AL MUSYRIF
Jurnal Bimbingan dan Konseling Islam
Vol. 9 No. 2, October 2026, 160-175
https://ejournal.uiidalwa.ac.id/index.php/almusyrif/
https://doi.org/10.38073/almusyrif.v9i2.4951

P-ISSN: 2655-5425
E-ISSN: 2808-2354

Transformative Da'wah Model Through Islamic Spiritual Guidance in Contemporary Health Services

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Article Information:
Received: 15 May 2026
Revised: 11 July 2026
Accepted: 14 August 2026
Published: 6 September 2026

Keywords:
Transformative Da'wah,
Islamic Spiritual Guidance,
Health Services,
Hospital Patients.

Abstract

This study investigates the transformative da'wah model through Islamic spiritual guidance in contemporary health services, focusing on patients at Roemani Muhammadiyah Hospital Semarang. The study addresses the critical gap in integrating spiritual care into medical treatment within Islamic health institutions in Indonesia. This qualitative research employs a phenomenological approach within an interpretive research paradigm. Data were gathered from twenty (20) patients through semi-structured interviews and participant observation between January 2025 and July 2025. Collected data were analysed thematically using deductive coding to identify recurring patterns related to the da'wah delivery, spiritual intervention, and patientwell-being outcomes. The study found that the transformative Da'wah model comprises four interrelated dimensions: (1) Prophylactic da'wah (preventive spiritual education), (2) Curative da'wah (healing-oriented spiritual intervention), (3) Rehabilitative da'wah (recovery-focused spiritual support), and (4) Promotive da'wah (well-being enhancement). Patients reported significant improvements in psychological resilience, spiritual well-being, and coping capacity when Islamic spiritual guidance was systematically integrated into healthcare delivery. Theoretically and practically, the model extends the scholarship of Islamic guidance and counselling (*bimbingan dan konseling Islam*) by offering hospital-based *rohaniawan* and Islamic counsellors a structured, stage-sensitive framework for designing, delivering, and evaluating spiritually integrated patient counselling services.

How to Cite this Article
Riyadi, A., Hasna, B. A., & Kasmuri, K. (2026). Transformative Da'wah Model Through Islamic Spiritual Guidance in Contemporary Health Services. *Al-Musyrif: Jurnal Bimbingan Dan Konseling Islam*, *9*(2), 160–175. https://doi.org/10.38073/almusyrif.v9i2.4951

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INTRODUCTION

Islamic da'wah, understood as the systematic invitation to the path of Allah (SWT), is not confined to preaching but encompasses education, counselling, social work, and health advocacy that guide individuals toward spiritual, moral, and social well-being (Abdullah, 2019; Affandi, 2012). Within institutional healthcare settings, where human vulnerability is most acutely experienced, this transformative orientation of da'wah finds direct expression as Islamic spiritual guidance and patient counselling. Roemani Muhammadiyah Hospital Semarang, one of the most prominent Islamic health institutions in Central Java, exemplifies this orientation: guided by the Muhammadiyah ethos of *rahmatan lil 'alamin* (mercy for all of creation), the hospital operates on the principle that healthcare is a holistic spiritual mission rather than a purely biomedical enterprise (Riyadi et al., 2019). Its da'wah unit, staffed by trained *rohaniawan* (Islamic spiritual counsellors), provides Islamic guidance and counselling that intersects faith-based accompaniment with evidence-based clinical care, raising the central question of how such guidance can be systematically structured, delivered, and evaluated to support healing, recovery, and spiritual transformation among hospitalised patients.

The concept of Islamic spiritual guidance in hospital settings has gained increasing attention among Indonesian scholars and healthcare practitioners (Post et al., 2000). Spiritual guidance involves the deliberate facilitation of a patient's inner spiritual resources, including faith (*iman*), trust in God (*tawakkal*), patience (*sabr*), and gratitude (*shukr*), to support physical healing, psychological resilience, and existential coping (D'Souza & Rodrigo, 2004). Research has consistently demonstrated that spiritual well-being is a critical determinant of health outcomes, with patients who maintain strong religious and spiritual coping mechanisms exhibiting lower levels of anxiety, depression, and pain perception (C. Puchalski, 2013; Swinton, 2001). Despite this growing evidence base, the systematic integration of da'wah as a transformative model in Indonesian Islamic hospitals remains theoretically underdeveloped and empirically underexplored.

