FIMA

YEARBOOK 2025

الكتاب السنوي 2025

Federation of Islamic Medical Associations

الاتحاد العالمي للجمعيات الطبية الإسلامية

ENCYCLOPEDIA OF ISLAMIC MEDICAL ETHICS –PART XI

موسوعة الأخلاقيات الطبية الإسلامية
الجزء الحادي عشر

Health Policy and Islamic Governance: Bridging Ethics and Public Health

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"*O my lord! Advance me in knowledge*"

The Glorious Qur'an: Taha 20: 114

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BRIDGING ETHICS AND PUBLIC HEALTH

السياسة الصحية والحوكمة الإسلامية:

ربط المبادئ الأخلاقية بالصحة العامة

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السَّلَامُ عَلَيْكُمْ وَرَحْمَةُ اللهِ وَبَرَكَاتُهُ

All praises be to Allāh (ﷻ) the Most Beneficent, Most Merciful.

Peace and blessings be upon Prophet Muhammad (ﷺ), his family, companions and followers until the end of time.

The year 2025 has witnessed a pivotal moment in the history of Islamic public health governance. The Eighth Session of the Islamic Conference of Health Ministers, held in Amman, Hashemite Kingdom of Jordan, in October 2025 under the theme "Health is Our Shared Responsibility", marked a significant milestone in reaffirming the collective commitment of OIC Member States to strengthen health research capacity, adopt data-driven policies, and establish robust mechanisms for sharing evidence and best practices. It signals an era of renewed urgency in addressing the health challenges confronting the Muslim *Ummah*.

Yet, as we navigate the complexities of modern health policy—from pandemic preparedness to the double burden of malnutrition, from mental health to reproductive health services—a fundamental question persists: How do we ensure that our public health policies are not only scientifically sound but also ethically grounded in the principles of Islamic governance?

Islamic governance, rooted in the rich legacy of *Shariah*-based policy, offers a comprehensive framework for addressing public health challenges. The Islamic approach is anchored in the *maqasid al-shariah*—the higher objectives of Islamic law—which prioritize the protection of five essentials (*daruriyyat*): faith and morality (din), life (*nafs*), intellect (*'aql*), progeny (*nasl*), and wealth (*mal*).

In this hierarchy, the sanctity of human life is prioritized, second only to the preservation of faith. As Allāh (ﷻ) reminds us in the Holy Qur'an: *"And if anyone saved one life, it would be as if he had saved mankind entirely"*. This profound verse establishes the ethical foundation upon which all health policy must rest—the preservation of life is not merely a matter of public welfare but a divine obligation.

The concept of *maslahah* (public benefit) and the principle of *la darar* (no harm) are central to the Islamic ethical discourse on health policy. Governments are permitted, through Shariah-based policy, to mandate treatment or vaccination in cases of public health threats, provided such measures strike a careful balance between individual rights and collective welfare. This is amanah—the sacred trust of governance exercised with wisdom, compassion, and justice.

The COVID-19 pandemic exposed the fault lines in health governance across the globe. In many Muslim-majority countries, the lack of integration of Islamic values into public health policy often led to societal resistance against interventions such as vaccination, pandemic protocols, and social restrictions. This resistance was not born of ignorance but of a disconnect between policy formulation and the ethical and spiritual frameworks that communities hold dear.

The FIMA approach to healthcare adopts a holistic medical model. Health, in the Islamic worldview, is not merely the absence of disease but a state of complete physical, mental, and

spiritual well-being. This holistic vision must inform our health policies at every level—from primary care to tertiary hospitals, from disease prevention to end-of-life care.

The Amman Declaration of 2025 appropriately emphasizes the strengthening of health research capacity and the adoption of data-driven policies. However, data without ethics is blind; science without spirituality is hollow. The challenge before us is to integrate evidence-based medicine with Islamic ethical principles, ensuring that our policies are both effective and morally coherent.

FIMA, through initiatives such as the FIMA Yearbook, and he Encyclopedia of Islamic Medical Ethics, has consistently worked to bridge the gap between contemporary medical science and Islamic ethical teachings.

This Yearbook 2025 continues that tradition, focusing on the critical intersection of health policy and Islamic governance. We have asked well-known Muslim scholars, public health experts, and social scientists to contribute their thoughts on this vital topic. The Editorial Board is pleased to have collated many informative articles addressing this subject from different angles.

As we look toward the future, several priorities demand our collective attention:

First, we must advocate for the integration of Islamic bioethics into medical education curricula across the Muslim world. Our future physicians must be trained not only in the science of healing but in the ethics of care as informed by Islamic teachings.

Second, we must strengthen the role of *waqf* in healthcare financing. Studies have demonstrated that health *waqf* can significantly reduce government spending while expanding access to care to achieve Universal Health Coverage in Muslim-majority nations.

Third, we must engage proactively with policymakers at all levels to ensure that Islamic ethical perspectives are represented in local and global health governance.

Fourth, we must invest in research that explores the application of *maqasid al-shariah* to contemporary health challenges, from artificial intelligence in medicine to mental health, from vaccine equity to the ethical dilemmas of end-of-life care.

As the Prophet Muhammad (ﷺ) taught us, "Cleanliness is half of faith"—a simple yet profound reminder that health is inseparable from spirituality, and that public health is a shared religious duty.

May Allah grant us the wisdom to formulate policies that protect life, preserve dignity, promote justice, and guide our efforts to bridge the gap between ethics and public health.

My sincere gratitude to sister Elham Mohamad Swaid at the Islamic Hospital, Amman-Jordan for her excellent secretarial support. May Allāh (ﷻ) reward and bless her bountifully.

We pray for Allāh's (ﷻ) guidance, mercy and acceptance in all our endeavours.

Musa Mohd Nordin
Editor- In -Chief

FEDERATION OF ISLAMIC MEDICAL ASSOCIATIONS (FIMA) IN BRIEF

- On 31st December 1981, FIMA was formed in Florida, USA. Senior medical professionals representing ten Islamic Medical Associations (IMA), from various parts of the world, convened and laid down the foundation of the Federation.
- FIMA was incorporated in the state of Indiana as a not-for-profit corporation on 18th January 1982 and re-incorporated in the State of Illinois on 30th March 1999.
- FIMA enjoys Tax Exempt status under Section 501 (C) (3) US Federal Income Tax by the Internal Revenue Service.
- In 2005, FIMA acquired Special Consultative Status to the United Nations Economic and Social Council (UN-ECOSOC).
- FIMA membership now include Islamic Medical Associations (IMA) and associates from 50 countries.
- FIMA aims to foster the unity and welfare of Muslim medical and healthcare professionals, promote healthcare services, education and research through the application of Islamic principles, mainstream Islamic perspectives of medical ethics, mobilize professional and economic resources for medical and humanitarian relief and collaborate with partners for the mercy and healing of mankind.
- First medical jurisprudence conference, Amman 1991.
- First humanitarian relief conference, Paris 1994.
- Launch of FIMA Year Book, Jakarta 1996.
- Consortium of Islamic Medical Colleges (CIMCO), Islamabad 2001.
- Islamic Hospital Consortium (IHC), Islamabad 2001.
- International Muslim Leaders Consultation on HIV/AIDS, Kampala 2001.
- FIMA Web, Kuala Lumpur 2005.
- FIMA Save Vision, Darfur 2005.
- FIMA Save Smile, Jeddah 2008.

- FIMA Save Dignity, Makkah 2009.
- FIMA awarded American College of Physicians Linda Rosenthal Foundation Award, USA 2009.
- Encyclopedia of Islamic Medical Ethics, Kuala Lumpur 2012.
- FIMA App on Care of Muslim Patients (Elsevier), Kuala Lumpur 2012.
- FIMA Declaration on Millennium Development Goals, Kuala Lumpur 2012.
- FIMA Green Crescent, Cape Town 2013.
- FIMA Declaration on Addiction, Cape Town 2013.
- FIMA Declaration for Polio Eradication, Cairo 2013.
- FIMA Book on Immunization Controversies, Makassar 2015.
- FIMA Save Heart 2016
- FIMA Safe Water, Istanbul 2017.
- International Journal of Human and Health Sciences (IJHHS), Istanbul 2017.
- FIMA Life Saver, Amman 2018.
- FIMA Declaration on Climate Health, 2020.
- FIMA Save Earth, Jakarta 2021.
- FIMA History of Islamic Medicine, Islamabad, 2022.
- FIMA Declaration on 2030 Strategic Planning 2023.

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ALIGNING PUBLIC HEALTH GOALS WITH *MAQĀSID AL-SHARĪ`AH*: PRIORITIZATION AND EQUITY IN RESOURCE ALLOCATION

*Mohammad Iqbal Khan**

Abstract

Public health is fundamentally concerned with prevention, population-level protection, and equity, especially when resources are constrained and risks are unequally distributed. In Muslim societies, ethical decision-making in health policy is meaningfully guided by the ***Maqāsid al-Shari`ah*** (higher objectives of Islamic law). These objectives prioritize preservation of **life, religion, intellect, lineage, and wealth,** and, in applied ethics, also reinforce dignity, confidentiality, and justice. This article outlines key public health goals and illustrates how the *Maq**ā**sid* can strengthen prioritization and resource allocation, aligning ethical duties ***maslahah*** (securing benefit) and ***mafsadah*** (preventing harm) with evidence-informed public health action. In *Maq**ā**sid*, primary emphasis are on preventive measures the principles deeply aligned with public health goals and with Sustainable Development Goal (SDG) 3. Equity based allocation of resources and just distribution of available funds, finely integrated in health systems. National healthcare management agenda is aligned with Islamic ethical values and socially responsive global public health goals.

Keywords: *Maqāsid al-Shariah;* public health ethics*; SDG 3;* equity; resource allocation*;* preventive health*;* Islamic bioethics*; maslahah; mafsadah.*

Introduction

The healthcare system treats people who are sick and also helps prevent individuals from becoming sick or injured. Public health, however, primarily aims to prevent people from getting sick or injured in the first place. It focuses on entire populations, while healthcare focuses on individual patients. Public health, therefore, requires system-level thinking: surveillance, policy, regulation, education, environmental safeguards, and equitable access. The Islamic jurisprudence and moral reasoning, the *Maq**ā**sid al-Sharī`a*h provide a coherent framework for protecting human well-being and preventing harm. These objectives can help prioritize public health goals and guide fair allocation of resources, particularly during outbreaks, disasters, health system constraints, and large burdens of preventable disease. *Al Maqāsid al -Sharī`ah* are comprehensive ethical purposes that provide the basic needs of human life, such as protection and preservation of life, faith, intellect, progeny, wealth, and honour. Based on these priorities, the principles of intention, certainty, hardship, harm, and customs are derived from Islamic jurisprudence, which are finely integrated and aligned with global public health needs.

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Public Health Goals

Public health goals focus on protecting and improving community health by preventing disease, promoting healthy living, ensuring health equity, and responding to crises, through activities such as tracking outbreaks, setting safety standards, advocating for healthy policies, and making healthy choices easier for everyone. Ultimately, public health aims for longer, healthier lives, free from preventable illness and disability. Important objectives include ensuring access to quality health services, controlling infectious diseases, promoting healthy behaviours, protecting against environmental hazards, eliminating health disparities, fostering healthy environments, and building resilient health systems to address threats such as infectious diseases, environmental hazards, and chronic conditions[1].

Public health goals are aligned with Sustainable Development Goal (SDG) 3: **"Ensure healthy lives and promote well-being for all at all ages."** Important objectives of public health include:

1. **Disease Prevention & Control:** preventing epidemics; controlling infectious diseases (e.g., AIDS, TB, malaria); and reducing chronic diseases (e.g., cardiovascular disease, diabetes).
2. **Health Promotion:** encouraging healthy behaviours, improving nutrition, increasing physical activity, supporting mental well-being, and promoting healthier lifestyles.
3. **Health Equity:** eliminating disparities and ensuring that everyone has the opportunity to be as healthy as possible, including access to healthcare services without any discrimination (regardless of socio-economic, colour, creed, faith, or other discriminatory background).
4. **Environmental Protection:** safeguarding communities from environmental hazards, such as pollution, and addressing climate change-related impacts.
5. **Health Services Assurance:** ensuring the quality, accessibility, and effectiveness of health services for all.
6. **Emergency Preparedness:** responding to disasters and assisting communities in rescue, recovery, and rehabilitation to mitigate the impacts of disasters.

Achieving Public Health Goals

Achieving public health goals requires a comprehensive, data-driven approach that focuses on disease prevention, health promotion, and equitable access to care. Key strategies include implementing policy changes (e.g., smoking bans), conducting community-wide health surveillance, and addressing social determinants such as education and housing. Successful initiatives reduce mortality, improve quality of life, and foster environments that support healthier behaviours.

Public health goals are achieved through well-designed strategies, including:

- **Assessment and Surveillance:** regular monitoring of community health, tracking disease outbreaks, and using data to identify, analyse, and address health threats.
- **Policy Development and Advocacy:** creating, implementing, and enforcing laws and regulations that promote health, such as safety standards, anti-smoking policies, and environmental regulations.
- **Assurance of Care:** ensuring access to necessary health services, including immunisations, screenings,

and preventive care for vulnerable populations.

- **Targeted Interventions:** addressing priority areas such as reducing maternal mortality, preventing HIV/AIDS, combating viral hepatitis, improving nutrition, controlling infectious diseases, reducing noncommunicable disease burden and improving overall health of the society.
- **Health Equity and Literacy:** reducing disparities by improving health literacy and providing equitable, high-quality care without any discrimination.

These strategies enable monitoring and need assessment, investigation of existing and emerging problems, community education, mobilisation of resources and partnerships, and implementation of legal and regulatory actions. They also require a skilled public health workforce, strengthened research and innovation, and resilient public health systems to address current and impending challenges.[3]

Global and National Target Frameworks

Major organisations establish specific, time-bound targets to measure progress. These include the **United Nations Sustainable Development Goal 3**, aiming for healthy lives by **2030**, with priorities that include ending epidemics, achieving universal health coverage, and reducing pollution-related deaths. The U.S. has **Healthy People 2030**, a set of 10-year national objectives aimed at improving health, reducing disparities, and improving health literacy. The WHO has system-level targets focusing on expanding universal health coverage, protecting populations from health emergencies, and improving well-being. Areas requiring sustained focus include health equity (addressing systemic barriers), environmental health (including climate impacts), emergency preparedness (strengthening early warning and response), and mental well-being (expanding access to services).[4]

Targets of Sustainable Development Goal 3 (WHO) to ensure healthy lives and promote well-being for all at all ages:

3.1. Maternal mortality: By 2030, reduce the global maternal mortality rate to less than 70 per 100,000 live births.

3.2. Neonatal and child mortality: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 years of age mortality to at least as low as 25 per 1,000 live births.

3.3. Infectious diseases: By 2030, end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases, and combat hepatitis, waterborne diseases, and other communicable diseases.

3.4. Noncommunicable diseases: By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention, lifestyle modification, and treatment, and promote mental health and well-being at all levels.

3.5. Substance abuse: Strengthen prevention and treatment of substance abuse, including narcotic drug abuse and use of alcohol, tobacco and others.

3.6. Road traffic: By 2020, the number of global deaths and injuries from road traffic accidents.

3.7. Sexual and reproductive health: By 2030, ensure universal access to sexual and reproductive health-care services, including family planning, information

and education, and the integration of reproductive health into national strategies and programmes.

3.8. Universal health coverage: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.

3.9. Environmental health: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination.[5]

Universal Health Coverage (UHC): achieve universal access to quality essential healthcare services and affordable medicines/vaccines for all.

Non-Communicable Disease (NCD) Reduction: reduce premature mortality from NCDs (e.g., heart disease, cancer, metabolic disorders, etc.) by one-third through prevention and treatment.

Public Health Functions: Public health agencies perform core functions to achieve these goals: assessing population health, developing policies, and assuring access to necessary health services and a competent workforce.[6]

Essential public health goals may be summarized as:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilise community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public and personal health care workforce.
9. Evaluate the effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Communities must undertake these goals to elevate the health and well-being of the masses.[7]

Maqāsid al Shari'ah in achieving public health goals

Islamic guidelines for public health are rooted in the ***Maqāsid al-Sharī`ah***, which prioritise preservation of **life, religion, intellect, lineage, and wealth** as essential duties. *Maqāsid al-Sharī`ah* and global public health goals, particularly SDG 3—are highly compatible, sharing a fundamental focus on promoting human well-being (***maslahah***) and preventing harm (**mafsadah**). *Maqāsid al-Sharū`ah* and public health goals converge in the best interests of humanity:

I) Protection of Life (*Hifz al-Nafs*)

This is the core pillar relating to health, aligning directly with SDG 3 and supporting key determinants of health. ***Hifz al-Nafs*** is one of the five foundational objectives of Islamic law. Human life is sacred and a trust (***amah)*.**

nah) from Allah; therefore, it must be protected from harm, danger, and destruction. In this framework, health is viewed as a trust that individuals and communities are religiously obligated to preserve, including physical, mental, social, and spiritual dimensions. Key preventive dimensions include: prevention through hygiene, diet, and lifestyle; and community responsibility through zakat and care for vulnerable populations.[8]

1. Disease Prevention and Personal Hygiene

Islamic teachings strongly emphasise prevention, often expressed in the maxim that 'prevention is better than cure'. Guidance includes regular exercise, cleanliness, avoiding unhealthy habits, and adopting healthy practices. *"A strong believer is better and is more lovable to Allah than a weak believer*."[9]

Cleanliness and purification are emphasised in the *Qur'ān* and *Hadīth*, including: *"Indeed, Allah loves those who are constantly repentant and loves those who purify themselves."*[10] Ablution and purification guidance is detailed in the *Noble Qur'ān* 5:6.[11] The Holy Prophet (PBUH) said: *"*Try to be clean as much as you can*..."*[12] and "Cleanliness is half of the *faith*."[13] Regular ablution before prayers reinforces routine hygiene.*[14]* Oral hygiene is emphasized through the use of miswak (care of oral hygiene and cleanliness): *"*Siwak is a means of purification for the mouth and is pleasing to the Lord."[15]

Islamic teachings also encourage preventive etiquette, such as covering the face when sneezing or coughing, and maintaining a preventive environment through the practical guidance demonstrated in the Sunnah of the Prophet (PBUH).

Lifestyle management is incorporated into the teachings of the Prophet (PBUH), from eating habits and dietary management to physical activity. Examples include:

a) **Moderation:** Overeating is discouraged; guidance includes balancing food, drink, and leaving space for breathing.

b) **Prohibitions:** substances proven harmful, such as alcohol and other intoxicants, are forbidden to protect the body and mind.

Obesity is discouraged, like the Prophet (PBUH) said: The best of you are my generation. Then those who come after them. And then those who come after them. Imran said: I do not know whether the Prophet PBUH) mentioned two or three generations. The Prophet (PBUH)| continued: There will be people after you who will be dishonest and not trustworthy. They will give testimony without being asked. They will vow but not fulfil their vows. And obesity will appear upon them"[16]. Other hadiths say: Abu Hurairah (May Allah Most High be pleased with him) narrated that the Messenger of Allah PBUH said: On the Day of Resurrection, a colossal obese man will come. He will not weigh the weight of the wing of a mosquito with Allah (Most High). Then He PBUH added, read: We shall not give them any weight on the Day of Resurrection[17].

Breastfeeding is promoted for up to two years to ensure optimal infant nutrition and immunity. *"Mothers shall suckle their children for two whole years, (that is) for those who desire to complete the term of suckling[18]".*

2. Management of Communicable Diseases

Management of Communicable Diseases: Prophet Muhammad ﷺ provided clear, foundational instructions regarding social

distancing, quarantine, and travel restrictions during the outbreak of a plague or contagious disease

Quarantine: The Prophet Muhammad ﷺ instructed about the management of pandemics: The Prophet ﷺ said, "If you hear of an outbreak of plague in a land, do not enter it; but if the plague breaks out in a place while you are in it, do not leave that place."[19].

Social distancing from infected: Guidance includes keeping those with contagious diseases apart from healthy individuals: Run away from the leper (the one with a contagious ailment) as you would run away from a lion[20]." Another Hadith; "Those with contagious diseases should be kept away from those who are healthy[21]

3. Moderation and Avoidance of Harm

Overeating is discouraged: "…one third of food, one third for drink, and one third for air."[22] Extravagance is prohibited: "Eat and drink without going to excess; for Allah does not like those who go to excess."[23] Actions that cause bodily or mental harm are prohibited, and self-destruction is condemned: "Do not let your own hands throw you into destruction…"[24]

II) Preservation of Religion (*Hifz al-Dīn*)

Protecting religion and protecting public health are integrated through *Maqāsid al-Sharī`ah*. Preservation of religion is one of the five essential goals (*daruriyyāt*) required for human flourishing.[25] In practice, *Shari'ah* recognises contextual flexibility: religious practices may be adjusted temporarily to protect public health during pandemics, consistent with the principle that preventable harm must be reduced.[26,27]

Convergence of public goals and faith

Integration, Islamic health principles complement modern medicine by promoting a holistic approach that includes physical, mental, and spiritual well-being. Empowerment**,** Religious guidelines are used to foster healthy behaviours, such as smoking cessation, improved nutrition, and seeking medical care, based on the principle that every illness has a cure.

Islamic teachings hold that "a strong believer is better than a weak believer," encouraging the maintenance of health to ensure the ability to perform religious duties, making public health a religious priority. This also harmonizes the goals and objectives, e.g., during crises like the COVID-19 pandemic, religious practices (such as congregational prayers) may be suspended to prioritize the protection of life, illustrating how religious and public health goals are harmonised through proportionality[27].

Religion provides the right to health care:

Integration of these principles leads to recognising a right to life and quality of healthcare as a divine and social obligation

Hifz al-Din is recognised by classical jurists (including al-Ghazali and al-Shatibi) as a principal objective of Islamic law, ensuring faith is upheld, practiced, and transmitted across generations.[28]

III) Protection of Intellect (*Hifz al-'Aql*)

Protection of intellect aligns with public health efforts addressing mental health, substance abuse, and cognitive well-being. *Hifz al-'Aql* preserves mental capacity by encouraging knowledge, reflection, and education, while forbidding substances and behaviours that impair judgment. Intellect is considered a divine gift and the basis of legal responsibility.

Shari'ah preserves intellect through:

1. **Preventive measures:** removing what impairs intellect.
2. **Prohibition of intoxicants:** "*O believers! Intoxicants…are filth of*

Satan's handiwork. So, shun them…"[30]

It also encourages reflection (*tafakkur*) and responsible inquiry.31,32

How *Shari'ah* protect intellect:

a. **Prohibition (Preventive):** Strict prohibition of alcohol and drugs (*khamr*) to prevent impairment of cognitive functions.

b. **Promotion (Positive):** Obligation to pursue knowledge, education, and critical thinking.

c. **Modern Context:** Beyond forbidding substances, this principle is applied to the modernisation of education, promoting critical thought, and navigating ethical challenges in the era of artificial intelligence.

In Islamic law, the intellect is considered a divine gift and the foundation for legal responsibility (*taklif*); without a sound mind, an individual is not held legally accountable for their actions. The purpose of *Hifz al-Aql* is achieved through two primary approaches.[29]

1. **Preventive/Defensive Measures:** These measures aim to eliminate anything that could impair, cloud, or destroy the intellectual faculty.
2. **Prohibition of Intoxicants:** This is the most cited traditional example. Shariah forbids alcohol (*khamr*) and drugs because they compromise judgment and intellectual function. *"O believers! Intoxicants, gambling, idols, and drawing lots for decisions are all filth of Satan's handiwork. So, shun them that you may be successful[30]".*
3. **Avoidance of Superstition:** It forbids engaging in irrational practices, myths, or sorcery that lead to intellectual misguidance. e.g., The *Noble Qur'ān* states that no misfortune occurs except by Allah's permission, emphasizing that nothing happens by chance or bad luck[31] and hadith; The Prophet Muhammad ﷺ said: "Believing in bad omen is polytheism".

Islamic law also establishes a positive duty to nurture and develop the mind.

Obligation of Seeking Knowledge: Education is considered a fundamental religious duty (*fard al- `ayn* for basics) to ensure the mind is enlightened and capable of distinguishing truth from falsehood.

Encouragement of Scientific Inquiry: Contemporary scholars include the promotion of modern sciences and critical thinking as ways to actualize *Hifz al-`Aql*.

Mental Health Awareness: Preservation of the mind includes maintaining "mental hygiene" through the treatment of psychological disorders and avoiding excessive stress that impairs thinking.

Reflection (*Tafakkur*): The Quran repeatedly calls on humans to use reason and reflect on the universe to recognize their Creator[32].

IV) Protection of Lineage (*Hifz al-Nasl*)

Hifz al-Nasl preserves lineage and protects the family structure. It includes protecting *nasab* within legitimate marriage, prohibiting zina, and preserving family ties.[33–35] It also

supports child welfare, pregnancy and neonatal care, and responsible upbringing. Ethically governed infertility treatment and certain assisted reproductive methods (within marital bounds) may be viewed as supporting this objective.

Protection of Lineage *(Nasab):* *Ensuring that children are born within a legitimate, recognized marriage so that family lines remain clear. e.g., "Call them by (the names of) their fathers; that is more just in the sight of Allah*[33]*. "And do not go near adultery; indeed, it is a shameful deed and an evil way*[34]*". The Noble Qur'ān* stresses respecting family ties and, by extension, the purity of descent: *"...and [fear Him regarding] the wombs [that bore you]*[35]*".* Modern techniques like genetic testing and counselling are supported as they help maintain the health and, by extension, the protection of the offspring.

V) Protection of Wealth (*Hifz al-Māl*)

Hifz al-Māl protects property/wealth through lawful acquisition, ethical management, fair circulation, and protection from harm. In healthcare, this includes protecting patients from financial ruin, managing costs ethically, and distributing health resources fairly. "*Do not devour one another's wealth illegally…*"[36]

Public health applications include financial protection, preventive care to reduce treatment cost on disease, *zakah*/*waqf* support for the poor, and risk-sharing mechanisms (*takāful*). Physicians should avoid exploitative pricing and unnecessary investigations. Accountability and compensation principles apply where negligence causes harm and financial loss.[37,38] Avoiding all sorts of exploitation and equity-based decisions are *Sharī`ah* objective; Prophet Muhammad ﷺ stated that "No flesh that was nourished with *harām* will enter paradise[37]. *Hifz al Māl* in public health , e.g.".

Financial Protection against Health Expenses: *Shariah* emphasizes protecting individuals from falling into poverty due to high-cost treatments. Public health strategies, such as the *Sehat Sahulat* Program in Pakistan, aim to provide financial protection to poor families, directly reflecting the principle of *Hifz al-Māl* by shielding them from debt or loss of assets.

Preventive Healthcare to Reduce Costs: A major goal is to reduce the financial burden of disease on both individuals and the state. By promoting preventative care, better nutrition, and hygiene, the need for expensive, curative, or invasive treatments is reduced, thus preserving wealth. Institutional safety nets like *zakah*, *waqf,* and *takāful* (Islamic insurance) should be used where appropriate in the best interest of the individual and community. Cash *Waqf* (endowments) is also utilized as a sustainable funding source for public health infrastructure, protecting the community from the financial strain of large-scale disease outbreaks. Efficient financial allocation, preventing financial wastage, just pricing, liability and compensations for preventable errors, avoidance of monopoly, resource stewardship, and ethical financial management of individuals' and community resources are important measures to be taken under *hifz al māl*[38].

VI) Protection of Honor (*Hifz al-'Ird*)

Hifz al-'Ird protects dignity, privacy, and social standing. Islam affirms human dignity and prohibits mockery, backbiting, and unjust intrusion.39–42 In public health practice, this strongly supports confidentiality and privacy to prevent stigma and discrimination, especially for sensitive

conditions. Ethical disclosure may be justified only to prevent greater harm, with proportionality and governance. Islam rejects superiority based on race, gender, or wealth, establishing that the most noble in the sight of Allah is the most righteous,[40] protect personal reputation[41], respect human life and equality in rewarding both men and women[42]. Medical Confidentiality and Privacy of the patients, and preventing social stigma, are also assured. While ethical disclosure (e.g., notifying a spouse of a contagious disease), balancing the individual's honour with the community's safety and the patient's right to make informed decisions about their own body and treatment, which is viewed as a prerequisite for maintaining personal dignity. Taking care of the vulnerable population, maintaining high moral character, appearance, and trustworthiness to uphold the "honour" of the healing profession, preventing errors, avoiding negligence, and keeping trust is mandatory for health care workers. The Quran emphasizes returning trusts to their rightful owners and performing tasks with high integrity[43]. Avoid malpractice, a must not use their position to harm others, such as in divorce proceedings, where retaining a woman simply to harm her is forbidden.[44]

This objective also supports patient autonomy, dignity in end-of-life care, and universal access so poverty does not translate into indignity. It reinforces professional integrity and high ethical standards

Public Health Ethical and Social Responsibility

Public health is a collective responsibility (***fard kifāyah***). Sharī`ah positions health as a major blessing and a trust (***amānah***), making its preservation a religious obligation.[45] Islamic public health ethics emphasise prevention, justice, and harm-reduction: *amānah*, moderation (*wasatiyyah*), no harm (*lā darar*), excellence (*ihsān*), and justice (‘*adl*).[46] These principles support evidence-informed public health measures, solidarity with vulnerable groups, accurate health communication, and protection of public spaces from pollution and hazards. The following measures must be taken to promote public health goals:

Social Solidarity: The duty to care for the vulnerable, orphans, and the elderly is central to Islamic social responsibility, often enacted through *zakah* (obligatory almsgiving).

Fighting Misinformation: Promoting accurate health information is considered a social and religious responsibility, protecting the public from harmful myths.

Hygiene and Public Spaces: Islamic teachings extend to public sanitation, with prohibitions against polluting water sources, roadbeds, or shaded areas.

Sharī`ah-Compliant Hospitals: These institutions go beyond medical care to ensure all policies adhere to Islamic principles, including gender-sensitive care, certified *halāl* food, and prayer facilities.

Preventive Measures: Daily prayers (requiring *wudu* or washing) are recognized as a form of early preventative health.

Mental Health: Spiritual wellness, achieved through remembrance of God, prayer, and community support, is seen as essential for mental stability.

These principles allow for a blended approach where modern, evidence-based public health interventions are enhanced by the traditional, ethical, and spiritual foundations of Islam, ensuring that health remains both a personal duty and a societal priority.[46]

Alignment with Modern Public Health:
Islamic principles strongly align with contemporary public health goals, emphasizing primary prevention, salutogenesis (factors that promote well-being), universal access, and addressing social determinants of health, making it a comprehensive framework for public health. The ethical "spirit" of Islamic bioethics is grounded in Sharia and its higher objectives (*Maqāsid al-Sharī`ah*), seeking to secure benefit (*maslahah*) and prevent harm (*mafsadah*). Public interest may, in defined circumstances, outweigh individual preference (e.g., quarantine during outbreaks), provided decisions are proportional, evidence-informed, and ethically governed.

Public Health Goals and Equity-based allocation of resources a *Sharī`ah* guideline

Shari'ah-guided public health prioritisation and resource allocation are rooted in *Maqāsid al-Shari'ah*. Key principles include:

- **Justice and equity (*al-`adl* and *al-qist*):** need-based allocation; non-discrimination; prioritising the most vulnerable.
- **Public interest (*maslahah)*:** community protection during emergencies, with proportionality.
- **Solidarity (*takāfu*l) and altruism (*ihsān*):** support for the needy via state and social mechanisms.
- **Ethical management:** avoiding waste (*isrāf*), transparency, and preventing exploitation.

In conclusion, Shariah guidelines emphasise a compassionate, just, and efficient system that ensures equitable access to healthcare, prioritises public well-being and upholds the dignity of every human life.[47]

***Sharī`ah* integration with Public Health**
Integration provides an ethical and spiritual dimension to technical targets:

- *Hifz al-Nafs* supports protection of life, universal health coverage, and disease prevention.
- *Hifz al-`Aql* supports mental health and substance-harm reduction.
- *Hifz al-Nasl* supports maternal/child health and family stability.
- *Hifz al-Māl* supports financial protection and stewardship.
- *Hifz al-`Ird* supports confidentiality and dignity.

These objectives guide the evaluation of medical interventions and ethical decisions. Preservation of life is emphasized in the *Noble Qur'ān*, 5:32, and Islam encourages seeking treatment while prohibiting unjustified taking of life (including suicide and euthanasia). Key maxims frequently applied include:

- Intention matters (*al-qasd*)
- Certainty is not overruled by doubt (*al-yaqīn*)
- Hardship brings facilitation (*al-mashaqqah*)
- Harm must be eliminated (*al-darar*)
- Custom (*al-`urf*) is authoritative where it does not contradict revelation (*al-wahī*).

Seeking Treatment: It is a religious duty to seek medical attention and use modern evidence-based remedies, as the Prophet stated that "for every disease, there is a cure". Islamic ethics (bioethics) in public health are grounded in several key tenets:
***Amānah* (Trust):** The human body is viewed as a trust from Allah, requiring individuals to care for their health.
***Wasatiyyah* (Moderation):** A balanced lifestyle and avoiding extremes in

consumption and behavior are highly emphasized.

***LāDarar* (No Harm):** The core principle of "no harm and no reciprocating harm" guides public health policy, encouraging measures like social distancing and vaccinations.

***Iḥsā*n (Excellence):** Striving for the highest standard in medical care and conduct.

`*Adl* (Justice): Ensuring fair access to healthcare resources. Islam emphasizes the individual's role as part of a community, rejecting isolation.

Collective Obligation: Infectious diseases and pandemics require collective, community-led responses, such as quarantine, as advised by the Prophet Muhammad ﷺ: "If you hear of an outbreak... do not enter it; but if [it] breaks out... while you are in it, do not leave".

Social Solidarity: The duty to care for the vulnerable, orphans, and the elderly is central to Islamic social responsibility, often enacted through *zakat* (obligatory almsgiving).

