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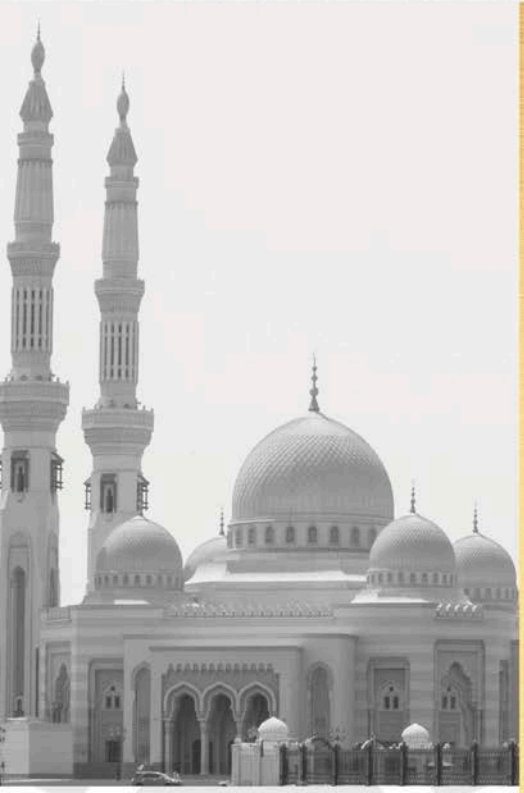

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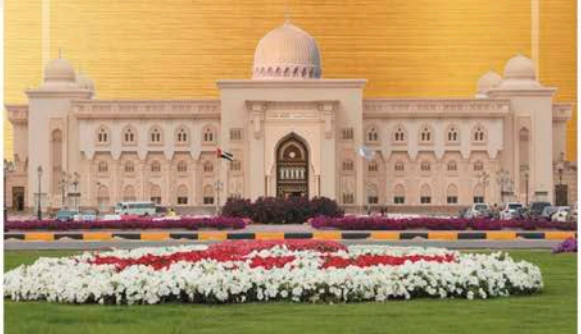

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دمج مؤسسات التمويل الاجتماعي الإسلامي في برامج الحماية الصحية: حالات مختارة من بلدان منظمة التعاون الإسلامي

INTEGRATING ISLAMIC SOCIAL FINANCE INSTITUTIONS INTO HEALTH PROTECTION PROGRAMS: CASES OF SELECTED OIC COUNTRIES[1]

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الملخص

إن مبادئ وقيم الإسلام، كقاعدة شاملة للحياة، تتناول كل جانب من جوانب الوجود الإنساني بما في ذلك المجالات الاجتماعية والروحية والسياسية والقانونية والصحية والاقتصادية. تهدف الدراسة الحالية إلى دمج مؤسسات التمويل الاجتماعي الإسلامية مثل الزكاة والوقف والصدقات وبيت المال في برامج الحماية الصحية الاجتماعية الوطنية. في سياق الدول الإسلامية التي تواجه تحديات اقتصادية، حيث تكون القيود على التمويل

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والموارد شائعة، تستخدم هذه الدراسة منهجية بحثية مكتبية لتقييم كيف يمكن لمؤسسات مثل الزكاة والوقف والصدقات وبيت المال تعزيز المبادرات الحكومية لمعالجة التحديات المتعلقة بتمويل الرعاية الصحية. وتكشف النتائج أن النماذج القائمة على الوقف هي الأكثر استخدامًا في برامج الحماية الصحية، تليها المبادرات الممولة من الزكاة. ومع ذلك، فإن استخدام هذه المؤسسات لخدمات الرعاية الصحية العامة يواجه العديد من التحديات والعقبات، بما في ذلك عدم الكفاءة البيروقراطية، والقيود على الموارد، ومحدودية الابتكار. تكمن أصالة هذه الدراسة في نهجها الجديد المتمثل في الإشارة إلى الأحكام العلمية وهيئات الفتوى والنصوص الدينية لدعم جدوى دمج المؤسسات الإسلامية المذكورة أعلاه مع أنظمة الرعاية الصحية المعاصرة. وفي حين أن حوكمة مثل هذه المبادرات غالبًا ما تقتصر على الكيانات الخاصة أو شبه الحكومية داخل الوزارات الدينية، إلا أن هناك اهتمامًا متزايدًا بين الحكومات في البلدان الإسلامية بتبني مثل هذه النماذج. تؤكد الآثار المترتبة على نتائج هذا البحث على أهمية تعزيز الجهود في زيادة الوعي ومكافحة الفساد وتحسين الخبرة وسن التشريعات الداعمة وتمتين التعاون وتأمين التمويل المستدام واعتماد التقدم التقني وترقية البنية التحتية للرعاية الصحية لتحقيق الإمكانات الكاملة لهذه التكاملات. على الرغم من محدوديته الدراسة، إلا أن هذه الدراسة تقدم رؤى قيمة وإطارًا أساسيًا لصناع السياسات الذين يهدفون إلى سد الفجوات في تقديم الرعاية الصحية من خلال الدمج الاستراتيجي لمؤسسات التمويل الاجتماعي الإسلامي.