The contemporary health crisis marked by rising rates of chronic diseases, mental health disorders, and existential suffering among hospitalised patients has underscored the inadequacy of purely biomedical approaches to healing (Organization, 2022). Patients increasingly seek meaning, comfort, and spiritual anchorage during illness, making spiritual care an indispensable dimension of comprehensive healthcare. In Islamic contexts, this need is expressed through requests for spiritual accompaniment, recitation of healing Quranic verses (*ruqyah syar'iyyah*), and guidance on Islamic practice during illness (*fiqh al-maridh*) (Sukayat, 2015). Roemani Muhammadiyah Hospital's da'wah programme responds to these needs but lacks a clearly articulated theoretical model that can be empirically validated, replicated, and refined. This study addresses this gap by developing and validating a transformative da'wah model grounded in patients' lived experiences.

The Muhammadiyah movement's approach to da'wah in health has always

emphasised the dialectic between tradition and modernity, maintaining fidelity to Quranic and Sunnah foundations while adapting methodologically to contemporary human conditions (Suciningtyas et al., 2025). This transformative orientation, often articulated as *da'wah bil-hal* (Da'wah through action and service), positions health service itself as an act of worship and a vehicle for spiritual transformation (Ghazali, 2020; Toha, 1995). The transformative dimension implies that da'wah in hospital settings should not only inform patients about Islamic teachings but should catalyse genuine personal, spiritual, and behavioural change, moving patients from states of spiritual distress to spiritual resilience, from confusion to clarity, and from isolation to communal spiritual belonging (Lane, 2005). Theoretical frameworks for understanding this transformation, however, remain fragmented and context-specific, necessitating a comprehensive empirical investigation.

A systematic reading of extant literature reveals four interconnected strands of scholarship relevant to this study. First, studies on hospital *rohaniawan* (Islamic spiritual counsellors) have documented their institutional roles, service systems, and counselling methods in Indonesian Islamic hospitals, including at RSI Sultan Agung Semarang and RS Ibnu Sina Makassar (Arifin, 2012; Hidayati, 2014). Second, the broader spiritual care literature demonstrates that Muslim patients' spiritual needs are multidimensional, spanning religious ritual, meaning-making, and relational support, and that structured spiritual care interventions improve psychological and existential outcomes (Abu Khait & Lazenby, 2021; Irajpour et al., 2018; Riyadi et al., 2022). Third, research on religious coping consistently links positive religious coping to reduced anxiety, depression, and improved quality of life among patients with chronic and life-threatening illness (Koenig & Carey, 2024; Sarwoko et al., 2022). Fourth, a smaller body of work on Islamic counselling for patients has begun to describe specific techniques, such as dhikr-based counselling and Qur'anic-recitation therapy, and their effects on patient anxiety (Hariawan et al., 2019; Karimah & Maulana, 2022; Lukmanulhakim & Syukrowardi, 2018).

Despite this expanding body of work, three gaps remain. First, existing studies have predominantly adopted single-dimensional lenses, focusing either on the counsellor's methodology, the patient's spiritual experience, or the institutional policy framework, without integrating these dimensions into a coherent transformative model. Second, extant literature has not sufficiently addressed the dynamic, processual nature of da'wah in hospital settings: how patients move through different phases of spiritual need, how da'wah interventions are calibrated to these phases, and how the outcomes of such interventions can be systematically evaluated. Third, within the field of Islamic guidance and counselling specifically, no prior Indonesian study has articulated an empirically derived, stage-based model that links distinct da'wah interventions to distinct phases of the illness trajectory. The novelty of the present study lies precisely in this contribution: it develops, from patients' lived experiences, a four-dimensional transformative da'wah

model, comprising prophylactic, curative, rehabilitative, and promotive da'wah, that fills these critical theoretical and empirical lacunae and offers Islamic counsellors a replicable framework for hospital-based practice.

Against this backdrop, this study investigates the transformative da'wah model through Islamic spiritual guidance among patients at Roemani Muhammadiyah Hospital, Semarang, guided by two central research questions: (1) What are the Demographic Characteristics and Context of the Spiritual Needs of Patients at Roemani Muhammadiyah Hospital, Semarang? (2) How does the transformative Da'wah model contribute to the spiritual and psychological well-being of hospitalised patients? By addressing these questions, the study aims to generate a theoretically robust and empirically grounded model that can inform the practice of Islamic spiritual guidance across Indonesian Islamic health institutions and contribute to the broader global discourse on integrating spirituality into contemporary healthcare.

