the region. With the help of Professor Kuntowijoyo, a Muhammadiyah activist and intellectual, the initiative to implement *qaryah thayyibah* in order to assist families in one particular village took place in that year. As a pilot project, Aisyiyah began implementing the *qaryah thayyibah* concept in the Mertosanan village of Potorono, Banguntapan subdistrict, Bantul district in Yogyakarta, a village where many nursing students from the Aisyiyah Nursing School conducted practical studies [*praktik kerja lapangan*]. During the National Congress in Banda Aceh in 1995, the *qaryah thayyibah* programme was officially launched and then disseminated

⁸² Aisyiyah defines *qaryah thayyibah* as a village or region whose inhabitants practise Islam comprehensively [*kafah*], both in religious matters [*hablu min Allah*] and social affairs [*habl min al-nas* or *mu’amalah dunyawiyah*].

⁸³ Interview with Siti Chamamah Soeratno, the President of Aisyiyah, 19 January 2009, in Yogyakarta.

⁸⁴ Interview with Siti Chamamah Soeratno, 19 January 2009; interview with Triyas Setiawati, 14 January 2009.

throughout Indonesia. Aisiyiah has attempted to implement the *qaryah thayyibah* concept in 214 villages. Yet it should also be noted that, due to the complex situation faced by villagers as well as by Aisiyiah activists, there are only a few villages in which *qaryah thayyibah* functions as it ought to.⁸⁵

The above description shows that there has been a significant transformation of corporate culture into Muhammadiyah and Aisiyiah social institutions, and this transformation has turned charitable works into socially oriented economic enterprises. At the same time, the nature of the relationship between Muhammadiyah and Aisiyiah social institutions and their *zakat* agencies has also changed. Despite the fact that such social institutions as hospitals, clinics and schools are at first supported by land *waqf* from the community (notably Muhammadiyah and Aisiyiah members and sympathizers), these Muhammadiyah and Aisiyiah associations can survive and thrive because of their 'social entrepreneurship' or 'socially-oriented economic enterprises'. In a nutshell, this reflects a wide diversity of methods and approaches in coping with welfare issues in Indonesia.

Of equal importance, one may assume that the rise of Islamic charitable clinics has resulted from the growing process of the Islamization of the middle class in the countryside, on the one hand, and of the increasing public awareness of charitable giving as a potential source and an alternative remedy for healing the rifts in society, on the other. However, Islamic charitable clinics set up by Dompot Dhuafa, Rumah Zakat Indonesia, BAZNAS and Muhammadiyah are not well acquainted with classical and newer forms of the so-called '*tibbun nawawi*' [prophetic medicine], a kind of traditional healing system that has recently been promoted by *salafi* groups. The efforts of Muslim physicians in Islamic hospitals or charitable clinics to intensify studies on 'Islamic bio-medical science' remain rare, as these institutions are more interested in developing 'Islamic ethics' [*adab*] while adopting Western medical technology.⁸⁶ This does not mean that an awareness of the necessity to develop Islamic knowledge and

⁸⁵ This is based on the results of the evaluation and assessment conducted by the Central Board of Aisiyiah and the Department of Community Development of Muhammadiyah. See PP Aisiyiah (2007), *Revitalisasi Konsep dan Strategi Implementasi Qaryah Thayyibah Aisiyiah*, PP Aisiyiah, Yogyakarta.

⁸⁶ M. B. Hooker's studies on *fatwa* [Muslim scholars' legal opinion] in Indonesia confirms that ethics and Islamic jurisprudence have been mainly employed to address health issues. However, there is no discussion about new efforts among Muslim

practice of medicine is totally absent from Islamic hospitals and charitable clinics. In Muhammadiyah hospitals, for example, efforts have been made to develop an Islamic code of conduct, derived from the Qur'an and *Sunna* [prophetic tradition], and Muhammadiyah's collection of *fatwas* such as Himpunan Putusan Tarjih (HPT) and *pedoman hidup Islami* [a guide to Islamic codes of practice] are employed for physicians and nurses in treating patients. Likewise, Dompot Dhuafa, in its new charitable hospital in Bogor, is equipped with a healing garden, a *zikir* room (for remembering God) and the like.