Abstract

The principles and values of Islam, as a comprehensive rule of life, address every facet of human existence, including the social, spiritual, political, legal, health, and economic spheres. The purpose of the present study is to integrate Islamic social finance institutions like *zakat, waqf, sadaqat,* and *baitul-maal* into national social health protection programs. In the context of economically challenged Muslim nations, where financing and resource constraints are

common, this study uses a library research methodology to examine how institutions like *zakat, waqf, sadaqat,* and *baitul-maal* can enhance government initiatives to address healthcare financing difficulties. The findings reveal that *waqf*-based models are the most employed in health protection programs, followed by *zakat*-funded initiatives. However, the use of these institutions for public healthcare services faces many challenges and obstacles, including bureaucratic inefficiencies, resource constraints, and limited innovation. The originality of this study lies in its novel approach of referencing scholarly rulings, *fatwa* boards, and religious texts to support the feasibility of integrating the aforementioned Islamic institutions with contemporary healthcare systems. While the governance of such initiatives is often confined to private or semi-governmental entities within religious ministries, there is a growing interest among governments in Muslim countries in adopting these models. The implications of this research underscore the need for enhanced efforts in raising awareness, combating corruption, improving expertise, enacting supportive legislation, fostering collaboration, securing sustainable funding, embracing technological advancements, and upgrading healthcare infrastructure to realize the full potential of these integrations. Despite its limitations, this study provides valuable insights and a foundational framework for policymakers aiming to bridge gaps in healthcare provision through the strategic incorporation of Islamic social finance institutions.

الكلمات الدالة: الوقف، الزكاة، الصدقات، بيت المال، التمويل الاجتماعي، حماية الصحة، أنظمة الرعاية الصحية.

Keywords: *Waqf*, *Zakat*, S*adaqat*, *Baitul-maal,* Social Finance, Health Protection, Healthcare Systems.

1.0 Introduction

Protecting life is one of the five basic levels of needs (*dharuriyat*) of the objectives of Shari'ah or *Maqasid al-Shari'ah* (Abdullah and Azam, 2020). Health is integral to the protection of life. It is an

essential component of a healthy society and a basic human right, regardless of one's financial capacity. Hence, healthcare is prioritized in most of the countries globally. Despite such prioritization, according to the World Health Organization (WHO) report, the existing healthcare is not enough for about half of the world's population. Moreover, the report reveals that the rising healthcare costs and lack of affordability have resulted in severe poverty for more than 100 million people every year. In many Muslim countries, the healthcare sector has seen significant transformations due to increased resource allocation, yet substantial gaps remain. The least developed countries with a Muslim majority face challenges such as slow health reforms, inadequate infrastructure, a scarcity of medical experts, and limited funding (SESRIC, 2019). This is particularly true in South Asia and Sub-Saharan Africa. In 2016, healthcare in Muslim countries got a meagre allocation of 4.4% of GDP and 8.5% of government expenditures, which is much lower than the global average (SESRIC, 2019), where public financing of healthcare is below the global average of 74.2%, resulting in households having to cover 37.8% or more, in some instances over 50% of the overall cost. A functional health system relies on many key elements: adequate finance, robust infrastructure, ample supplies, skilled health professionals, evidence-based health programs, and sensible regulations (OIC, 2010).

Islamic social finance institutions like *waqf*, *zakat*, *sadaqat*, and *baitul-maal* have impressive records of supporting public services like healthcare, raising a significant amount of funds to finance these services (Ainol-Basirah and Siti-Nabiha, 2020; Iskandar, Kurlillah, and Munadiati, 2023). These institutions have also been instrumental in combating poverty and promoting various social welfare programs with great emphasis on health. Historically, these institutions, in many cities of the Muslim world, supported advanced healthcare systems, but their effectiveness has diminished due to colonization and secularization (Haruna and Ibrahim, 2021; Kakar, Zaenal, and Jalil, 2022).