METHOD

This qualitative research employs a phenomenological approach within an interpretive research paradigm, enabling the researcher to explore the lived experiences of patients receiving Islamic spiritual guidance at Roemani Muhammadiyah Hospital, Semarang. The phenomenological approach was deemed most appropriate for this study because it foregrounds the subjective meaning that patients attach to their experiences of illness, spiritual guidance, and transformation dimensions that quantitative methods cannot adequately capture (Creswell & Poth, 2016). The interpretive paradigm positions the researcher as an active meaning-maker who engages reflexively with patients' narratives, contextualising them within broader Islamic scholarly and healthcare frameworks (Pervin & Mokhtar, 2022).

Sample and Sampling Technique

Twenty (20) patients at Roemani Muhammadiyah Hospital Semarang were purposively selected for this study using a judgemental sampling technique. Patient were selected based on the following criteria: (1) Muslim patients who had received at least three sessions of Islamic spiritual guidance from the hospital's *rohaniawan* unit; (2) patients aged 21 years and above; (3) patients willing to provide informed oral consent for participation; and (4) patients representing diverse disease categories, including chronic illness, post-surgical recovery, and acute illness. The deliberate diversification of the sample across disease types, genders, and educational backgrounds ensured a rich and comprehensive dataset that captured the multidimensional nature of the da'wah experience in hospital settings.

Data Collection

Semi-structured interviews were the primary method of data collection, supplemented by non-participant observation of da'wah sessions and document analysis of the hospital's spiritual guidance protocols. Each interview lasted between forty-five and ninety minutes, was conducted in Bahasa Indonesia, and was audio-recorded with the

patient's consent. Interview questions were organised around four thematic domains: (1) patients' experiences of illness and spiritual distress; (2) the forms and content of Islamic spiritual guidance received; (3) perceived outcomes of the guidance on spiritual, psychological, and physical well-being; and (4) recommendations for enhancing the da'wah programme. Observation data provided contextual triangulation, enabling the researcher to corroborate interview data with first-hand observations of the spiritual guidance process.

Non-participant observation was conducted over six months, from January to July 2025, coinciding with the interview phase, with the researcher present during 32 da'wah sessions across the inpatient wards (an average of two to three hours per visit). Document analysis covered the hospital's written spiritual guidance protocols, da'wah unit service records, and patient visitation logs for the same period. The da'wah unit comprised eight *rohaniawan* (five men and three women, aged 28–55 years), all holding a minimum qualification of a bachelor's degree in Islamic studies and certified through Muhammadiyah's internal *rohaniawan* training programme; their average tenure at the hospital was 6.4 years.

Research Ethics

This study received ethical clearance from the Health Research Ethics Committee affiliated with the researcher's institution before data collection, under Ethical Clearance No. B-3.3/23/RSR/II/2025. All participants received oral and written explanations regarding the study's purpose, procedures, confidentiality safeguards, and their right to withdraw at any time without any consequence for their care. Oral informed consent was subsequently obtained and audio-recorded in accordance with local ethical norms for interviewing hospitalised patients. Confidentiality was maintained by anonymising all transcripts and referring to participants only by numerical codes, such as Patient 7. Any potentially identifiable clinical details were removed or generalised in the reporting.

Data Analysis

Transcriptions were analysed thematically using deductive coding guided by the theoretical framework of transformative da'wah. Following Braun and Clarke's (2006) six-phase thematic analysis procedure, the researcher (1) familiarised herself with the data through repeated reading; (2) generated initial codes; (3) searched for themes; (4) reviewed themes for coherence and distinctiveness; (5) defined and named themes; and (6) produced the final analytical report. Member checking was employed to validate the interpretations with four purposively selected patients, enhancing the credibility and trustworthiness of the findings (McKim, 2023). Peer debriefing with two senior Islamic counselling scholars ensured that the analytical framework was grounded in established Islamic scholarly traditions.

Although phenomenological inquiry typically favours inductive, participant-driven theme generation, a directed (deductive) approach to coding was adopted here for a specific reason: prior institutional and scholarly literature on da'wah already identifies broad functional categories of spiritual intervention (preventive, healing-oriented, recovery-focused, and well-being-oriented), and the study aimed to test and refine, rather

than construct de novo, this conceptual structure against patients' lived experience. To preserve openness to unanticipated experience, the deductive framework was used only to organise higher-order categories, while all sub-themes and illustrative quotations reported in the Results were generated inductively from the transcripts themselves, following (Braun & Clarke, 2006) recommendation that deductive and inductive coding be combined for theoretically informed thematic analysis.