Conclusion

Both voluntary and private sectors have made serious efforts to build a synergy with the purpose of creating a more decisive relief project for poorer families, especially regarding health. Islamic charitable clinics are not, therefore, simply a manifestation of Islamic giving, but also of social aid from 'secular' institutions. The enthusiastic involvement of national and international corporations in social enterprises, and in co-operating with *zakat* agencies, reveals that the so-called practice of indigenous charity has been underpinned by the moral economy of 'secular corporations'. In the case of Muslim societies, *zakat* signifies 'a key component of the moral economy' as it is also overwhelmingly related to the redistribution of wealth for 'social benefit' or 'public welfare' [*al-maslahat al-ijtima'yah* and *al-maslahat al-'ammah*].⁸⁷ This arose when a number of Muslim professionals working in NGOs, *zakat* agencies and national and multinational companies were in a position to bring Islamic ideas of social justice in their restricted scope of action into being. In accordance with this, the mobilization of Islamic aid and the emergence of Islamic charitable clinics in Indonesia conceal the recent discourse of the 'common good' among Indonesian Muslims. The appearances of Islamic aid associations such as *zakat* agencies that specifically cater to disadvantaged groups of society may signify, to quote Mark Le Vine and Armando Salvatore's words, their 'rational

physicians to develop 'Islamic bio-medical sciences' in Islamic hospitals. See M. B. Hooker (2003), *Indonesian Islam: Social Change through Contemporary fatwa*, Allen & Unwin, NSW, and University of Hawa'i Press, Honolulu, especially Chapter 4, 'Islam and medical science', pp 157–193.

⁸⁷ Charles Tripp (2006), *Islam and the Moral Economy: The Challenge of Capitalism*, Cambridge University Press, Cambridge, pp 119, 124.

responses to insufficient provision of crucial service (health, education, welfare and security)'.⁸⁸ It is certainly correct that charitable actions are closely related to the notion of *maslaha*, 'the public good', 'public interest' or 'public welfare'.⁸⁹ And in Muslim societies, the meaning of public good may reach 'beyond the immediate family to include extended family, neighbours, fellow subjects or citizens, and the Muslim *ummah* altogether'.⁹⁰

Islamic charitable clinics in Indonesia have played a pivotal role in stress reduction among poorer families, while at the same time attempting to bring the capital held by both individual and private institutions down to the grass-roots level. While the existing institutions work with grass-roots and middle class groups, there is a lack of resistance in religious and political discourse to the state failure to provide viable social security. Consequently, charitable institutions such as clinics funded by *zakat* agencies do not specifically work for structural change. They seem to avoid utilizing political affairs in their discourse and activities, for example, by organizing an advocacy movement for health reform. Therefore, there is no serious tension between charitable institutions and the state apparatus.

Top-down relationships between givers and recipients have led to a lack of participation by the poor in a long-term agenda of charitable clinics and in strengthening social security among the poor themselves. Realizing the necessity to provide health care for uninsured, poorer families, *zakat* agencies have simply functioned as an 'intermediary' between the 'haves' and the 'have nots', be they individuals or institutions, yet not between the state and society. While we cannot disregard the contributions made by charitable clinics to the social development process, as they grow significantly in number, collaboration between the existing charitable institutions remains rare. The absence of a larger association (union) of charitable clinics through which the existing clinics may address more fundamental issues on health care in both urban and rural areas has shaped the attitudes of Indonesian

⁸⁸ See Mark Le Vine and Armando Salvatore (2005), 'Socio-religious movements and the transformation of "common sense" into a politics of "common Good"', in *Religion, Social Practice, and Contested Hegemonies: Reconstructing the Public Sphere in Muslim Majority Countries*, Palgrave Press, London, p 32.

⁸⁹ Robert L. Payton and Michael P. Moddy (2008), *Understanding Philanthropy: Its Meaning and Mission*, Indiana University Press, Bloomington and Indianapolis, IN, p 27; see also Amy Singer (2008), *Charity in Islamic Society*, Cambridge University Press, Cambridge, p 8.

⁹⁰ Singer, *supra* note 89, at p 8.

Muslim voluntary associations towards health. This in turn has led to the absence of an attempt within the existing charitable clinics to establish more comprehensive health insurance for poor families, at least among clinic members, and to a lack of structural change that would promote a more comprehensive health care system for the poor, over and above that supported by the policies of the state.