In recent years, these institutions have been revived with *waqf* emerging as a powerful tool for providing public infrastructure and services (Hassanudin Mohd Thas Thaker, 2023; Kakar, Zaenal, and Jalil, 2022). Modern applications, like the UNHCR's Refugee *Zakat*

Fund and the International *Waqf* Fund, demonstrate their potential. Despite significant contributions to socio-economic welfare, there is a need for further exploration of their applications in modern healthcare programs (Sotwali, 2021), especially given that many Muslim countries have inadequate access to healthcare services and facilities (Sulistyowati et al., 2022).

While there is a growing body of literature on *waqf*, *zakat*, *sadaqat*, and *baitul-maal* (Abdulsalam Ahmed and Mustafa Omar, 2021; Haspari.M.I. et al., 2022; Hassan et al., 2023; Sulaiman et al., 2016), research linking these institutions to contemporary social health protection is scarce. Hence, the objective of the present study is to investigate the challenges and effectiveness of these Islamic social finance institutions in healthcare provision. It examines the historical development of healthcare in Muslim civilization, explores current integration efforts, and showcases health services in Muslim countries. The study also references rulings of scholars and *fatwa* boards to justify the integration of these Islamic social finance institutions with healthcare systems. As a pioneering area of research, it aims to provide insights and recommendations for governments, *zakat* and *waqf* administrators, and policymakers to enhance public welfare, particularly in healthcare and sanitation.

To achieve its objectives, the study employs a systematic literature review approach. The study is structured into seven sections, including the introduction. The subsequent section two discusses healthcare in the history of Muslims, followed by sections three and four examining the *fatwas* on the use of *zakat* and *waqf* funds, respectively, for healthcare provision. Section five reviews and discusses various issues and challenges Islamic social finance faces towards the provision of healthcare programs. Section six deliberates on cases of integrating *zakat*, *waqf*, *sadaqat*, and *baitul-maal* with public healthcare programs across the various regions and countries in the Arab world, Africa, the Indian subcontinent, Southeast Asia, and the country Turkiye. The final section seven concludes the study and provide insights and recommendations for enhancing the role of these Islamic social finance institutions to support public healthcare services.

2.0 Healthcare in the History of Muslims

Modern healthcare owes much to the systematic framework established in early Muslim societies, influenced by contributions from Caliphs, Sultans, physicians, scholars, and philanthropists. These early institutions, precursors to modern hospitals, originated during the time of Prophet Muhammad (pbuh), with notable examples such as the makeshift treatment centre led by Rufayda (ra) during the Battle of Khandaq. The Prophet Muhammad (pbuh) laid the groundwork for a holistic public health system focusing on preventive measures, hygiene, dietary guidelines, and mental well-being. Caliphs like Abu Bakr (ra) and Umar Ibn Al Khattab (ra) implemented inclusive welfare initiatives, with state treasury funds supporting aid during famines and plagues (Khalil, 2016). During the Umayyad and Abbasid periods, the welfare system evolved significantly, with notable advancements under Caliph Omar ibn Abdul Aziz and later during the Abbasid Caliphate (The *Zakat* Foundation of America, 2008; Khalil, 2016).

2.1 Features of Muslim Hospitals

The first documented hospital, established in Damascus by Umayyad Caliph al-Walid in the 8th century, primarily treated leprosy (Ragab, 2015). The term "Bimaristan," popularized in the 9th century, signified the growth of Islamic hospitals, with the first in Baghdad established by Harun al-Rashid (Al-Ansari, 2013). By the 12th century, hospitals were integral to major towns and urban centers, forming part of state public health initiatives.

Unlike Byzantine hospitals, Islamic hospitals were secular, inclusive, and usually provided free healthcare services. They were often funded by *waqf* (endowments) from rulers, physicians, and philanthropists, ensuring their sustainability and continuous improvement (Maravia and Al-Ghazal, 2021). Female founders also contributed, such as Bimaristan al-Sayyida, established by Caliph al-Muqtadir's mother in 918 CE (Al-Ansari, 2013). These hospitals were notable for their architectural design and efficient operation, often serving as centers for medical training and education with extensive libraries (Tschanz, 2014).