Data collection continued until thematic saturation was reached: no substantively new codes or sub-themes emerged across the final three interviews, consistent with (Guest et al., 2006) benchmarks for saturation in homogeneous, narrowly focused qualitative samples. As all interviews were conducted in Bahasa Indonesia, verbatim transcripts were first coded in the original language; only the quotations selected for reporting were translated into English by the researcher and independently reviewed by a bilingual Islamic-studies colleague for conceptual equivalence, following the forward-translation and expert-review procedure recommended by (Chen & Boore, 2010) for cross-language qualitative health research.

RESULTS AND DISCUSSION

Demographic Characteristics and Context of Patient Spiritual Needs

Table 1 demonstrates that the patients represented diverse demographic and clinical backgrounds, reflecting the complex psychosocial and spiritual dimensions experienced by hospitalised patients.

Table 1. Patient Demographic Variables (n = 20)

No	Variables	Category	Frequency	Percentage
1	Age	21–30 years	5	25%
		31–40 years	7	35%
		41–50 years	5	25%
		>50 years	3	15%
2	Gender	Male	9	45%
		Female	11	55%
3	Education	Primary/Secondary	6	30%
		Diploma/Bachelor	10	50%
		Postgraduate	4	20%
4	Occupation	Civil Servant	5	25%
		Private Employee	8	40%
		Self-employed	4	20%
		Unemployed	3	15%
5	Disease Type	Chronic Illness	12	60%
		Post-Surgical	5	25%
		Acute Illness	3	15%

The majority of patients were within the productive age range of 31–40 years (35%), followed by patients aged 21–30 years and 41–50 years (25% respectively). This

age distribution indicates that spiritual distress and the need for religious guidance are not limited to elderly patients but are also strongly experienced by adults facing productive-life responsibilities, family obligations, and uncertainty regarding their future health conditions. Several patients expressed that their illness generated deep existential anxiety, particularly concerning their roles as parents, spouses, and breadwinners.

One participant stated:

> *"When I was diagnosed with a chronic illness, I was not only afraid of death but also worried about my children and family. Spiritual guidance helped me calm down and accept my condition more sincerely." (Patient7)*

Similarly, another participant explained:

> *"The illness made me question many things in life. The presence of Islamic spiritual counsellors gave me emotional strength and reminded me to remain close to Allah." (Patient12)*

Gender composition also showed a relatively balanced distribution, although female patients slightly predominated (55%). Interestingly, female patients tended to express emotional and spiritual concerns more openly during interviews, particularly regarding fear, surrender (*tawakkul*), and the search for inner peace. Male patients, on the other hand, more frequently articulated concerns related to social responsibility and economic pressures caused by illness. These findings suggest that spiritual care services in hospitals should consider gender-sensitive approaches in delivering Islamic spiritual guidance.

Educational backgrounds among patients were varied, with half possessing diplomas or bachelor's degrees (50%). Patients with higher educational attainment generally demonstrated greater openness toward reflective spiritual discussions, including theological interpretations of suffering, patience (*sabr*), and divine wisdom behind illness. Nevertheless, patients from lower educational backgrounds also exhibited strong spiritual needs, primarily expressed through the desire for prayer assistance, Qur'anic recitation, and emotional reassurance from religious counsellors.

A participant with postgraduate education remarked: *"Medical treatment heals the body, but spiritual guidance strengthens the soul. Both are equally important during illness." (Patient3)* Meanwhile, a participant with secondary education stated: *"When the ustaz came to pray and recite the Qur'an beside me, I felt calmer and no longer alone." (Patient 15)*

From the clinical perspective, most patients were patients with chronic illnesses (60%), followed by post-surgical patients (25%) and acute illness patients (15%). Patients suffering from chronic diseases generally experience prolonged psychological burdens, uncertainty about recovery, and existential struggles that intensify their spiritual needs. Long-term hospitalisation often led patients to seek meaning, emotional comfort, and spiritual resilience through religious practices and counselling. This finding confirms that

chronic illness frequently creates conditions of spiritual vulnerability, making Islamic spiritual guidance an essential component of holistic patient care.

One participant explained: *"Being hospitalised for months exhausted me mentally. Sometimes medicine was not enough; I needed spiritual encouragement to keep surviving." (Patient5)* Another participant added: *"The spiritual counselling sessions helped me accept my illness as part of Allah's plan rather than merely a punishment." (Patient18)*

These findings indicate that demographic and clinical factors significantly shape patients' spiritual experiences and expectations toward hospital-based Islamic spiritual care services. The diversity of patients also highlights the necessity for adaptive, compassionate, and patient-centred da'wah approaches within healthcare settings. Islamic spiritual guidance in hospitals, therefore, functions not merely as a religious complement but as an integral psychosocial-spiritual intervention that supports emotional stability, existential meaning-making, and holistic healing among patients.