Fighting Misinformation: Promoting accurate health information is considered a social and religious responsibility, protecting the public from harmful myths.

Hygiene and Public Spaces: Islamic teachings extend to public sanitation, with prohibitions against polluting water sources, roadbeds, or shaded areas.

Shariah-Compliant Hospitals: These institutions go beyond medical care to ensure all policies adhere to Islamic principles, including gender-sensitive care, certified halal food, and prayer facilities.

Holistic Preventive Measures: Daily prayers (requiring *wudu* or washing) are recognized as a form of early preventative health. Islamic teaching stress on prevention of all sorts of health hazards.

Mental Health: Spiritual wellness, achieved through remembrance of Allah, critical thinking, spiritual purification, sanctification, prayer, positive attitudes, and community support, is seen as essential for mental stability.

These principles allow for a blended approach where modern, evidence-based public health interventions are enhanced by the traditional, ethical, and spiritual foundations of Islam, ensuring that health remains both a personal duty and a societal priority.[46] Bridging mechanisms include Shariah-compliant healthcare environments, Islamic social finance (waqf and zakat), takaful, and value-based initiatives supporting accountability and sustainability.

Environmental Health: Shariah prohibits pollution and encourages stewardship of the earth, as seen in Islamic environmentalism, which focuses on cleanliness and sustainable resources.

Environmental Stewardship: Muslims are prohibited from polluting water sources, public roads, or shaded areas. *Maqāsid* scholars emphasize that preserving life is impossible without a clean environment. This aligns with global goals for clean water, sanitation, and climate action (SDGs 6, 13, 14, 15). In current practice, several mechanisms bridge the gap between Islamic law and health goals[47-48]:

***Sharī`ah*-Compliant Healthcare:** Hospitals increasingly adopt Shariah-compliant models that ensure gender-sensitive treatment, halal-certified food and medicine, and spiritual support, which can improve patient outcomes and encourage medical tourism.

Islamic Social Finance (*Waqf* and *Zakah*): Endowments (*waqf*) are being used as sustainable funding sources for inclusive health services, particularly for low-income communities.

***Takāful* (Islamic Insurance):** Takaful providers now offer specific medical cards and health insurance schemes that include mental health coverage, aligning with the *Maqāsid* of protecting both life and intellect.

Key Differences

While highly compatible in welfare and harm-prevention, they differ in foundations[48]:

- **Source:** *Maqāsid* is rooted in the *Noble Qur'ān* and *Sunnah*, whereas SDGs are a secular, multi-national framework.
- **Dimension*:*** *Maqāsid* includes spiritual accountability beyond material outcomes.

Conclusion

Maqāsid al-Sharī`ah provides a principled, ethically grounded framework that finely integrates with modern public health goals, especially prevention, equity, dignity, and responsible stewardship of limited resources. Applied alongside evidence-informed public health practice, this framework strengthens legitimacy, supports fair prioritisation, and reinforces community responsibility in achieving healthier lives and well-being for all.

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UNIVERSAL HEALTH COVERAGE AND ISLAMIC SOCIAL ETHICS: CONVERGENT VALUES, DIVERGENT REALITIES

*Ahmad Fuady**

Abstract

Universal Health Coverage (UHC) has emerged as one of the defining commitments of the global health agenda. While the normative foundations of UHC are most commonly articulated through the frameworks of human rights, welfare economics, and social contract theory, this paper argues that the core principles of UHC are deeply consonant with Islamic moral philosophy. Drawing on Qur'anic injunctions, Prophetic traditions, and classical Islamic jurisprudence, this paper also highlights that the primary objectives of Islamic law and other Islamic principles together constitute a robust and internally coherent Islamic moral framework for UHC. However, there have been persistent implementation gaps in Muslim-majority low- and middle-income countries, despite the strength of the normative convergence. Muslim-majority countries in sub-Saharan Africa and South Asia record among the lowest service coverage indices globally, while financial hardship rates remain alarmingly high.

This paper identifies four structural challenges: chronically inadequate health financing; systematic underinvestment in primary health care; critical health workforce shortages compounded by maldistribution and inadequate remuneration; and persistent gaps in the quality of care. An Islamic policy framework–one that translates values to actions—is proposed, organized around five actionable imperatives: engaging Islamic scholars as partners in health system reform; systematically mobilising Islamic social finance instruments within national health financing strategies; explicitly prioritising the most marginalised populations in UHC expansion; recognising fair remuneration for health workers as a matter of Islamic justice; and treating primary health care strengthening as the highest-priority investment.

This paper also calls for a further growing body of scholarship at the intersection of health policy and Islamic ethics, Islamic moral tradition not merely as symbolic endorsement of UHC, but as a substantive normative architecture capable of motivating political commitment, guiding resource allocation, and mobilising community solidarity in support of health system strengthening across Muslim-majority societies.

Keywords: Universal Health Coverage; Islamic ethics; health equity; resource allocation; social solidarity; health financing; health workforce

1. Introduction

Universal Health Coverage (UHC) has become a cornerstone of the global commitment to ensuring that all people receive the health services they need, ranging from prevention, promotion, treatment, rehabilitation, to palliative care, without suffering financial hardship[1, 2].

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This concept has risen to the centre of the global health agenda over the past two decades, and it has gained particular prominence since the Millennium Development Goals (MDGs, 2000–2015) and their successor, the 2030 Sustainable Development Goals (SDGs), under which UHC is enshrined as Target 3.8[3, 4].

The concept of universal access to health care has roots that lie considerably earlier than the MDGs, in two foundational milestones of twentieth-century moral and political thought. The first is the Universal Declaration of Human Rights, adopted by the United Nations General Assembly in 1948, which proclaimed in Article 25 the right of every person to a standard of living adequate for health and wellbeing, including medical care[5, 6]. The second is the Declaration of Alma-Ata of 1978, which issued the rallying call of "Health for All" and affirmed that the attainment of the highest possible level of health is a fundamental human right and a worldwide social goal[7]. Taken together, these declarations establish that UHC is not merely a policy instrument for managing health expenditure, but a moral imperative rooted in the inherent dignity and equal worth of every human being.

In practice, however, UHC has increasingly been operationalised through a technocratic lens: conceptualised through three interlocking dimensions, often illustrated as a “coverage cube”[8]. The first dimension is the breadth of population coverage, which defines who is covered and how many people are reached. The aim is to ensure that access to health services is universal, and that no one is excluded on the basis of identity, geography, socioeconomic status, gender, or any other characteristic. The second dimension is the depth of service coverage, which describes what services are included. This encompasses the range of health interventions within a defined benefit package, from primary care through to more specialised treatments. The third dimension is the height of financial protection, which reflects the share of healthcare costs borne by the system rather than the individual. This dimension is essential to shield individuals and families from catastrophic out-of-pocket expenditure.

These three dimensions are grounded in four key normative principles: equity, solidarity, efficiency, and accountability[8, 9]. Equity requires that resources and services be distributed according to need rather than ability to pay, with particular attention to disadvantaged and marginalised groups. Solidarity reflects the concept of mutual support, whereby the healthy cross-subsidise the sick, the wealthy cross-subsidise the poor, and the working-age cross-subsidise both the young and the elderly. This is a principle operationalised in practice through risk pooling within social health insurance schemes[6, 10]. Efficiency requires that scarce resources be allocated in ways that maximise health gains across the population. Accountability underscores the importance of transparent governance, ensuring that health systems remain responsive and answerable to the populations they serve.

The progress is accordingly tracked through two headline indicators: coverage of essential health services and the incidence of catastrophic health expenditure[9]. According to the latest WHO report, an estimated 4.5 billion people, meaning more than half of the world's population, remain without full coverage, and out-of-pocket health spending continues to push approximately one billion people into poverty each year. These are important metrics[11]. Yet measuring UHC solely through the lens of financial protection and service coverage risks reducing a fundamentally moral commitment to an actuarial exercise, obscuring the richer principles from which it was born.

In principle, UHC encapsulates a vision of health as simultaneously a social and a moral entitlement. It demands fairness for all parties involved in healthcare provision — including health facilities, health workers, government at all levels, and the population itself. It also requires equity in the distribution of resources and access across geographic and socioeconomic groups. Beyond these two dimensions, the extent to which UHC promotes quality of care is equally critical[12]. These principles are not supplementary aspirations layered onto a financial core; they are constitutive of what UHC truly means. A system that extends formal insurance coverage while perpetuating inequities between rich and poor, urban and rural, or majority and marginalised populations has not achieved UHC in any meaningful sense.

These principles have historically been articulated through the frameworks of human rights, welfare economics, and social contract theory — frameworks that are powerful and carry broad international legitimacy. Importantly, they also find strong resonance within Islamic thought. The Qur'an and the Sunnah together affirm the sanctity of human life, command the pursuit of justice, mandate collective care for the vulnerable, and prohibit the infliction of harm[13]. These injunctions, elaborated over centuries by Muslim jurists and scholars, provide a robust ethical architecture for the full realization of UHC. Yet a significant gap remains between principle and practice: WHO and World Bank UHC tracking reports consistently show that Muslim-majority countries in sub-Saharan Africa, South Asia, and the Middle East lag significantly behind on both service coverage and financial protection indices[11].

This paper examines the convergence between Islamic values and the principles of UHC, and interrogates the gap between these shared ideals and on-the-ground realities. The central question is not merely whether Islamic values are compatible with UHC principles, but whether engaging Islam's rich tradition of social ethics could help bridge the distance between principle and practice in these settings. To that end, this paper attends carefully to the real challenges of UHC implementation — particularly in resource-constrained settings — and draws on Islamic normative guidance to address questions of equitable resource allocation and fair remuneration for health workers.

2. Convergent Values: Islamic Moral Imperatives and UHC

Islamic ethics offers a sophisticated and comprehensive framework for thinking about health, justice, and the obligations of the political community. At its core, Islamic moral philosophy holds that human life is sacred (*hurmat al-nafs*) and that its preservation is one of the five essential interests (al-daruriyyat al-khams) identified by classical Islamic jurisprudence as the objectives of the *Shari'a* (*maqasid al-Shari'a*) [14]. The Qur'an repeatedly commands the protection of human life. The verse "*Whosoever saves a life, it is as though he has saved all of mankind"* (Al-Ma'idah 5:32) is perhaps the most frequently cited expression of this imperative, but the obligation runs deeper and wider. The remaining four objectives of the *Shari'ah*, which are the preservation of religion (*hifz al-din*), intellect (*hifz al-'aql*), lineage (*hifz al-nasl*), and property (*hifz al-mal*), though not concerned with health directly, are nonetheless intimately connected to it: the capacity to fulfil one's religious, intellectual, familial, and economic duties depends substantially on physical and mental wellbeing[15].

These imperatives are not, however, assigned solely to the individual. Islamic ethics distinguishes between obligations incumbent upon every Muslim (*fard al-'ayn*) and

obligations of collective sufficiency (*fard al-kifaya*) — duties that, when fulfilled by a sufficient number of members of the community, are discharged on behalf of all. The provision of healthcare falls within this latter category. This principle finds further grounding in the Qur'anic concept of *khilafa* — the notion that human beings are stewards of the earth and its resources, charged with governing them in ways that sustain and protect life. Taken together, fard al-kifaya and khilafa furnish a strong Islamic justification for collective, state-level responsibility for health provision.

The principle of collective sufficiency is particularly significant for UHC. It establishes that the community as a whole, and the political authority acting on its behalf, bears responsibility for ensuring that health services are available to all who need them [16]. This is functionally analogous to the solidarity dimension of UHC: the burden of providing healthcare is shared across the community rather than left to individuals to bear alone. Several further Islamic principles reinforce and extend this convergence, as discussed below.

2.1. Equity

The Qur'anic injunction on justice (*al-'adl*) and its corollary, equity, is foundational to the Islamic case for UHC.

"Indeed, God commands you to render trusts to whom they are due and when you judge between people, to judge with justice" (An-Nisa' 4:58).

Justice in the Islamic tradition is not mere formal equality, i.e., treating all persons identically. Justice also includes proportional fairness: giving each person what is due to them according to their circumstances and needs. This substantive conception of justice maps closely onto the equity dimension of UHC, which requires that health resources be allocated according to need, with greater investment directed toward those who are most disadvantaged.

Equity, particularly for marginalised populations, is an Islamic obligation, not merely a policy aspiration. The Qur'an repeatedly identifies the faqir (the poor), the miskin (the destitute), the ibn al-sabil (the wayfarer in need), and the orphan as those who hold special claims on communal resources. This is institutionalised most explicitly through zakat, which is designated for eight categories of recipients, several of whom correspond to what we would today recognise as marginalised and vulnerable groups[17]. The categorical structure of zakat may thus serve as a normative benchmark for how UHC frameworks prioritise resource allocation and target the most vulnerable.

The principle of equity in geographic access, which is extending health services to rural, remote, and underserved areas, is fully consistent with Islamic norms. The political authority bears an obligation to provide for the welfare of all subjects, not merely those living in urban centres. This is reflected in Ibn Khaldun's concept of 'umran (civilisation or social flourishing), which implies a concern for the wellbeing of all communities under political authority, not only those concentrated in capital cities [18]. The concentration of health resources in urban areas at the expense of rural and remote populations therefore constitutes a violation of the Islamic principle of justice, and must be actively corrected through health policy.

2.2. Financial protection

The prohibition of harm — la darar wa la dirar ("no harm shall be inflicted or reciprocated") — is a foundational maxim of Islamic jurisprudence, derived from a well-known Prophetic tradition. In UHC and health financing, it establishes that no person should be made to bear a burden exceeding their financial capacity. This is a norm that

maps directly onto the UHC objectives of financial protection and the prevention of catastrophic health expenditure [19]. This principle has concrete implications for health financing governance: systems that compel the sick and the poor to choose between seeking care and meeting other basic necessities inflict precisely the kind of harm that Islamic jurisprudence prohibits. Catastrophic out-of-pocket health expenditure, the primary mechanism by which health systems impoverish the poor, stands in direct tension with this maxim and must be treated as a moral, not merely a technical, problem.

2.3. Solidarity

Islam promotes the concept of takaful (mutual guarantee or solidarity), which is central to Islamic social ethics, as the Prophet (peace be upon him) described the believers as 'like one body: when any part of it suffers, the rest of the body responds with sleeplessness and fever'. The takaful concept -has a close institutional parallel in the principle of social solidarity that underpins UHC. The logic of collective response to individual suffering is precisely what animates the solidarity dimension of UHC: no person should be left to bear the burden of illness alone. Islamic financial instruments give concrete form to this solidarity: zakat (obligatory almsgiving), sadaqa (voluntary charity), waqf (endowment), and takaful (mutual insurance) together constitute a distinctive Islamic architecture for social protection with direct relevance to health financing [17].

2.4. Resource Allocation

A central challenge in governing any health system is the allocation of scarce resources — human, financial, and technological — in ways that are both effective and equitable. This is among the most contested issues in health policy. Standard normative frameworks draw on utilitarian (maximise aggregate health gain), egalitarian (prioritise the worst-off), and contractarian (what principles would rational agents choose behind a veil of ignorance) approaches. Islamic ethics does not offer a single algorithmic answer, but it provides a set of normative commitments that can meaningfully guide allocation decisions.

The maqasid al-Shari'ah framework, i.e., the objectives of Islamic law, offers a hierarchical structure for thinking about health priorities. Within this framework, the preservation of life is the paramount objective[15], such that interventions preventing death or severe disability take precedence over those addressing lesser health needs. This aligns with the principle of prioritising essential services in UHC benefit packages, and is consistent in practice with the use of health technology assessment to rank interventions systematically [20]. It accounts not only for mortality outcomes, but also for quality-adjusted and disability-adjusted life years [21].

These priorities resonate with the principle of 'awlawiyya (priority-setting), which is well developed in Islamic jurisprudence and has been applied to resource allocation questions by contemporary Muslim scholars[22]. Needs-based priority is the default position: resources should flow to where need is greatest. This aligns directly with the progressive universalism approach advocated by health economists, which holds that UHC expansion should prioritise the poorest and most vulnerable, ensuring they benefit at least as much as, if not more than, better-off groups.

2.5. Fair Remuneration for Health Workers

One of the most critical yet most neglected dimensions of UHC implementation is the fair treatment of health workers. The global

health workforce crisis, which is characterised by shortfalls, maldistribution, migration, and poor working conditions, is in significant measure a consequence of health systems' failure to remunerate workers adequately and equitably[23]. From an Islamic perspective, this failure is not merely a management problem; it is a moral wrong. Both the Qur'an and the Prophetic tradition are explicit that workers must be paid their due promptly and in full. Applied to health workers, these norms require that governments and health system managers ensure that salaries are commensurate with the skill, effort, and responsibility involved, and that payment is made reliably and on time.

The concept of ujrah (fair wage) in Islamic jurisprudence is determined by reference to the prevailing customary rate for work of comparable skill and effort ('urf), adjusted for the specific conditions of the contract [24]. While this does not resolve the complex empirical questions about what a fair wage for health workers should be in any given context, it establishes a clear normative baseline: health workers are entitled to remuneration that reflects the value of their work and enables them to meet their own and their families' needs with dignity. Paying health workers poverty wages — as is common in many low- and middle-income countries, particularly for community health workers and nurses — violates this standard.

Fair remuneration is also instrumentally important for UHC. Inadequate and inequitable pay contributes to absenteeism, low morale, the informal charging of patients, and the migration of skilled workers to higher-paying environments — all of which undermine health system performance and impede UHC progress. From both an ethical and a pragmatic perspective, investing in a fairly compensated and well-motivated health workforce is inseparable from the UHC agenda. Muslim-majority countries that aspire to realise UHC as an Islamic obligation must therefore treat health workforce remuneration as a matter of both justice and practical necessity.

Beyond salaries, the Islamic concept of ihsan — excellence, or doing more than the minimum required — encourages a culture of genuine care and professional dedication. Health workers who understand their vocation as an act of worship (ibada) and social service are motivated by intrinsic as well as extrinsic factors. Cultivating this sense of vocation, alongside ensuring adequate material compensation, may offer a distinctive approach to health workforce motivation that resonates particularly within Islamic cultural contexts.

3. Divergent realities: Implementation gaps in Muslim-majority countries

Despite broad political endorsement, the path from commitment to implementation remains strewn with formidable obstacles. WHO and World Bank tracking of UHC progress reveals stark disparities between high-income and low-income countries[11]. Most wealthy nations have achieved near-universal coverage of essential health services, while many LMICs, including numerous Muslim-majority countries in sub-Saharan Africa, South Asia, and the Middle East, lag significantly behind.

Based on the 2025 WHO report on UHC tracking, Muslim-majority countries (here defined as countries where Muslims constitute more than 50% of the total population) continue to struggle in achieving UHC. On SDG indicator 3.8.1 (Service Coverage Index), Muslim-majority countries in the Gulf states and Central Asian republics tend to perform best: Kazakhstan (83), Saudi Arabia (83), and UAE, Kuwait, Qatar, and Brunei (84), while Sub-Saharan African countries record the lowest scores, with Chad (26) and Somalia (30) at the bottom. On SDG

indicator 3.8.2 (Financial Hardship), many Muslim-majority countries in South Asia and sub-Saharan Africa face severe out-of-pocket health expenditure burdens, with Nigeria (47.4%), Sierra Leone (47.9%), and Bangladesh (41.7%) among the highest.

These findings reveal a significant discrepancy between the principles of equity and solidarity that Islamic values espouse and the health coverage outcomes reflected in these indicators. Several structural challenges help explain this gap.

3.1. Chronically Inadequate Health Financing

The first and most fundamental challenge is that health financing remains chronically inadequate in many Muslim-majority LMICs. The WHO has estimated that achieving a basic package of essential health services requires health expenditure of at least USD 86 per person per year [25], yet many low-income countries spend only a fraction of this amount. Most sub-Saharan African nations, which are home to several of the world's largest Muslim-majority populations, allocate fewer than USD 75 per capita in domestic government health expenditure [26]. Similarly, populous Muslim-majority countries in South Asia, including Pakistan and Bangladesh, rank among the lowest globally in per capita government health spending. These figures stand in sharp contrast to a global average exceeding USD 860 per capita, and to the USD 3,700 and USD 5,500 spent per capita in Australia and the United States, respectively. While the COVID-19 pandemic prompted a temporary surge in health expenditure across many LMICs, this increase was largely reactive and crisis-driven rather than reflective of sustained systemic commitment[27, 28].

Domestic resource mobilisation is further constrained by narrow tax bases, large informal economies, political commitment, and competing fiscal priorities[29]. External aid, while important, is volatile and frequently misaligned with country-defined health priorities. Out-of-pocket payments — the most inequitable and financially hazardous form of health financing — remain the dominant source of health expenditure in many low-income settings, accounting for more than 40% of total health spending in some countries. For Muslim-majority LMICs, the structural challenge is therefore twofold: how to secure adequate and growing health financing, and how to ensure that available resources are allocated efficiently across infrastructure, supply chains, and the policy frameworks needed to build genuinely resilient health systems.

A related distortion arises when countries conflate financial risk protection with the expansion of health insurance, treating the latter as a proxy for UHC itself. Indonesia, for example, channels approximately 30.9% of national health expenditure through its public insurance scheme [30]. While public health insurance is an important instrument, it captures only a portion of total health expenditure, and evidence suggests that covered spending flows disproportionately toward curative inpatient and outpatient care, without simultaneously and adequately strengthening primary health care systems.

3.2. Weak Primary Health Care Systems

The second major structural challenge is the systematic underinvestment in primary health care (PHC). PHC is widely recognised as the foundation of UHC: it accounts for more than 75% of the projected health gains associated with achieving the SDGs, and underpins more than 90% of health services under a comprehensive UHC framework[31]. Yet despite its centrality, PHC systems remain weak and chronically under-prioritised in many Muslim-majority LMICs. The COVID-19 pandemic exposed this vulnerability with particular starkness. Countries with underprepared PHC systems

experienced acute supply shortages, overwhelmed facilities, and disproportionately high mortality rates [32]. Strengthening PHC is therefore not optional but foundational, and must address a cluster of interrelated deficits: a critical shortfall in health workers, infrastructural inadequacies, insufficient diagnostic capacity, the asymmetric geographic distribution of health facilities, and chronic underfinancing[32, 33].

3.3. Health Workforce Shortages and Maldistribution

The third structural challenge is the health workforce crisis, which poses a fundamental constraint on UHC achievement. The global deficit of health workers is concentrated overwhelmingly in LMICs, and Muslim-majority countries in sub-Saharan Africa and South Asia are among the most severely affected[34]. Compounding the absolute shortage is the persistent maldistribution of available workers: inequities between urban and rural areas, public and private sectors, and curative and preventive services mean that the populations most in need are precisely those least likely to access skilled care[23].

These disparities are further deepened by the compounding barriers faced by marginalised groups. Ethnic and religious minorities, persons with disabilities, migrants and refugees, and indigenous communities often encounter overlapping obstacles to health access — geographic remoteness, language and cultural distance from health systems, discrimination, poverty, and social exclusion. Women, in many cultural contexts, face additional barriers including restrictions on mobility and limited autonomous decision-making over health-seeking behaviour. People living in rural and remote areas typically encounter longer distances to care, fewer providers, and lower-quality services than their urban counterparts. These inequities are not merely technical problems amenable to logistical solutions; they reflect deeper patterns of power and social organisation that health systems both mirror and reproduce — patterns that stand in direct tension with the Islamic principles of justice and equity elaborated in the previous section. This crisis is aggravated by chronically low and often inequitable remuneration. While Islamic values, as discussed above, mandate fair and timely payment for labour, the reality in many Muslim-majority LMICs falls far short of this standard. Inadequate pay undermines workforce morale and retention, and contributes directly to the phenomenon of brain drain: health workers trained at public expense migrate to wealthier countries offering better salaries and working conditions, depleting the very systems most in need of their skills [35].

3.4. Quality of Care

Even where coverage exists on paper, the quality of care is frequently substandard [36]. Access to a health facility that lacks essential medicines, trained staff, or functional equipment constitutes, in any meaningful sense, no access at all. The concept of "effective coverage" — the proportion of those who need a service and receive it at sufficient quality to achieve a genuine health benefit — is consistently and substantially lower than nominal coverage rates, particularly in low-resource settings. This gap between coverage on paper and effective coverage in practice is among the most consequential yet underacknowledged dimensions of the UHC implementation challenge. Addressing quality is therefore not a supplementary concern but an integral and indispensable component of the UHC agenda.

4. Islamic Framework for UHC Policy: what to do?

The foregoing analysis suggests that Islamic ethics does not merely endorse UHC from the outside; it provides an internal normative logic for its realisation. The principles elaborated in the preceding section constitute an Islamic case for UHC that is both philosophically coherent and practically actionable. Several policy implications follow for Muslim-majority countries.

4.1. Engaging Religious Authority in Health Policy

Political leaders and health policymakers should actively engage Islamic scholars (*ulama*) in the development and communication of UHC policy, drawing on the moral authority of religious discourse to build public support for health system reform. The conversation between policymakers and religious scholars need not be confined to questions of permissibility, for example controversial discourse in Indonesia of whether health insurance was halal or haram[37], though these remain important. More productively, it should focus on how Islamic values can be translated into concrete commitments: what obligations the state bears toward the sick and the poor, and what standards of justice and solidarity health systems must meet to be considered Islamically legitimate.

4.2. Mobilising Islamic Social Finance for Health

Islamic social finance instruments, e.g., zakat, sadaqa, waqf, and takaful, need to be considered to be systematically integrated into national health financing strategies, with appropriate governance frameworks to ensure accountability and efficiency. This integration raises several important design questions: who should be covered and prioritised for assistance; what constitutes a fair contributory share; and whether these instruments can be consolidated into a unified pooling mechanism targeting the poor and near-poor (fuqara and masakin). A mixed public-private financing architecture, anchored in these Islamic instruments alongside domestic government revenue, offers a promising model for expanding fiscal space for health in resource-constrained settings.

4.3. Prioritising the Most Marginalised

UHC expansion should be explicitly directed toward the most marginalised populations, in direct accordance with the Qur'anic emphasis on the faqir, the miskin, and other vulnerable groups, including those living in remote and undeserved areas. This requires targeted investment in underserved geographic areas, particularly rural and remote communities, where health infrastructure, workforce presence, and service quality are most deficient. Reaching these populations is not merely a logistical aspiration; from an Islamic perspective, it is a moral obligation.

4.4. Fair Remuneration as a Matter of Justice

Investment in a fairly remunerated and well-motivated health workforce must be recognised as a matter of Islamic justice, not merely of administrative efficiency. This requires action across several dimensions simultaneously: expanding domestic revenue and health financing pools, ensuring the sustained availability and predictable disbursement of funds, and establishing transparent payment governance systems. These are not peripheral concerns; they are preconditions for a functional and equitable health system, and their neglect constitutes, in Islamic terms, a failure of the duty of ujrah.

4.5. Primary Health Care as the Priority Investment

Consistent with both the maqasid al-Shari'a framework and the evidence base in health economics, the strengthening of primary health care should be treated as the highest-priority investment in UHC expansion. PHC delivers the greatest health gains per unit of resource, reaches the broadest and most underserved populations, and provides the platform on which all other health system functions depend. Systematic efforts to address PHC deficits — in workforce, infrastructure, diagnostics, financing, and governance — are therefore both an Islamic imperative and a pragmatic necessity.

It is important to acknowledge the limits of this analysis. The diversity of Islamic jurisprudential traditions (madhabs) and the plurality of scholarly opinion on many relevant questions means that there is no single, uncontested Islamic position on the specifics of UHC policy. Different scholars and communities may reach different conclusions about the appropriate mix of public and private financing, the role of insurance versus direct provision, or the permissibility of specific health interventions. The goal of this paper is not to resolve these debates, but to establish the broad normative foundation on which they can productively proceed. This highlights a foundation that affirms the Islamic moral imperative for UHC while respecting the diversity of legitimate opinion on its implementation.

Conclusion

Universal Health Coverage, understood as the aspiration that all people receive the health services they need without financial hardship, is consonant in its deepest principles with the moral vision of Islam. However, the journey from moral aspiration to policy reality is long and difficult. Resource constraints, health workforce shortfalls, and structural inequities present formidable challenges to UHC implementation, particularly in the Muslim-majority LMICs where the gap between need and access is greatest. Islamic normative guidance does not dissolve these challenges, but it provides ethical direction: allocate resources according to need, prioritise the most vulnerable, pool financial risk through solidarity mechanisms, and pay health workers justly. These are not merely policy recommendations; they are moral imperatives rooted in the Qur'an, the Sunnah, and centuries of Islamic jurisprudential wisdom. Much further research is needed to explore how Islamic ethics can be operationalised in health systems and how the authority of Islamic scholarship can be mobilised in support of UHC advocacy in Muslim-majority societies.

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UNIVERSAL HEALTH COVERAGE AS AN ISLAMIC MORAL IMPERATIVE: *ZAKAT*, *WAQF*, AND THE ETHICAL ARCHITECTURE OF EQUITABLE HEALTHCARE

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Abstract

Universal Health Coverage (UHC) mandates access to essential health services without inducing financial hardship. Although global health institutions widely promote UHC (1, 15, 21), the prevailing justifications predominantly rely upon secular human rights frameworks and utilitarian economic arguments (13, 14). This paper argues that UHC is robustly embedded within Islamic moral and legal thought. Drawing upon the doctrine of *maqāsid al-sharī`ah* (the higher objectives of Islamic law), specifically the preservation of life (*hifz al-nafs*), this study demonstrates that providing equitable healthcare constitutes a collective religious obligation (*fard kifāyah*). The *Qur'ān* establishes a universal moral standard, declaring that saving one life is equivalent to saving all of humanity (*Qur'ān, al-Mā'idah,* 5:32) (7). Furthermore, historical precedent indicates that institutions such as *zakāt* (obligatory alms) and *waqf* (charitable endowments) effectively operationalised distributive justice and funded sustainable healthcare provision (9–12, 19). By comparing the Islamic approach to UHC with secular welfare models (13–15, 20), this paper highlights convergences in practical health outcomes while delineating fundamental divergences in moral reasoning, financing mechanisms, and the conceptualisation of rights versus duties. Ultimately, advocating for UHC in Muslim-majority regions represents a revival of indigenous ethical systems rather than the adoption of external paradigms.

Keywords: Universal Health Coverage, UHC, Islamic Bioethics, *Maqāsid al-Shari'ah*, *Zakat*, *Waqf,* Health Equity, Islamic Social Finance, Global Health.

Introduction

Universal Health Coverage (UHC) is a defining objective of contemporary global health policy. Championed by the World Health Organization (WHO) and codified within the United Nations Sustainable Development Goals (SDG 3.8) (1, 2), the fundamental premise is clear: all individuals must receive requisite health services without incurring catastrophic financial ruin (1, 21).

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International organisations typically validate UHC using secular frameworks, invoking social contract theory, universal human rights, and the macroeconomic benefits of a productive workforce (13–15). However, translating global targets into national realities requires frameworks that possess local cultural legitimacy. In Muslim-majority societies, secular utilitarian arguments often fail to generate the societal consensus necessary for systemic health reform.

This article situates UHC within Islamic theological, jurisprudential, and economic traditions. It posits that healthcare equity is not merely a secular policy preference, but a strict moral and legal imperative grounded in Islamic conceptions of justice, human dignity, and communal accountability. By synthesising classical legal theory with the mechanisms of Islamic social finance, this paper presents an ethical architecture for implementing and sustaining UHC.

Literature Review and Conceptual Framework

Modern arguments for UHC consistently rely on the philosophy of distributive justice (1, 2). Political theorists such as John Rawls contend that justice demands fair equality of opportunity, a standard that inherently requires accessible healthcare to enable civic participation (14). Concurrently, Amartya Sen conceptualises health not merely as the absence of disease, but as a foundational capability critical for human freedom and socioeconomic agency (13).

Institutions such as the World Bank underscore the pragmatic benefits of UHC, noting its capacity to mitigate poverty and stabilise economies (15, 20). While these arguments are logically sound, they remain anthropocentric; they are predicated on negotiated social contracts and state authority. In paradigms where moral duties are inextricably linked to divine revelation, these secular rationales may lack the transcendent authority required to mobilise institutional change.

Islamic jurisprudence provides an alternative, duty-based framework for public welfare. Classical scholars, notably Al-Ghazali, identified the preservation of life (*hifz al-nafs*) as a primary, indispensable objective of Islamic law (*maqāsid al-sharī`ah*) (3). Al-Shatibi subsequently expanded this doctrine, asserting that all legal rulings must inherently promote public welfare (*maṣlahah*) and prevent harm (4).

Contemporary scholars employ this framework to navigate modern policy challenges (5, 6). Within this paradigm, health is not a market commodity; it is a prerequisite for fulfilling one's obligations to society and the Creator. The Qur'an issues binding commands for justice and equity (Qur’an 16:90) and categorises human life as a sacred trust (*amānah*) (*Qur’ān*, *al-Baqarah*, 2:195) (7). Modern Islamic bioethics scholars assert that establishing universal healthcare is the direct operationalisation of *maqāsid*, serving to protect human dignity and dismantle structural inequalities (16, 17, 22).

Islamic Social Finance: *Zakāt* and *Waqf*

The Islamic tradition encompasses the structural financial mechanisms required to sustain UHC. The *Qur'ān* explicitly designates the poor and vulnerable as the rightful recipients of *zakāt* (an obligatory wealth tax) (*Qur’ān, al-Tawbah*, 9:60) (7). Economists highlight that *zakat* functions to prevent the monopolisation of wealth and guarantee necessities (9, 10). Because *zakat* is classified as an act of worship, wealth redistribution is framed as a moral obligation rather than discretionary philanthropy, thereby protecting the dignity of the recipient (18).