Management of *waqf*-based hospitals involved both primary endowments (establishing hospitals) and secondary endowments

(maintenance and operations), with responsibilities initially held by physicians and later by judges or religious scholars (Al-Ansari, 2013). The Bimaristan of al-Mansur Qalawun in Cairo exemplified the inclusive and charitable ethos of these institutions, offering free care to all regardless of background (Tschanz, 2014). The success of Islamic hospitals stemmed from their alignment with religious and social traditions, political support, and the *waqf* system, which ensured quality and sustainability (Ragab, 2015). Cultural beliefs and ethical governance further supported the establishment and operations of these hospitals, highlighting the importance of accountability and resource efficiency (Khalil, 2016).

2.2 Famous Muslim Hospitals (Bimaristans)

Historical examples of hospitals in the Muslim world highlight how the *waqf* model supported inclusive, sustainable, and progressive public welfare systems. Hospitals, among other charitable public welfare centers, proved to be the longest-lasting and most impactful institutions. Bimaristan Al-Adudi in Baghdad, established in 982 CE by Adud al-Dawla, started with 25 physicians, expanding to 60 by 1171. This hospital, like others, was supported by significant endowments, including properties like textile markets and mills, ensuring its self-sufficiency for over two centuries (Al Ansari, 2013).

Bimaristan al-Nuri in Damascus, founded in 1154 CE by Nur al-Din Mahmud Ibn Zaki, was the first hospital to maintain medical records and became a leading medical center by the 13th century. It symbolized political influence and communal upliftment, serving disadvantaged Muslims with a staff of physicians, oculists, and pharmacists (Al Ansari, 2013; Rahman and Sidek, 2017). Similarly, Bimaristan al-Mansuri in Cairo, established by Sayf al-Din Qalawun, was inspired by his healing experience at Bimaristan al-Nuri and supported by a *waqf* deed ensuring substantial yearly income and detailed management arrangements (Ragab, 2015).

Hospitals in the Ottoman Empire, predominantly waqf-based institutions, catered to public health needs and integrated medical and educational functions. Imperial *waqf*s, founded by the Sultanate and prominent officials, yielded substantial revenue from urban and provincial properties, forming a comprehensive social welfare system

(Orbay, 2017). Ottoman hospitals, governed by superintendents and chief physicians, operated within a complex administrative framework that intertwined Islamic and state systems, contributing to their longevity and efficiency (Shefer-Mossensohn, 2014).

3.0 *Fatwas* on the Use of Zakat Funds for Healthcare Provisions

Prominent national *Fatwa* bodies, including the International Islamic Fiqh Academy (IIFA), Majma ul Buhos al Islamiyah bil Azhar, Dar Al-Ifta' Al-Misriyyah, the European Council for *Fatwa* and Research, and the Assembly of Muslim Jurists of America, have authorized the use of *zakat* funds for healthcare. Hospitals may receive *zakat* funds for poor patients based on principles of cooperation and necessity. The European Council for *Fatwa* and Research allows *zakat* for poor patients, even extending to non-Muslims, though not explicitly for general patients like those suffering from COVID-19 (IslamOnline, 2022). The British *Fatwa* Council supports *zakat* for urgent medical treatments for the poor (Al-Azhari, 2020).

The Egyptian Dar Al-Ifta permits hospitals frequented by poor patients to receive *zakat* for healthcare services, emphasizing that healthcare is a basic need (IslamOnline, 2022). This includes providing medical tools, medicines, and maintenance, based on the interpretation of "and in the cause of Allah" (Surah At-Tawba: 60). Dar Al-Ifta also approves *zakat* for hospitals treating non-Muslim patients, comparing it to a poor Muslim hosting non-Muslim guests (Shariff and Norzitah, 2022). The Assembly of Muslim Jurists of America allows *zakat* for hospitals in serious need but emphasizes that this should be decided by local scholars based on the country's specific needs (AMJA Online, 2011).

Islamic scholars issued specific *fatwas* for healthcare assistance schemes supported by *zakat* for heart disease patients' healthcare costs (Rahman et al., 2021). Furthermore, the establishment of healthcare clinics through *waqf* initiatives, such as the Universiti Sains Islam Malaysia (USIM) Specialist healthcare clinic, exemplifies the benevolent use of *waqf* to improve community health and provide better healthcare access to the less fortunate (Ascarya and Tanjung, 2021). Overall, based on various *fatwas*, hospitals may receive *zakat*

funds, especially in times of necessity, to support healthcare for the poor and ensure basic needs are met.