Transformative Da'wah Model through Islamic Spiritual Guidance in Contemporary Health Services

The findings reveal that Islamic spiritual guidance in healthcare settings functions not merely as a complementary religious activity but as a transformative da'wah approach that strengthens patients' spiritual resilience, emotional stability, and existential acceptance during illness. Based on thematic analysis of interviews and field observations, this study formulates a transformative da'wah model within contemporary healthcare services. The conceptual framework of the model is presented in Figure 1.

The thematic analysis revealed four interconnected dimensions of the transformative Da'wah model, each corresponding to a distinct yet overlapping phase of the patient's spiritual journey during illness and hospitalisation. These dimensions, prophylactic, curative, rehabilitative, and promotive da'wah, do not operate in isolation; rather, they form a dynamic continuum in which Islamic spiritual counsellors continuously recalibrate their approaches according to patients' emotional conditions, existential struggles, and evolving religious needs. The findings demonstrate that Islamic spiritual guidance within hospital settings functions not merely as ritual accompaniment, but as a holistic psycho spiritual intervention capable of reconstructing meaning, strengthening resilience, and restoring patient spiritual equilibrium amid experiences of suffering, uncertainty, and vulnerability.

This integrative model resonates with contemporary discussions on spiritual care in healthcare, which emphasise the inseparability of emotional, psychological, and spiritual dimensions in patient recovery processes. Scholars such as Harold G. Koenig, John Swinton, and Christina M. Puchalski argue that spirituality plays a crucial role in helping patients cope with illness, construct existential meaning, and maintain hope during medical crises (Balboni et al., 2014; C. Puchalski, 2013). Within the Islamic perspective, illness is not solely understood as biological dysfunction, but also as a spiritual and existential experience that may become a medium for self-purification (*tazkiyat al-nafs*), repentance, patience (*sabr*), and spiritual awakening (*yaqzah*).

Consequently, the transformative da'wah model identified in this study reflects an integration between Islamic theological values and contemporary holistic healthcare paradigms.