Historically, the institution of *waqf* (irrevocable charitable endowments) was the primary mechanism for financing hospitals (*bimaristans*) throughout the

Islamic world (11, 12). Historical records indicate these medieval institutions provided comprehensive medical care, pharmaceuticals, and convalescence stipends without charge, independent of the patient's socioeconomic status or religious affiliation (11, 12). Recent institutional analyses suggest that modernising the *waqf* system offers a potent mechanism to finance contemporary public health infrastructure (19, 25). These historical models demonstrate that Islamic civilisations successfully operationalised universal healthcare long before the advent of the European welfare state.

Theological Foundations of Islamic UHC

The rationale for UHC within Islamic jurisprudence is anchored in the sanctity of human life. The *Qur'ā*n declares: "*Whoever saves one life, it is as if he saved all humanity*" (*Qur'ān*, *al-Mā'idah,* 5:32) (7). This establishes an absolute moral equivalence regarding the preservation of life.

The traditions of the Prophet Muhammad ﷺ (*Ḥadīth*) reinforce the obligation of medical intervention. He instructed his followers to pursue medical care, stating: "Seek treatment, for Allah has not created a disease without appointing for it a remedy" (8, 23).

Within Islamic law, providing healthcare transcends individual discretion. Classical jurists classify the provision of medical infrastructure and the training of medical personnel as a collective societal obligation (*fard kifāyah*). Should a community fail to ensure adequate healthcare access, the moral and spiritual liability extends to the entire society and its governing authorities.

Consequently, establishing a UHC system is a binding governance duty, rather than a secondary charitable endeavour.

Discussion: Comparing Islamic and Secular Models

While both Islamic and secular welfare paradigms aim to mitigate human suffering and expand health access, they operate on fundamentally distinct philosophical foundations, structural principles, and enforcement mechanisms.

1. Normative Foundations

Secular UHC derives its mandate from constitutional law, democratic consensus, and the Rawlsian social contract (14, 15). Justice is thus a negotiated societal agreement. Conversely, Islamic UHC derives its legitimacy from a divine covenant. The mandate to preserve life and ensure equity is an *a priori* command from God, operating independently of shifting political consensuses or demographic majorities (3–6).

2. Rights and Duties

Secular human rights models place primacy on the citizen's *entitlement* to healthcare. The Islamic framework approaches this dynamic through the lens of *obligation*. Healthcare for the vulnerable is conceptualised as a divinely mandated right (*haqq*) embedded within the community's wealth (Qur'an 9:60) (7). This significantly alters the power dynamic: when the wealthy or the state provide healthcare via *zakāt*, they are not acting as benevolent benefactors dispensing charity. Rather, they are merely discharging a strict religious duty and returning resources that rightfully belong to the marginalised (9, 10). This removes the stigma of state dependency often associated with secular welfare systems.

3. Financing Mechanisms and Economic Resilience

Modern secular systems typically fund UHC through general taxation, payroll

deductions, and risk-pooling insurance models (15, 20). These systems are highly vulnerable to demographic shifts (such as aging populations), market failures, and the erosion of the tax base. An Islamic health system can integrate these modern tools but mitigate their vulnerabilities by expanding the fiscal base through indigenous social finance:

- ***Zakāt* Redistribution:** Operating as a wealth tax rather than an income tax, *zakat* provides counter-cyclical economic stabilisation. It legally ring-fences funds specifically for the most vulnerable, ensuring that healthcare subsidies for the poor are not compromised during state budget deficits (9, 24).
- ***Waqf* Sustainability:** *Waqf* facilitates intergenerational asset accumulation. By using charitable endowments to construct hospitals, fund medical research, and procure equipment, the capital expenditure burden on the state treasury is permanently reduced. These assets operate outside standard fiscal constraints and remain insulated from political cycles (11, 19).
- **Public Treasury (*Bayt al-Māl*):** Standard state funding derived from general revenues to cover administrative and systemic costs.
- **Risk-Sharing (*Takāful*):** Cooperative insurance models predicated on mutual assistance and shared responsibility, explicitly rejecting the commercial exploitation of health risks.

While both systems seek financial risk protection, Islamic financing uniquely fuses macroeconomic policy with spiritual devotion, creating a hybrid model less susceptible to the standard failures of purely tax-based systems.

4. Moral Motivation and Enforcement

Secular welfare systems rely on national identity and the concept of shared citizenship to motivate solidarity (14). This solidarity is inherently restricted by geographic borders and can be undermined by political polarisation. Islamic solidarity (*takaful*) is transnational, motivated by shared faith, human brotherhood, and the profound awareness of accountability in the Hereafter (*akhirah*) (3, 4, 23). This theological accountability serves as an internal enforcement mechanism, mitigating the "free-rider" problems and tax evasion that frequently undermine secular welfare funding. Furthermore, recognising that Islamic civilisations pioneered free, state-of-the-art public hospitals (*bimaristans*) between the 8th and 12th centuries allows modern policymakers to frame UHC as the reclamation of Islamic heritage, overcoming ideological resistance to perceived Western policy imports (11, 12).

Policy Implications

Policymakers in Muslim-majority countries—particularly in resource-constrained contexts such as the Eastern Mediterranean (26)—must align global UHC targets with local normative values. An Islamic UHC framework can achieve this alignment through concrete institutional integration:

- Managing national health insurance systems via cooperative *Takāful* models rather than commercial insurers.
- Legally ring-fencing state-collected *Zakāt* funds to directly subsidise healthcare premiums and out-of-pocket costs for impoverished demographics.
- Structuring *Waqf* investments into modern financial instruments, such as health bonds (*sukuk*), to generate capital for hospital infrastructure and advanced medical technology.
- Establishing formal regulatory collaboration between ministries of health, ministries of finance, and

ministries of religious endowments (*Awqāf*).

This synthesis satisfies the pragmatic objectives of the United Nations (1, 2) while maintaining strict fidelity to the ethical parameters of Islamic jurisprudence.

Conclusion

Analysed through the prism of Islamic ethics, Universal Health Coverage is an unequivocal religious imperative. It is compelled by the jurisprudential requirement to preserve life (*Maqāsid al-sharīi'ah*), mandated by Qur'anic instruction, guided by Prophetic tradition, and practically sustained by historical economic models including *Zakāt* and *waqf* (3–12, 19).

While the Islamic approach shares the practical public health objectives of secular welfare models (13–15, 20), it provides a fundamentally distinct, duty-based foundation. By systematically embedding Islamic social finance into modern health policies, Muslim-majority nations can construct healthcare systems that are economically resilient and culturally legitimate. Framing UHC as an Islamic moral duty supplies the cultural traction required to transform health equity from a global aspiration into a national reality.

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REPRODUCTIVE HEALTH AND FAMILY PLANNING IN MUSLIM CONTEXTS: INTEGRATING FIQH RULINGS, AUTONOMY, AND PUBLIC HEALTH NEEDS

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Abstract

Reproductive health and family planning constitute fundamental pillars of individual well-being and public health, particularly in Muslim-majority societies where healthcare decision-making intersects with Islamic jurisprudence (*fiqh*), personal autonomy, and population health priorities. In the contemporary digital era, unprecedented access to information has expanded individual choice while simultaneously exposing communities to fragmented and misleading narratives concerning contraception, abortion, infertility treatment, and harmful traditional practices. These challenges are intensified in emergency settings—including natural disasters, armed conflict, and public health crises such as the COVID-19 pandemic—where health systems experience significant disruption. Evidence from crisis contexts underscores the critical role of religious leaders and faith-based actors in shaping community trust, health behaviors, and service uptake. This chapter examines key reproductive health issues through the integrated lenses of *fiqh* rulings, individual autonomy, and public health imperatives, advocating for context-sensitive and ethically grounded approaches to strengthen reproductive health policies and services in both stable and crisis-affected Muslim societies.

Keywords: Reproductive health; Family planning; *Fiqh* rulings; Autonomy; Public health needs

1. Introduction

Reproductive health and family planning are critical determinants of individual well-being and public health. The World Health Organization (WHO) defines reproductive health as a state of complete physical, mental, and social well-being in all matters relating to the reproductive system, emphasizing its central role in achieving public health goals. The WHO further identifies family planning as a key component of reproductive health, enabling informed decisions regarding the timing and spacing of births in ways that support maternal, child, and population health [1].

In Muslim contexts, reproductive health decisions are shaped not only by medical considerations but also by religious norms, ethical values, and jurisprudential interpretations. Islamic jurisprudence (*fiqh*) has long addressed matters such as birth spacing, maternal care, and marital responsibility, drawing upon the Qur'an, Sunnah, and juristic reasoning [3-5]. The objectives of Islamic law (*maqāṣid al-sharīʿah*), particularly the preservation of life (*ḥifẓ al-nafs*) and lineage (*ḥifẓ al-nasl*), provide a foundational ethical framework for engaging with contemporary reproductive health challenges [3,4].

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The Qur'an affirms the value of family and progeny as part of divine provision: *"And Allah has made for yourselves spouses and made for you from your spouses, children and grandchildren"* (Qur'an, An-Nahl 16:72) [7]. Prophetic traditions acknowledge practices such as ʿazl (coitus interruptus), indicating early recognition of birth spacing within ethical limits [8].

In the digital era, reproductive decision-making is increasingly influenced by easy access to online information. While digital platforms may enhance health awareness and autonomy, they also expose individuals to misinformation (hoax) and value-conflicting guidance. This context underscores the need for balanced and trustworthy information grounded in both *fiqh* rulings and scientific evidence to support informed and responsible reproductive choices [12].

At the population level, many Muslim-majority countries continue to face pressing public health challenges, including unmet need for family planning, unsafe abortion, infertility, and demographic pressures [1,2]. Recent developments illustrate these tensions: procedural changes affecting access to legal abortion for rape survivors in Indonesia have raised concerns about delays in care and increased risk of unsafe abortion [9]; global stagnation in maternal mortality reduction has been linked to health system constraints and reduced financing [10,11]; and pronatalist policy shifts in countries such as Iran have renewed debates on reproductive rights and state intervention [13]. These examples highlight how reproductive health remains a contested domain where religious guidance, legal frameworks, and public health needs intersect.

These challenges are further intensified in emergency settings. Disruptions associated with disasters and crisis situations have highlighted how breaks in health service delivery and ethical guidance can increase reproductive health risks. In such contexts, religious leaders and Islamic faith-based organizations frequently act as trusted social actors, mediating health information and shaping community responses where institutional communication is limited [14,15].

Based on this background, this chapter discusses key domains of reproductive health and family planning—contraception, abortion, female genital mutilation/cutting (FGM/C), assisted reproductive technologies (ART), maternal health, and population policies—through the lenses of *fiqh* rulings, autonomy, and public health needs. The chapter begins by delineating the Islamic ethical foundations and *fiqh* rulings that govern reproductive health, which serve as the analytical basis for the subsequent discussion of specific reproductive health domains.

2. Islamic Ethical and *Fiqh* Frameworks on Reproductive Health

Islamic perspectives on reproductive health are grounded in a comprehensive ethical system that integrates divine revelation, human reasoning, and social responsibility. Within this framework, reproductive health is not treated solely as a private medical matter but as an area where individual well-being, family stability, and societal interests intersect. Islamic jurisprudence (*fiqh*) provides normative guidance for reproductive decision-making through interpretation of the Qur'an, Sunnah, scholarly consensus (*ijmāʿ*), and analogical reasoning (*qiyās*), while remaining responsive to changing contexts through ijtihād [3-5]. For example, classical jurists reached consensus (*ijmāʿ*) on the permissibility of *ʿazl* (coitus interruptus), as

the practice was reported among the Companions without prohibition from the Prophet ﷺ, thereby establishing an early Islamic precedent for birth spacing within ethical limits [8,14]. Practices of ʿazl were reported from the Prophet ﷺ:

كُنَّا نَعْزِلُ عَلَى عَهْدِ رَسُولِ اللَّهِ ﷺ وَالْقُرْآنُ يَنْزِلُ

"We practiced 'azl during the time of the Messenger of Allah ﷺ while the Qur'an was being revealed." (Sahih al-Bukhari, Kitab al-Nikah)

Building on this consensus, jurists have employed analogical reasoning (*qiyās*) to extend the ruling of ʿazl to temporary modern contraceptive methods, based on a shared effective cause (ʿ*illah*): preventing conception without causing permanent harm to reproductive capacity. Through this reasoning, reversible contraceptive methods are generally regarded as permissible, while permanent sterilization remains restricted except in cases of clear medical necessity [5,15].

Central to Islamic ethics is the concept of *maqāṣid al-sharīʿah*—the higher objectives of Islamic law—which aims to promote benefit (*maṣlaḥah*) and prevent harm (*mafsadah*). Classical scholars identified the preservation of life (*ḥifẓ al-nafs*) and lineage (ḥifẓ al-nasl) as core objectives directly relevant to reproductive health [3,4]. These principles establish ethical priorities such as safeguarding maternal life, ensuring the well-being of offspring, and maintaining the integrity of family lineage, which inform juristic deliberations on contraception, abortion, infertility treatment, and maternal care. For example, the principle of *ḥifẓ al-nafs* underpins the permissibility of life-saving medical interventions during pregnancy, while *ḥifẓ al-nasl* informs juristic positions on birth spacing and assisted reproductive technologies. In situations of disaster, conflict, or public health emergencies, these *maqāṣid*-based principles provide ethical flexibility to prioritize urgent health needs while remaining anchored in Islamic moral objectives.

Ethical reasoning in Islamic reproductive health further balances individual autonomy with moral responsibility. Islam recognizes human agency and decision-making capacity, yet frames autonomy within accountability to God and responsibility toward one's spouse, offspring, and the wider community. This balance is reflected in the Prophetic principle that harm should neither be inflicted nor reciprocated (*lā ḍarar wa lā ḍirār*), which serves as an ethical anchor in reproductive decision-making, particularly when medical interventions are considered to prevent serious harm [18]. By analogy (*qiyās*) with this principle and the objective of preserving life (*ḥifẓ al-nafs*), jurists have also permitted limited medical interventions during pregnancy, including therapeutic abortion where continuation of pregnancy poses a serious threat to the mother's life [5,16].

In contemporary settings, Islamic ethical principles are increasingly operationalized through faith-based medical and health organizations that integrate religious values with health service delivery and advocacy. In Indonesia, Muhammadiyah and its women's organization 'Aisyiyah operate extensive networks of hospitals, clinics, and community health programs, including maternal and family health services, reflecting an Islamic commitment to safeguarding life and family well-being [6,19,20]. At the global level, organizations such as the Federation of Islamic Medical Associations (FIMA) provide ethical guidance and professional platforms for Muslim health practitioners, demonstrating how *fiqh*-informed principles can be

translated into evidence-based public health practice [21].

Together, these ethical frameworks provide a coherent foundation for addressing contemporary reproductive health challenges in Muslim societies. They allow for principled engagement with medical innovation and public health needs while maintaining fidelity to Islamic moral values. The following sections apply these frameworks to specific domains of reproductive health and family planning.

3. Family Planning, Contraception, and Population Policies

Contraception and family planning occupy a central place in Islamic discussions on reproductive health as practical means to promote family well-being, maternal safety, and responsible parenthood. As discussed earlier, birth spacing has long been acknowledged as ethically permissible, serving as a reference point for contemporary deliberations on family planning methods [8,14]. Building on this foundation, juristic attention has shifted toward assessing modern contraceptive options in the context of their purposes, effects, and potential harms. The ethical basis for responsible parenthood is reflected in the Qur'anic emphasis on parental responsibility and child welfare:

لْيَخْشَ ٱلَّذِينَ لَوْ تَرَكُوا۟ مِنْ خَلْفِهِمْ ذُرِّيَّةً ضِعَٰفًا خَافُوا۟ عَلَيْهِمْ

"Let those fear [Allah] who, if they left behind weak offspring, would be worried about them." (Qur'an, An-Nisāʾ 4:9)

Using analogical reasoning (*qiyās*), most contemporary scholars regard temporary and reversible contraceptive methods—including oral contraceptives, intrauterine devices, and barrier methods—as permissible, provided they do not cause harm and are used for ethically legitimate purposes [5,15]. These methods share a common ethical rationale: preventing conception without permanently impairing reproductive capacity. Permanent contraceptive methods are addressed more restrictively and are therefore not discussed in detail here, except where clear medical necessity warrants consideration.

From a public health perspective, empirical evidence demonstrates that access to voluntary and informed family planning is associated with reductions in unintended pregnancies, safer birth spacing, and lower risks of maternal morbidity and mortality [28,29]. For example, evidence from Indonesia supports these associations through improved breastfeeding practices and the prevention of obstetric complications [22,25,27]. Similar findings have been reported in other Muslim-majority settings, where access to voluntary family planning has contributed to declines in maternal mortality and improved reproductive health outcomes [28,29].

At the population level, Islamic ethical guidance cautions against approaches that compromise human dignity or parental responsibility. The Qur'an explicitly rejects coercive practices driven by fear or economic pressure:

وَلَا تَقْتُلُوٓا۟ أَوْلَٰدَكُم مِّنْ إِمْلَٰقٍ نَّحْنُ نَرْزُقُكُمْ وَإِيَّاهُمْ

"Do not kill your children out of poverty; We provide for you and for them." (Qur'an, Al-Anʿām 6:151)

However, several challenges continue to limit the effectiveness of family planning programs in many Muslim-majority settings. These include persistent unmet need for contraception due to misinformation and sociocultural barriers, limited access to

youth-friendly and culturally sensitive services, and concerns among health providers regarding religious permissibility, which may hinder counselling and service provision [2,23,24]. Such challenges highlight the importance of aligning *fiqh*-informed guidance with accurate health information and health system strengthening.

Within this context, contraception and family planning represent an area where *fiqh* rulings, autonomy, and public health needs converge at both individual and population levels. When grounded in ethical reasoning and supported by empirical evidence, family planning practices—and the population policies that frame them—can play a critical role in promoting maternal well-being, child health, and responsible reproductive decision-making in Muslim societies.

4. Contested Reproductive Practices: Abortion, ART, and FGM/C

4.1 Abortion

Abortion is among the most ethically sensitive issues in Islamic ethics, as it directly engages with the sanctity of life and the obligation to prevent harm. The Qur'an emphasizes the inviolability of human life:

لَا تَقْتُلُوا النَّفْسَ الَّتِي حَرَّمَ اللَّهُ إِلَّا بِالْحَقِّ

"And do not take a life which Allah has made sacred, except in the course of justice" (Qur'an, Al-Isrāʾ 17:33) [36].

This principle forms the moral basis for the general prohibition of abortion, while allowing narrowly defined exceptions under conditions of necessity (*ḍarūrah*) within juristic deliberation.

Islamic juristic deliberations commonly distinguish abortion based on the stage of pregnancy, particularly in relation to *nafkh al-rūḥ* (ensoulment), widely understood to occur at 120 days of gestation. There is broad agreement that abortion after ensoulment is prohibited, except when continuation of pregnancy poses a serious and imminent threat to the mother's life. Prior to ensoulment, juristic opinions are more diverse, resulting in nuanced *fiqh* rulings under restricted circumstances such as severe fetal anomalies incompatible with life, significant maternal health risks, or pregnancy resulting from rape [38-40]. These deliberations are closely linked to the Prophetic principle:

لَا ضَرَرَ وَلَا ضِرَارَ

"There should be neither harm nor reciprocating harm." (Hadith, Ibn Mājah) [18].

From a public health perspective, empirical evidence consistently shows that legal and procedural barriers delaying access to abortion care increase the risk of unsafe abortion, which remains a major contributor to preventable maternal morbidity and mortality [33-35]. Clinical uncertainty among healthcare providers is frequently driven by fear of legal consequences, particularly in settings where abortion regulations are ambiguous or inconsistently applied. Such concerns may lead providers to delay or withhold medically indicated care—even in life-threatening obstetric situations—in order to avoid legal liability [41]. In addition, misinterpretation or limited understanding of religious norms often reinforces the perception that all forms of abortion are categorically prohibited in Islam, despite the existence of juristic allowances under conditions of necessity. This gap between *fiqh* rulings and prevailing perceptions among providers and communities may further delay referrals and appropriate care [31,42].

Contemporary Islamic ethical discourse has therefore emphasized the principle of harm prevention (*dar al-mafsadah*) in abortion-related care. Scholars such as Ragab highlight the relevance of maqāṣid al-sharīʿah in integrating ethical norms with population health realities, particularly in preventing avoidable maternal harm [30]. Authoritative institutions, including Al-Azhar, affirm that while abortion is generally prohibited, narrowly defined exceptions may be considered under conditions of necessity to protect maternal life [31]. In Indonesia, Muhammadiyah's ethical guidance on medical decision-making similarly prioritizes the preservation of life and public health considerations [32].

Ethical engagement with abortion requires balancing firm moral boundaries with the obligation to prevent greater harm, integrating fiqh rulings, clinical evidence, and public health considerations to support humane and context-sensitive reproductive health policies in Muslim societies.

4.2 Female Genital Mutilation/Cutting (FGM/C)

Beyond abortion, female genital mutilation/cutting (FGM/C) represents another reproductive practice that has generated ethical contestation. While sometimes framed as a religious or cultural obligation, there is no explicit Qur'anic mandate supporting FGM/C. Islamic ethical reasoning increasingly recognizes that practices causing physical or psychological harm without medical benefit contradict the objectives of Islamic law, particularly harm prevention and the protection of human dignity. Evidence compiled by UNFPA and WHO consistently demonstrates the association between FGM/C and adverse reproductive, obstetric, and mental health outcomes [43-45].

In Indonesia, Muhammadiyah has explicitly rejected FGM/C by emphasizing the absence of religious obligation and the clear evidence of harm, aligning its position with Islamic ethical principles and public health evidence [32]. Similar positions have been articulated by Kongres Ulama Perempuan Indonesia/Indonesian Congress of Women 'Ulama (KUPI), which frames the abandonment of FGM/C as a religious and moral responsibility grounded in the protection of women's health and dignity. These faith-based positions resonate with global efforts led by UNFPA to eliminate FGM/C through community engagement, religious dialogue, and rights-based public health strategies [46,47].

4.3 Assisted Reproductive Technologies (ART)

Beyond abortion and other practices primarily associated with the prevention of harm, contemporary reproductive health debates in Muslim societies also extend to the use of advanced medical interventions to address infertility. Rapid advances in medical technology have brought assisted reproductive interventions into the centre of Islamic ethical and public health discussions [17,26,38].

Assisted Reproductive Technology (ART) constitutes a distinct yet ethically contested reproductive practice, particularly in addressing infertility while safeguarding lineage (ḥifẓ al-nasl) and human dignity. The Qur'an affirms that procreation ultimately occurs by divine will, while allowing human effort within lawful means:

لِلَّهِ مُلْكُ السَّمَاوَاتِ وَالْأَرْضِ ۚ يَخْلُقُ مَا يَشَاءُ

"To Allah belongs the dominion of the heavens and the earth. He creates what He wills." (Qur'an, Ash-Shūrā 42:49)

Based on Islamic juristic reasoning, infertility treatment—such as in vitro fertilization (IVF)—is generally permitted only within a valid marriage and using the couple's own gametes, while third-party involvement (donor sperm, donor eggs, or surrogacy) is prohibited due to the risk of lineage confusion and social harm [5,16,17,38]. This position is consistently articulated by major Islamic authorities, including Muhammadiyah's Majlis Tarjih and Tajdid and Al-Azhar, and is grounded in the Prophetic principle safeguarding nasab: "The child is attributed to the lawful bed" (Sahih al-Bukhari; Sahih Muslim).

In this context, individual decision-making regarding infertility treatment is acknowledged, yet exercised within ethical boundaries that emphasize informed consent, spousal responsibility, and protection from exploitation, rather than unrestricted consumer choice [17,26]. At the population level, infertility also presents broader concerns related to equity, regulation, and patient protection, as ART services are often characterized by high cost, commercialization, and uneven access [17,39]. The expansion of digitally mediated and cross-border reproductive care further underscores the need for coherent governance that aligns *fiqh*-informed guidance with public health regulation to maintain ethical standards and public trust [26,39].

Taken together, these contested practices illustrate how gaps between ethical guidance, public understanding, and health system implementation can amplify reproductive health risks.

5. Maternal, Newborn, and Adolescent Health

Maternal, newborn, and adolescent health constitute core pillars of reproductive health and are central to both Islamic ethical priorities and public health goals. As discussed in earlier sections, Islamic ethical frameworks place strong emphasis on the preservation of life (ḥifẓ al-nafs), the prevention of harm, and the protection of vulnerable populations. These principles provide a coherent moral foundation for maternal and child health interventions across diverse settings.

From a public health perspective, preventable maternal and neonatal mortality remain persistent challenges, often driven by delayed care-seeking, weak referral systems, and unequal access to skilled health services. Global evidence consistently demonstrates that timely antenatal care, skilled birth attendance, emergency obstetric services, and postnatal follow-up are essential to reducing maternal and newborn deaths [48-51]. These maternal and newborn health service interventions become even more critical when routine services are disrupted, as delays in referral and shortages of skilled personnel substantially increase preventable risks [22,23]. In such contexts, faith-based organizations with established health service networks—such as Muhammadiyah Disaster Management Centre (MDMC), the Turkish Red Crescent, and Islamic Relief Worldwide—can help sustain essential maternal services through standardized facilities, trained personnel, and community-based referral support. These systemic disruptions also have spillover effects on adolescents, particularly by limiting access to accurate information and youth-friendly services at a time when health needs and risk-taking behaviours may increase.

Adolescent health represents an increasingly complex dimension of reproductive health in the digital era. Access to information through social media and online platforms has transformed how adolescents obtain

knowledge related to sexuality, contraception, HIV, and health behaviours. While digital technologies offer opportunities for health education and service linkage, they also expose adolescents to misinformation and conflicting norms, which may influence risk perception and decision-making [53,54]. Empirical evidence from Muslim-majority contexts, including Indonesia, indicates that digital exposure significantly shapes adolescent preventive behaviours and health-seeking practices related to sexual and reproductive health [55,56]. Evidence shows that effective adolescent reproductive health interventions combine community-based, peer-led, and faith-engaged approaches. Evaluations of initiatives supported by the Faith to Action Network (F2AN) demonstrate that engagement of religious leaders increases awareness and uptake of family planning and healthy timing and spacing messages among young people [60,61]. In Indonesia, the Generasi Berencana (Genre) program has been associated with improved adolescent knowledge and peer outreach on reproductive health through structured education and counselling [62,63]. Complementary evidence from youth-led interventions further indicates that peer education can improve adolescents' reproductive knowledge and preventive behaviours, including HIV prevention [64,65].

Overall, maternal, newborn, and adolescent health illustrate the practical convergence of fiqh rulings, autonomy, and public health needs discussed throughout this chapter. Strengthening these services through ethically grounded, digitally responsive, and partnership-based approaches is essential for improving health outcomes and advancing reproductive health equity in Muslim societies.

6. Conclusion and Way Forward

This chapter has discussed reproductive health and family planning through the integrated lenses of Islamic ethical frameworks, fiqh rulings, autonomy, and public health needs. Grounded in the objectives of Islamic law (maqāṣid al-sharīʿah), particularly the preservation of life (ḥifẓ al-nafs) and lineage (ḥifẓ al-nasl), Islamic ethics offers principled yet adaptable guidance for contemporary health challenges.

Key gaps persist between fiqh-informed guidance, public understanding, and health system practice, especially for contested issues such as contraception, abortion, FGM/C, infertility care, and adolescent health. In the digital era, misinformation further complicates informed decision-making. These challenges become more pronounced in emergency settings, including natural disasters, humanitarian crises, and public health emergencies, when routine reproductive health services are disrupted and ethical clarity is urgently needed.

Moving forward, reproductive health efforts in Muslim societies should prioritize: (1) translating *fiqh*-based guidance into clear and accessible information; (2) strengthening ethical capacity among health providers; and (3) engaging faith-based actors as partners in routine and emergency health response. Aligning Islamic ethical reasoning with empirical evidence and emergency-responsive public health strategies is essential to ensure reproductive health services remain ethical, humane, and context-sensitive in both stable and crisis settings.

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MENTAL HEALTH IN THE ISLAMIC CONTEXT: DESTIGMATISATION, SERVICE PROVISION AND SPIRITUAL WELL-BEING

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Abstract

Mental health is a core component of holistic well-being in Islam; however, stigma, misconceptions, and insufficient integration between spiritual care and evidence-based treatment continue to hinder help-seeking within many Muslim communities. Rates of depression, anxiety, trauma, and psychosocial distress are increasing globally, while culturally and religiously responsive mental health services remain limited [18].

"Islamic teachings emphasise the importance of addressing mental health through spiritual, psychological, and social perspectives, encouraging believers to seek both faith-based and professional solutions while fostering empathy, community support, and well-being" [6].

This article examines mental health through the framework of *maqasid al-Shariah* (objectives of Islamic law), particularly the preservation of intellect (*hifz al-aql*), life (*hifz al-nafs*), and human dignity (*karamah*) [3,7]. It also attempts to explore stigma, service gaps, and the role of spiritual practices such as *ruqyah*, *dua*, *tawakkul*, and Quranic reflection, highlighting the importance of integrating faith-sensitive approaches and contemporary psychiatric care. Strategies for culturally competent clinical practice, community engagement, and policy development are discussed, with emphasis on collaboration between healthcare systems and religious institutions to promote accessible, ethical, and holistic mental health services.

Keywords: mental health; Islamic ethics; *maqasid al-Shariah*; spiritual care; cultural competence; religion and medicine

Mental Health as an Islamic Imperative

Mental health is central to holistic well-being in Islam, yet discussions surrounding mental illness remain constrained by stigma, misconceptions, and limited-service integration. From an Islamic ethical perspective, well-being encompasses physical, psychological, social, and spiritual dimensions. Preservation of mental functioning is intrinsically linked to the higher objectives of Islamic law (*maqasid al-Shariah*), particularly the preservation of intellect (*hifz al-aql*) and life (*hifz al-nafs*) [3,7].

The Prophet Muhammad ﷺ, despite his elevated spiritual rank, experienced profound emotional distress. Classical commentaries describe fear and anxiety during the onset of revelation and deep grief during the Year of Sorrow following the deaths of his wife Khadijah (RA) and uncle Abu Talib [11]. These experiences illustrate that emotional suffering is inherent to the human condition rather than a reflection of spiritual deficiency.

The Prophet ﷺ sought solace through prayer, supplication, Quranic reflection, and social support, approaches that align with contemporary therapeutic principles and demonstrate compatibility between Islamic practice and mental health care [10,19].

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Islam explicitly recognises emotional struggle and encourages healing and treatment.
The Quran states: *"And We send down in the Quran that which is a healing and a mercy for the believers"* (Quran 17:82) [15].
The Prophet ﷺ instructed: "Seek treatment, for Allah has not created a disease except that He has created for it a cure" [12].

Seeking mental health care is, therefore, not a sign of weak faith but an act consistent with Islamic teachings and ethical responsibility.

Ahkam al-Shariah and Mental Illness

Islamic jurisprudence has long recognised the moral and legal implications of mental illness. Individuals whose cognitive capacity is significantly impaired are granted reduced or removed legal accountability (*taklif*), reflecting divine justice and compassion [10].
The Prophet ﷺ stated: "The pen is lifted from three: the sleeping person until he awakens, the child until maturity, and the mentally incapacitated until he regains reason" [13].
This principle affirms that mental illness is not a moral failure but a condition warranting protection, care, and dignity. Contemporary scholars of Islamic psychiatry emphasise that classical jurists recognised obsessive-compulsive phenomena, psychosis, and melancholia as medical conditions rather than purely spiritual failings [4,5]. Within this framework, treatment is not merely permissible but ethically encouraged. Neglecting care contradicts the legal maxim: "There should be neither harm nor reciprocating harm" [12].

Mental health care, therefore, aligns with Islamic legal principles of harm prevention (*daf al-darar*) and welfare promotion (*jalb al-maslahah*).

Destigmatisation in the Prophetic Tradition

The Prophetic community normalised emotional suffering rather than concealing it. Companions openly expressed grief, fear, and sadness, and these experiences were met with empathy rather than moral judgment [11]. The Prophet ﷺ did not equate sadness with lack of faith; instead, he validated suffering while encouraging hope, patience (*sabr*), and trust in Allah (*tawakkul*).
The Qur'anic narrative of Prophet Yaʿqūb (AS) exemplifies this balance: *"I only complain of my suffering and grief to Allah"* (Qur'an 12:86) [18].
This verse affirms emotional expression while situating coping within a spiritual framework. Another foundational reassurance is found in: *"Allah does not burden a soul beyond what it can bear"* (Qur'an 2:286) [14].
Such verses establish a theological basis for acknowledging psychological vulnerability without attributing it to spiritual inadequacy.

Historical Precedents: Islamic Civilisation and Mental Health Care

Early Islamic civilisation institutionalised mental health care through the establishment of *bimaristans* (hospitals) that formally recognised psychological illness as a medical condition requiring treatment. Psychiatric wards were established in Baghdad in the eighth century under the Umayyad caliph al-Walid ibn Abd al-Malik [9]. These institutions provided publicly funded care grounded in compassion (*rahmah*) and human dignity (*karamah*).
Patients received medical, social, and supportive interventions rather than punishment or isolation. This model contrasted with contemporaneous approaches elsewhere, where mental illness was frequently attributed to moral or supernatural causes. The Islamic medical

tradition thus established an early precedent for integrating spiritual values with clinical practice [9].

Contemporary Challenges in Muslim Communities

In Muslim-majority regions and diaspora settings alike, mental health challenges are shaped by intersecting social, political, and cultural determinants. Epidemiological data indicate that populations exposed to armed conflict, forced displacement, and economic instability, particularly in parts of the Middle East, North Africa, and South Asia, experience elevated rates of depression, anxiety, and trauma-related disorders compared with global averages [19]. Refugees and asylum seekers from Muslim-majority countries demonstrate disproportionately high prevalence of post-traumatic stress disorder (PTSD) and mood disorders, compounded by barriers to accessing culturally appropriate care [19].