4.0 *Fatwas* on the Use of *Waqf* Funds for Healthcare Provisions

Waqf, though not directly mentioned in the *Qur'an*, is alluded to in verses about charity and almsgiving. Key verses include:

- "*The example of those who spend their wealth in the way of Allāh is like a seed [of grain] which grows seven spikes; in each spike is a hundred grains. And Allāh multiplies [His reward] for whom He wills. And Allāh is all-Encompassing and Knowing*" (*Al-Baqarah*, 261).
- "*Indeed, the men who practise charity and the women who practise charity and [they who] have loaned Allāh a goodly loan - it will be multiplied for them, and they will have a noble reward*" (*Al-Hadid*, 18).
- "*Never will you attain the good [reward] until you spend [in the way of Allah] from that which you love. And whatever you spend - indeed, Allah is Knowing of it*" (Ali-Imran, 92).

Meanwhile, *waqf* and its practices have been directly mentioned in the *hadiths*:

- Narrated Ibn 'Umar (r.a.): Umar bin Khattab (r.a.) consulted the Prophet (p.b.u.h.) about land in Khaibar. The Prophet (pbuh) advised, "*If you like, you can give the land as endowment and give its fruits in charity*." Umar (r.a.) did so, specifying that its yield would support the poor, kin, and other causes (Bukhari, Vol 3, Book 50, *Hadith* 895).
- Abu Huraira (ra) reported: "*When a man dies, his acts come to an end, but three, recurring charity, or knowledge (by which people get benefit), or a pious son, who prays for him (for the deceased)*" (Muslim, Book 13, *Hadith* 4005).

Cash *waqf* can be used to finance health projects, as established by various *fatwa* organizations such as the International Fiqh Academy, which permitted cash *waqf* in 2004, noting that it fulfils the Shari'ah objective of preserving the principal and offering permanent benefits. Cash *waqf* can be used for investment or loans, encouraging public participation through *waqf* shares. Additionally, the Indonesian Ulema Council validated cash *waqf* in 2002, including money and

share certificates, with conditions that it must be used for shari'ah-compliant purposes and its value must be preserved (Mauluddin and Rahman, 2018). In Malaysia, the Selangor Share Endowment Scheme, introduced in 2009, raised significant funds for charity and public projects, setting a minimum limit per unit and using proceeds to purchase permanent assets (Abd Rahman and Awang, 2018).

5.0 Issues and Challenges

The integration of *zakat*, *waqf*, *sadaqat*, and *baitul-maal* into the healthcare systems of Muslim countries holds immense potential to enhance public welfare. However, this potential is often hampered by several challenges. The literature has documented several issues and challenges of utilizing *zakat, waqf, sadaqat and baitul maal* to enhance the public healthcare system. The main issues and challenges include lack of understanding and awareness; pervasive corruption, mismanagement, and diminished public trust; insufficient human resources and expertise; inadequate governmental will and legal constraints; insufficient funding; inadequate technology and digitalization; deficits in transparency and accountability; bureaucratic procedures leading to inefficiencies; and deficiencies in collaboration and coordination, among others.

Limited understanding of the socioeconomic potential of these Islamic institutions is one of the key challenges. Often, they are perceived solely as means to establish religious facilities, overshadowing their potential to support sectors like healthcare (Ismail et al., 2019). In places like Brunei and Bangladesh, public awareness of *waqf*'s role in social development remains low (Halim, 2017). This general lack of awareness extends to institutional stakeholders and hampers efforts to establish a robust legal framework for *waqf* institutions (Nabi et al., 2019).

Corruption and mismanagement significantly limit the use of *waqf*, *zakat*, and *sadaqat* for healthcare services. In Zanzibar, mismanagement of *waqf* assets led to a decline in public trust and *waqf* donations (Hamad, Suleiman, and Gunda, 2017). Issues of corruption and mistrust similarly undermine public confidence in these institutions in countries like Nigeria (Fa-Yusuf, Busari, and Shuaibu, 2021). The politicization of *waqf* and *zakat* institutions further

exacerbates these problems, leading to mismanagement and ineffective utilization of resources (Amuda and Embi, 2013).

Mismanagement and corruption normally flourish in the absence of disclosure and transparency. A consistent lack of transparency and accountability undermines public trust and participation. Effective governance, including rigorous reporting standards and regulatory frameworks, is crucial for building trust and credibility in *waqf*, *zakat*, and *baitul-maal* institutions (Hasan, Ahmad, and Siraj, 2022). Standardizing *waqf* accounting and reporting practices can significantly enhance transparency (Adnan, 2022).