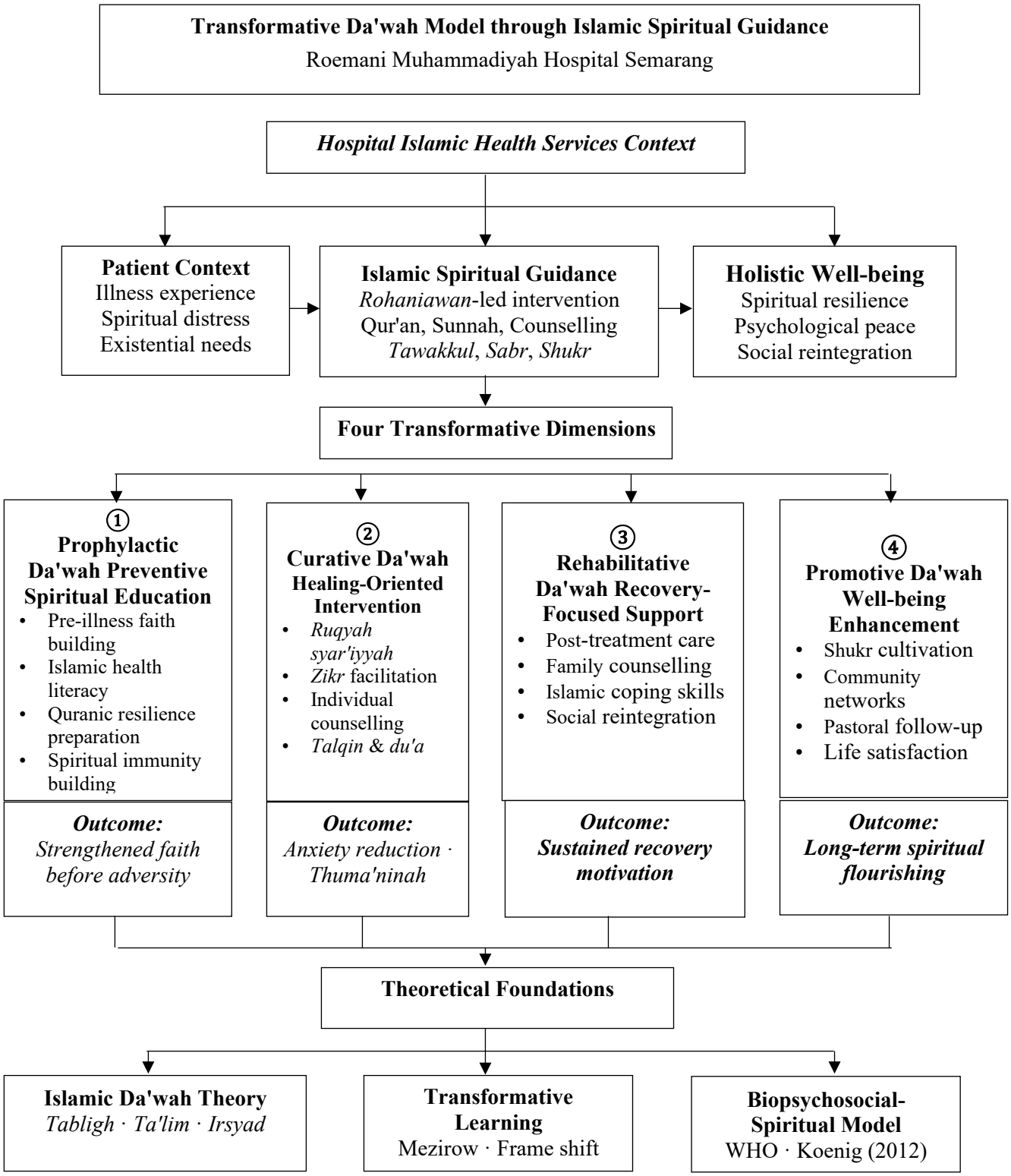

Figure 1. The Transformative Da'wah Model through Islamic Spiritual Guidance in Contemporary Health Services

The first dimension, namely prophylactic da'wah, refers to the preventive and preparatory function of Islamic spiritual guidance designed to strengthen patients' spiritual foundations before psychological distress escalates into deeper existential crises (C. M. Puchalski et al., 2014). This dimension was particularly evident among patients newly diagnosed with chronic illnesses or facing major medical procedures. Spiritual counsellors routinely provided religious education concerning Islamic understandings of illness, suffering, divine destiny (*qadar*), patience, and hope in God's mercy. Participants reported that these sessions significantly reduced panic, despair, and feelings of abandonment commonly experienced during the early stages of hospitalisation.

One participant explained:

> *"At first, I kept asking why Allah gave me this disease. I felt angry, hopeless, and mentally exhausted. But after the ustadz explained that illness can erase sins and elevate one's spiritual rank, I began to see my condition differently. I became calmer and more accepting." (Patient 4)*

Another participant stated:

> *"Before receiving spiritual guidance, I only focused on fear-fear of surgery, fear of death, fear of leaving my family. The counselling sessions helped me realise that illness is not always punishment; sometimes it is Allah's way of bringing people closer to Him." (Patient 9)*

These findings reinforce the argument advanced by Harold G. Koenig that spiritual preparation serves as a protective factor against severe psychological deterioration during health crises. Similar observations have also been documented in studies on Islamic spiritual care, which demonstrate that religious coping mechanisms significantly contribute to reducing anxiety, strengthening optimism, and improving emotional adaptation among hospitalised patients (Koenig & Carey, 2024). From the perspective of transformative da'wah, prophylactic spiritual interventions function as preventive meaning-making processes that help patients reinterpret illness within a sacred theological framework rather than perceiving it solely as physical suffering.

The second dimension, Curative da'wah, encompasses healing-oriented spiritual interventions conducted during acute phases of illness, particularly when patients experience severe pain, emotional instability, fear of death, or feelings of helplessness. This dimension represented the most intensive form of spiritual engagement observed in the study. The interventions included Qur'anic recitation (*tilawah*), *ruqyah syar'iyyah*, guided *zikr*, collective prayer, emotional counselling, and bedside spiritual accompaniment. These practices were perceived by participants as sources of immediate psychological relief capable of reducing anxiety and restoring emotional stability amidst clinical uncertainty.

One participant described the experience:

> *"When the ustadz recited Surah Yasin beside me before surgery, I suddenly felt peaceful. My body was still weak, but my heart became stronger. It was as if Allah reminded me that I was not alone." (Patient 13)*

Another participant noted:

> *"There were nights when I could not sleep because I was terrified of dying. The spiritual counsellor sat beside me, listened to my fears, and guided me to recite dhikr slowly. After that, my chest felt lighter, and my mind became calmer." (Patient 16)*

Interestingly, several participants emphasised that the emotional presence of spiritual counsellors was often as meaningful as the religious rituals themselves. Patients perceived compassionate listening, empathetic communication, and non-judgmental accompaniment as manifestations of Islamic mercy (*rahmah*) within healthcare settings.