Stigma remains a central deterrent to help-seeking across diverse Muslim contexts. Studies among Muslim populations in Western countries demonstrate that fear of social judgment, concerns about family reputation, and beliefs that mental illness reflects weak faith or spiritual failing significantly reduce willingness to engage with professional services [2,8]. These beliefs are often reinforced by explanatory models that attribute symptoms primarily to jinn possession, the evil eye, or divine testing, which may delay clinical assessment and treatment [2]. Qualitative research further suggests that concealment of illness within families is common, leading to prolonged, untreated illness and increased caregiver burden [8].

In diaspora communities, structural barriers further complicate access to care. Limited availability of Muslim or Muslim-competent clinicians, language discordance, and mistrust of secular institutions contribute to underutilisation of services [8,19]. Younger Muslims face additional pressures related to identity negotiation, Islamophobia, and intergenerational conflict, which have been associated with heightened vulnerability to anxiety and depressive symptoms [2]. Despite these challenges, Muslim populations remain underrepresented in mental health research, constraining the development of evidence-based, culturally responsive interventions [19].

From an Islamic ethical perspective, these gaps undermine the *maqāsid*-based imperatives to preserve intellect (*hifz al-aql*) and life (*hifz al-nafs*). Failure to address stigma and access barriers perpetuates preventable harm and contradicts the principle of harm prevention (*daf al-darar*). Integrating public health strategies with Islamic moral reasoning offers a culturally resonant framework for advancing early intervention, prevention, and equitable service provision.

Spiritual Dimensions of Healing

Spiritual coping constitutes a primary interpretive and therapeutic framework for many Muslims experiencing psychological distress. Practices such as *ruqyah* (Quranic recitation for healing), *dua* (supplication), dhikr (remembrance of God), and reflective engagement with the Quran are widely used to regulate emotion, restore meaning, and cultivate resilience. The Quranic affirmation that *"in the remembrance of Allah do hearts find rest"* (Qur'an 13:28) [18] provides a theological basis for spiritual-emotional integration.

Empirical literature supports the clinical relevance of spiritually integrated approaches. Islamically adapted psychotherapeutic models demonstrate improved engagement and acceptability when treatment incorporates patients' religious beliefs, moral frameworks, and spiritual practices [1]. Such approaches may enhance cognitive reframing through religious meaning-making and support behavioural activation grounded in values of patience (sabr), hope (*raja'*), and trust in God *(tawakkul)* [1,9]. Community-based

psychoeducation programs delivered through mosques have also shown promise in increasing mental health literacy and reducing stigma by framing distress within an Islamic ethical narrative [5].

However, uncritical reliance on spiritual interventions alone poses clinical risks. Exclusive attribution of symptoms to supernatural causes may delay diagnosis of mood disorders, psychosis, or trauma-related conditions, leading to deterioration and preventable harm [2,8]. Islamic ethical principles do not support such neglect; rather, they mandate treatment seeking and harm prevention. The Prophet ﷺ instructed believers to seek medical care for illness, affirming the legitimacy of clinical intervention alongside spiritual practice [12].

A biopsychosocial-spiritual model provides the most coherent framework for integrating faith and psychiatry. Within this model, spiritual practices function as complementary supports to evidence-based assessment and treatment rather than substitutes. Clinicians who respectfully incorporate religious language and practices, while maintaining diagnostic rigour, can strengthen therapeutic alliance and improve adherence without compromising scientific standards [1,8]. This balanced integration upholds both the sanctity of spiritual life and the ethical duty to preserve mental functioning, aligning clinical care with the *maqasid al-Shariah*.

Clinical Applications: Integrating Islamically Sensitive Mental Health Care

Incorporating Islamic Values

Mental health outcomes improve when clinicians acknowledge religious identity and faith-based coping strategies [1,10]. Culturally adapted therapies that integrate Islamic values demonstrate higher acceptability and stronger therapeutic alliance among Muslim patients, particularly when interventions are framed in ways that resonate with concepts such as patience (*sabr*), trust in God (*tawakkul*), and moral responsibility [4]. Recognising the role of prayer, supplication, and religious concepts made within therapy can enhance engagement without compromising clinical rigour [1].

Engaging Imams and Community Leaders

Mosques and religious leaders play a central role in shaping community attitudes toward mental illness. Collaboration between clinicians and imams facilitates destigmatisation, culturally appropriate psychoeducation, and timely referral to professional services [2,5]. Training imams in basic mental health literacy improves early identification of distress and helps distinguish spiritual concerns from conditions requiring medical or psychological intervention [5]. Such partnerships reflect a model of shared responsibility between religious and healthcare institutions.

Training Professionals

Culturally competent training should address Islamic concepts of suffering, family dynamics, modesty, and confidentiality to improve diagnostic accuracy and therapeutic rapport. Awareness of religious idioms of distress reduces misinterpretation of spiritual language as pathology and supports more nuanced assessment [8]. Providers trained in culturally responsive approaches demonstrate improved treatment adherence and reduced dropout among Muslim patients [8].

Social Responsibility and Communal Obligation

In Islam, mental health care constitutes a collective ethical obligation (*fard kifayah*). Families, communities, and institutions share accountability for ensuring access to care and preventing avoidable harm.

The Qur'an instructs:

"Cooperate in righteousness and piety" (Qur'an 5:2) [17].

Historically, Muslim societies institutionalised mental health care through publicly funded hospitals that reflected Islamic ethical principles of dignity (*karamah*), compassion (*rahmah*), and justice (*adl*) [9]. These institutions recognised mental illness as a condition requiring treatment rather than moral condemnation.

Failure to provide appropriate care perpetuates suffering and violates both legal and ethical obligations within Islamic moral reasoning [3,10]. From a *Maqāsid* perspective, neglecting mental health services undermines the preservation of intellect (*hifz al-aql*) and life (*hifz al-nafs*), thereby contradicting foundational objectives of Islamic law.

Future Directions and Conclusion

Mental health must be prioritised as a core component of healthcare in Muslim societies. Investment is required in culturally responsive policy, workforce development, and research. Evidence from Dr Awaad's work demonstrates that culturally adapted psychotherapy combined with spiritual support improves treatment engagement and psychological outcomes in Muslim patients [4].

Policy initiatives aligned with the *maqasid al-Shariah*, particularly with the preservation of intellect and prevention of harm, can strengthen service delivery and public mental health literacy [3,7]. Community-based programs delivered through mosques and cultural centres have demonstrated potential to reduce stigma and promote early help-seeking [2,5].

In conclusion, mental health care in Muslim communities is both a clinical and moral imperative. Integrating spiritual well-being with evidence-based practice enables holistic, ethical, and compassionate care, fulfilling Islamic principles of justice (*adl*), mercy (rahmah), and communal responsibility.

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END-OF-LIFE CARE & THE SANCTITY OF LIFE: ISLAMIC PERSPECTIVES ON PALLIATIVE CARE, EUTHANASIA, AND WITHHOLDING TREATMENT

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Abstract

The complex ethical challenges surrounding end-of-life care are deeply sensitive to cultural and religious contexts. This review examines euthanasia, palliative care, and treatment withholding through the integrated lenses of Islamic jurisprudence and modern bioethics, with particular attention to Southeast Asian Muslim communities. Drawing upon the Holy Qur'an and Hadith, Shafi'i jurisprudence, regional fatwas, and empirical studies from Southeast Asia, this paper synthesizes foundational Islamic principles with contemporary clinical applications. The analysis demonstrates that Islam upholds the sanctity of human life while recognizing death as a natural component of God's divine plan. Islamic bioethics mandates compassionate end-of-life care as a religious obligation, absolutely prohibits assisted suicide and active euthanasia, yet permits the withholding or discontinuation of medically futile therapy under specific conditions. Decision-making frameworks emphasize shared consultation among patients, families, and physicians, guided by Islamic principles of hope, acceptance (*riḍā*), and mindfulness of God (*al-taqwā*). This paper offers evidence-based recommendations for culturally competent end-of-life care among Southeast Asian Muslim populations and outlines research priorities for advancing Islamic bioethics scholarship globally.

Keywords: end-of-life care, decision making, patient rights, Islamic bioethics, medical ethics

Introduction

Medical technology advancements have fundamentally transformed end-of-life care, generating profound ethical dilemmas concerning medical futility, quality of life, and dignified death.[1] Life-sustaining interventions can extend biological existence, yet raise significant questions: When does treatment become futile? How do we balance the sanctity of life against the reality of suffering? Who determines the withdrawal of support?

These issues are amplified in Southeast Asia, home to over 240 million Muslims, constituting approximately 13% of the 1.8 billion global Muslim population.[2] Indonesia, as the world's largest Muslim-majority nation (235 million Muslims, 87% of 270 million population[3]), Malaysia (20.6 million Muslims, 63.5% of population based on 2020 census[4]), Singapore (15.6% Muslim minority[5]), and significant Muslim communities in Brunei, southern Thailand, and the southern Philippines have each developed sophisticated mechanisms for addressing bioethical challenges.

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These Muslim populations generally adhere to the Shafi'i school of jurisprudence among the four major Sunni legal traditions. Cultural diversity has additionally shaped Islamic perspectives in Southeast Asia. Indonesian Islam is influenced by Javanese, Sundanese, and Minangkabau traditions; Malaysian Islam by Malay, Chinese, and Indian Muslim communities; and Singaporean Muslims navigate a multicultural societal context.

Southeast Asian Muslims have established institutional frameworks to address bioethical issues. In Indonesia, the Majelis Ulama Indonesia (MUI), established in 1975, issues officially recognized fatwas, including crucial determinations regarding life support withdrawal (MUI Fatwa No. 1/2010) and criteria for brain death (MUI Fatwa No. 6/2013).[6,7] These fatwas have provided clear guidance for clinicians and families facing end-of-life decisions. Malaysia has developed an advanced Islamic institutional framework, including state-level Islamic councils issuing healthcare fatwas.[8] Malaysia's state-level Islamic Religious Councils (Majlis Agama Islam Negeri) provide locally adapted guidance on healthcare ethics, coordinated nationally through the Department of Islamic Development (JAKIM). Singapore has led the integration of Islamic bioethics into conventional healthcare through the Islamic Religious Council of Singapore (MUIS). Singapore's MUIS Office of the Mufti issued a landmark 2006 fatwa permitting advance medical directives within Islamic parameters, integrated with secular healthcare law.[9,10]

Healthcare professionals in Southeast Asia report significant challenges in understanding Muslim patients' end-of-life beliefs. Suleman (2023), in an empirical study conducted in the United Kingdom, revealed that clinicians often misinterpret Muslim families' concurrent commitments to hope and acceptance as psychological "denial," failing to recognize these as theologically coherent virtues.[11] Malek et al. (2021) studied Malaysian Muslim patients, showing that they prefer family-involved decision-making over independent individual autonomy; however, healthcare systems often lack accommodation for this preference.[12] In Indonesia, studies indicate that only 0.4% of cancer patients received palliative care. Barriers included opioid access restrictions, limited palliative care service availability (approximately 200 facilities nationally), inadequate healthcare provider training, and cultural misconceptions, particularly regarding pain management.[13,14] In addition to these barriers, the Isfandiari (2017) study noted that the Islamic concept of medical futility in Indonesian clinical settings remains challenging and requires integration into clinical decision-making protocols for effective implementation.[15]

This review addresses these gaps by synthesizing Islamic theological foundations, classical Shafi'i jurisprudence relevant to Southeast Asia, regional fatwas, and empirical evidence related to healthcare settings and clinical practice applications. The aim is to provide healthcare professionals with evidence-based guidelines for culturally sensitive treatment of Muslim patients, while identifying research priorities for the global advancement of Islamic bioethics.

Foundational Islamic Principles on Life and Death

Before examining specific end-of-life interventions, we must understand the theological foundations shaping Islamic perspectives. Islamic jurisprudence operates within a comprehensive ethical framework known as *maqāṣid al-sharīʿah* (the higher

objectives of Islamic law). This framework was systematically developed by classical Islamic jurists, including Imam al-Ghazali (d. 1111 CE) and Imam al-Shatibi (d. 1388 CE), who identified the ultimate purposes underpinning Islamic legal rulings and provided a methodological foundation for contemporary Islamic bioethics.[16] The five essential objectives of *maqāṣid al-sharīʿah* that Islamic law pursues to protect and promote, ranked in order of importance, are: preservation of religion (*ḥifẓ al-dīn*), preservation of life (*ḥifẓ al-nafs*), preservation of intellect (*ḥifẓ al-ʿaql*), preservation of lineage (*ḥifẓ al-nasl*), and preservation of property (*ḥifẓ al-māl*).

Relating to end-of-life care, preservation of life (ḥifẓ al-nafs), as the second highest objective, establishes the importance of life-preserving actions. Islam affirms life's inviolable sanctity as a divine trust (amānah). The Qur'an declares:

"Whoever kills a soul unless for a soul or for corruption in the land – it is as if they had slain mankind entirely. And whoever saves one – it is as if they had saved mankind entirely" (Qur'an, Al-Ma'idah: 5:32).[17]

However, the maqāṣid framework is holistic; when the preservation of biological existence conflicts with the prevention of intolerable suffering or when treatment is deemed futile, Islamic jurisprudence permits complex reasoning. This paradigm facilitates the differentiation between obligatory treatment (providing reasonable hope), permissible treatment (uncertain benefit), and permitted refusal (futile interventions that merely prolong dying).[6],[18]

Mahfudz (2016) clarifies that sanctity encompasses human dignity (*karāmah*) throughout life's trajectory, from birth through natural death, and does not mandate preserving biological existence at all costs regardless of suffering or outcome. Rather, life's sanctity encompasses human dignity throughout life's trajectory, from birth through natural death—not mere biological life. This understanding prevents both vitalism (preserving biological functions indefinitely through technology) and abandonment (premature treatment withdrawal).[19]

In Islam, God alone holds supreme authority over life and death. The Qur'an states:

"...Indeed, we belong to God and indeed to Him we return" (Qur'an, Al-Baqarah: 2:156).[20]

Humans are stewards (*khalīfah*), not absolute owners of their lives. *Ajal* (death) is a concept of designated lifespan by God, as the Qur'an says:

"No soul can die except by God's permission, at a predetermined time" (Qur'an, Al-Imran: 3:145).[21]

These verses raise profound questions: if death's timing is predetermined, why seek medical treatment? Does aggressive medical intervention attempt to thwart God's will? Imam al-Ghazali, a prominent Islamic scholar and philosopher, explained that while ultimate outcomes rest with God, humans remain obligated to take reasonable means (asbāb) to preserve life, including medical treatment, as part of their stewardship of life.[22] Seeking treatment demonstrates trust that God works through natural causes, including medical interventions. Fate provides a spiritual framework for accepting death when it arrives despite best medical efforts, not justification for neglecting available care. This understanding prevents both extremes of medical fatalism (refusing all treatment as "interfering with God's plan")

and technological absolutism (pursuing all interventions as if human effort alone determines outcome).[16],[23]

Western bioethics frequently positions "sanctity of life" and "quality of life" as conflicting values demanding compromise. Islamic bioethics counters this distinction, perceiving them as complementary rather than antagonistic. The sanctity of life remains constant regardless of health status, disability, or suffering. Islam acknowledges that extending biological life through interventions that provide no significant benefit, merely prolonging the process of dying, does not fulfil the sacred duty of preserving life.

The Sunnah of the Prophet illustrates this balance beautifully. When the Prophet Muhammad's grandson lay dying, the Prophet counselled his grieving daughter: "It is for Allah what He takes, and it is for Allah what He gives, and everything has its fixed time. So be patient and look for Allah's reward" (Al-Bukhari, Ṣaḥīḥ al-Bukhārī, Hadith 1284).[24] Fachruddin (2017) applies this principle to contemporary contexts: Islam's rejection of euthanasia stems not from requiring endless prolongation of dying, but from prohibiting deliberate killing. Allowing natural death by forgoing futile interventions fundamentally differs from actively causing death. This distinction becomes crucial when technology enables biological existence to continue even when meaningful recovery is impossible.[25]

Islamic Perspectives on Palliative Care

Palliative care encompasses comprehensive symptom management and holistic support for patients facing life-limiting illness.[1] Islamic ethics mandates compassionate care as a communal religious obligation (*farḍ kifāyah*). The Prophet taught: "The believers in their mutual kindness, compassion, and sympathy are just like one body. When one limb suffers, the whole body responds with wakefulness and fever" (Muslim ibn al-Hajjaj, Ṣaḥīḥ Muslim, Hadith 2586).[26] The Arabic concept *raḥmah* (mercy/compassion) encompasses Islamic healthcare teachings. MUI Fatwa 1/2010 requires continuing "basic care" including pain management, hygiene, comfort, and spiritual support even when life-sustaining treatment is withdrawn.[6]

Islam obligates relief of suffering through effective symptom management. The Prophet encouraged seeking treatment: "O servants of God, seek treatment, for God has not created a disease without creating its cure" (Abu Dawud al-Sijistani, Sunan Abī Dāwūd, Hadith 3855).[27] Islamic scholars across all institutes agree this prophetic teaching applies to symptom relief even when cure proves impossible, mandating palliative interventions that ease suffering in terminal illness.

A crucial ethical question concerns pain medications, particularly opioids, that may inadvertently shorten life through respiratory depression. Islamic jurisprudence employs the principle of double effect: when an action produces both beneficial and harmful consequences, the determining factor is intention (*niyyah*). If the primary intent is relieving pain, medication is given in appropriate therapeutic doses, and no alternative treatment exists for managing suffering, then inadvertent life-shortening does not constitute prohibited killing. It fundamentally differs from administering lethal medication doses with the primary intent to cause death (euthanasia). Indonesian pain management specialists emphasize that opioid analgesics are not only Islamically permissible but obligatory when needed for adequate symptom control.[28]

Despite Islamic clarity on pain management permissibility, Southeast Asian Muslims face barriers to adequate palliative care. International data reveal regional disparities in opioid availability. Singapore has 33.5 mg morphine-equivalent consumption per capita annually (approaching Western levels), reflecting robust palliative care infrastructure. Malaysia (4.2 mg per capita) shows moderate levels due to government initiatives improving access, whilst Indonesia (0.2 mg per capita) is among the world's absolute lowest despite being the fourth most populated nation.

Indonesia's severe opioid shortage reflects multiple barriers: complicated regulatory requirements demanding numerous forms for a single prescription, limited healthcare provider training in pain management, physician fear of regulatory penalties, and cultural misconceptions equating therapeutic opioid use with drug abuse. These conditions result in Indonesian cancer patients dying in agony despite the availability of effective pain relief.[13] MUI has not issued a specific fatwa on medical opioid use, representing an important gap in authoritative guidance that could help overcome cultural and regulatory barriers.

For palliative care, the family and community play an important role since their presence provides both practical support and spiritual comfort during illness. The extended family system (keluarga besar) in Southeast Asian Muslim communities creates rich resources but also complexities. When a family member faces terminal illness, extended family members, including siblings, cousins, in-laws, and particularly respected elders, often gather. Indonesian research shows 78% of Muslim patients prefer family involvement in serious healthcare decisions, with only 15% wanting to decide alone. Southeast Asian hospitals must accommodate extended families through flexible visitation policies, larger private rooms or shared spaces facilitating family presence, and designated areas for family prayer and deliberation. Cultural competency training should address how diverse Southeast Asian Muslim family structures shape decision-making processes.[29]

Workforce limitations compound access problems, including insufficient palliative care specialists and trained Islamic healthcare chaplains, only a few curricula for training health professionals which integrate Islamic bioethics comprehensively, and hospitals often relying on untrained religious volunteers rather than professionally prepared chaplains.[14] Another barrier is cultural misconceptions. Beliefs that suffering has inherent spiritual purification value discourage pain management requests; fatalistic attitudes ("if Allah wills death, treatment is useless") lead to late or refused palliative care; stigma around hospice as a "place to die" rather than comprehensive symptom management persists. Despite these barriers, promising developments emerge on strategies for palliative care within Southeast Asian countries.[13],[14]

Prohibited Actions: Euthanasia and Physician-Assisted Suicide

Islamic law delineates a clear and committed distinction between permitting natural death by abstaining from futile therapy and intentionally causing death. Islamic jurisprudence, according to all major schools of law (*madhāhib*)—Hanafi, Maliki, Shafi'i, Hanbali in Sunni tradition; Ja'fari in Shi'a tradition—prohibits active euthanasia and physician-assisted suicide as grave sins equivalent to murder and suicide, respectively.[25],[30] This represents one of the clearest consensuses in Islamic law.

The Qur'anic foundation is explicit:

"Do not kill yourselves, for verily God has been to you Most Merciful" (Qur'an, Al-Nisa': 4:29).[31]

Prophetic traditions strengthen the prohibition. The Prophet warned: "Whoever kills himself with something in this world will be punished with it on the Day of Resurrection" (Al-Bukhari, Ṣaḥīḥ al-Bukhārī, Hadith 1297).[32] This severe warning applies equally to suicide and to assisting another's suicide, regardless of motivation, even alleged mercy.

Islam views worldly trials, including illness, as tests of faith that develop spiritual strength. The Qur'an states:

"We will certainly test you with fear and hunger, and loss of wealth and lives and fruits, but give good tidings to the patient (*ṣābirīn*)" (Qur'an, Al-Baqarah: 2:155).[33]

This teaching does not mean refusing symptom relief. Islam mandates pain management but provides a framework for finding meaning in suffering rather than seeking escape through death. Tawakkul (trust in divine wisdom) cultivates acceptance of trials rather than demanding escape.

Contemporary Islamic scholars warn that permitting euthanasia creates slippery slopes affecting vulnerable groups, such as the elderly, disabled, and economically disadvantaged, who might feel pressured to choose death to avoid burdening families or society.[30] In Indonesia, law reflects Islamic prohibition. The Criminal Code (KUHP) prohibits both killing another person and assisting suicide, with no exceptions for terminal illness or suffering.[25] Unlike jurisdictions such as the Netherlands, Belgium, Canada, or certain U.S. states permitting physician-assisted death under specified conditions,[1] Southeast Asian legal and religious frameworks maintain absolute prohibition.[25]

Discontinuing medically ineffective interventions that only prolong dying—not because one intends death, but because intervention no longer serves a legitimate medical purpose—allows natural disease progression. Death results from underlying illness, not physician action. The intent focuses on avoiding futile burdensome treatment, not on causing death, and is permissible.[12],[25]

Islamic healthcare providers must compassionately address patients whose suffering leads to demands for euthanasia, despite a strict prohibition on the practice. Such requests generally indicate: insufficient symptom management requiring intensive palliative care; psychological distress, including depression, anxiety, or despair, requiring mental health intervention; spiritual crisis requiring Islamic chaplaincy; or feelings of abandonment requiring family and community presence. Adhering to the Islamic ban on euthanasia requires simultaneously ensuring access to excellent palliative care, adequate pain management, psychological support, and spiritual counselling. Simply stating that "euthanasia is prohibited" without addressing the underlying suffering undermines the compassionate principles of Islamic ethics and may induce patients toward prohibited choices out of desperation.[23]

Withholding and Withdrawing Treatment: Islamic Frameworks

Islamic jurisprudence distinguishes treatment obligations based on clinical effectiveness. When treatment offers reasonable hope of

cure or meaningful benefit, seeking treatment generally becomes obligatory (*wājib*) to fulfil the duty of life preservation.[34] However, when treatment provides no medical benefit and merely prolongs dying without possibility of recovery, the obligation is lifted. Classical Shafi'i jurists, including the influential scholar Imam al-Ghazali, identified conditions permitting treatment refusal: chronic disease with unlikely recovery; terminal illness with imminent death; treatment causing unbearable suffering exceeding any benefit; and impossibility of obtaining treatment.[12] Contemporary application recognizes that modern technology can sustain biological functions long after meaningful recovery becomes impossible, making futility determinations more complex yet more critical.

The Islamic legal maxim al-ḍarar *yuzāl* (harm must be removed) supports discontinuing interventions causing harm without corresponding benefit.[6] Medical futility (*al-ʿilāj al-ʿabath*) in Islamic ethics refers to interventions unable to achieve therapeutic goals or whose burdens dramatically exceed potential benefits.[15] The Indonesian Council of Ulama (MUI) issued Fatwa No. 1/2010 providing detailed guidance on withdrawing life support—the most comprehensive Southeast Asian Islamic ruling on this topic. It specifies permissible conditions and prohibited actions.

Permissible conditions include:

- A minimum of three specialist physicians who are qualified, experienced, and trustworthy (*ʿadl wa thiqah*) determine that treatment is medically futile with no reasonable hope of recovery.
- Competent patient or their surrogate decision-makers (family) provide informed consent after receiving adequate information about prognosis, treatment options, benefits and burdens of continuing intervention, and consequences of withdrawal.
- Pain management (*iḥtiwāʾ al-alam*), hygiene, comfort measures, and spiritual support must continue even when life-sustaining treatment is withdrawn.

Prohibited actions include:

- Active euthanasia or any intervention with primary intent to cause death.
- Withdrawal motivated by economic cost considerations rather than medical futility.
- Withdrawal without proper medical assessment or family consultation.
- Premature withdrawal before a reasonable trial of treatment.

There are also specific clinical applications due to refraining from putting a terminally ill patient on life support, respirator, or dialysis if the medical treatment team has confirmed and is certain that there is no hope of benefit for the patient in these measures.[12]

Patient Autonomy Within the Islamic Framework

The fatwa recognizes patient rights to abstain from treatment if he is content with what Allah has decreed for him (namely, death) and prefers patience (*ṣabr*) to disease.[12] In Indonesia, there are challenges for implementing the fatwa. Isfandiari (2017) found only 30% of Indonesian physicians were familiar with MUI Fatwa No. 1/2010, indicating urgent need for medical education integration and broader dissemination. Additional challenges include: many hospitals lacking ethics committees to review withdrawal decisions; healthcare providers reporting anxiety about legal liability despite

fatwa protection; family disagreements complicating implementation when extended family members hold differing views; and rural hospitals often lacking specialist physicians required for proper assessment.[15]

In Malaysia, the federal structure means Islamic rulings are issued at the state level, creating some variation. However, Malaysian Islamic authorities generally agree that: brain death is a valid death criterion; withdrawal of futile treatment fundamentally differs from euthanasia; family consultation is essential; and pain management must continue.[8] In Singapore, it is permissible by Islamic law for a mentally competent individual to make a pledge to refuse life support treatment in the event of terminal illness with the consent of the patient.[9]

Decision-Making Processes in End-of-Life Care

Physicians possess critical expertise that patients or families lack. Islamic ethics highly regards medical professionals' specialized knowledge (*ahl al-dhikr*), creating an obligation for physicians to: provide accurate prognostic information; explain treatment options with honest assessment of benefits and burdens; offer professional recommendations based on medical judgment; and educate about Islamic bioethics principles when relevant. However, physicians are advisors and partners, not dictators. They cannot impose treatment over patient or family objection (except in emergencies threatening life), nor override Islamic ethical prohibitions even if locally legal (as with euthanasia in some jurisdictions). Indonesian healthcare law requires informed consent with information on diagnosis, options, risks, benefits, and alternatives, aligning Islamic emphasis on patient knowledge with legal requirements.[35]

When there are issues regarding decision-making in the family, health professionals should: identify a designated family spokesperson early; when disagreements arise, suggest the family consult a local Islamic authority together; provide medical information clearly to all involved family members; allow adequate time for family deliberation; consider ethics consultation when conflicts become intractable; and document the decision-making process thoroughly.

Conclusion

This review synthesizes Islamic perspectives on end-of-life care from foundational principles through contemporary clinical applications, with particular focus on Southeast Asian contexts. Islam affirms life's profound sanctity as a divine trust while recognizing death as a natural transition. Islamic ethics mandates compassionate palliative care as a religious obligation. The prohibition of euthanasia and assisted suicide remains absolute. Yet withholding or withdrawing medically futile treatment is permissible when proper conditions are met. In Southeast Asia, regional authorities demonstrate how classical Shafi'i jurisprudence addresses contemporary clinical dilemmas. However, Southeast Asia faces severe palliative care access disparities, healthcare provider education in Islamic bioethics remains inadequate, and legal frameworks insufficiently protect physicians following Islamic guidelines. Opportunities exist through growing regional cooperation, emerging bioethics scholarship, and strong family-community support structures.

As global healthcare becomes increasingly multicultural, diverse ethical paradigms, including Islamic virtue ethics and jurisprudential frameworks, enrich bioethics for all. Southeast Asian experiences

navigating religious pluralism offer valuable lessons. This commitment to culturally competent, ethically grounded care fulfils both professional obligations and the Islamic mandate of compassionate service to suffering humanity.

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ORGAN DONATION AND TRANSPLANTATION IN ISLAMIC BIOETHICS: JURISTIC FOUNDATIONS AND THE ROLE OF TRANSPLANT REGISTRIES

*Mohammad Iqbal Khan**

Abstract

Organ transplantation is an established life-saving therapy, yet access remains constrained by a profound global shortage of organs, system inefficiencies, and persistent legal and ethical challenges. In Muslim-majority societies, these challenges are further shaped by juristic deliberations on the sanctity of the human body, the definition of death (including brainstem death), and valid consent. This review synthesises the scale of unmet transplant need, the clinical and ethical requirements for donors and recipients, and the Islamic jurisprudential concepts of *darūrah* (necessity) and *ḥājāt* (need) that inform permissibility. It also highlights the central role of secure, transparent organ-donation databases in equitable allocation, traceability, and public trust. The paper aims to support clinicians and policymakers in aligning contemporary transplant systems with *Sharī`ah* objectives—preserving life while safeguarding dignity and preventing exploitation.

Keywords: Organ Transplantation, ethics, donation, jurist's opinion, database, registries, consent and lifesaving medical interventions.

Introduction

Organ transplantation sits at the intersection of clinical urgency, ethics, law, and ethical norms within Muslim societies—juristic guidance. Advances in intensive care, organ preservation, and immunosuppression have made transplantation feasible for end-stage organ failure. However, the widening gap between organ demand and supply continues to result in avoidable deaths and pressures that can foster inequity and abuse if governance is weak and an ethical framework is not implemented.

This article reviews the scale of organ shortage and its drivers, summarises medical and legal prerequisites for donation and transplantation, and discusses *darūrah* and *ḥājāt* as applied to transplantation in Islamic bioethics. It further outlines the role of transplantation databases, clarifies the Islamic ethico-legal discussion on defining death (including brainstem death), and examines consent through registries, bequests, and next-of-kin authority. The objective is to present a coherent, clinician-aware synthesis that preserves dignity while prioritising the preservation of life.

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Scale of the problem

Organ transplantation is a surgical procedure in which a healthy organ is removed from a donor and transplanted into a recipient who requires it for survival or sustained function. The success of this procedure depends upon multiple factors, including careful matching and lifelong medical management. Core bioethical principles guide practice to protect both donors and recipients, focusing on medical compatibility, legal consent, and the overall health of both[1].

There is a persistently rising gap between the high demand for organs and their limited supply. Worldwide, only an estimated 10% of the need for organ transplants is currently met. Approximately 2 million transplants are required per year, while approximately 173,727 organ transplants were performed worldwide in 2024 [1].

Waiting lists and avoidable mortality

Thousands of patients remain on national waiting lists globally. In the United States alone, over 100,000 people are on the national transplant waiting list, and approximately 13 people die every day while waiting for a life-saving organ. In Europe, over 100,000 people were on a waiting list for a transplant in 2023, but fewer than half received one. In France, 852 patients died in 2024 due to a lack of access to a transplant.[2]

In Muslim countries such as Pakistan and Saudi Arabia, reliable national data on patients requiring organ transplantation are limited, but the situation appears to be worse[3].

The world faces a huge organ shortage, and the number of patients requiring organs is growing day by day. For instance, in the U.S., the number of patients on waiting lists increased approximately sixfold over recent decades, while the number of transplants only doubled in the same period.[2]

Drivers of organ shortage. Major contributing factors to organ shortage and the widening gap between demand and supply include:

a) **System inefficiencies and legislative barriers** lead to delays in organ transportation, lack of coordination among transplant centres, and the unavailability of integrated donor-recipient data.

b) **Low donor registration**, often due to procrastination, limited public awareness, and cultural or religious misconceptions.

c) **Family refusal** for organ procurement despite an individual's registration as a donor; in many systems, families can override the decision of the deceased

d) **Medical constraints**, including strict age and health criteria that can restrict organ retrieval.

e) **Inequalities**: global disparities exist, with a small number of developed countries having high transplant rates, while many others, especially in Africa and parts of Asia, fail to meet their population's needs.

f) **Aging population and chronic disease burden**: aging populations and rising non-communicable diseases (e.g., chronic kidney and liver disease) are contributing to increasing transplant need.

These and other socio-economic and medical reasons contribute to an expanding mismatch between organ need and availability[4].

Legal, ethical, and medical requirements of organ donation and transplantation

Requirements for recipients

Recipients must meet specific criteria to be placed on a national transplant waiting list. Requirements focus on severe organ failure, overall health for major surgery, psychological readiness, and strict adherence to post-transplant care. Matching typically considers blood type, tissue compatibility, size, urgency, and waiting time; recipients must demonstrate commitment to lifelong immunosuppression and follow-up, as non-compliance raises serious concerns. Potential exclusion factors include active infections (e.g., HIV, hepatitis), recently untreated cancers, severe obesity (BMI > 35), history of blood clots, and non-compliance with prior medical instructions. Thorough psychosocial evaluation ensures the recipient has the support system and capacity to adhere to demanding post-transplant care.

Requirements for donors (and sources of organs)

Requirements for organ donation vary by person, organ, and jurisdiction. In 2026, medical professionals emphasised that almost anyone can register because suitability is determined by health status at the time of death. Actual donation requires specific circumstances, particularly for deceased donors (brain death in a hospital). Living donors must typically be in excellent physical and mental health, usually adults (18+, with some centres requiring 21+ or higher thresholds for certain categories), and undergo thorough medical and psychological evaluation, with organ-specific criteria (e.g., adequate kidney function for kidney donation). Medical conditions, lifestyle, and age are assessed, but even individuals with health issues may still be eligible for certain tissues; final suitability is determined by clinicians.