In addition to corruption and lack of transparency, *Waqf*-based public hospitals face bureaucratic challenges that impede progress. Issues such as documentation rigidity, slow decision-making, and inter-departmental communication breakdowns are prevalent (Adnan, 2022). Standardized laws could help mitigate these bureaucratic hurdles and enhance efficiency.

Insufficient funding is a major obstacle for these institutions to contribute significantly to the healthcare sector. Many *waqf* lands lie dormant due to a lack of financial resources for their development (Nabi et al., 2019). Studies advocate for integrating *waqf* with *zakat* and other financing mechanisms, exploring viable funding alternatives such as cash *waqf* and corporate *waqf* (Handayani and Kamilah, 2019).

Efficiency is normally enhanced by optimal use of technology. The absence of robust technological infrastructure and data systems is another barrier. Leveraging digital technology can enhance the management of *waqf* and *zakat* funds, improving transparency and efficiency. Further, the lack of digitalization hampers the potential contributions of these institutions to healthcare services (Sulistyowati et al., 2022).

A shortage of qualified human resources and expertise, particularly in fiqh and healthcare management, impedes the effectiveness of *waqf*-based healthcare initiatives (Sulistyowati et al., 2022). Countries like Bangladesh and Malaysia face significant challenges due to the lack of professional and technical expertise required to manage and develop *waqf* properties effectively (Nabi et al., 2019; Tagoranao, Gamon, and Zain, 2019).

The integration of *waqf*, *zakat*, and *baitul-maal* into public healthcare systems requires a strong commitment from the government and well-crafted policies. However, many Muslim countries struggle with inadequate governmental efforts and complex regulatory frameworks (Adnan, 2022). Legal obstacles, such as issues related to '*istibdal*' in Islamic law, hinder the development of health *waqf* (Sulistyowati et al., 2022). Countries like Nigeria and Guinea lack comprehensive legislation and independent bodies for *waqf* governance, posing major hurdles to its effective use (Sano and Kassim, 2021).

Engaging in collaborative endeavors with private sector experts and forming cross-sector partnerships can help *waqf* institutions overcome challenges related to asset development and fund utilization. Effective coordination among various organizations is crucial to prevent resource overlap and inefficiency, as demonstrated by the Kuwait Awqaf Public Foundation (Saad et al., 2018).

There are some studies that have documented cases of challenges Islamic social finance face, hindering their efforts to achieve efficiency in supporting healthcare and other socio-economic welfare programs. This study presents the case of *baitul-maal* Institution in Saki, Nigeria to substantiate these challenges in practice.

Despite successfully establishing a baitul-maal to mobilize funds for health and education in Saki, Nigeria, several challenges hinder its efficiency and effectiveness. According to Kareem and Adetoro (2017), the primary obstacle is the shortage of funds, as the institution relies heavily on zakat and sadaqat contributions. This necessitates increased public support through awareness programs and strategic investments by the baitul-maal to generate additional revenue.

The funds are crucial for the Muslim School of Basic Midwifery and the Muslim Medical Foundation, as well as for improving equipment, facilities, staff salaries, and covering medical expenses for poor patients at The Muslim Hospital. Additional challenges include a lack of professionally qualified staff, communication gaps between the *baitul-maal* operators and the public, and the non-remittance of donations by certain Imams. Issues of poor accountability, inadequate

understanding of programs, and the inability to support other poverty-oriented projects further complicate operations.

To enhance project success and impact, the institution requires better consultation, modern tools and systems, and improved facilities. Islamic finance professionals' guidance could improve fund management and operations. Ensuring accountability through regular audits, remittance of collected funds, and accountability to the Nigeria Supreme Council for Islamic Affairs (NSCIA) and registration with the Corporate Affairs Commission for legal status are also recommended (Kareem and Adetoro, 2017).

6.0 Integration of *Zakat*, *Waqf*, *Sadaqat*, and *Baitul-Maal* with Public Healthcare in Selected Muslim Countries

The potential of *waqf* and *zakat* as alternative healthcare financing in Muslim nations is highlighted in ISDB's Health Sector Policy (ISDB, 2019). Many Muslim countries lack proper public healthcare services, necessitating innovative funding sources. While wealthier nations use oil revenues or tax funds, poorer countries rely on out-of-pocket expenditures. Despite growing charitable efforts, integrating *waqf* and *zakat* into healthcare systems remains limited, primarily through private initiatives, though some governments are increasingly interested in these institutions for healthcare support (Kareem and Adetoro, 2017).