A participant suffering from chronic kidney disease remarked:

> *"Sometimes what patients need is not only medicine, but someone who sincerely listens without judging. The ustadz not only prayed for me; he made me feel valued as a human being." (Patient 2)*

This finding demonstrates that curative da'wah operates not only through ritualistic practices but also through relational spirituality grounded in compassion, empathy, and emotional accompaniment. Such findings parallel the concept of "presence-based spiritual care" developed by Christina M. Puchalski, who argues that authentic spiritual healing frequently emerges through compassionate human presence rather than doctrinal instruction alone.

From the perspective of Islamic psychology, the transformative mechanism underlying curative da'wah can be understood through the concept of *thuma'ninah,* a condition of spiritual tranquillity produced through conscious remembrance of God and existential surrender (*tawakkul*). The repeated practice of *zikr*, Qur'anic recitation, and guided prayer helped the patient regulate fear, reconstruct emotional balance, and cultivate hope despite uncertain prognoses. This finding is highly significant because it indicates that Islamic spiritual guidance contributes not only to religious fulfilment but also to psychological coping and emotional resilience during illness.

Furthermore, the findings reveal that the curative dimension frequently facilitated profound existential reflection among participants. Illness became a transformative moment, prompting patients to reevaluate life priorities, interpersonal relationships, and spiritual commitments.

One participant reflected deeply:

> *"Before becoming ill, I was too busy chasing work and worldly matters. Being hospitalised made me realise how fragile life is. Through spiritual guidance, I slowly rebuilt my relationship with Allah and my family." (Patient 11)*

Another participant similarly stated:

"The illness changed me spiritually. I started praying more sincerely, forgiving people, and appreciating life differently. The guidance I received in the hospital became a turning point in my faith." (Patient 6)

These narratives suggest that transformative da'wah within healthcare settings extends beyond short-term emotional support; it also facilitates long-term spiritual reconstruction and existential transformation. In this regard, illness paradoxically becomes a catalyst for religious awakening, self-reflection, and moral renewal. The hospital, therefore, emerges not merely as a biomedical institution, but also as a spiritual space where processes of healing, repentance, meaning-making, and religious transformation intersect simultaneously.

Table 2 Transformative Da'wah Model

Da'wah Dimension	Sub-Themes / Interventions	Patient Well-being Outcomes
Prophylactic Da'wah (Preventive)	Pre-illness spiritual education	Strengthening faith before adversity
	Health promotion through Islamic values	Islamic lifestyle counselling
	Quranic literacy programmes	Spiritual resilience building
Curative Da'wah (Healing)	Quranic recitation (*Ruqyah*)	Reduction of anxiety and fear
	Talqin and zikr facilitation	Psychological comfort and peace
	Individual spiritual counselling	Meaning-making and acceptance
Rehabilitative Da'wah (Recovery)	Post-treatment spiritual support	Sustained recovery motivation
	Family faith-based counselling	Social spiritual reintegration
	Islamic coping skills training	Prevention of relapse and despair
Promotive Da'wah (Well-being)	Gratitude (*shukr*) cultivation	Enhanced life satisfaction
	Community spiritual networks	Social spiritual belonging
	Follow-up pastoral care	Long-term spiritual flourishing

The rehabilitative da'wah dimension focuses on post-treatment spiritual support, assisting patients in reintegrating into their family, social, and spiritual communities after discharge. This dimension addresses the often-neglected transition phase, during which patients may experience spiritual regression, loss of momentum, or social disconnection (Oktaviani et al., 2026). The hospital's da'wah unit provides family faith-based counselling sessions and Islamic coping skills training, equipping both patients and their families with the spiritual resources needed for sustained recovery. This finding corroborates (Hidayati, 2014) argument that effective Islamic spiritual guidance must extend beyond the hospital ward to encompass the full recovery arc.

The promotive da'wah dimension represents the highest transformative aspiration of the model: the cultivation of long-term spiritual flourishing and enhanced quality of life. Participants who had received comprehensive da'wah interventions across all three preceding dimensions reported not only recovery from illness but a profound spiritual transformation, a deepened relationship with Allah, renewed commitment to Islamic practice, and enhanced gratitude (*shukr*) as an enduring disposition. This dimension aligns with the Muhammadiyah concept of 'Islamic civil society', wherein individual

spiritual transformation contributes to collective social well-being (Widodo & Yusuf, 2019).