Sources of organs include deceased donation and living donation. Xenotransplantation and artificial organ transplantation are also discussed as potential sources, though currently less practical. Deceased organ donation typically occurs after brain death (irreversible cessation of brain function) in a hospital setting, often after a severe accident or stroke, requiring ventilator support. Anyone can register, but only a small proportion of deaths ultimately qualify for organ retrieval. At the time of death, clinicians assess suitability for infection, malignancy risk, and organ damage; some illnesses may not rule out donation.

Living donation (e.g., kidney and partial liver) generally requires excellent physical and mental health and normal organ function. Donors should not be using drugs, should preferably be non-smokers, and must undergo a comprehensive evaluation, including physical examination, laboratory tests, cancer screening where appropriate, and mental-health assessment. Risks must be clearly explained, and the donor's decision must be voluntary and independent. Donors should be accorded health *Takāful* and post-donation monitoring.[4]

Types of organs and their requirements

Transplants are needed for end-stage organ failure caused by conditions such as chronic disease (e.g., diabetes, hepatitis), genetic conditions (e.g., cystic fibrosis), or severe injury. Organs that can be transplanted include:

- **Kidneys:** most commonly transplanted; a person can live with one healthy kidney.
- **Liver:** a portion from a living donor, or a whole liver from a deceased donor.
- **Heart:** typically only from a deceased donor.

• **Lungs:** one or both, usually from a deceased donor.
• **Pancreas:** often transplanted with a kidney for severe diabetes.
• **Intestines:** less common, usually from a deceased donor.
• **Tissues:** corneas, bone marrow, skin, heart valves, and tendons can also be transplanted[5].

Needs of recipients (and allocation)

Recipients must meet specific criteria to be placed on a national transplant waiting list:
• **Medical need:** end-stage organ failure, with transplant judged the best or only option for survival or meaningful quality-of-life improvement.
• **Overall health:** sufficient physiological reserve for major surgery and lifelong therapy; active infections or recent cancer may defer transplantation until controlled.
• **Commitment to post-transplant care:** lifelong check-ups, lifestyle changes, and immunosuppressant medication to prevent rejection.
• **Psychosocial evaluation:** capacity and support system to adhere to demanding post-transplant care[6].

Organ allocation should be managed by national systems (e.g., UNOS/OPTN in the U.S.) that prioritise candidates based on medical urgency, compatibility, time on the waiting list, and distance/logistical feasibility.

Necessity and desire (*Darūrah and Hajāt*) in the Islamic context

Contemporary issues in human activity continue to develop. In addressing emerging problems, Islam provides *Sharī`ah* principles that facilitate human welfare, preserve dignity, and prevent undue hardship. *Maṣlaḥah* (expediency/prudence) is a central aim of *Shariah*. *`Allāmah* al-Shatibi and Imam al-Ghazāḥ articulated the objectives of *Sharī`ah* (*Maqāsid al-Sharī`ah*) in five elements: protection of religion (*hifz al-dīn*), protection of life/soul (*hifz al-nafs*), safeguarding of reason (*hifz al-ʻaql*), protection of offspring/lineage (*hifz al-nasl*), and protection of property (*hifz al-māsl*). Accordingly, juristic reasoning seeks the *Maqāsid* underlying each phenomenon and legal problem in society [7].

In *Sharī`ah*, ***darūrah*** (necessity) refers to a dire circumstance—life-threatening or function-threatening—where otherwise prohibited acts may be permitted to preserve life or essential well-being. *Hājāt* (need) refers to hardship below the level of immediate threat to life or limb; failure to meet it causes substantial difficulty, though not necessarily destruction. These principles provide juristic flexibility and align with *Sharī`ah* objectives, prioritising preservation of religion, life, intellect, lineage, and property[8].

***Darūrah* (necessity): scope and conditions**

Darūrah is an extreme and urgent circumstance where adherence to a *Sharī`ah* prohibition would lead to certain or irreparable harm (death, severe injury, loss of organ, or disability). The legal maxim applies: **"Necessity makes the prohibited permissible" (*al-darūrat tubūh al-mahzura*t)**. Its application is constrained by conditions:

a) The threat must be real and immediate, not merely assumed or speculative.
b) No lawful alternative is available to avert the harm.
c) The concession must be limited to the minimum required (proportionality).
d) The action must not intentionally harm others or violate more fundamental *Sharī`ah* principles.

Examples include consuming prohibited food to avoid death by starvation; using medicine containing prohibited substances when no halal alternative exists for a life-threatening

illness; and, in rare circumstances, tolerating otherwise forbidden financial arrangements as a last resort to av*ert severe harm to basic survival needs.*[9]

Hājāt (need): scope and application

Hājah refers to a state of need that, if not fulfilled, causes difficulty, hardship, or constraint for an individual or the community, though it does not necessarily lead to destruction or death (unlike *darūrah*). Ordinary inconvenience does not qualify. However, where hardship becomes significant—especially if widespread (*hājat ʻāmmah*)—*Sharīʿah* may allow concessions (*rukhsah*) to prevent undue difficulty in ordinary life. Unlike darurah, such concessions may be long-term if the need persists. The voluntary *Salāt al-Hājah* (Prayer of Need) remains an encouraged prayer in which a Muslim asks Allah for help in fulfilling legitimate needs or resolving a problem[10].

Applying *darūrah* and *hājāat* to organ donation and transplantation

Applying these maxims to transplantation, organ donation and transplantation are generally allowed and in certain contexts encouraged, provided strict ethical conditions are met. Donation is often regarded as a charitable act (*sadaqah*) that saves lives, supported by the principles of necessity (*darūrah*) and need (*hājāt*). While the human body is sacred and a trust (*amānah*) from Allah. "Allah has indeed purchased from the believers their lives and wealth in exchange for Paradise"[11]). Many contemporary scholars consider that stewardship permits donation within Shariah limits, provided stipulated conditions are met.

The permissibility is grounded in the maxim **"necessity overrides prohibition" (*al-darūrāt tubīh al-mahzurāt*)**. Therefore, transplantation may be permitted when it is the only viable method to save a patient's life (e.g., heart or liver failure) and, in some circumstances, to restore major function or meaningfully improve quality of life, consistent with Shariah's aim of ease and removal of hardship[12].

To ensure *darūrah* and *hājah* are not misused, strict safeguards are applied:

a)**No alternative:** no equally effective, safer, lawful medical solution exists.

b) **No harm to donor:** donation must not cause the donor's death or destroy a vital, non-regenerative organ.

c) **Voluntary donation:** it must be a gift, not a sale; selling organs is prohibited (*harām*).

d) **Valid consent:** from the living donor, or through documented consent and/or next-of-kin authority for deceased donation.

e) **Reasonable probability of success:** strong medical probability of benefit and success.

Shari'ah perspectives on organ donation and transplantation

In an Islamic ethical framework, the relevant maxims include:

a) "Necessity renders prohibited things permissible" (*al-darūrāt tubīh al-mahzurāt*).

b) "Harm must be eliminated" (*al-darar yuzal*).

c) "A greater harm is removed by a lesser harm."

Accordingly, the majority of contemporary jurists permit organ retrieval and transplantation under strict ethical conditions and with absolute prohibition of exploitation and commercialisation. However, some scholars, particularly in the Indian subcontinent, maintain that bodily sanctity is absolute and that *darūrah* cannot override the prohibition against mutilation even to save a life[13].

Database of organ donation and transplantation

Databases for organ donation, transplantation, and waiting lists operate at international, national, and regional levels to enable secure matching of donors with recipients, track outcomes, and support policy and scientific analysis. They promote efficient use of available organs, reduce wastage, and improve equity and transparency.

International databases

1. **International Registry in Organ Donation and Transplantation (IRODaT):** a primary global database providing information on donation and transplantation activity by country, covering deceased and living donation and specific organ data; 117 countries reported their organ procurement and transplantation data.
2. **WHO-ONT (Organización Nacional de Trasplantes) Global Observatory on Donation and Transplantation:** a comprehensive global source for transplantation activities, legal aspects, and organizational frameworks, produced in collaboration with the Spanish Transplant Organization[14].

Regional and national organ databases (examples)

1. **Eurotransplant:** manages a central database for eight European countries (Austria, Belgium, Croatia, Germany, Hungary, Luxembourg, the Netherlands, and Slovenia), providing real-time 24/7 matching and supporting research.
2. **Canadian Organ Replacement Register (CORR):** a national database tracking end-stage organ failure, transplants, and donor trends, supporting monitoring and research.
3. **NHS Blood and Transplant (UK):** maintains the National Organ Donor Register for the UK.
4. **NHS Organ Donor Register (UK):** official UK database where individuals record decisions to donate; organ-specific datasets are available for authorized research.
5. **Living Donor Collective (LDC):** a specialized registry managed by SRTR to track outcomes for living kidney and liver donors in the U.S.
6. **Organ Procurement and Transplantation Network (OPTN):** managed by UNOS under a federal contract in the U.S.; contains national data on waiting lists, donation, matching, and transplantation.
7. **SRTR (Scientific Registry of Transplant Recipients):** analyses OPTN data and provides public summary reports, program-specific reports, and annual reports.
8. **National Donate Life Registry (RegisterMe.org):** a U.S. donor registry enabling a legal “document of gift” for organ, eye, and tissue donation across state lines[15].

Purposes and utilization

These databases support: fair allocation based on blood type, tissue type, urgency, organ size, and geography; comprehensive records for donors and recipients, including HLA typing; rapid matching to minimize wastage; traceability from recovery to implantation to support graft survival and reduce disease transmission risk; auditing and benchmarking to improve quality; and 24/7 citizen access to register donation consent16.

Defining death/brain stem death and *Shari'ah* guidelines

In Shari'ah, death is theologically defined as the permanent departure of the soul (*rūh*) from the body. Since this transition is metaphysical, Islamic jurisprudence relies on observable indicators to determine the legal state of death[17]. Classical scholars focused on cessation of breathing and heartbeat; modern life-support technologies have expanded the discussion.

The irreversible cessation of circulation and respiration is universally accepted as death across Islamic legal schools. The majority opinion—including the Islamic Fiqh Academy (OIC) and Muslim World League—accepts brain death (specifically brainstem death) as legal death, provided criteria are met:

a) all brain functions have completely and irreversibly ceased;
b) cessation is confirmed by specialized, competent physicians; and
c) (in some deliberations) the brain has begun to physically disintegrate[17].

Summary of clinical criteria (brainstem death)

Brainstem death determination typically includes persistent coma; absence of motor or verbal response to painful stimuli; absence of brainstem reflexes (pupillary light response, corneal reflex, gag/cough reflex, oculocephalic/oculovestibular reflexes); and apnea testing. Where needed, ancillary tests (e.g., cerebral angiography, CT perfusion, EEG) may be used to confirm the absence of blood flow or electrical activity in the brain[17]. After thorough investigation, brain death should be declared by **not less than three physicians**, none of whom should be involved in organ harvesting or transplantation.

Dissenting views

A significant minority of scholars, particularly from the Indian subcontinent, reject brain death and maintain that life continues as long as the heart beats, even if mechanically assisted[18].

Shari'ah guidelines for the deceased

Once death is confirmed, communal obligations (*fard kifāyah*) fall upon the community: gentle handling and washing (*ghusl*), shrouding (*kafan*), funeral prayer (*Salat al-Janāzah*), and prompt burial ideally within 24 hours—to preserve dignity. Islam prohibits cremation; the body should be returned to the earth[19].

End-of-life and medical ethics (selected points)

a) **Withdrawal of life support:** if recovery is medically impossible and death is confirmed (including brainstem death where accepted), withdrawal of life-sustaining treatment is permissible.
b) **Euthanasia and suicide:** strictly prohibited (*haram*); *Sharī`ah* prohibits intentional hastening of death.

c) **Organ donation:** generally permitted as *sadaqah jariyah*, provided consent is present and the sale/purchase of organs is excluded.
d) **Autopsies:** generally discouraged but may be permitted if legally required or for essential scientific benefit.
e) **Debts and funeral expenses:** should be settled before distribution of inheritance[20].

Will or bequest and consent for organ donation and harvesting

Organ donation and harvesting require legal consent, usually provided through national registries, driver's license designations, or

opt-out systems in some jurisdictions. Legal requirements must be met before procurement[21].

a) **Validity of consent:** a registered decision in a national registry serves as binding legal consent in many jurisdictions.

b) **Will or bequest:** a will is often impractical for organ donation because it is commonly read after the time window for organ retrieval. A donor card or registry registration is therefore preferable.

c) **Role of the family:** if no registry or written consent exists, clinicians seek family consent. In many systems, family may veto; in "first-person authorization" systems, the deceased's documented decision is final.

d) **Brain death:** retrieval typically requires death to be declared by accepted criteria (often neurologic).

Additional considerations include types of donations (organs and tissues), specialized donation (e.g., hands/face/limbs requiring additional agreements), medical suitability at time of death, and the legal ban on organ trading[21].

Practical steps often advised

1. Register in the official donor registry (e.g., PHOTA in Pakistan, NHS in the UK, state registries in the U.S.).
2. Inform families clearly; they are often crucial in timely authorization and provision of medical history.
3. Document intent (including in a will), while recognizing registry documentation as paramount.

Will, bequest, and consent in Islamic perspective

Voluntary consent is essential. A living donor must consent without coercion; for deceased donation, consent should be clearly expressed before death through a will, donor card, or registry, or granted by next of kin if no directive exists. Many scholars view organ donation as *sadaqah jariyah*; therefore, making a clear written bequest (*wasiyyah*) is considered permissible and encouraged by many Middle Eastern and Western Islamic councils. Some Shia jurists, such as Ayatullah Makaram Shirazi, consider posthumous donation permissible provided it is explicitly declared in the donor's will. Where no will exists, closest relatives may grant consent.

Juristic conditions for the permissibility of organ harvesting

• **Necessity overrides prohibition** within limits: Qur'an 2:173, 6:145, 16:115 (and related principles of *iztirār*)[22].
• **Respect for the body:** dignity (*karamah*) must be preserved (Qur'an 17:70)[23].
• **No harm to living donor:** donation cannot be of a vital organ and must not cause significant detriment.
• **No commercialization:** sale of organs is prohibited (Qur'an 9:111)[24].
• **Defining death:** debate persists on retrieval after brainstem death versus only after cardiopulmonary death[28].

In Islamic perspectives, organ donation is generally evaluated through preservation of life (*maqasid al-sharia*) and sanctity of the human body. While opinions differ, the majority consider it permissible under strict conditions, emphasizing altruism and rejecting commercial transactions [25].

Role of wills and bequests

A bequest (*wasiyyah*) is often the primary mechanism for expressing consent for posthumous organ donation. Some jurists recognize a clear will as sufficient authorization; others (notably some South Asian scholars) dispute this, arguing that the body is an *amānah* and cannot be bequeathed as personal property. Many scholars, however, accept donation where a will is

present and next-of-kin consent is also obtained [26].

Consent for organ harvesting

Consent is a prerequisite in most Islamic legal frameworks. Where no prior consent exists, the decision typically falls to next of kin or guardians; many permissive rulings allow heirs to grant consent to save another life [27].

Conditions for permissibility (operational summary)

• Preservation of dignity: retrieval must be respectful and should allow timely burial rites.
• No commercialism: donation must be voluntary.
• Necessity: transplant should be medically necessary to save life or restore vital function.
• Definition of death: many councils accept brain death; others require cessation of heartbeat[28].

Ethical framework of organ donation and transplantation in Islamic perspectives

Ethical frameworks for organ donation and transplantation have been discussed among jurists, medical experts, and social scientists. In many Muslim societies, cultural norms can become deeply embedded to the extent that they are sometimes conflated with Shariah injunctions. Transplantation is particularly sensitive because definitions of death, handling of the deceased, and bodily sanctity involve both ethical reasoning and juristic evaluation.
Today, many Muslim jurists allow living-related and cadaveric organ transplantation, but they vehemently reject commercial incentives. Concerning equating brainstem death with cardiovascular death, clear opinions and fatwas have been issued by scholars representing diverse regions. Societies, however, often resist the removal of organs despite clear rulings from religious authorities. Some fatwa-issuing bodies have permitted cadaveric organ retrieval in narrowly defined circumstances, even in the absence of a documented will. Donation has also been discussed in contexts where a deceased person declares that money obtained from the recipient be used to pay debts or for public welfare, and that the organ be used to save a life. There is no restriction on organ donation between people of different religions in normal circumstances[29].
In 2026, the ethical framework in Islam is characterized by a widespread but not universal consensus of permissibility, grounded in preserving life. Commonly cited maxims include:

• **Preservation of life:** "Whosoever saves the life of one person, it would be as if he saved the life of all mankind"[30].
• **Necessity overrules prohibition** when genuine necessity exists, and limits are observed (Qur'an 2:173; 6:119; 5:3; 2:185; 4:28) 31–35.
• **Public interest (*maslahah*):** welfare of the living is prioritized where a significant humanitarian purpose is served36.
• **Lesser of two harms:** choosing the lesser harm to prevent a greater harm[37–39].

Strict conditions and quality standards

With consultation from specialists, scholars prescribe strict conditions:

1. **Strictly voluntary:** donation must be a gift (*sadaqah*); selling organs is prohibited.
2. **Explicit consent:** from the living donor or, for deceased donation, through prior documentation and/or next-of-kin consent.
3. **No significant harm to donor:** donation must not cause death or

permanent disability; donation of vital organs is forbidden.
4. **High probability of success:** transplantation should have a strong likelihood of benefit and be the only effective option remaining.
5. **Exclusion of reproductive organs:** gonads are generally forbidden because they carry genetic information and risk confusion of lineage.
6. **Local tradition:** respected where it does not contradict *Shari'ah*.

Areas requiring continued deliberation

• **Brain death:** accepted by many councils yet remains contested in some communities.
• **Ownership vs stewardship:** whether bodily autonomy permits donation or whether *amānah* restricts disposal.
• **Dignity of the corpse:** traditions compare harming the dead to harming the living; thus, retrieval must be conducted with maximal respect. "Breaking the bones of the deceased is like breaking his bones when he is alive"[40–41].

Apart from solid organs, jurists have discussed the transplantation of nerve tissues to treat conditions such as Parkinsonism, where efficacy is established. Gonads remain excluded because of lineage implications and potential complications in inheritance distribution.

Conclusion

This review shows the broad contemporary acceptance of organ transplantation as a modality of treatment that saves lives and improves quality of life. Islamic teachings and the *fatawā* issued by multiple councils permit organ donation and transplantation if required conditions are fulfilled. In April 2025, the Council of Islamic Ideology (CII) in Pakistan issued a significant ruling officially recognizing organ donation after death as a permissible act of *sadaqah jāriyah* (ongoing charity). There is an increasing trend toward promoting organ donation in Muslim-majority countries as a humanitarian act of mercy, with initiatives focusing on aligning local medical ethics with juristic opinions to reduce societal resistance.

Jurists also impose stipulations governing the use of necessity: the necessity should be real and not imagined; it should be invoked only when no lawful alternative exists; the quantity permitted is determined by the magnitude of necessity; and a solution should not lead to a more harmful result. Hence, a Muslim should deal with the rule of necessity cautiously, with piety and respect for Allah's limits, and should attempt all lawful outlets before resorting to prohibitions[42].

The condition of necessity should not be linked only with life-saving procedures; it can also apply to restoring major function and easing severe hardships. The report of 'Urijah bin As'ad—whose silver nasal prosthesis caused infection and was replaced with gold by Prophetic instruction—illustrates this applied reasoning[43, 44 45]. Therefore, as a last resort to save a life or restore major function, with consent and ethical conditions met, organ transplantation is not only permissible but may be encouraged, aligning with Islamic values of compassion and sacrifice.

These conclusions are based on examination of systemic, logistical, and ethical challenges surrounding missed opportunities in organ transplantation and concerns of potential donors. By synthesizing current knowledge and identifying gaps in practice, this review aims to support improvements in organ donation and transplantation systems. Further deliberation and research are required to enhance efficiency and address the critical organ shortage. Although not discussed in detail, xenotransplantation, particularly using genetically modified animal sources, may help bridge the supply-demand gap. Where

scholarly disagreement persists, the primary tool for navigating differing opinions remains a robust system of informed consent, public policy, and a comprehensive database of diverse scholarly rulings.

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ISLAMIC ETHICAL FRAMEWORKS FOR ARTIFICIAL INTELLIGENCE IN HEALTHCARE: BALANCING PRIVACY, AUTONOMY, AND JUSTICE

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Abstract

The rapid advancement of digital technology, particularly Artificial Intelligence (AI), has driven significant transformation in healthcare through improvements in diagnostic accuracy, service efficiency, and the utilization of big data. However, AI implementation presents complex ethical challenges concerning patient data privacy, autonomy, informed consent, and algorithmic bias. In Muslim societies, these issues necessitate examination through Islamic medical ethical values derived from the Qur'an, Sunnah, and maqasid al-shariah. This article presents a literature review analyzing health information ethics and AI utilization in healthcare from an Islamic perspective, emphasizing trustworthiness (amanah), justice ('adl), protection of human dignity, and preservation of life.

Current ethical frameworks for AI in healthcare primarily address Western bioethical principles of autonomy, beneficence, non-maleficence, and justice. However, these frameworks inadequately address the unique challenges posed by AI's black-box nature, information asymmetry, and the erosion of individual accountability in digital systems. Furthermore, existing approaches often lack robust mechanisms for addressing algorithmic bias against marginalized populations and fail to cultivate the inner moral responsibility essential for managing health data as a sacred trust.

Islamic ethical principles fill these critical gaps by:
(1) reframing privacy as a sacred trust (*amanah*) rather than merely a legal right, thereby strengthening individual accountability; (2) emphasizing human dignity (*karamah*) as a transcendental foundation that cannot be overridden by technological efficiency; (3) establishing justice (*'adl*) as an active obligation requiring proactive inclusion of vulnerable populations; and (4) mandating human oversight through the principle of human moral agency (*ikhtiyar*). This integrated framework potentially advances the field by offering a more comprehensive ethical approach that addresses both technical and spiritual dimensions of AI deployment, providing a model for responsible innovation that can inform global ethical standards.

Keywords: Artificial Intelligence, Health Information Ethics, Islamic Medical Ethics, Privacy, Algorithmic Bias.

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Introduction

Rapid technological advancement in the era of the Fourth Industrial Revolution has created significant opportunities for digital transformation across the global healthcare sector. This transformation promises to expand public access to healthcare services, improve diagnostic accuracy, enhance service quality, and strengthen large-scale data-driven analytical capabilities. One of the key manifestations of digital transformation in healthcare is the implementation of Artificial Intelligence (AI).[1,2]

AI, a concept introduced by John McCarthy, refers to machines or software systems designed to simulate human intelligence through problem-solving, decision-making, and the evaluation of new data based on previously acquired information. In healthcare, AI applications span diverse fields including electronic medical records, disease screening and prediction, population health monitoring, medical imaging analysis, clinical decision support systems, surgical robotics, healthcare service management, virtual medical assistants, drug screening, and laboratory diagnostics. While these advancements offer considerable benefits, they also give rise to complex ethical challenges related to patient data privacy and protection, informed consent, algorithmic bias, safety, and justice.[3,4]

The ethical analysis of AI in Muslim societies requires examining two distinct dimensions: first, the use of AI by individuals and healthcare providers; and second, the development of AI systems for healthcare applications. These dimensions are governed by different Islamic ethical considerations. Individual use primarily concerns accountability (*taklif*) and intentionality (*niyyah*) in employing AI tools, while development involves broader responsibilities regarding data governance, algorithmic fairness, and systemic justice. Islamic jurisprudence offers rich precedents for adapting to technological innovations, as demonstrated historically through the integration of medical knowledge from Greek, Persian, and Indian sources, the development of Islamic hospitals (bimaristans), and the establishment of ethical codes for physicians. These historical examples illustrate how Islamic civilization successfully adapted foreign technologies while maintaining ethical integrity grounded in revelation.

The article demonstrates how Islamic principles can fundamentally rewire contemporary thinking about ethical AI by shifting the focus from mere compliance to spiritual accountability, from individual rights to communal justice, and from technological efficiency to holistic human flourishing. In Muslim societies, medical ethics cannot be separated from sharia values derived from the Qur'an and Sunnah, as well as *ijtihad* and *qiyas* in cases where explicit rulings are unavailable.[4] These issues are particularly significant because they are closely associated with fundamental Islamic ethical principles including trustworthiness (*amanah*), preservation of life (*hifz al-nafs*), justice (*'adl*), truthfulness (*sidq*), beneficence (ihsan), and the protection of honor (hifz al-'ird), all of which constitute the primary objectives of Islamic law (*maqasid al-shariah*).[5,6]

The Qur'an affirms human dignity in Surah Al-Isra (17:70): "Indeed, We have honored the children of Adam…" serving as a transcendental reminder that all forms of medical innovation must uphold human values. Similarly, Surah Ash-Shu'ara (26:80) emphasizes that true healing ultimately comes from Allah: "And when I am ill, it is He who cures me." This verse reinforces that technology functions merely as a means

(*wasilah*) and cannot replace empathy or the spiritual dimension of healing. Therefore, literature examining health information ethics and AI must be integrated with Islamic medical ethics to ensure healthcare technology is not only technically effective but also morally grounded and aligned with Islamic values.

Privacy, Autonomy, Informed Consent, and Trust (*Amanah*) in Digital Healthcare

Human dignity and privacy are fundamental rights inherent in every individual and constitute central pillars in bioethical discourse. In Islam, human life is regarded as a sacred *amanah* (trust) that must be preserved and respected. Medical confidentiality functions as both an ethical and professional obligation to protect patient dignity and prevent potential misuse of personal information. Islamic medical ethics emphasize the moral responsibility of healthcare professionals, which is not only professional in nature but also religiously grounded. Healthcare professionals are therefore required to protect patients' personal information obtained throughout the processes of diagnosis, treatment, and care, encompassing verbal, written, visual, and digital records.[9]

The implementation of electronic medical records (EMRs) and health-related algorithms across digital platforms has facilitated large-scale accumulation of medical data. While patient consent remains a standard practice in many regions, a significant ethical concern arises when AI developers access patient data—often without explicit disclosure—to train algorithms and generate specific outputs. Many users remain unaware that their data may be retained and utilized for AI training, constituting a breach of privacy and a violation of the trust relationship inherent in the patient-provider dynamic. From an Islamic perspective, such practices violate the principle of *amanah,* as health data fall within the private domain and are closely linked to individual honor and dignity.[10]

Islamic ethics offers a powerful framework by transforming the abstraction inherent in digital solutions into concrete moral accountability. When a healthcare provider or AI developer accesses patient data, Islamic jurisprudence conceptualizes this as being entrusted with a secret (sirr)—information whose disclosure may result in harm, discomfort, or violation of personal dignity. All medical information affecting a patient's honor, psychological condition, spiritual well-being, or social life is regarded as an *amanah* that must be safeguarded.[6] This obligation applies to all parties involved in healthcare services, including technology developers who may never directly interact with patients.

Breaches of patient confidentiality directly contradict the principle of protecting human dignity, which constitutes a primary objective of Islamic medical ethics. A prophetic tradition states, "Render the trust to the one who entrusted you, and do not betray the one who betrays you" (Hadith narrated by Abu Dawud and al-Tirmidhi).[11] The Qur'an further affirms, "O you who believe, do not betray Allah and the Messenger, nor betray the trusts entrusted to you knowingly" (Qur'an 8:27). These sources establish a robust ethical foundation emphasizing that the obligation to protect medical data must be upheld diligently—not merely as a legal requirement, but as an ethical, moral, and spiritual responsibility.

Cultivating this inner responsibility is particularly crucial when dealing with AI due to the significant information asymmetry inherent in AI systems. Unlike traditional

medical tools whose operations are relatively transparent, AI—particularly deep learning systems—operates through "black box" mechanisms that obscure how decisions are reached. This opacity creates asymmetries in knowledge between developers, healthcare providers, and patients. In such contexts, external regulations alone are insufficient to prevent ethical violations. Islamic ethics fills this gap by developing internal moral consciousness—the understanding that one is ultimately accountable to Allah—which serves as a more robust safeguard against misuse than external compliance mechanisms alone. This inner accountability becomes the foundation for ethical behavior even when violations are undetectable to external observers.

Patient autonomy in Islamic ethics is conceptualized through *ikhtiyar* (the capacity to choose) and *ridha* (voluntary consent). Patient autonomy aligns with Islamic values of *hurriyah* (freedom), and the application of AI in healthcare—when implemented in a manner that ensures patient understanding and voluntary agreement—has the potential to support and strengthen the process of informed consent.[6] However, this requires that patients are adequately informed not only about traditional medical procedures but also about how AI systems operate, their limitations, and how patient data will be used.

Algorithmic Bias, Big Data, Artificial Intelligence, and Justice from an Islamic Ethical Perspective

The optimization of algorithms, Big Data, and AI in healthcare enables earlier disease detection, more precise treatment, and improved access to healthcare services. Contemporary medical practice increasingly demonstrates reliance on AI as a tool to enhance diagnostic accuracy. Nevertheless, from an Islamic perspective, humans must remain central to medical decision-making processes, as only humans possess conscience, ethical responsibility, and spiritual awareness.[12]

Islamic principles establish a healthy environment for responsible AI solutions by reinforcing the concept of "human-in-the-loop"—the requirement that humans retain ultimate decision-making authority, particularly in high-stakes medical contexts. This aligns with the EU AI Act 2024, which classifies healthcare AI as high-risk and mandates human oversight to prevent algorithmic manipulation. In Islamic ethics, human moral agency (*ikhtiyar*) cannot be delegated entirely to autonomous systems because ethical accountability is inherently personal and non-transferable. A physician who relies blindly on AI recommendations without exercising independent judgment would be failing in their professional and religious obligations.

The theory of algorithmic bias explains that AI systems are not entirely neutral. Algorithmic bias may manifest in various forms, including representation bias, data selection bias, labeling bias, and output interpretation bias. AI systems trained on biased datasets may unintentionally reinforce negative stereotypes or discriminatory practices that result in harm.[13] Generally, AI systems involved in medical decision-making are developed based on data derived from specific population groups, particularly urban communities with adequate internet access and more favorable socioeconomic conditions. In contrast, vulnerable populations—such as rural communities, older adults, persons with disabilities, individuals with limited internet access, and low-income groups—are often underrepresented in these datasets.[10]
AI models developed from imbalanced or non-representative data have the potential to

reinforce pre-existing inequalities, as system performance depends heavily on input data quality. Deficiencies in datasets may lead to biased and discriminatory decisions, reducing diagnostic accuracy and appropriateness of medical recommendations. This imbalance in representation contributes to algorithmic bias that may compromise diagnostic outcomes and clinical decision-making. Such conditions clearly contradict Islamic principles that uphold universal human dignity and emphasize justice (*'adl*) for all humankind.[14] The Qur'an affirms in Surah Al-Baqarah (2:286): *"Allah does not burden a soul beyond its capacity."* This verse provides normative guidance that all systems, including healthcare technologies, should be designed with consideration for human capabilities and limitations, particularly those of vulnerable groups. Systems that demand digital readiness without accommodating societal conditions reflect a violation of moral principles rooted in justice and humanity.[10]

This Qur'anic wisdom resonates with established change management frameworks such as ADKAR (Awareness, Desire, Knowledge, Ability, Reinforcement), which recognize that successful technology adoption requires attention to human capacity and readiness. Islamic ethics similarly emphasizes that knowledge (*ilm*) and capability (*qudrah*) are prerequisites for responsible action. Implementation of AI in healthcare settings must therefore include capacity-building components, particularly for vulnerable populations, ensuring that technological advancement does not exacerbate existing inequities. This approach transforms justice from a passive concept into an active obligation requiring intentional effort to include those who might otherwise be excluded.

To address these challenges, a Qur'anic and practical approach is required—one that emphasizes inclusivity, compassion (*rahmah*), justice (*'adl*), and *amanah*. This may be achieved by integrating principles of fairness, responsibility, and transparency into AI algorithm design, including involvement of marginalized communities in processes of testing, validation, and evaluation grounded in empathy and social participation. By openly disclosing how AI systems operate, developers not only strengthen public trust but also fulfill their ethical obligation to provide information that is accurate, clear, and accountable.[10,13]

Conclusion

The application of Artificial Intelligence in modern healthcare systems presents substantial opportunities to enhance service quality, diagnostic efficiency, and healthcare accessibility. However, alongside these benefits, significant ethical challenges persist, particularly concerning protection of patient data privacy, fulfillment of informed consent, patient autonomy, and potential for algorithmic bias that may exacerbate social inequality.

Current ethical frameworks inadequately address the unique challenges posed by AI, particularly information asymmetry, black-box opacity, and the erosion of individual accountability in digital systems. Islamic principles fill these critical gaps by: (1) reconceptualizing privacy as a sacred trust (*amanah*) that cultivates inner moral responsibility; (2) establishing human dignity (*karamah*) as a transcendental principle that cannot be compromised for technological efficiency; (3) transforming justice (*'adl*) into an active obligation requiring proactive inclusion of vulnerable populations; and (4) mandating human oversight through the principle of moral agency (*ikhtiyar*).

This integration potentially advances the field by offering a more comprehensive ethical framework that addresses both technical and spiritual dimensions of AI deployment. The Islamic approach moves beyond mere compliance to cultivate internal accountability, provides robust mechanisms for addressing algorithmic bias, and offers a model for responsible innovation that can inform global ethical standards. Historically, Islamic civilization successfully adapted and developed technologies while maintaining ethical integrity; contemporary Muslim societies can similarly lead in developing ethical AI frameworks that serve both Muslim communities and the broader global community.