Waqf, *zakat*, and *sadaqat* are being institutionalized within social security systems to provide medical care, financial aid, food, and education. *Baitul-maal* institutions remain scarce, with few nations establishing national or regional organizations for healthcare support.

6.1 Selected Countries in the Arab Region

The Arab region shows varied integration of *Zakat* and *Waqf* institutions into healthcare, involving both private and public efforts. Jordan utilizes the National *Zakat* Fund (NZF) and National Aid Fund (NAF) to support non-contributory social protection schemes, including healthcare (Bilo and Machado, 2019). The Al Makassed Charitable Society Hospital in Jordan operates under the Jordanian *Zakat* Fund, providing free healthcare to the needy (Essa & Al-Otoum,

2022). Yemen's National Health Strategy 2010-2025 acknowledges the need for alternative funding sources, including endowments, to support its fragile healthcare system.

GCC countries, including Saudi Arabia, the UAE, Oman, Qatar, and Kuwait, recognize the potential of *waqf* resources for healthcare. Saudi Arabia's Vision 2030 emphasizes sustainable financing through *waqf*, with initiatives like the Al-Shifa Health Endowment Fund supporting healthcare (Saudi Gazette, 2023). The ZMZM Society and various Awqaf foundations in Saudi Arabia direct funds towards health services (UN Saudi Arabia and ICD, 2021). The UAE channels *waqf* funds into patient treatment and healthcare facilities (General Authority of Islamic Affairs & Endowments UAE Website). Qatar's *Waqf* Bank for Healthcare collaborates with healthcare institutions to support the sector. The Kuwait Awqaf Public Foundation (KAPF) manages healthcare-focused *waqf* projects and coordinates with governmental and non-governmental organizations to prevent resource wastage (Kamarubahrin and Ayedh, 2018; Saad et al., 2018). Oman’s Health Endowment Fund, established in 2020, aims to optimize endowment resources for healthcare services, including financing treatments and medical research (Oman Observer, 2020).

6.2 Selected Countries in Africa

In Africa, *zakat*, *waqf*, *sadaqat*, and *baitul-maal* are recognized for bolstering healthcare for the poor. Sudan integrates *zakat* into its national social protection scheme, financing healthcare for the poor through the *Zakat* Chamber and the Ministry of Finance (Ebaidalla and Iddress, 2022; Bilo and Machado, 2019). The Sudan *Waqf* Board also supports healthcare initiatives (Kasdi et al., 2022). In Nigeria, *zakat* and *waqf* are managed by state boards, supporting healthcare through various foundations like the Jaiz and Sultan Foundation (Raimi et al., 2016). Despite these efforts, healthcare heavily relies on out-of-pocket payments and limited government funding (Popoola et al., 2015). Uganda's 'House of *Zakat* and *Waqf* Uganda' supports healthcare institutions like the Lugazi Muslim Health Centre (Hamzah, 2019). The Saidina Abubakar Islamic Hospital in Uganda integrates *waqf* and charity into healthcare, with support from international organizations.

6.3 Selected Countries in Indian Subcontinent

In the Indian Subcontinent, *zakat*, *waqf*, and other philanthropy significantly support healthcare. Pakistan's Indus Hospital (TIH) provides high-quality healthcare to the underprivileged, funded by *zakat* and private philanthropy (Samad et al., 2015). The Pakistan Bait-ul-Mal (PBM) serves as a social safety net, focusing on healthcare for vulnerable populations (Laila et al., 2021). In Bangladesh, Islamic philanthropy supports hospitals like those under the Islami Bank Foundation and the Ibn Sina Trust, offering affordable or free healthcare (Nesa and Paivansalo, 2021). The Centre for *Zakat* Management (CZM) also supports healthcare through programs like Jeebika and Ferdousi (Osmani and Al Masud, 2021). In the Maldives, the government initiated a healthcare program funded by the *Zakat* Fund to support those not covered by health insurance.