CONCLUSION

This study has developed an empirically grounded Transformative Da'wah Model through Islamic Spiritual Guidance, derived from the lived experiences of twenty patients at Roemani Muhammadiyah Hospital, Semarang. The model comprises four interrelated dimensions: Prophylactic, Curative, Rehabilitative, and Promotive Da'wah that collectively address the spiritual needs of hospitalised patients across the entire illness experience. The findings demonstrate that systematically integrated da'wah-based spiritual guidance produces significant positive outcomes in patient psychological resilience, spiritual well-being, and coping capacity, extending beyond the biomedical dimensions of care to encompass holistic healing.

The study makes three major contributions to the field. Theoretically, it advances the scholarship on Islamic Da'wah by situating it within a contemporary health services context and articulating a four-dimensional transformative model that bridges da'wah studies and healthcare research. Empirically, it provides rich phenomenological evidence of the mechanisms through which Islamic spiritual guidance produces patient transformation, enriching the growing literature on spirituality and health in Muslim-majority contexts. Practically, it offers a replicable framework for Islamic healthcare institutions to systematise, evaluate, and enhance their spiritual guidance programmes.

This study is not without limitations. First, the sample comprised twenty purposively selected patients from a single Islamic hospital in Semarang; the transferability of the model to other institutional, cultural, or denominational contexts should be established through further research rather than assumed. Second, the qualitative, cross-sectional design captures patients' retrospective and in-the-moment accounts of spiritual guidance but cannot establish causal or longitudinal claims about the model's effect on health outcomes. Third, because data were collected, transcribed, and analysed in Bahasa Indonesia before selected quotations were translated into English, some nuances of meaning may not be fully captured in translation, notwithstanding the bilingual review procedure employed. Given these limitations, the four-dimensional model developed here should be regarded as empirically grounded rather than definitively validated; broader confirmation would require quantitative, mixed-method, or Delphi-based validation across multiple Islamic hospital settings.

Based on the findings, the study recommends that hospital administrators institutionalise Da'wah-based spiritual guidance as a formal and structured component of patient care, with trained *rohaniawan* deployed across all wards. Policymakers within Muhammadiyah health institutions and the Indonesian Ministry of Health should develop national standards for Islamic spiritual care in hospitals, drawing on the transformative da'wah model developed in this study. Future research should examine the quantitative impact of the model on measurable health outcomes, including recovery rates, medication adherence, and post-discharge well-being, across multiple Islamic hospital contexts in Indonesia and beyond.

DECLARATION OF AI AND AI-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

In the preparation of this manuscript, the authors utilized OpenAI ChatGPT to assist with language refinement, grammar correction, academic editing, and manuscript

formatting. All outputs generated through the tool were critically reviewed, verified, and substantially revised by the authors. The authors assume full responsibility for the originality, accuracy, interpretation, and final content of this manuscript.

AUTHOR CONTRIBUTION STATEMENT

Agus Riyadi conceived the study, developed the research design, conducted data collection and analysis, interpreted the findings, and drafted the manuscript. Bilqis Amalia Hasna contributed to the conceptual development, interpretation of the findings, and critical revision of the manuscript. Kasmuri contributed to the methodological review, validation of the analytical process, and final editing of the manuscript. All authors have read and approved the final version of the manuscript.

FUNDING STATEMENT

This research was supported by the DIPA Fund of the Faculty of Da'wah and Communication, Universitas Islam Negeri Walisongo, Semarang, Indonesia.

DATA AVAILABILITY STATEMENT

The qualitative data supporting the findings of this study are available from the corresponding author upon reasonable request. Access to the complete interview transcripts is restricted to protect participants' confidentiality and to comply with institutional research ethics requirements.

DECLARATION OF INTERESTS

The authors declare that they have no financial, personal, professional, or other competing interests that could have influenced the conduct or reporting of this study.

ACKNOWLEDGMENT

The authors express their sincere gratitude to Roemani Muhammadiyah Hospital Semarang, particularly the Islamic Spiritual Guidance (*Rohaniawan*) Unit, for facilitating this research. The authors also thank all patients who voluntarily participated in this study and acknowledge the academic support provided by the Faculty of Da'wah and Communication, Universitas Islam Negeri Walisongo Semarang, throughout the research process.

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