From the perspective of Islamic medical ethics, healthcare technology is regarded as a wasilah (means) that must be employed responsibly while upholding the principles of amanah, justice ('adl), compassion (rahmah), and the protection of human dignity and life as integral components of maqasid al-shariah. Accordingly, AI implementation should not replace human moral agency in medical decision-making. Instead, AI systems must be designed and deployed in a transparent, inclusive, and accountable manner, ensuring protection of vulnerable populations and fairness in data representation. The integration of Islamic ethical values into healthcare technology policies and practices constitutes a crucial foundation for ensuring that digital transformation in healthcare proceeds in a just, humane, and morally grounded manner.

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ISLAMIC ETHICAL GOVERNANCE AND HEALTHCARE CORPORATE SOCIAL RESPONSIBILITY (CSR) IN BANGLADESH'S ISLAMIC BANKS

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Abstract

Bangladesh's health landscape presents a paradox of impressive progress and deep inequity. While life expectancy has risen and mortality rates have dropped, access to healthcare remains unequal. A weak public system receives only 2.6% of GDP, forcing families to cover over 65% of costs out-of-pocket, pushing millions into poverty annually. Within this crisis, Islamic banks have emerged as distinctive ethical actors. Holding a quarter of banking assets, they operate in accordance with Shari'ah principles such as justice and the preservation of life. For them, healthcare CSR is a divine duty, not charity. They build hospitals, organize medical camps, deploy disaster teams, and utilize zakat to fund critical treatments, providing a vital lifeline. However, challenges such as fragmented efforts and weak measurement limit their impact. Realizing the full potential of this ethical finance model requires stronger coordination, integration into national health policy, and a shift from sporadic philanthropy to sustained social investment. Bangladesh's experience demonstrates that finance, guided by a moral compass, can be a genuine instrument of healing and equity.

Keywords: CSR, GDP Zakat, Shari'ah.

1. Introduction: The Health-Access Crisis and an Ethical Response

Healthcare is the bedrock of human dignity and productivity; its absence traps families in cycles of poverty and despair. The World Health Organization's goal of Universal Health Coverage (UHC) remains a distant dream for many in low-income nations (2). Bangladesh, with over 170 million people in a densely packed landscape, embodies this challenge with acute intensity (5).

The country's health achievements are justifiably hailed. Child mortality rates have been slashed, and lifespans have dramatically lengthened (1). Yet, these national averages mask a brutal inequality. Access to care frequently depends on financial capacity, gender, and geographic location. The public system, though vast, is underfunded and overstretched, while the private sector is expensive and inconsistently regulated. Consequently, households face a catastrophic financial burden, with out-of-pocket expenses among the highest globally, making illness a primary driver of poverty (3, 4).

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Amid this systemic strain, a unique player operates: the Islamic bank. Its identity is fundamentally ethical. It rejects interest-based transactions, emphasizes risk-sharing, and views capital through a lens of social trust. Its commitment to social welfare is not a discretionary add-on for good publicity; it is structurally embedded in its faith-based operational model. This chapter, therefore, investigates a critical question: How do Bangladesh's Islamic banks leverage their distinctive ethical governance framework to address the nation's healthcare access crisis? We will trace the journey from religious principles like maqasid al-shariah (the Higher Objectives of Islamic Law) to practical, life-saving interventions in communities, assessing both their tangible impact and inherent limitations.

2. A System Under Strain: The Structure of Healthcare in Bangladesh

Bangladesh's pluralistic healthcare system resembles a vast, overloaded pyramid. The base comprises more than 13,000 community clinics, each designed to serve approximately 6,000 people with basic primary care (6). They are the first, and often only, point of contact for rural millions. The next tier includes Upazila (sub-district) Health Complexes for more advanced care, followed by district hospitals. At the apex are specialized tertiary hospitals in major cities.

Despite this impressive geographic coverage, the public pyramid is cracking under pressure. The human resource gap is stark. Bangladesh has approximately 5.3 doctors and 3.1 nurses per 10,000 population, far below WHO recommendations and regional averages (7). These professionals are also concentrated in urban areas, leaving rural facilities critically understaffed. A community clinic may be run by a single, overstretched paramedic. Patients frequently face long waits, stock-outs of essential medicines, and referrals they cannot afford to follow.

Alongside this public structure thrives a bustling, largely unregulated private sector. In cities such as Dhaka and Chattogram, private hospitals offer advanced technology and shorter wait times, but at a high cost (8). For the average citizen, a major illness often means choosing between the overcrowded public facility and financially crippling private care. Non-governmental organisations (NGOs) such as BRAC have historically played a significant role, particularly in community-based maternal and child health, but their programs often depend on volatile donor funding (9). This three-part ecosystem—public, private, and NGO—creates a labyrinth where the poorest and most remote citizens are most likely to get lost. The most formidable barrier within this maze, however, is not just finding care, but affording it.

3. The Poverty Trap: The Crushing Weight of Out-of-Pocket Payments

In Bangladesh, the fear of medical bills is a pervasive anxiety. The health financing model is direct and onerous: patients pay for services immediately upon receiving them. Out-of-pocket payments constitute a staggering 67% of total health expenditure, one of the highest rates globally (3). In contrast, government spending covers less than one-third. This places the heaviest burden on those least able to bear it.

Consider the example of Anwar, a farm labourer from northern Bangladesh. When his wife needed an emergency caesarean section, the family faced a bill of 40,000 BDT (approx. $365). This sum represented four months of Anwar's income. To pay, they borrowed from a local moneylender at

exorbitant interest, pledging their future harvest as collateral. Years later, they are still repaying the debt. Anwar's story is not unique. Medicines alone account for nearly half of all household health spending, followed by diagnostic tests and hospital costs (10).

The macroeconomic consequence is devastating. Research consistently shows that health shocks are a primary driver of impoverishment. An estimated 5–6 million Bangladeshis are pushed into or deeper into poverty each year due to healthcare costs (4). The threat of destitution leads to dangerous coping strategies. People delay seeking care, resort to unqualified providers, or skip essential treatments. This "self-rationing" leads to worse health outcomes and, ironically, higher costs over time when conditions become critical.

Bangladeshi citizens generally lack access to health insurance, although some private insurance companies offer limited health coverage (11). For the vast majority working in the informal sector—the drivers, street vendors, and domestic workers—there is no financial safety net. Health-related financial shocks remain a constant and perilous uncertainty. This reality creates a profound social and ethical imperative for intervention. It is into this chasm of financial risk that Islamic banks, guided by their moral framework, direct a significant portion of their social efforts.

4. The Moral Compass: Foundations of Islamic Ethical Governance

To understand the Islamic bank's approach to health, one must first understand its moral DNA. Islamic ethical governance is not a compliance checklist; it is a worldview. It is rooted in the Qur'an, the traditions (Sunnah) of Prophet Muhammad (peace be upon him), and centuries of juristic scholarship. At its core is the concept of Amanah—a sacred trust. Leadership and wealth are not rights, but responsibilities held in trust from God, requiring accountability to both the divine and society (12).

This governance is animated by cardinal principles:
a) Justice ('Adl): Requires fairness, equity, and the prohibition of exploitation (zulm) in all transactions.
b) Compassion (Rahmah): Mandates mercy, kindness, and a proactive concern for the welfare of others.
c) Public Interest (Maslahah): Demands that decisions and actions secure benefit and prevent harm for the community.
d) Trustworthiness (Amanah): Enjoins honesty, transparency, and the fulfillment of all obligations.

These principles find their ultimate purpose in Maqasid al-Shariah (Higher Objectives of Islamic Law). Classical scholars identified five essential values to be protected: religion, life, intellect, lineage, and property (13). The preservation of life (hifz al-nafs) is paramount. Critically, this is not a passive injunction against killing. It is an active commandment to promote all that sustains and enhances life: health, nutrition, clean water, and shelter (14). Therefore, investing in healthcare is not merely a social good; it is a direct fulfilment of a primary objective of the Shariah. This framework provides an immutable ethical foundation, transforming health from a sectoral issue into a theological imperative and creating a powerful, intrinsic motivation for action that transcends conventional business logic.

5. CSR as Divine Duty: Reimagining Social Responsibility in Islamic Finance

In conventional corporate practice, CSR is often viewed as strategic philanthropy—a

way to "give back" and enhance reputation. In Islamic banking, this concept is fundamentally reconstituted. CSR is an operational mandate, woven into the financial architecture through specific, faith-prescribed instruments (15).

a) Zakat: The cornerstone. It is a mandatory annual wealth purification levy (typically 2.5%) for eligible Muslims. Its recipients, specified in the Qur'an, include the poor, the needy, and those in debt—categories that directly encompass those burdened by illness and medical costs (16). Islamic banks often manage massive zakat funds on behalf of clients and shareholders, creating a structured pipeline for health financing.
b) Sadaqah: Voluntary charity, unlimited in its potential for addressing individual hardship.
c) Waqf: A perpetual charitable endowment. A donor can dedicate a property or asset, the ongoing revenue from which funds a specific social purpose, like a hospital or clinic, in perpetuity.
d) Qard al-Hasan: A benevolent, interest-free loan. This can provide a critical bridge for families facing medical bills without plunging them into the debt trap of usurious loans.

Because of these mechanisms, social responsibility is institutionalized. The central bank, Bangladesh Bank, issues CSR guidelines for the entire banking sector (17). For conventional banks, these are soft recommendations. For Islamic banks, this often serves as a baseline; their internal ethical drive compels them to go further. The bank's role expands beyond that of a mere financial intermediary to that of a social intermediary and trustee. Its performance metrics extend beyond profit and loss to include social impact and the fulfilment of maqasid. When an Islamic bank allocates resources to health, it is executing a core function of its religious-economic model, directly linking financial activity to societal well-being and divine pleasure.

6. Faith in Action: Healthcare CSR Interventions on the Ground

The ethical framework materializes in diverse, tangible health initiatives across Bangladesh. Islamic banks employ a multi-pronged strategy:

a) Building Institutional Capacity: The most significant capital investment is in healthcare infrastructure. Islami Bank Bangladesh Limited (IBBL), the pioneer, operates the 500-bed Islami Bank Central Hospital in Dhaka and another major hospital in Chattogram. These are full-service, modern facilities providing heavily subsidized care. In 2022–23, IBBL's hospitals reported serving over 500,000 low-income patients, with massive subsidies for dialysis, surgery, and diagnostics (18). Other banks, like Social Islami Bank and First Security Islami Bank, run smaller hospitals and specialized therapy centres.

b) Reaching the Last Mile: Medical Camps: Banks routinely organize free medical camps in remote and underserved areas. These camps, often held in partnership with local doctors, provide consultations, basic diagnostics, and free medicines. For example, Al-Arafah Islami Bank regularly conducts eye camps, providing free cataract surgeries and glasses to thousands in rural communities (19). These interventions address immediate, unmet needs and serve populations otherwise excluded from formal care.

c) Disaster Response as Healthcare: When cyclones or floods strike—a frequent occurrence in Bangladesh—Islamic banks activate crisis response. This includes

deploying mobile medical teams and distributing emergency medical supplies, water purification tablets, and hygiene kits. This work provides critical primary care and epidemic prevention when public systems are disrupted.

d) Zakat and Sadaqah for Critical Care: This is where religious alms meet acute medical need. Banks meticulously distribute zakat funds to cover expensive, life-saving treatments for the indigent. This can include chemotherapy for cancer patients, open-heart surgery for children, or prosthetic limbs for accident victims. Case studies from banks like Shahjalal Islami Bank show zakat funds preventing family destitution by covering single bills that can exceed a household's annual income (20).

e) Focused Maternal and Child Health Programs: Aligning with national priorities, many banks run targeted initiatives for mothers and children, including prenatal check-ups, nutrition support, and immunization awareness drives, directly supporting the reduction of maternal and infant mortality.

7. Measuring the Impact: Lives Touched and Gaps Bridged

Assessing the impact of these interventions reveals both meaningful contributions and inherent limitations.

Positive Impacts:
a) Financial Protection: This is the most direct benefit. Zakat-funded surgeries and subsidized hospital services directly shield families from catastrophic health expenditure, breaking the sickness-poverty link for beneficiaries (21).
b) Improved Physical Access: Medical camps and mobile clinics provide essential services to geographically isolated communities, increasing the utilization of basic healthcare.
c) Building Social Capital and Trust: Ethical, transparent health programs enhance the bank's social license to operate and build community trust in institutions.
d) Complementing State Capacity: By adding hospital beds, specialty services, and disaster response, banks fill specific gaps in the overstretched public system, particularly at the secondary care level.

However, the scale of impact must be contextualized. The needs are immense. Millions face financial ruin annually. Bank CSR, while significant, touches hundreds of thousands. It is a vital complement, not a substitute, for systemic reform. Critiques note that these interventions often address the symptoms (catastrophic bills, lack of access) rather than the structural causes (low public funding, poor regulation) of the health crisis (22). Their strength lies in agility and targeted relief for specific individuals and communities, while their weakness lies in their inability to transform the health sector's underlying financing and governance.

8. Navigating Challenges: Fragmentation, Sustainability, and Governance Gaps

Despite their ethical drive, Islamic banks' healthcare CSR faces significant operational and strategic hurdles.

a) Fragmentation and Lack of Synergy: Initiatives are largely bank-specific, with minimal inter-bank coordination or collaboration with the Ministry of Health. This leads to duplication of effort in some areas and complete neglect in others. A coordinated, needs-based national map for private health CSR is absent (23).

b) The "Project" vs. "Program" Dilemma: Many activities are one-off events (e.g., a

single medical camp). They lack continuity and a long-term care pathway. A patient diagnosed with hypertension at a camp may have no means to access ongoing medication. Moving from sporadic projects to sustained, integrated health programs remains a key challenge.

c) Weak Impact Measurement and Reporting: Reporting focuses overwhelmingly on inputs (money spent) and outputs (patients seen). There is a critical lack of data on health outcomes (e.g., morbidity reduction, mortality prevention) and on the long-term economic impact (e.g., poverty averted). This limits accountability, learning, and evidence-based scaling of successful models (24).

d) Sustainability Concerns: Reliance on annual CSR budgets and variable zakat collections makes long-term planning difficult. The development of self-sustaining models, such as revenue-generating waqf properties dedicated to funding a health facility, is still in its infancy.

e) Governance and Transparency Risks: The discretionary distribution of zakat and sadaqah, while generally well-intentioned, can raise questions about nepotism or lack of rigorous need assessment. Strengthening the governance, transparency, and independent auditing of social funds is essential to maintain trust and religious integrity.

f) Evolving Disease Burden: The healthcare system's greatest emerging challenge is the rise of non-communicable diseases (NCDs) like diabetes, heart disease, and cancer, which require chronic, expensive management. Most bank CSRs are geared towards acute, episodic care and are not yet strategically equipped to address this NCD epidemic.

9. The Path Forward: Strategic Imperatives for Policy and Practice

Maximizing the potential of Islamic ethical finance for health requires concerted action from both regulators and bank leadership.

For Policymakers (Government & Bangladesh Bank):
a) Strategic Integration: Formally recognize Islamic banks as health financing partners. Establish a joint coordination council with the Ministry of Health to align CSR activities with national health priorities and geographic gaps.
b) Develop Enabling Frameworks: Create legal and regulatory frameworks for large-scale, pooled zakat and waqf funds dedicated to health, moving beyond individual bank projects to collective impact (25).
c) Incentivize Outcome-Based CSR: Shift regulatory guidelines from mandating CSR spending to encouraging outcome-oriented projects. Offer incentives (e.g., preferential regulatory treatment) for initiatives that demonstrate measurable health improvements and financial risk protection for the poor.
d) Co-create Standards: Collaborate with banks to develop a standardized impact measurement and reporting framework for health CSR.

For Islamic Banks:
a) Adopt a Strategic Social Investment Approach: Reframe health CSR from philanthropy to strategic social investment in human capital. Develop multi-year health strategies with clear, measurable goals tied to maqasid al-shariah.
b) Embrace Collaboration: Actively partner with other banks, public health agencies, and professional medical associations to pool resources, share expertise, and avoid duplication.

c) Innovate for Sustainability: Prioritize the development of waqf-based health infrastructure and explore Shariah-compliant social impact sukuk (bonds) to fund large health projects.
d) Strengthen Governance: Establish independent, expert-led Shariah Supervisory and Social Audit Committees to oversee the collection, management, and distribution of all social funds, ensuring utmost transparency.
e) Address the NCD Challenge: Design innovative programs for NCD management, such as subsidized medication clubs, community-based screening, and awareness campaigns, leveraging their deep community networks.

The ultimate goal is a synergistic model where the state provides strong regulation, primary care, and public health stewardship, while Islamic banks provide ethically-driven, complementary financing and innovation for secondary care, financial protection, and reaching the most vulnerable.

10. Conclusion

This chapter analyzes how Islamic banks in Bangladesh leverage their unique ethical governance to address healthcare inequity. Operating under maqasid al-shariah principles, which prioritize the preservation of life, these banks treat healthcare CSR as a core religious duty, not optional philanthropy. They translate this mandate into practical interventions: building and subsidizing hospitals, organizing rural medical camps, deploying disaster relief, and using zakat to fund critical treatments for the poor. These actions provide vital financial protection and access in a system where high out-of-pocket costs often cause impoverishment. However, challenges like fragmented projects and weak impact measurement limit scalability. The chapter concludes that maximizing this model's potential requires Islamic banks to evolve from donors to strategic health investors, while the state must create policies to integrate these efforts into the national health strategy, forging an ethical finance partnership for systemic impact.

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SOCIAL DETERMINANTS OF HEALTH FROM AN ISLAMIC LENS: POVERTY, ENVIRONMENT, AND SOCIAL JUSTICE

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Abstract

Social determinants of health (SDOH) including poverty, environmental conditions, access to water and sanitation, and housing, shape health outcomes more profoundly than clinical services alone. In Muslim societies, these determinants intersect with Islamic teachings that emphasize justice (*adl*), compassion (*raḥmah*), public welfare (*maṣlaḥah*), and stewardship (*khilafah*) of the earth. This essay explores SDOH through an Islamic lens, drawing on Qur'anic injunctions related to wealth distribution, social protection, and environmental care, as well as Prophetic guidance on water conservation, neighborly rights, and the moral urgency of addressing poverty. By aligning Islamic principles with contemporary public health evidence, this paper proposes frameworks that FIMA-affiliated institutions and Muslim countries can adopt to strengthen policy, health equity, and community resilience. The integration of Islamic ethics in SDOH programming offers a culturally resonant and morally compelling basis for advancing health and social justice globally.

Keywords: Social determinants; Islamic bioethics; Zakat; Environmental justice; Public health; FIMA.

Introduction

Social determinants of health (SDOH) are the structural conditions in which people are born, live, work, and age, and they account for nearly 50–60% of population health outcomes[1]. Factors such as poverty, unequal wealth distribution, environmental degradation, inadequate sanitation, and poor housing amplify the risk for infectious diseases, chronic illnesses, malnutrition, and mental health disorders, particularly in low- and middle-income countries (LMIC).

In Muslim-majority societies, SDOH are not only public health concerns but also moral responsibilities deeply rooted in the Islamic worldview. The Qur'an repeatedly commands fairness in wealth distribution, the protection of vulnerable groups, ecological balance, and community solidarity. Prophetic teachings reinforce these principles through practical guidance on water conservation, neighborly rights, and economic justice.

This article provides a comprehensive Islamic framing of core SDOH domains — poverty, environment, water, sanitation, and housing. It also highlights the opportunities for FIMA's global network to integrate Islamic ethics into fortifying health systems and policy advocacy.

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Poverty as a Social Determinant of Health

Poverty is one of the strongest predictors of health inequities. It limits access to nutritious food, healthcare, education, safe environments, and opportunities for social mobility.

a. Qur'anic Emphasis on Wealth Circulation and Social Protection

كَيْ لَا يَكُونَ دُولَةً بَيْنَ الْأَغْنِيَاءِ مِنْكُمْ

"...So that wealth may not merely circulate among the rich among you." (Surah Al-Hashr, 59:7)

This verse establishes equitable wealth circulation as a divine command. Contemporary interpretations parallel the need for welfare centric taxation, social protection, and health financing.

وَفِي أَمْوَالِهِمْ حَقٌّ لِلسَّائِلِ وَالْمَحْرُومِ

"And in their wealth is a rightful share for the beggar and the deprived." (Surah Adh-Dhariyat, 51:19)

The verse defines support for the poor not as charity but as a *right*, establishing a rights-based approach to health equity centuries before modern frameworks.

b. Prophetic Warnings on the Harms of Poverty

كَادَ الفَقْرُ أَنْ يَكُونَ كُفْرًا

"Poverty may lead to disbelief." (Narrated by al-Bayhaqi, Shuʿab al-Imān)

The hadith underlines poverty as a threat to psychological wellbeing, social stability, and faith corresponding to research linking extreme poverty with depression, anxiety, and suicide[2].

c. Zakat and Sadaqah as Health Equity Mechanisms

Zakat can function as an Islamic form of universal health coverage for the poor and destitute (*fuqara, masakin*), people with medical debt, chronic disease patients without means, and widows, orphans, and the structurally vulnerable

Evidence from Malaysia and Sudan shows effective integration of zakat into national health programs[3,4].

Environmental Health, Water, and Sanitation

Environmental conditions are central determinants of population health. Air pollution contributes to cardiovascular and respiratory disease, whereas unsafe water and sanitation drive infectious morbidity, and climate change exacerbates heat-related illness and vector-borne diseases. The World Health Organization (WHO) explicitly recognizes environmental conditions, including water and sanitation, as core social determinants of health requiring coordinated policy action across sectors[7].

a. Islamic Teachings on Environmental Stewardship (Khilafah)

إِنِّي جَاعِلٌ فِي الْأَرْضِ خَلِيفَةً

"I am placing upon the earth a vicegerent (khalifah)."
(Surah Al-Baqarah, 2:30)

The Qur'anic concept of *khilāfah* frames humans as trustees responsible for maintaining ecological balance, preventing harm (*ḍarar*), and ensuring sustainability. Islamic environmental ethics emphasize moderation, accountability, and intergenerational responsibility, principles that align closely with modern environmental health and sustainability frameworks[5].

b. Prohibition of Wastefulness

إِنَّ الْمُبَذِّرِينَ كَانُوا إِخْوَانَ الشَّيَاطِينِ

"Indeed, the wasteful are brothers of the devils." (Surah Al-Isra', 17:27)

This prohibition extends to excessive consumption of water, energy, and natural resources. Islamic scholarship regards environmental degradation and pollution as violations of the ethical mandate of *khilafah*, with direct implications for public health and social justice[5].

c. Prophetic Teachings on Water Conservation

لَا تُسْرِفْ فِي الْمَاءِ وَلَوْ كُنْتَ عَلَى نَهَرٍ جَارٍ

"Do not waste water, even if you are at a flowing river."
(Narrated by Ibn Majah).

Islamic jurisprudence treats water as a shared trust (*amanah*), emphasizing conservation, protection from contamination, and equitable access. Islamic juridical discussions on water, cleanliness, and sanitation closely parallel modern public health approaches to water, sanitation, and hygiene (WASH) and disease prevention[6].

Housing, Urban Livability, and Social Justice

Adequate housing reduces respiratory infections, injuries, exposure to toxins, and psychosocial stress. Islam emphasizes housing as a component of dignity.

a. Prophetic Emphasis on Adequate Housing

مَنْ كَانَ لَهُ مَنْزِلٌ فَلْيُوَسِّعْهُ عَلَى أَهْلِهِ

"Whoever owns a home should make it spacious for his family."
(Narrated by al-Bayhaqi).

Islamic jurisprudence also prohibits harming neighbors (*la ḍharar wa-la ḍhirar*), a basis for modern urban planning, noise control, and safety regulations.

b. Urban Justice and Islamic Principles

Equitable housing policies align with:

- The Qur'anic prohibition of deprivation,
- Neighborhood rights (*ḥuquq al-jar*),
- And public welfare (*maṣlaḥah*)

***Maqasid al-Shari'ah* and the Social Determinants of Health**

The framework of *maqāṣid al-sharīʿah* conceptualizes social, economic, and environmental conditions as moral obligations. This framework closely aligns with contemporary SDOH theory, which recognizes that health is shaped by structural determinants rather than healthcare alone[7].

- **Preservation of life** (*ḥifẓ al-nafs*): Achieved through health access and safe environments.
- **Preservation of intellect** (*ḥifẓ al-aql*): Supported by nutrition, education, and mental health.
- **Preservation of dignity/lineage** (*ḥifẓ al-nasl*): Promoted through adequate housing and family stability.
- **Preservation of wealth** (*ḥifẓ al-mal*): Supported by economic justice.
- **Preservation of Islamic way of life** (*hifz al-deen):* Requiring policies that promote ethical governance and equity in various walks of life.

SDOH interventions are therefore *shari'ah* driven and spiritually meritorious.

Opportunities for FIMA's Global Network

FIMA can lead SDOH-based Islamic public health reforms through developing & implementing Zakat-based health financing models. Leveraging Zakat for poverty alleviation and community health is a

powerful, underutilized tool for addressing the economic determinants of health. It should be viewed not merely as charity but as a form of economic justice and the "wealth of the poor".

Effective Zakat Policies and Systems for Poverty Alleviation & Climate Justice

FIMA should advocate and support the development of effective policies and systems that are focused on poverty alleviation than transient relief, as indicated below.

- Modernizing Zakat distribution by moving beyond immediate relief to sustainable, asset-building programs. This includes providing tools for trade, funding education, and offering interest-free microfinancing to lift recipients out of poverty.
- Encouraging the community institutions to build bridges with public health organizations and local governments to holistically address social determinants like food insecurity and transportation. Zakat funds could be strategically deployed to support such partnerships and co-design programs that tackle the root causes of poor health.
- Environmental health campaigns rooted in *khilafah* as in FIMA Save Earth Program. Climate change, which disproportionately harms vulnerable communities globally, including many Muslim-majority nations, is a matter of climate justice. An Islamic response involves holding corporations and governments accountable, reducing fossil fuel consumption, and advocating for policies that protect the most vulnerable from climate-related health risks.
- Water and sanitation programs integrating Islamic messaging as in FIMA Safe Water program. The Islamic imperative to avoid misusing water aligns perfectly with Sustainable Development Goal (SDG) 6, which aims to ensure availability and sustainable management of water and sanitation for all. Community advocacy can focus on improving WASH infrastructure in vulnerable Muslim-majority regions, framed as both a religious and public health obligation.

Healthcare subsidies for poverty alleviation

An improvement can be achieved by linking subsidies to poverty metrics & prevention. With tiered and targeted subsidies, we move from flat subsidies to ones based on a multi-dimensional poverty index (income, housing quality, employment, disability). The most vulnerable get near-full coverage.

Organizations & institutions to invest in primary & preventive care

A significant portion of subsidy funds should be allocated to free screenings, vaccinations, maternal health, and management of chronic diseases (like diabetes, hypertension). This prevents catastrophic expenses later.
Smart linkages integrate subsidy eligibility with other programs e.g. renewing a full healthcare subsidy could require attending a free financial literacy workshop or a pediatric wellness check.

The utilization of digital vouchers and digital wallets for subsidies, would increase health accessibility and protect the dignity of the beneficiaries

Housing and social protection advocacy

Stable housing is a vaccine against poverty and disease. Generate local evidence by partnering with academic institutions to

map "hotspots" where poor housing (e.g., mold, overcrowding) correlates with high rates of asthma, lead poisoning, or mental health issues and use this data for advocacy. Build a cross sector coalition and advocacy front with public health professionals, housing NGOs, legal aid societies, and community leaders. A doctor's testimony on a child's asthma is powerful in a housing policy hearing.
Advocate for specific health-linked policies and for laws requiring landlords to address mold, pests, and safety hazards.
Push for programs for rental assistance & security that prevent medical debt from leading to eviction.
Advocate for "health-enabled" social housing where residents can access subsidized clinics, social workers, and job training on-site.

Training modules on Islamic SDOH ethics for clinicians and policymakers

Clinicians at the micro level, should be trained to understand that their Islamic calling and duties goes beyond their clinic and hospital walls. Qur'anic verses *("And whoever saves one [life], it is as if he had saved mankind entirely"* (5:32) and Hadith on removing harm from the path should be the frame for SDOH. Train them in practical skills on simple screening tools for food insecurity, housing risk, and debt stress. Provide a "community resource guide" and connect patients to social services. This is *Ihsan* (excellence) in practice.

Role of the Policymakers & Top level executives

Policymakers & administrators at the macro level should try to fulfill the *Maqasid al-Shari'ah* (Higher Objectives of Islamic Law) through policy.

Poverty alleviation should be framed as protecting Life (*Nafs*), Intellect (*Aql*), Progeny (*Nasl*), and Wealth (*Mal*). *Zakat* and *Sadaqah* should not be seen as only serving charity, but as systemic tools for wealth circulation and justice (*Adl*). The current subsidy and housing policies should be reframed through the lens of *Maslaha* (public interest) and preventing *Dharar* (harm).

Ethical Framework for prioritizing resource utilization

Finally, the development of sector-specific ethical frameworks and guidelines grounded in *Maqasid al-Shariah* is essential for prioritizing resource utilization in ways that effectively address the social and environmental determinants of health. Such frameworks should be firmly aligned with the core Islamic principles of *Khilafah* (stewardship), *'Adl* (justice), and *Ihsan* (excellence and compassion). The formulation and implementation of these guidelines have the potential to lay the foundation for a transformative paradigm in equitable, sustainable, and ethically responsible resource governance.

The above mentioned could position FIMA as a global pioneer of faith-driven health and social justice.

Conclusion

Islam provides a robust ethical foundation for addressing social determinants of health. Its principles anticipate modern public health frameworks, emphasizing wealth redistribution, environmental stewardship, water conservation, and dignified housing. By integrating these teachings into SDOH programming, Muslim health institutions can develop culturally grounded, morally compelling, and sustainable models of health equity and social justice. FIMA's global network is well-positioned to lead this transformation by using the affiliated IMAs to advocate corresponding health initiatives and reforms in the Muslim majority countries and organizations.

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FOOD SECURITY AND THE *UMMAH*: GLOBAL CHALLENGES, ISLAMIC PRINCIPLES, AND PATHWAYS TO RESILIENCE

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Abstract

Food security remains one of the most critical global challenges, shaped by climate change, economic instability, conflict, and pandemics. The Food and Agriculture Organization (FAO) defines it through four pillars—availability, access, utilization, and stability—yet for Muslim communities an additional dimension exists: ensuring food that is *halalan* and *tayyiban* (wholesome). This article explores food security through global and Islamic perspectives, highlighting challenges such as conflict-driven hunger in Gaza, climate shocks in Pakistan, and the nutrition transition in Gulf states. It also examines Islamic principles of moderation, justice, and solidarity, and the role of zakat and waqf in supporting vulnerable groups. By combining these ethical frameworks with modern approaches in policy, finance, and agriculture, Muslim societies can strengthen resilience and contribute to the global goal of Zero Hunger by 2030.

Keywords: Food Security; Muslim Communities; *Halalan* and *Tayyiban*; Zakat and Waqf; Climate Resilience; Sustainable Diets.

Introduction

Food is defined as any substance consisting of protein, carbohydrate, fat , and other nutrients habitually consumed by individuals to sustain growth and vital processes and to furnish energy. It forms important determinants of the health of populations worldwide. Nutrition and health interactions are complex and their determinants include: the social, economic, and cultural issues related to making the right food choices; purchasing and eating the 'correct' types of food in 'appropriate' quantities; as well as the daily human activity and behaviour related to food. In the context of recent events , this text has to be changed to include that food is being weaponised to cause starvation , genocide and ethnic cleansing. It was worsened by the non-interference of neighbours who become complicit in this scenario.

Food Security is defined by the Food and Agriculture Organization (FAO) as a condition in which "all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food" (FAO, 2023), it encompasses four pillars: availability of the food, economic and physical access to food, utilization of the food by the body, and stability of the above 3 factors over time. Today, climate change, economic volatility, conflicts, and pandemics continue to threaten these pillars. For Muslim communities, food security carries an additional dimension: ensuring food that is not only accessible and nutritious but also *halalan* and *tayyiban* (wholesome), in line with Islamic principles.

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In the report of *The State of Food Security and Nutrition in the World 2025*, it highlighted that high inflation rates in many countries has undermined purchasing power especially amongst low-income populations to access healthy diets. The report also documented that high food price inflation is associated with increases in food insecurity and child malnutrition. The most vulnerable groups are low-income households, women and rural communities. In response to food price inflation, fight against hunger and malnutrition and to prevent future price shocks, the report examines policy measures adopted by countries, and outlines what is necessary going forwards. It stresses the importance of coherent implementation of fiscal and monetary policies to stabilize markets, promote open and resilient trade, and protect vulnerable populations. Additionally, it calls for better data systems and sustained investment in resilient agrifood systems to build long-term food security and nutrition. These coordinated actions are vital to reignite progress towards ending hunger and malnutrition by 2030.(FAO, IFAD, UNICEF, WFP and WHO. 2025. The State of Food Security and Nutrition in the World 2025 – Addressing high food price inflation for food security and nutrition. Rome.)

Global Food Security Trends

Global statistics paint a concerning picture: around 735 million people faced hunger in 2022, with food prices rising due to inflation and supply chain disruptions (World Bank, 2022). Muslim-majority countries, especially within the Organization of Islamic Cooperation (OIC), face a dual challenge. While some are highly dependent on imports (e.g., Gulf countries), others struggle with low agricultural productivity and conflict-related food insecurity (UNICEF & WHO, 2021).

Food Security in the Muslim Context

Food in Islam is not only sustenance but also part of religious observance and ethical living. The Qur'an and Hadith emphasize balance, moderation, and the prohibition of waste (Qur'an 7:31). Halal certification systems have become critical for Muslim consumers to ensure lawful consumption. Furthermore, zakat (almsgiving) and waqf (charitable endowments) provide mechanisms to redistribute food and resources to vulnerable groups (Khan, 2019).