6.4 Selected Countries in Southeast Asia

In Southeast Asia, *waqf*, *zakat*, and other philanthropic instruments support healthcare services, too. Malaysia's government emphasizes *waqf*-based healthcare financing, with initiatives like USIM's Specialist Health Clinic and WANCorp's *Waqf*-An-Nur Clinics (Ismail et al., 2019; Saad et al., 2018). Malaysia also has ongoing *waqf*-based hospital projects, such as the Specialist Medical Complex in Johor (Atan, Johari, and Zulkefli, 2017). University Sains Islam Malaysia's Specialist Health Clinic, financed through *waqf*, is another example. Indonesia employs social, productive, and integrated *waqf* models for healthcare, with institutions like Rumah Sehat Terpadu-Dompet Dhuafa Hospital providing free healthcare for the poor (Ascarya and Tanjung, 2021). Brunei's productive *waqf*, managed by Majlis Ugama Islam Brunei (MUIB), supports healthcare through investments in sectors like housing and business facilities, benefiting institutions such as the Raja Isteri Pengiran Anak Saleha Hospital (Hubur, 2019).

6.5 Turkey

Waqf played a significant role in public health during the Ottoman era but is no longer the primary provider in modern-day Turkey (Azrak, 2022). The Ministry of Health is now the main healthcare provider, funded by the state budget. The Directorate General of Vakifs (DGV)

oversees *waqf* activities, including healthcare. Efforts to revive *waqf*'s role include Bezmialem Vakif University's research hospital and contributions from private foundations like Hakyol and IHH, which act as intermediaries for *waqf*, *zakat*, and *sadaqat* (Saad et al., 2018). The Diyanet Vakfi funds medical treatments establish hospitals and supplies medical equipment. The Vehbi Koç Foundation supports institutions such as VKV American Hospital and Koç University Hospital.

7.0 Conclusion

This study has achieved three primary objectives. Firstly, it has explored the historical significance and roles of *zakat*, *waqf*, *sadaqat*, and *baitul-maal* institutions in healthcare provision throughout Muslim history, addressing the associated challenges. Secondly, it has assessed the efficacy and efficiency of these institutions in delivering healthcare services. Lastly, it has examined the extent to which these Islamic social finance institutions have been integrated into contemporary public healthcare programs by national governments in Muslim countries.

The research demonstrates that *zakat*, *waqf*, *sadaqat*, and *baitul-maal* institutions have significantly contributed to healthcare provision in various ways. Despite setbacks during the colonization of Muslim lands, there is a growing resurgence of these institutions in healthcare, particularly highlighted by the 2020 COVID-19 pandemic and the United Nations' Sustainable Development Goals on healthcare. The study traces the historical foundations of healthcare in early Muslim societies and their enduring impact on modern systems, referencing scholarly rulings and *fatwas* that justify the integration of Islamic institutions into contemporary healthcare systems.

Findings reveal that current healthcare models funded by these institutions are primarily *waqf*-based, followed by *zakat*. The integration of these institutions into healthcare services across the Muslim world shows both progress and potential for further development. The governance structure of these institutions remains largely private and semi-governmental, often associated with religious ministries or departments. This governance structure presents challenges to the efficiency and effectiveness of healthcare provision,

including bureaucratic red tape, poor human resource quality, gaps in transparency and accountability, limited collaboration with governments and international entities, funding and sustainability concerns, and a lack of innovation, particularly in technology and digitization.

As evidenced in the literature, integrating these Islamic social finance institutions into public healthcare policies requires concerted efforts from governments, institutions, and communities. Key steps include raising public awareness, combating corruption, enhancing expertise, enacting supportive legislation, promoting collaboration, improving funding and sustainability, embracing technology, exploring innovative models, and investing in healthcare infrastructure.

The novelty of this study lies in its pioneering approach of identifying and thematizing rulings of scholars and *fatwa* boards to substantiate the integration of Islamic social finance institutions with health protection systems. It presents a critical review of the literature on the roles of *zakat*, *waqf*, *sadaqat*, and *baitul-maal* in healthcare provision and their integration in selected Muslim countries. Future research can build on this study to develop an integrated Islamic model for public healthcare services, leveraging these institutions and subjecting the model to empirical testing for viability and acceptance.

The study's limitations arise from its reliance on existing literature and secondary data to assess the integration of these institutions within healthcare provision across the Muslim world. The accuracy and completeness of this data depend on the quality and reliability of the sources, making it susceptible to biases. Additionally, data accessibility varies across countries, especially concerning English-language resources, potentially affecting the depth of analysis for each country. Future research should employ primary data collection methods, such as surveys, interviews, and fieldwork, to provide a more up-to-date and comprehensive evaluation. Triangulation techniques, drawing data from varied sources, and conducting cross-country comparative studies can significantly enhance the accuracy and comprehensiveness of assessments in this domain.

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