Challenges Faced by Muslim Communities

1. **Conflict and Displacement**: Countries such as Yemen, Syria, and Palestine experience severe food shortages due to blockades and wars.

The recent report (16 October 2024) by United Nations Peace and Security, quotes the IPC (Integrated Food Security Phase Classification) highlighted that more than 1.8 million Palestinians in Gaza are experiencing "extremely critical" levels of hunger, with 70 per cent of crop fields destroyed and livelihoods decimated during the ongoing Israeli military offensive, a UN-backed food security assessment released recently revealed

IPC food security initiative show that 133,000 people – or 6 per cent of the enclave's population – are already experiencing Phase 5 or "catastrophic" food insecurity. It's feared this number could rise to around 345,000 people – or 16 per cent of the entire population – between the winter months of November and April next year.

"The risk of famine persists across the whole Gaza Strip. Given the recent surge in hostilities, there are growing concerns that this worst-case scenario may materialize," the assessment noted.

The UN Secretary-General is alarmed by the IPC report's findings amid high displacement and restrictions on

humanitarian aid flows, UN Deputy Spokesperson Farhan Haq told reporters during a recent news briefing in New York.
"One year into the conflict, famine looms. This is intolerable," Mr. Haq said.
The Secretary-General is also calling on Israel to immediately reopen all crossing points, he added. But recent events showed that the genocidal terrorist entity had blatantly disregarded the agreement as proposed by President Trump. On 22 October 2025 Al-Jareera reported "Israel has killed nearly 100 Palestinians in Gaza and wounded 230 since the fragile truce brokered by the United States came into effect on October 10th 2025". And HAMAS obediently subscribed to the agreement – maybe waiting the right opportunity to retaliate accordingly
In addition, Mr. Haq emphasised bureaucratic impediments must be removed, and law and order must be restored inside Gaza so that UN agencies can deliver lifesaving humanitarian assistance.
The IPC assessment led to its recommendation to prevent the human tragedy due to food insecurity. IPC stressed that immediate access to adequate food, medical supplies, water, and basic services across the Gaza Strip, can reduce the risk of a rapid descent into famine. It also calls for an immediate, unconditional and sustained ceasefire, restoration of food systems, and better prevention and management of rising and acute malnutrition. To help starving children, blanket, supplementary feeding programmes and infant and young child feeding programmes need to be bolstered, including promotion of breastfeeding and care for non-breastfed infants.
UN agencies for their part continue their efforts to assist all Gazans despite severe challenges, including insecurity, access difficulty, and ongoing evacuation orders and fighting. The UN Food and Agriculture Organization (FAO), for instance, has prioritised reactivating local food production and restoring the availability of highly nutritious food, especially as the winter season approaches. Even prior to the war, winters in Gaza saw spikes in hunger and malnutrition.
"To curb acute hunger and malnutrition, we must act now – immediately cease hostilities, restore humanitarian access to deliver critical and essential food aid and agricultural inputs in time for the upcoming winter crop planting season which has already started – to allow them to grow food," said Beth Bechdol, the agency's Deputy Director-General.
"Humanitarian aid alone is not enough. People need fresh, nutritious food. To make a difference, we also need to support farmers to continue and restart the production of food, as well as the flow of imported food and non-food items," she added.
FAO also voiced "deep concern" over significant losses of livestock, which are indispensable for the livelihoods and basic survival of Gaza's population.
The agency has set up a programme to safeguard some 30,000 sheep and goats – representing around 40 per cent of the remaining livestock. As of the end of September, it has distributed fodder to over 4,400 livestock holders in Rafah, Khan Younis and Deir al-Balah, and veterinary kits to about 2,400 herder families.
It stands ready to deliver more essential supplies, including additional fodder, greenhouse plastic sheets, plastic water tanks, vaccines, energy blocks and animal shelters, once access, security, and mobility conditions are restored, FAO said.
"By nourishing these animals, enough milk can be provided for all of Gaza's children," it added.
The Office for the Coordination of Humanitarian Affairs (OCHA) reports that ongoing hostilities are severely hampering access to essential resources, particularity water. In Jabalya and Beit Lahya, municipal well water production has completely stopped. Daily water distribution in northern Gaza has plummeted to just 638 cubic meters, compared to 380,000 cubic

metres throughout Gaza before October 2023.

Mr. Haq also noted that UN partners are "preparing for winter and taking urgent steps to mitigate the risk of flooding."

Despite these challenges, humanitarian efforts continue. The second round polio vaccination campaign in central Gaza reached over 181,000 children, with plans to expand it to southern Gaza soon.

Reality is brutal in Gaza and gets worse every day, while essential humanitarian supplies and assistance are being blocked at every turn, a senior UN official reported to the Security Council.

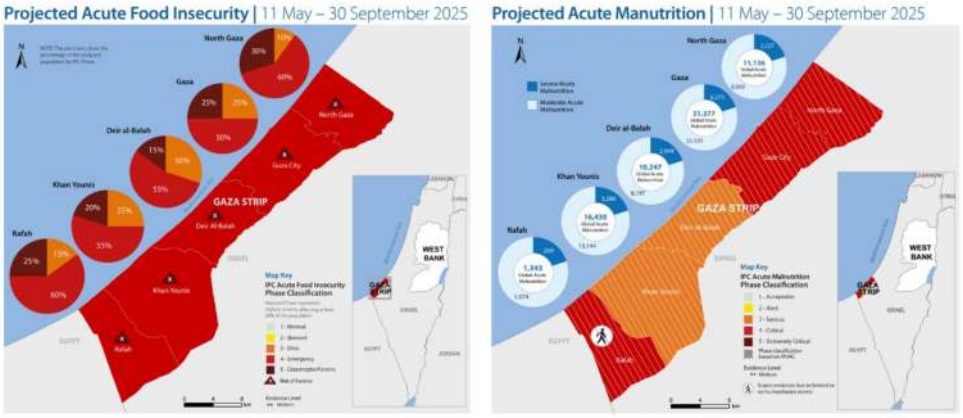
2. **Climate Change**: Although majority of Muslim countries did not face many challenges due to climate change phenomena, some Muslim-majority regions in the Middle East and North Africa are among the most water-scarce in the world, directly affecting agricultural production.

On the other hand, flooding caused damage to food crops as what happened in rice (basmati) belt in Punjab, particularly Gujranwala division – including the Sialkot and Narowal districts – are among the areas worst hit by recent flooding as reported by Foreign Agricultural Service (FAS) of the US Department of Agriculture.

3. **Economic Inequality**: Low-income Muslim households often spend a high proportion of their income on food, making them vulnerable to price shocks.

The blockage by Israel of Humanitarian Aid hinders consignment of food, water, medicine to reach population in Gaza. Due to this blockage the cost of essential food items become very extreme and cause the cycle of poverty continues to escalate and seen by people in the world, yet unable to do anything.

In the Special IPC report that refers between 1 April and 10 May 2025, over 1.9 million people (93 percent of the total population in the Gaza strip) are classified in IPC Acute Food Insecurity(AFI) Phase 3 (Crisis) or above and are in urgent need of humanitarian food assistance. Among them, 244,000 people (12 percent) are classified in IPC AFI Phase 5 (Catastrophe), associated with an extreme lack of food and/or other basic needs even after full employment of coping strategies, leading to starvation, death, and destitution; while 925,000 people (44 percent) are in IPC AFI Phase 4 (Emergency) and 775,000 people (37 percent) in IPC AFI Phase 3 (Crisis).



Some areas are classified in IPC Phase 4 (Emergency) despite the prevalence of households in IPC Phase 5 (Catastrophe) exceeding 20 percent. Households may be in IPC Phase 5 (Catastrophe), but the area may not be classified as IPC Phase 5 (Famine) if widespread deaths and acute malnutrition have not yet materialised at area level. I Disclaimer: The information shown on the maps does not imply official recognition or endorsement of any physical and political boundaries I For more information please contact ipc@fao.org.

4. **Nutrition Transition**: While this article is focusing on the food insecurity affecting the Muslims, it is a fact that in some other Muslim countries, the shift towards processed and high-sugar foods has led to rising rates of obesity and diabetes in countries such as Malaysia, Saudi Arabia, and the UAE (UNICEF & WHO, 2021).

A study by M Badran et al, noticed that obesity has also reached epidemic proportions affecting people of the Arabic-speaking countries, especially those in higher-income, oil-producing countries. The prevalence of obesity in children and adolescents ranges from 5% to 14% in males and from 3% to 18% in females. There is a significant increase in the incidence of obesity with a prevalence of 2%–55% in adult females and 1%–30% in adult males. Changes in food consumption, socioeconomic and demographic factors, physical activity, and multiple pregnancies may be important factors that contribute to the increased prevalence of obesity engulfing the Arabic-speaking countries.

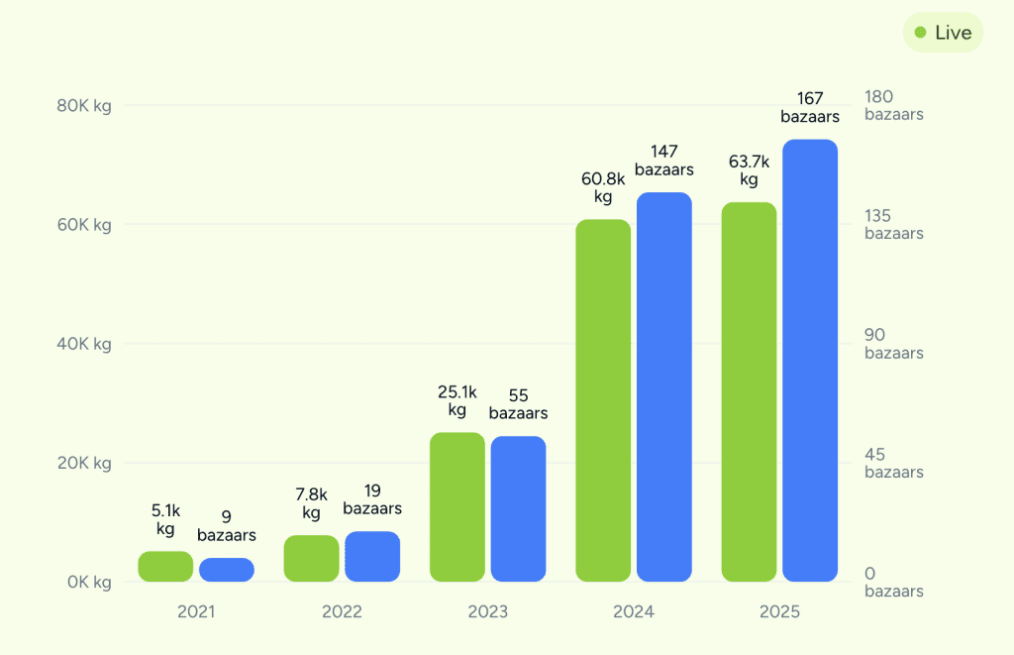
Islamic Principles and Food Security

Islamic teachings provide guidance on sustainable food systems. The concept of *tayyib* stresses that food must be wholesome and beneficial, not merely *halal* (Al-Qaradawi, 2010). The Prophet Muhammad (PBUH) discouraged wastefulness, and during Ramadan, Muslims are reminded of moderation. Unfortunately, studies indicate that food wastage spikes during Ramadan, with 25–40% of food being wasted in some Muslim countries (OIC, 2018). Tackling this issue could significantly enhance food security.

According to President, Consumers Association of Penang (CAP), Mr Mohideen Abdul Kader, “Ramadan is supposed to be a month of worship for Muslims but for some people, it is a month for feasting and wasting money. Islam tells its people to avoid being greedy, wasteful, and extravagant”.

Malaysia’s food waste issue becomes especially obvious during Ramadan as the culture of Ramadhan bazaar is unavoidable. In 2023 alone, the Consumers Association of Penang (CAP) reported that 90,000 tonnes of food were discarded during the fasting month, a figure reflecting a 15 to 20% increase compared to other months. This surge is largely driven by overbuying and over-preparing food, particularly at Ramadan bazaars. The Solid Waste Management and Public Cleansing Corporation (SWCorp) also warned that without effective intervention, around 75,000 tonnes of food will be wasted during Ramadan every year – echoing the same 15% to 20% increase compared to other months.

However, in recent years there were efforts to reduce wastage by organising charity, re-channelling the excess food to better distribution channels.



Graph 1: Displays the amount of food saved by MYSaveFood and the number of articipating bazaars involved in salvaging and redistributing surplus food. (Source: MySaveFood/ReMeal)
It is hoped that Muslims will be more sensitive in spending during Ramadan and think more of their unfortunate Muslims elsewhere.

Strategies for Strengthening Food Security in Muslim Communities

1. *Halalan* and *Tayyiban* Food Systems

Strengthening *halalan* and *tayyiban* food systems requires more than certification. It involves securing integrity across the entire supply chain—from farm to fork. This means ensuring transparency, digital traceability, and resilient halal logistics such as cold chain management. The concept of *tayyib* also reminds communities that food should be not only lawful but also wholesome and nutritious. Embedding these principles helps build consumer confidence while protecting public health and aligning with global sustainability goals.

2. Supporting Farmers through Islamic Finance

Smallholder farmers, who form the backbone of food production in many Muslim-majority countries, often lack access to conventional credit. Islamic finance tools such as *qard al-hasan* (benevolent loans), *mudarabah* (profit-sharing), and micro-takaful (Islamic insurance) can empower these farmers to adopt climate-smart technologies, diversify crops, and sustain production. Case studies from Indonesia show how zakat-based microfinance initiatives have successfully lifted small farmers out of poverty and improved food security.

3. Mobilizing *Zakat, Waqf*, and *Sadaqah Jariyah*

Zakat and *waqf* have historically played vital roles in redistributing

wealth and sustaining community welfare. In the modern context, these instruments can be strategically mobilized to fund food banks, school feeding programs, and community kitchens. Innovative models such as "*waqf* farms" or "green *waqf*" have been proposed to establish self-sustaining agricultural projects that both feed the poor and generate continuous rewards (*sadaqah jariyah*) for donors.

4. Promoting Sustainable Diets and Reducing Waste

Muslim societies must encourage dietary habits that are both healthy and sustainable. This includes promoting traditional diets rich in grains, legumes, and vegetables, and discouraging excessive reliance on processed foods linked to obesity and diabetes. Equally important is addressing the culture of food wastage, particularly during Ramadan. The Qur'an (7:31) reminds believers not to waste, as Allah does not love the wasteful. Campaigns like Malaysia's MYSaveFood demonstrate how salvaging and redistributing surplus food can reduce waste while feeding vulnerable populations.

5. Building Climate-Resilient Agriculture

With climate change exacerbating droughts, floods, and water scarcity, Muslim countries must prioritize resilience. Investment in water-saving irrigation systems, drought-resistant crops (such as millet and sorghum), and agroecological practices can help secure future food supply. Saudi Arabia's adoption of advanced irrigation technologies and Morocco's investment in drought-resistant crops serve as practical examples.

6. Policy and Governance

Food security cannot be addressed by the agricultural sector alone. It requires coordination across ministries of health, agriculture, Islamic affairs, and social development. Faith-based organizations, NGOs, and local communities should also be actively involved. The OIC's *Strategic Plan of Action on Food Security 2035* provides a blueprint, but its effectiveness will depend on coherent implementation at the national level, supported by reliable data systems, fair trade policies, and investments in sustainable food systems.

Conclusion

Food security is not merely an economic or political concern but a moral and spiritual obligation. In Islam, access to *halalan* and *tayyiban* food is central to human dignity and wellbeing. The Qur'an (7:31) reminds believers to eat and drink but not to waste, while the Prophet Muhammad ﷺ emphasized feeding the hungry as part of faith. These ethical principles highlight that ensuring food security is both a development priority and a religious responsibility.

For Muslim communities, strengthening food systems requires a multidimensional approach: enhancing *halal* and t*ayyib* supply chains, promoting sustainable diets, reducing food waste, and mobilizing Islamic social finance instruments such as zakat and waqf. At the same time, governments and faith-based organizations must work together to address conflict-driven hunger, mitigate the impacts of climate change, and promote nutrition

education to curb the growing burden of obesity and malnutrition.

The challenges are severe—conflicts in Gaza, floods in Pakistan's rice belt, and rising obesity in Gulf states reveal the diverse threats to food security. Yet they also show opportunities for resilience. Muslim societies can harness solidarity through community kitchens, zakat-based food banks, and innovative *waqf* farms, while also adopting modern agricultural technologies and governance frameworks. The OIC's Strategic Plan of Action on Food Security 2035 provides a guiding framework, but implementation will require national commitment and grassroots participation.

Ultimately, food security for Muslim communities is not only about ending hunger but about upholding justice, protecting the vulnerable, and maintaining balance in creation. By aligning modern innovations with Islamic principles of moderation, solidarity, and stewardship, Muslim societies can contribute meaningfully to the global vision of achieving Zero Hunger by 2030.

May our collective efforts, guided by knowledge and grounded in faith, bring nourishment to the hungry, dignity to the poor, and *barakah* to the resources entrusted to us. May Allah enable us to uphold justice, avoid waste, and safeguard His creation, so that we may fulfil our responsibility as stewards of the earth and contribute to the realization of food security for all.

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CLIMATE CHANGE, ENVIRONMENTAL HEALTH, AND ISLAM: A POLICY CALL TO STEWARDSHIP (*KHILĀFAH*)

Musa Mohd Nordin, and Sherjan P. Kalim ***

Abstract

The accelerating climate crisis, manifesting in rising global temperatures, extreme weather events, and ecosystem collapse, presents the most profound existential and ethical challenge of our time. Its impacts on environmental health—from air and water quality to food security and the spread of infectious diseases—are disproportionately borne by the world's most vulnerable, including many Muslim-majority nations.

The Islamic tradition, with its foundational principles of stewardship*, balance (mīzān), and the prevention of harm (darʿ al-ḍḍarar), offers a compelling Islamic framework for environmental ethics and practical* climate action.

Moving beyond theological discourse, we urge Islamic institutions, governments, and civil society to operationalize this framework.

This call to action is based on the Maqasid al-Shari'ah (higher objectives of the Islamic Law) to build resilient health systems, mitigate climate change, and fulfill the trust (amānah) of protecting the Earth and its inhabitants.

Keywords: Climate Crisis, Environmental Health, Islamic Environmental Ethics, *Khilāfah, Mizān*, *Maqāsid al-Sharī'ah*, *Amānah*.

1. Introduction

The scientific consensus, as articulated by the Intergovernmental Panel on Climate Change (IPCC), is unequivocal: human activity is the dominant driver of global warming. The consequences—heatwaves, droughts, floods, and sea-level rise—directly degrade environmental determinants of health. Respiratory illnesses from polluted air, malnutrition from failed crops, and water-borne diseases from contaminated water are no longer distant threats but present realities, particularly in Lower- and Middle-Income Countries (LMIC). (1)

For the global Muslim community (Ummah), this is not solely a scientific or political issue; it is a deep test of faith. The *Noble Qur'ān* declares,

"It is He who has appointed you stewards (khilafah) on the earth…" (2)

This concept of *Khilāfah* imposes a sacred trust *(amānah*) upon humanity to care for the planet with justice (*'adl*) and mercy (*rahmah*). The current ecological breakdown represents a collective failure of this fiduciary duty and responsibility. A robust Islamic environmental ethic, translated into concrete policy, is essential for effective and just climate action.

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2. The Scientific Basis

Climate change acts as a threat multiplier for environmental health. Key mechanisms include:
· Thermal Stress: Increased morbidity and mortality from heatwaves, exacerbating underlying illnesses including cardiovascular disease, diabetes, and mental health. Heat-related mortality for people over 65 years of age increased by approximately 85% between 2000–2004 and 2017–2021 (3)
· Air Quality: Climate change is expected to worsen harmful ground-level ozone, increase people's exposure to allergens like pollen, and contribute to worsening air quality, complicating asthma and chronic obstructive pulmonary disease (COPD). (4)
· Water and Food Security: Climate change can affect crops, livestock, soil and water resources, rural communities, and agricultural workers, leading to malnutrition and water-borne diseases.(5)

· Infectious Diseases: Climate is recognized as a major environmental factor influencing the distribution of vector-borne disease (VBD), e.g., malaria and dengue fever. Climate change exacerbates the risk and burden of both vectors and pathogens, allowing them to be introduced and dispersed into new regions. (6)
· Mental Health: The trauma of displacement, loss of livelihood, and "ecological grief" constitute a growing public health burden. (7)
These impacts violate the Islamic objective (*maqsad)* of preserving life (*ḥifẓ al-nafs*) and preserving wealth or resources (*ḥifẓ al-māl*). (8)

3. The Islamic Ethical Framework:

Foundations for Islamic environment policy are rooted in the primary sources:

a. *Tawḥhīid* (Oneness of God): The universe is a unified, balanced (*mīzān*) creation, and disrupting it is an act of corruption (*fasād*) on earth.
As for the sky, He raised it high and set the balance of justice. (9)
Corruption has spread on land and sea as a result of what people's hands have done, so that Allah may cause them to taste the consequences of some of their deeds and perhaps they might return to the Right Path. (10).
b. *Khilāfah* (Stewardship): Humanity is a custodian, not an owner, and is accountable for its actions.
Prophet Muhammad ﷺ*said: "*The world is beautiful and verdant, and verily God, be He exalted, has made you His stewards in it, and He sees how you acquit yourselves"*'* (11)
c. *Mīzān* (Balance): Every creation has intrinsic value and rights, and exploitation that disrupts ecological balance is prohibited.

d. *Maṣlaḥah* (Public Interest) and *Maqāsid al-Sharī`ah*: The higher objectives of Islamic law—protecting religion, life, intellect, progeny, and wealth—are critically threatened by climate change. Environmental protection is a prerequisite for fulfilling these objectives. (12)

· *Wasatiyyah* (Moderation) and Prohibition of *Isrāf* (Extravagant Waste): Consumerism and resource depletion are condemned.
"*Eat and drink, but do not waste. Indeed, He does not like the wasteful*." (13).

4. A Policy Call to Action

We call upon policymakers in Muslim-majority nations, Islamic financial institutions, religious scholars (*'ulamā*), and civil society to consider the following actions:

A. For Islamic Governments and Intergovernmental Bodies (Organization of Islamic Cooperation - OIC):

1. Revise National Development Strategies: Align all national development plans (Vision 2030s, etc.) with the principles of *Khilāfah* and *mīzān*, adopting rigorous decarbonization targets and nature-based solutions. Decarbonization is the process of reducing and ultimately eliminating carbon dioxide (CO2) emissions and other greenhouse gases (GHGs) that result from human activities. The Paris Agreement targets net-zero carbon emissions by 2050 to mitigate the impacts of climate change. (14)
2. Establish "Green *Awqāf*": Dedicate endowment (*waqf)* assets explicitly for renewable energy projects, reforestation, water conservation, and sustainable agriculture. Create a global Islamic Green *Waqf* Fund. Green *Waqf* is vital for integrating environmental conservation with socio-economic development. (15)
3. Integrate *Maqāsid* into Climate Policy: Utilize the *Maqāsid al-Sharī`ah* framework to conduct "*Sharī`ah* - Based Climate Impact Assessments" for all major infrastructure and industrial projects.

4. Lead in Climate Diplomacy: As a collective bloc, advocate for climate justice, equity, and grounding arguments in universal ethics of justice and responsibility.

B. For Islamic Financial Institutions:

1. Mandatory Green *Sukūk* Standards: Green Islamic bonds (*Sukūk*) are environmentally friendly with a focus on climate finance, which encompasses funding for climate mitigation, adaptation, and resilience building. Develop and scale green and sustainability-linked sukuk to finance renewable energy, public transport, and climate-resilient health infrastructure. (16)

2. Shariah-Compliant ESG Screening: Integrate stringent Environmental, Social, and Governance (ESG) criteria, based on maq*āsid,* into all investment decisions, divesting from fossil fuels and extractive industries causing ecological harm *(ḍarar*).
3. Microfinance for Resilience: Develop Islamic microfinance products to help vulnerable communities adapt (e.g., for drought-resistant crops, solar-powered irrigation, or flood-resistant housing).

C. For Religious and Educational Institutions:

1. Issue a Collective Fatwa: A recognized transnational Islamic authority should issue a clear, contemporary fatwa declaring the prevention of catastrophic climate change a religious obligation (*farḍ al-kifāyah*) and affirming the prohibition of destructive environmental practices.
2. Revise Educational Curricula: Integrate ecological consciousness (*tarbiyah bī'iyyah*) and climate science into curricula of madrasas, schools, and universities, linking it to Qur'anic verses and Prophetic teachings. (17)
3. Deliver impactful *Khutbahs* (Sermons)*:* Develop and disseminate model Friday sermons *(khutbahs*) on environmental stewardship, connecting local environmental health issues to Islamic teachings.

D. For Healthcare Systems in Muslim Communities:

1. Build Climate-Resilient Health Facilities: Ensure hospitals and clinics are powered by renewable energy, have

water security, and can serve as shelters during climate extremes. (18)

2. Train Healthcare Workers: Educate medical professionals on climate-sensitive diseases and integrate environmental health into public health surveillance.
3. Advocate for a "One Health" Approach: Promote the Islamic holistic view that aligns with the "One Health" model, recognizing the interconnection between human, animal, and ecosystem health.

5. Conclusion

The climate crisis is the tangible manifestation of our collective neglect of the trust (*amānah*). Islam provides not merely solace but a rigorous, actionable paradigm for engagement. The proposed policies, from green *Awqāf* and *Sukūk* to faith-based education and *Maqāsid*-driven governance, are pathways to operationalize our creed.

The time for theoretical discussion has passed. (19) The Muslim world must lead by example, transforming the principle of *Khilāfah* into a living reality. In doing so, we protect the most vulnerable of God's creation, preserve the balance He ordained, and honor our sacred trust as stewards of this fragile, beautiful Earth.

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GLOBAL HEALTH DIPLOMACY ROLE OF ISLAMIC ORGANIZATIONS IN SHAPING INTERNATIONAL HEALTH POLICY

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Abstract

Global health diplomacy (GHD) increasingly demands ethical legitimacy, cultural credibility, and trust across political and civilizational divides. Islamic organizations such as the Organization of Islamic Cooperation (OIC), the Federation of Islamic Medical Associations (FIMA), and allied institutions could contribute to international health policy through an ethical framework that is universal rather than aligned to geopolitical blocs. This reflective scientific article examines how Islamic ethical universality grounded in justice, human dignity, stewardship, and collective responsibility enables engagement across diverse systems and communities.

Drawing on selected Qur'anic guidance and Prophetic traditions, the paper illustrates how health equity in Islam is framed as a shared human obligation rather than charity or mere regional aligning. Through state-level coordination, professional diplomacy, and humanitarian engagement, Islamic organizations can function as moral bridge-builders in global health governance. This non-aligned ethical posture strengthens policy legitimacy and supports a more inclusive and humane global health order.

Keywords: Global health diplomacy; Islamic ethics; health equity; ethical universality; international health policy; humanitarian health.

Introduction

Global health diplomacy (GHD) refers to the processes by which state and non-state actors negotiate, shape, and implement international health policies and norms[1]. While geopolitical power, economic interests, and institutional influence have historically shaped global health governance, recent crises, most notably pandemics and climate-related health threats have exposed the limits of alignment-based and interest-driven approaches[2].

Contemporary discourse often frames global health inequities through binary lenses such as Global North versus Global South. Although analytically useful, such framings risk entrenching divisions that obscure shared human vulnerability and moral responsibility[3]. Islamic ethical thought offers an alternative: a universal moral framework that addresses humanity as a single moral community, without erasing diversity or denying context.

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The Qur'an states:

يَا أَيُّهَا النَّاسُ إِنَّا خَلَقْنَاكُم مِّن ذَكَرٍ وَأُنثَىٰ وَجَعَلْنَاكُمْ شُعُوبًا وَقَبَائِلَ لِتَعَارَفُوا

"O mankind, We created you from a male and a female and made you peoples and tribes that you may know one another."
(Qur'an, Surat al-Ḥujurat 49:13)[4]

Within this worldview, health is understood as a trust (*amanah*), a right (*ḥaqq*), and a collective responsibility (*farḍ kifayah*), applicable to all human beings[5]. Islamic organizations engaged in global health diplomacy thus operate not as representatives of a civilizational bloc, but as ethically motivated actors accountable to universal principles.

Islamic Ethical Universality and Global Health

Islamic ethics articulate universality through moral obligation rather than cultural dominance. Justice (*adl*) is commanded as a public duty:

إِنَّ اللَّهَ يَأْمُرُ بِالْعَدْلِ وَالْإِحْسَانِ

"Indeed, Allah commands justice and excellence."
(Qur'an, Surat al-Naḥl 16:90)[4]

Similarly, the sanctity of human life is affirmed without distinction:

وَمَنْ أَحْيَاهَا فَكَأَنَّمَا أَحْيَا النَّاسَ جَمِيعًا

"Whoever saves one life, it is as if he has saved all of mankind."
(Qur'an, Surat al-Maʾidah 5:32)[4]

These principles align with contemporary human rights and equity frameworks while grounding them in a moral anthropology that emphasizes accountability, restraint, and care [6]. In global health diplomacy, this universality enables Islamic actors to engage across political, cultural, and institutional divides without requiring ideological alignment.

Organization of Islamic Cooperation (OIC):

Ethical Coordination without Bloc Politics

The Organization of Islamic Cooperation (OIC), comprising 57 member states, provides a platform for coordination on international issues, including health[7]. While the OIC represents Muslim-majority countries, its health engagement is not intrinsically oppositional or bloc-based. Instead, it functions as a mechanism for ethical coordination and policy coherence.
The Qur'anic principle of cooperation for the common good underpins this approach:

وَتَعَاوَنُوا عَلَى الْبِرِّ وَالتَّقْوَى

"And cooperate in righteousness and piety."
(Qur'an, Surat al-Maʾidah 5:2) [4].

Through health ministers' conferences and collaboration with the World Health Organization (WHO), the OIC contributes to global health discussions on communicable diseases, maternal and child health, and health system resilience[8]. Its added value lies in offering culturally legitimate ethical perspectives that enhance policy acceptance rather than asserting geopolitical counterweights[9].

Federation of Islamic Medical Associations (FIMA):

Professional Humanism in Action

FIMA is a global federation of Islamic medical associations representing healthcare professionals across more than 70 countries[10]. Its engagement in global health diplomacy is primarily professional and humanitarian, operating through Track

II and Track III diplomacy at advocacy and community level engagements[11].

The Prophetic tradition frames healthcare work as an act of mercy and social responsibility:

الرَّاحِمُونَ يَرْحَمُهُمُ الرَّحْمٰنُ

"The merciful are shown mercy by the Most Merciful." (Sunan al-Tirmidhi, 1924) [12].

FIMA's humanitarian missions, disaster responses, and capacity-building initiatives translate this ethical orientation into practice, generating trust and field-based insights that inform policy dialogue[13]. Importantly, FIMA collaborates with diverse partners — secular, multilateral, and faith-based demonstrating a non-aligned, human-centered approach to global health engagement.

Complementary Actors in Global Health Diplomacy

The Islamic Development Bank (IsDB) supports health infrastructure, pandemic preparedness, and system strengthening through development finance aligned with ethical accountability[14]. Islamic humanitarian organizations, such as Islamic Relief Worldwide, engage in emergency health response while participating in international humanitarian coordination mechanisms[15].

Academic and research institutions informed by Islamic ethics contribute by producing policy-relevant scholarship grounded in diverse sociocultural contexts, addressing epistemic gaps in global health knowledge production[16].

Box 1. Islamic Ethical Universality in Global Health Diplomacy

- Humanity as the primary moral subject
- Health equity framed as obligation, not charity
- Engagement across systems even without ideological alignment
- Trust-building through ethical consistency
- Accountability grounded in dignity and justice

Challenges and Opportunities

Despite their ethical potential, Islamic organizations face challenges including fragmentation, limited visibility in formal global health governance, and insufficient investment in diplomatic and research capacity[11,16]. Strengthening coordination, documentation of impact, and ethical articulation in policy language can enhance their contribution to global health diplomacy.

Formalizing the FIMA-OIC link would help to enhance institutional cohesion. FIMA can function as the official technical health advisory body to the OIC. A joint secretariat or liaison office would further strengthen this link.

Since 2005, FIMA acquired Special Consultative Status to the United Nations Economic and Social Council (UN-ECOSOC). Together with the OIC, this would be a dedicated, technically skilled FIMA-OIC health diplomacy caucus for UN and WHO meetings, with pre-negotiated positions on priority health issues.

FIMA-OIC can identify and lead on ecological stewardship (*Khalifah*) of planetary health e.g. climate change, pandemic preparedness, and animal welfare. And lead global dialogue on the ethics of AI in health, gene editing and neuro-technology from a faith based ethical perspective

In this respect there is an urgent need to train a critical mass of OIC diplomats and FIMA leaders in WHO, UN negotiations, legal instruments and science communication.

They need to be armed with good data and research and thus the importance of a unified health data and research unit to collect data, produce evidence based policy reports which gives the FIMA-OIC bloc an authoritative analytical voice.

The Muslim world have an excellent legacy of successful contemporary health initiatives. The massive public health success of Hajj Health can be a model for the world for mass gathering medicine. The OIC vaccine equity initiative can leverage vaccine manufacturing capacity in OIC countries to distribute essential vaccines and technology transfer to the Global South framed as *sadaqah jariah* (ongoing charity).

Together FIMA-OIC can shift the narrative from being perpetual beneficiaries to active contributors of global health. Examples of the latter are our glorious medical history, vaccine production by OIC states (Indonesia, Turkiye) and FIMA's disaster response activities.

We need to build strategic alliances with other faith based organizations e.g. the Vatican, the G77, and the African Union on shared goals like health equity, access to medicines and vaccines.

FIMA is very rich in healthcare professional human resources. Coupled with the OIC Health Fund, financed by member state contributions, *Zakat. Waqf*, and philanthropies, this would transition FIMA-OIC beyond charity to sustainable investment.

Conclusion

Islamic organizations such as the OIC and FIMA contribute to global health diplomacy through an ethical universality that transcends geopolitical alignment. Rooted in justice, dignity, and stewardship, their engagement reframes health equity as a shared human obligation rather than a function of regional or ideological affiliation. In a fragmented global landscape, this non-aligned moral posture positions Islamic organizations as bridge-builders capable of enriching global health governance with conscience, credibility, and compassion.

The challenge for FIMA and the OIC is to transform their latent potential — moral authority, demographic weight, and professional networks into structured diplomatic influence.

Success hinges on moving from fragmentation to cohesion, from reactivity to agenda-setting, and from charity-based to system-based approaches.

By strategically focusing on areas where Islamic principles provide unique value and building robust technical and diplomatic machinery, they can evolve from being participants to becoming legitimate shapers of a more equitable, culturally resonant, and effective global health order. The path is difficult, given geopolitical headwinds, but the need for their unique perspective has never been greater.

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DISABILITY RIGHTS AND INCLUSIVE HEALTH POLICIES: AN ISLAMIC ETHICAL APPROACH—LESSONS FROM INDONESIA

*Ekasakti Octohariyanto**

Abstract

Disability rights and inclusive health policies have emerged as central concerns within global public health and human rights discourse. Within Islamic ethical thought, disability is not construed as a deficiency in human worth but rather as an integral aspect of the divinely ordained diversity of creation. This article examines how foundational Islamic principles—particularly justice (ʿadl), compassion (raḥmah), human dignity (karāmah), and social solidarity (taʿāwun)—provide a robust ethical foundation for advancing disability rights and inclusive health policies. Drawing upon Qur'anic verses, Prophetic traditions (Ahadith), and contemporary bioethical scholarship, the paper contends that inclusive health systems represent not merely a technical or administrative obligation but a moral imperative rooted in Islamic theology. The article further explores how Islamic ethics can inform modern policy frameworks, promote equitable access to healthcare, and counter stigma and discrimination against persons with disabilities. By integrating Islamic ethical perspectives with contemporary rights-based approaches, this study offers a normative framework for developing culturally grounded, ethically sound, and socially just health policies in Muslim-majority and pluralistic societies.

Keywords: Disability rights; inclusive health policy; Islamic ethics; public health; social justice

Introduction

Disability affects more than one billion people worldwide and remains closely associated with poverty, marginalization, and unequal access to healthcare. Despite the existence of international legal instruments such as the United Nations Convention on the Rights of Persons with Disabilities (CRPD), persons with disabilities continue to face systemic barriers to healthcare, education, employment, and social participation. In many societies, cultural, religious, and moral worldviews significantly shape public attitudes and policy responses to disability.

Islamic ethical thought offers a rich normative tradition that emphasizes human dignity, social justice, and collective responsibility. However, disability is often misunderstood within religious contexts, sometimes framed as a punishment, a trial, or a source of social stigma. Such interpretations can unintentionally reinforce exclusion and discrimination. This article seeks to re-examine disability through an Islamic ethical lens and to articulate how Qur'anic teachings and Prophetic guidance support disability rights and inclusive health policies.

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The objectives of this article are threefold: (1) to outline the Islamic ethical foundations relevant to disability and health equity; (2) to analyze Qur'anic verses and Ahadith that affirm human dignity and inclusion; and (3) to discuss policy implications for inclusive healthcare systems informed by Islamic values.

Conceptualizing Disability in Islamic Ethics

Islamic ethical thought conceptualizes disability not as a moral deficit or ontological inferiority but as part of the divinely intended diversity of human creation. The Qur'an consistently affirms that human worth is grounded in divine endowment rather than physical or cognitive capacity. This theological anthropology challenges utilitarian or productivity-based notions of human value that often marginalize persons with disabilities in modern societies.

Human Dignity (Karāmah)

The Qur'anic affirmation of inherent dignity establishes a foundational ethical principle:

وَ لَقَدْ كَرَّمْنَا بَنِي آدَمَ وَحَمَلْنَاهُمْ فِي الْبَرِّ وَالْبَحْرِ وَرَزَقْنَاهُمْ مِ
نَ الطَّيِّبَاتِ وَفَضَّلْنَاهُمْ عَلَىٰ كَثِيرٍ مِمَّنْ خَلَقْنَا تَفْضِيلًا

"And We have certainly honored the children of Adam and carried them on the land and sea and provided for them of the good things and preferred them over much of what We have created, with [definite] preference." (Qur'an 17:70) [1].

This verse signifies that dignity is intrinsic to all human beings, irrespective of bodily form, intellectual capacity, or social status. Disability, therefore, does not diminish a person's moral standing or entitlement to rights. In Islamic ethics, dignity is not contingent upon autonomy, productivity, or physical perfection; it is a divinely bestowed attribute that obliges society to protect and uphold the rights of every individual.

Diversity as Divine Will

Human difference is framed in the Qur'an as a sign (āyah) of divine wisdom:

وَمِنْ آيَاتِهِ خَلْقُ السَّمَاوَاتِ وَالْأَرْضِ وَاخْتِلَافُ أَلْسِنَتِكُمْ وَأَلْوَا
نِكُمْ ۚ إِنَّ فِي ذَٰلِكَ لَآيَاتٍ لِّلْعَالِمِينَ

"And of His signs is the creation of the heavens and the earth and the diversity of your languages and your colors. Indeed in that are signs for those of knowledge." (Qur'an 30:22) [2].

Although this verse explicitly references linguistic and ethnic diversity, classical and contemporary Islamic scholarship extends this principle to bodily and cognitive variation. Disability, within this interpretive framework, is neither a deviation from divine intent nor a mark of spiritual deficiency but an integral component of human plurality. This theological framing undermines stigmatizing interpretations that portray disability as punishment or divine displeasure.

Moral Agency and Responsibility

Islamic ethics recognizes varying degrees of moral responsibility (taklīf) based on capacity. However, exemption from certain legal obligations does not entail exclusion from the moral community or from social rights. Persons with disabilities remain full members of the ummah (community), entitled to participation, protection, and support. This distinction between legal responsibility and moral worth is critical for grounding inclusive policies that accommodate diverse needs without diminishing human dignity.

Qur'anic Foundations for Inclusion

The Qur'an articulates an ethical vision rooted in justice, mercy, and social solidarity. These principles form a normative basis for disability-inclusive health policies.

Justice (*ʿAdl*)

Justice is a central command in Islamic ethics:

إِنَّ اللَّهَ يَأْمُرُ بِالْعَدْلِ وَالْإِحْسَانِ وَإِيتَاءِ ذِي الْقُرْبَىٰ وَيَنْهَىٰ عَنِ الْفَحْشَاءِ وَالْمُنْكَرِ وَالْبَغْيِ يَعِظُكُمْ لَعَلَّكُمْ تَذَكَّرُونَ

"Indeed, Allah orders justice and good conduct and giving to relatives and forbids immorality and bad conduct and oppression. He admonishes you that perhaps you will be reminded." (Qur'an 16:90) [3]

Justice, in this context, entails more than formal equality; it requires substantive fairness that accounts for differential needs. For persons with disabilities, justice demands reasonable accommodation, equitable resource allocation, and proactive removal of barriers to healthcare access. Islamic jurisprudence interprets justice as a dynamic obligation to rectify structural inequities that undermine human flourishing.

Compassion (*Raḥmah*)

The Qur'an emphasizes mercy as a defining attribute of divine governance:

وَمَا أَرْسَلْنَاكَ إِلَّا رَحْمَةً لِلْعَالَمِينَ

"And We have not sent you, [O Muhammad], except as a mercy to the worlds." (Qur'an 21:107) [4]

Raḥmah functions as a moral impetus for prioritizing vulnerable populations, including persons with disabilities. An inclusive health system, from this perspective, is not merely an administrative construct but a manifestation of collective compassion that seeks to alleviate suffering and promote well-being.

Social Responsibility

The Qur'an repeatedly links individual piety with social obligation. This ethical interdependence mandates communal responsibility for those facing physical or cognitive limitations. Disability inclusion thus becomes a collective moral duty rather than an act of discretionary charity.

Prophetic Traditions (*Ahadith*) and Disability

The Prophetic model (Sunnah) offers practical ethical guidance on inclusion, non-discrimination, and care for vulnerable populations.

Equality and Non-Discrimination

The Prophet Muhammad (peace be upon him) repudiated hierarchies based on social or physical status:

لَا فَضْلَ لِعَرَبِيٍّ عَلَى أَعْجَمِيٍّ وَلَا لِأَعْجَمِيٍّ عَلَى عَرَبِيٍّ إِلَّا بِالتَّقْوَى

"There is no superiority of an Arab over a non-Arab, nor of a non-Arab over an Arab... except by righteousness." (Hadith, Musnad Aḥmad) [5]

This principle establishes an ethical paradigm of equality that encompasses bodily and cognitive differences. Moral worth, in this view, is not indexed to physical ability but to ethical character.

Care for the Vulnerable

The Prophet emphasized the moral centrality of vulnerable populations:

هَلْ تُنْصَرُونَ وَتُرْزَقُونَ إِلَّا بِضُعَفَائِكُمْ

"You are only given victory and provision because of your weak ones." (Hadith, Sunan Abī Dāwūd) [6]

This Hadith reframes vulnerability as a moral asset rather than a social burden, underscoring the collective obligation to support persons with disabilities.

Institutional Inclusion

Historical accounts indicate that the Prophet appointed individuals with disabilities to positions of responsibility. Ibn Umm Maktūm, a blind Companion, was appointed as a mu'adhdhin (caller to prayer) and entrusted with governance roles during the Prophet's absence. This precedent demonstrates an early Islamic commitment to functional inclusion and social participation.

Islamic Ethical Principles and Inclusive Health Policy

Islamic ethics offers a coherent normative framework for contemporary health governance.

Social Solidarity (Taʿāwun)

The Qur'anic injunction:

وَتَعَاوَنُوا عَلَى الْبِرِّ وَالتَّقْوَىٰ ۖ وَلَا تَعَاوَنُوا عَلَى الْإِثْمِ وَالْعُدْوَانِ ۖ وَاتَّقُوا اللَّهَ ۖ إِنَّ اللَّهَ شَدِيدُ الْعِقَابِ

"And cooperate in righteousness and piety, but do not cooperate in sin and aggression. And fear Allah; indeed, Allah is severe in penalty." (Qur'an 5:2) [7]

Taʿāwun mandates intersectoral collaboration and community engagement in health service delivery. Inclusive health policy, within this framework, is a collective enterprise that integrates governmental, civil society, and religious institutions.

Public Interest (*Maṣlaḥah*)

The jurisprudential principle of maṣlaḥah (public interest) legitimizes policy interventions that enhance social welfare and protect vulnerable populations. Disability-inclusive health reforms—such as accessible infrastructure, assistive technologies, and targeted service programs—clearly serve the public good by promoting health equity and social cohesion.

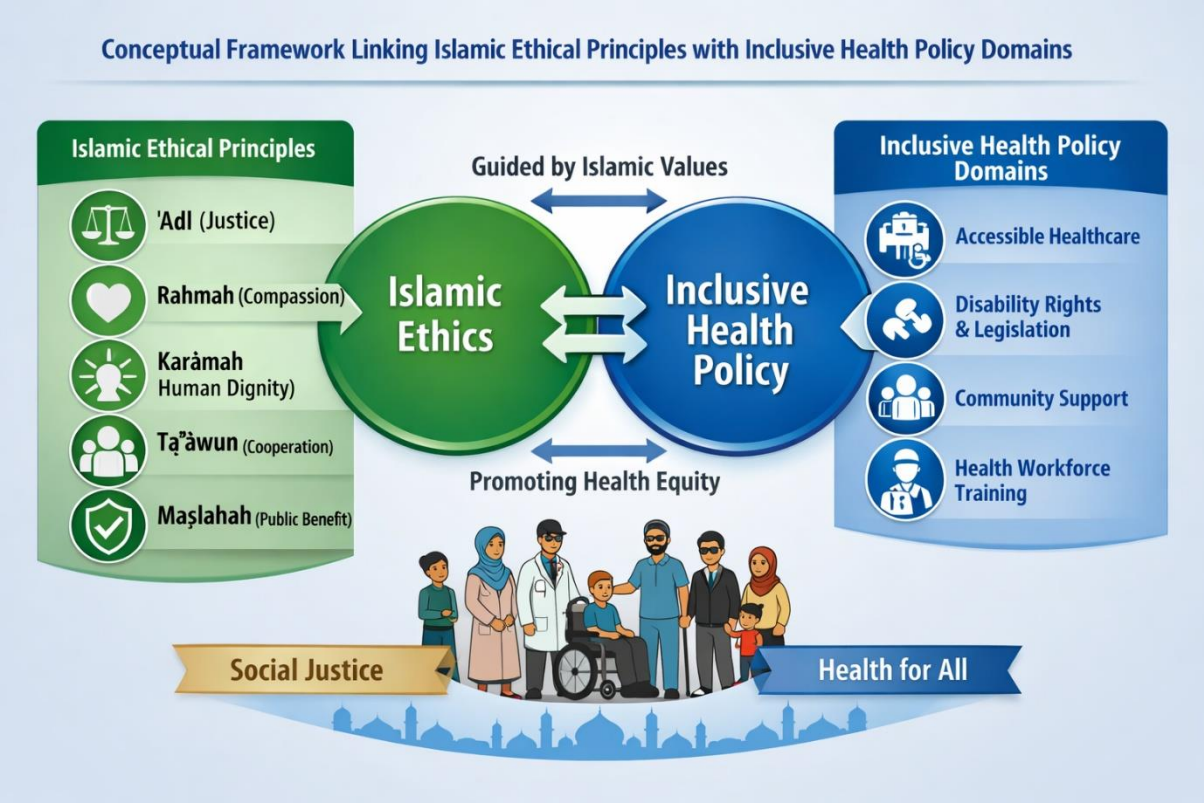
Prevention of Harm (Dafʿ al-Ḍarar)

The Prophetic maxim:

لَا ضَرَرَ وَلَا ضِرَارَ

"There should be neither harm nor reciprocating harm." (Hadith, Ibn Mājah) [8]

This principle obliges policymakers to eliminate structural harms that disproportionately affect persons with disabilities, including inaccessible facilities, discriminatory practices, and neglectful service delivery.



[Figure 1. Conceptual framework linking Islamic ethical principles with inclusive health policy domains.]

Policy Implications for Contemporary Health Systems

Islamic ethics provides a culturally resonant moral vocabulary for advancing disability-inclusive health governance.

Rights-Based and Ethics-Based Integration

Islamic ethics complements international human rights frameworks by grounding disability rights in theological and moral reasoning. Policymakers in Muslim-majority contexts can integrate the principles of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) with Islamic values such as justice (ʿadl), compassion (raḥmah), and human dignity (*karāmah)* to enhance legitimacy and cultural resonance. [9]

Indonesia ratified the CRPD through Law No. 19 of 2011 and enacted Law No. 8 of 2016 on Persons with Disabilities. [10,11] These legal instruments mandate equal access to health services, reasonable accommodation, and non-discrimination. From an Islamic ethical perspective, these obligations resonate with the Qur'anic command for justice and excellence (Qur'an 16:90) and the Prophetic maxim of preventing harm (Hadith, Ibn Mājah).

Integrating Islamic ethical narratives into policy communication can strengthen public acceptance of disability-inclusive reforms, particularly in Muslim-majority provinces.

Inclusive Design and Universal Access

Infrastructure, health information systems, and service delivery models should adopt universal design principles to accommodate diverse physical and cognitive needs. The development of disability-friendly Puskesmas (primary health centers) in several Indonesian provinces illustrates early efforts toward inclusive design, including ramps, accessible toilets, visual signage, and priority service lanes. Embedding these initiatives within an Islamic ethical discourse of taʿāwun (mutual cooperation) can frame accessibility not merely as regulatory compliance but as a collective moral responsibility.

Training of Health Professionals

Medical and public health curricula should include disability ethics, cultural competence, and Islamic bioethical perspectives to foster respectful and inclusive care. The United Kingdom's National Health Service integrates disability awareness training into professional development to reduce bias and improve communication. [12] Muslim-majority contexts can adapt similar modules grounded in *raḥmah* and *karāmah*.

Community Engagement and Stigma Reduction

Religious institutions can play a pivotal role in reshaping public narratives about disability. Islamic organizations such as Muhammadiyah and Nahdlatul Ulama engage in disability-inclusive social welfare and health programs. Friday sermons and community study circles that emphasize Qur'anic affirmations of dignity can counter stigma and promote social inclusion.

Indonesia Case Study: Disability-Inclusive Primary Care and Faith-Based Engagement

Context. Indonesia's primary healthcare system (Puskesmas) serves as the frontline of universal health coverage under the National Health Insurance (Jaminan Kesehatan Nasional). In recent years, selected districts have piloted disability-friendly service models, including barrier-free physical access, priority registration counters, and community outreach for persons with disabilities.

Policy and Practice. These initiatives operationalize Law No. 8 of 2016 by embedding reasonable accommodation into routine service delivery. From an Islamic ethical standpoint, such reforms reflect the principles of *karāmah* (human dignity) and *dafʿ al-ḍarar* (prevention of harm), as they remove structural barriers that previously excluded persons with disabilities from essential care.

Faith-Based Engagement. In parallel, faith-based organizations—most notably Muhammadiyah and Nahdlatul Ulama—have expanded disability-inclusive social and health programs, including rehabilitation services, inclusive education, and community-based support. Mosques have begun introducing accessible facilities and disability-sensitive programming, framing inclusion as a moral obligation grounded in Qur'anic justice (*ʿadl*) and compassion (*raḥmah*).

Ethical Significance. This convergence of statutory reform, service delivery innovation, and religious advocacy illustrates how Islamic ethical narratives can enhance the legitimacy and sustainability of inclusive health policies. Indonesia thus offers an emerging model of Islamic–public health

synergy, in which theological values are translated into concrete institutional practices. The World Health Organization's Global Disability Action Plan aligns with Islamic principles of *maṣlaḥah* and *daf' al-ḍarar* by prioritizing barrier removal and inclusive governance. [13]

Table 1. Mapping Islamic Ethical Values to Contemporary Disability Rights Principles

Islamic Ethical Value	Description	Disability Rights Principle
'Adl (Justice)	Ensuring fairness, equal treatment, and preventing harmto vulnerable groups	**Non-discrimination & Equality** Ensuring equal rights and opportunities for persons with disabilities
Rạhmah (Compassion)	Showing empathy and care for the inherent dignity of all individuals, including persons with disabilities	**Human Dignity & Respect** Promoting respect for the inherent dignity and autonomy of persons with disabilities
Karâmah (Human Dignity) Recognizing the in lanic worth and rights of every individual as created by Allah (SWT)	Recognizing the intrinsic worth and rights of every individual as created by Allah (SWT)	**Accessibility & Inclusion** Ensuring access to health services, facilities, and information for persons with disabilities
Tạ'âwun (Cooperation) Advancing the public good and the well-being of society, including	Fostering mutual assistance and community support for the well-being of all members of society	**Social Participation & Support**
Maşlahah (Public Benefit) Advancing the public good and the well-being of society	Advancing the public good and the well-being of society, including protecting vulnerable groups	**Empowerment & Protection** Empowering persons with disabilities to make decisions and advocating for their safety and protection

[Table 1. Mapping Islamic ethical values to contemporary disability rights principles.]

Discussion

The convergence of Islamic ethics and disability rights offers a robust normative framework for inclusive health policy. Unlike purely legalistic or technocratic approaches, Islamic ethics embeds disability inclusion within a moral ecology of compassion, justice, and social responsibility.

However, persistent challenges remain. Stigmatizing cultural narratives, misinterpretations of religious texts, and resource constraints continue to impede inclusive reform. Addressing these barriers requires interdisciplinary collaboration among theologians, policymakers, health professionals, and disability advocates. Future research should explore empirical case studies of Islamic-inspired inclusive health programs, assess their impact on health equity, and develop context-sensitive policy tools.

Indonesia's evolving legal and institutional landscape illustrates both the promise and the complexity of translating ethical ideals into policy practice. Integrating Islamic ethical narratives into public health communication can strengthen societal commitment to inclusion.

Conclusion

Disability rights and inclusive health policies are deeply consonant with Islamic ethical teachings. The Qur'an and Sunnah affirm human dignity, diversity, and social responsibility, providing a moral foundation for equitable healthcare.

By integrating Islamic ethics with contemporary rights-based frameworks, health systems can become more inclusive, compassionate, and just. Such integration is particularly salient in Muslim-majority societies but offers universal ethical insights for global public health governance.

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FIQH OF PANDEMICS AND COMMUNICABLE DISEASE CONTROL: BALANCING INDIVIDUAL RIGHTS AND COLLECTIVE WELFARE

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Abstract

The COVID-19 pandemic has renewed global attention to the ethical foundations of epidemic governance, including within Islamic jurisprudence. Classical Islamic law (*fiqh*) contains a well-developed framework for managing communicable diseases, grounded in the preservation of life (*ḥifẓ al-nafs*), the prevention of harm (*darar*), and the promotion of public interest (*maṣlaḥah*). Drawing on textual analysis of the Qur'an, Prophetic traditions, and juristic scholarship across the Sunni legal schools, this study examines the Islamic ethical response to pandemics and integrates contemporary *fatwa* resolutions issued during recent global health emergencies. The analysis focuses on four domains of public health intervention: quarantine and isolation, travel restriction and social distancing, vaccination, and the temporary suspension of congregational worship. It demonstrates that measures commonly employed in modern epidemic control are firmly supported by Islamic legal maxims and historical precedent, provided they are necessary, proportionate, time-limited, and guided by expert evidence. The study further explores contemporary challenges, including vaccination mandates, data disclosure, contact tracing, and genomic epidemiology, highlighting how Islamic ethics balances individual rights with collective responsibility through principles of necessity, proportionality, and trust (*amanah*). The synthesis affirms that Islamic jurisprudence offers a coherent, compassionate, and pragmatic ethical framework for communicable disease control that aligns with modern public health ethics and international health regulations. Far from being in tension, faith-based reasoning and evidence-based policy emerge as complementary tools in safeguarding human life during epidemics.

Keywords: religion and public health, ethics medical, infectious disease prevention, health policy, vaccination, quarantine

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Introduction

Communicable diseases have accompanied human civilization since its earliest periods, yet their moral and spiritual dimensions are uniquely addressed in Islam. The emergence of global pandemics, from the plague of *Amwas* of the early Islamic centuries to the modern COVID-19 pandemic [1,2], has consistently prompted Muslim scholars to articulate responses rooted in revelation, reason, and compassion. Islamic jurisprudence (*fiqh*) treats epidemic control not only as a medical concern but as a moral duty and a question of stewardship: how to safeguard life while honoring human dignity, faith, and collective responsibility.

وَلَا تَقْتُلُوا أَنفُسَكُمْ إِنَّ اللَّهَ كَانَ بِكُمْ رَحِيمًا

"Do not kill yourselves; indeed Allah is Most Merciful to you." (Quran 4:29)

This verse establish the foundational obligation to preserve human life and prevent both self harm and harm to others. The Prophet Muhammad (peace be upon him) reinforced this ethic through the well known hadith [3]:

لَا ضَرَرَ وَلَا ضِرَارَ

"There should be no harm and no reciprocating harm." (Sunan Ibn Majah, no. 2341) [4]

This hadith later formed the basis of a legal maxim recorded in the *Majallat al Ahkam al Adliyyah* (Article 19) [5,6], which jurists apply to matters of public safety, including epidemic prevention, environmental protection, and regulation of medicine. The principle empowers authorities to restrict harmful practices such as concealing infection or refusing treatment.

Throughout Islamic history, epidemic governance was treated as a collective obligation (*fard kifayah*) [7]. When outbreaks occurred, the duty to protect life took precedence over personal convenience or individual rights. Scholars such as Ibn Hajar al Asqalani, who lived through the plague in Cairo, composed detailed treatises including *Badhl al Maun fi Fadl al Taun*, documenting both theological reflection and practical guidance on isolation and care [8]. Contemporary scholars continue this tradition by emphasizing that compliance with public health measures constitutes obedience to Allah when motivated by the intention to preserve life.

The following sections explore these principles systematically, beginning with the *maqasid al shariah* framework before examining specific rulings on quarantine, travel restriction, temporary suspension of congregational prayer, and vaccination.

Foundational Principles in Islamic Epidemic Ethics

Maqāsid al Shari'ah and the Preservation of Life

Imam al Shatibi in *al Muwafaqat* outlined five essential objectives of the divine law: protection of religion (*hifz al din*), life (*hifz al nafs*), intellect (*hifz al aql*), lineage (*hifz al nasl*), and property (*hifz al mal*) [9]. Among these, the preservation of life stands as the foremost purpose because the remaining objectives depend upon it [9]. Hence, any policy or ruling that prevents the loss of life or widespread disease directly fulfills a divine command.

Allah commands,

وَمَنْ أَحْيَاهَا فَكَأَنَّمَا أَحْيَا النَّاسَ جَمِيعًا

"Whoever saves one life, it is as if he had saved all of mankind" (Quran 5:32).

This verse captures the universal value of life preservation that underpins epidemic governance in Islam. Protecting human life is not only a moral virtue but a religious

duty; it embodies obedience to Allah and compassion towards creation.

Islam creates a protective framework around these five core objectives of life, such that when a crisis like a pandemic occurs, these priorities guide both governments and societies in determining the most appropriate course of action when competing benefits or harms conflict. This framework enables decision makers to weigh outcomes ethically and to select the option that best preserves overall welfare.

For example, the prioritization of the preservation of life over congregational worship reflects this ethical reasoning. During a pandemic, viral transmission may increase substantially, particularly when the pathogen spreads through airborne particles or respiratory droplets during large gatherings such as *Jumuʿah* prayer. If such transmission leads to serious illness or death, the fundamental objective of preserving life is compromised. Since life itself is the foundation that enables faith and worship, protecting individuals from harm ensures that they remain able to fulfil their religious obligations over the long term. In this way, safeguarding life ultimately sustains faith, rather than undermining it.

The Principle of Maslahah (Public Welfare)

Al Ghazali in *al Mustasfa* defined maslahah as that which secures benefit or prevents harm[10]. Jurists employ maslahah mursalah, meaning public interest that is neither explicitly commanded nor prohibited in scripture, when deriving rulings for unprecedented circumstances. Outbreak control represents a prime example. There is no direct verse addressing vaccination or modern quarantine, yet the overarching objectives of the shariah require measures that minimize harm. As such, state mandated health interventions are legitimate applications of maslahah amma, or public welfare.

That is why, during a pandemic, Islamic ethics teaches the acceptance of minor hardship in order to prevent major harm. Temporary inconvenience, such as staying at home, is justified to avert widespread disaster. In this context, individual freedom of movement is secondary to the collective right of society to remain safe and healthy. This reasoning reflects the legal maxim that a specific harm may be tolerated to prevent a general harm.

Accordingly, an individual's right to move freely, which constitutes a personal benefit, may be legitimately restricted when such movement poses a risk of large scale transmission of infectious disease and threatens public safety. These limitations are not punitive in nature but are ethical measures designed to protect life and preserve societal wellbeing.

The No Harm Principle (*Darar*)

The prophetic maxim *la darar wa la dirar* provides a universal legal rule stating that one must neither inflict harm nor reciprocate harm [4]. Any behavior that endangers others, such as ignoring infection, refusing treatment when contagious, or violating isolation, is contrary to this principle. Conversely, participation in preventive health measures, including quarantine and vaccination, exemplifies adherence to this ethical mandate. The *Majallat al Ahkam al Adliyyah* codified this principle in Ottoman legal practice, highlighting Islam's long standing concern with harm reduction and public safety [11].

Prophetic Guidance on Epidemic Containment

Prophet Muhammad (peace be upon him) taught clear epidemiological guidance over fourteen centuries ago. He said,

إِذَا سَمِعْتُمْ بِهِ فِي أَرْضٍ فَلَا تَقْدَمُوا عَلَيْهَا، وَإِذَا وَقَعَ بِأَرْضٍ وَأَنْتُمْ فِيهَا فَلَا تَخْرُجُوا مِنْهَا

"If you hear of plague in a land, do not enter it, and if it occurs in a land where you are, do not leave it." [12]

This hadith establishes a framework for geographic containment and is frequently cited by Muslim jurists as evidence of Islam's early endorsement of quarantine as a public health measure. Ibn Hajar al Asqalani explained that the command not to enter or leave a plague affected area prevents both self harm and the spread of disease to others, thereby fulfilling the juristic principle that the prevention of harm takes precedence over the acquisition of benefit [13].

The legal maxim *la darar wa la dirar*, meaning there should be no harming nor reciprocating harm, constitutes a cornerstone of Islamic bioethics. When an individual is aware that they are ill with an infectious disease, or when there is a high probability that they may be an asymptomatic carrier, their personal right to attend crowded public spaces such as mosques, markets, and schools is superseded by the obligation to protect public safety by preventing disease transmission.

In such circumstances, refraining from public interaction is not a restriction of rights but a moral duty rooted in the Islamic commitment to preserving life and preventing harm to others.

The Quran likewise commands prudence. Allah says,

وَلَا تَعْتَدُوا إِنَّ اللَّهَ لَا يُحِبُّ الْمُعْتَدِينَ

"Do not transgress, for Allah does not love the transgressors" (Quran 2:190).

Together, these Quranic verses and prophetic instructions form a comprehensive moral foundation for epidemic management in Islam. They call for responsible action, the avoidance of harm, and the protection of both individual wellbeing and societal safety [13].

Travel Restrictions and Social Distancing

In Islamic history and jurisprudence, travel restrictions and social distancing are not regarded as modern impositions but as foundational public health strategies. These measures are intended to interrupt chains of transmission and thereby limit the spread of infectious disease. Within Islamic legal theory, this approach is articulated through the principle of *sadd al dhara'i*, which refers to blocking the means that lead to harm. By restricting actions that may facilitate disease transmission, Islamic law proactively prevents foreseeable harm and safeguards public welfare.

The prophetic prohibition against entering or leaving a plague affected region forms the foundation of Islamic rulings on travel restriction. This guidance reflects not fear but faith expressed through responsible action. In another context, the Prophet Muhammad (peace be upon him) instructed his companions to avoid unnecessary proximity to contagious illness, saying,

وَفِرَّ مِنَ الْمَجْذُومِ كَمَا تَفِرُّ مِنَ الْأَسَدِ

"Flee from the leper as you would flee from a lion." [14]

This statement carries not the tone of panic but of prudence, reminding believers to respect natural causes while maintaining trust in Allah. The early Muslim community understood this command as a public health measure. Umar ibn al Khattab, when advised that plague had broken out in Syria, turned back his army at Sargh on the road to Damascus. When questioned whether he fled from the decree of Allah, he replied that they were fleeing from the decree of Allah to the decree of

Allah, affirming that taking precautions is itself obedience to divine law.
This attitude unites tawakkul with action and is consistent with the Quranic injunction

فَإِذَا عَزَمْتَ فَتَوَكَّلْ عَلَى اللَّهِ إِنَّ اللَّهَ يُحِبُّ الْمُتَوَكِّلِينَ

"Once you make a decision, put your trust in Allah. Surely Allah loves those who trust in Him." (Quran 3:159).

Travel restrictions therefore protect both individuals and communities [15]. Entering an infected area without necessity risks one's own life, while leaving such an area during an outbreak endangers others. Both actions fall within the prohibition of self-destruction and the causing of harm to others.

Classical scholars elaborated these implications in detail. Ibn Battal observed that Umar's decision and the Prophet's guidance established a clear precedent for governmental authority to limit movement during epidemics [16,17]. Zakaria al Ansari later affirmed that those afflicted with contagious diseases should avoid public places such as mosques and markets, not out of exclusion but to safeguard the congregation [18]. Ibn Hajar al Haitami reasoned that when credible risk of harm exists, isolation becomes obligatory, since the principle of la darar wa la dirar requires the prevention of injury to others [19].

The hadith literature provides further reinforcement of this ethic. Abu Hurairah reported that the Prophet Muhammad (peace be upon him) said,

لَا يُورِدَنَّ مُمْرِضٌ عَلَى مُصِحٍّ

"The sick should not be brought near the healthy."

In another narration, the Prophet said,

إِذَا سَمِعْتُمْ بِالطَّاعُونِ بِأَرْضٍ فَلَا تَدْخُلُوهَا، وَإِذَا وَقَعَ بِأَرْضٍ وَأَنْتُمْ فِيهَا فَلَا تَخْرُجُوا مِنْهَا

"If you hear that plague is in a land, do not enter it, and if it occurs where you are, do not leave it."

Taken together, these reports reveal a coherent epidemiological policy consistent with modern containment strategies and travel restrictions. They demonstrate that preventive isolation was endorsed by the Prophet Muhammad (peace be upon him) as an act of mercy rather than punishment [20].

During later outbreaks such as the plague of *Amwas* in the seventh century, these teachings guided the response of the companions. Saidina Amr ibn al As gathered the affected population of Syria and relocated them to surrounding hills to separate the ill from the healthy until the contagion subsided. Ibn al Athir records that when news of this reached the Caliph Umar, he did not censure the action, recognizing the wisdom of limiting movement to control infection [21].

These historical examples illustrate that travel restrictions and social distancing were not viewed as infringements upon faith but as necessary expressions of maslahah. The Quranic legal principle that the decisions of the ruler are bound by public interest provides the basis for governmental authority to impose such measures in times of crisis [22].

When public gatherings or pilgrimages are suspended to prevent widespread infection, these actions align with the maqasid of protecting life [23]. The Quran enjoins obedience to lawful authority,

يَا أَيُّهَا الَّذِينَ آمَنُوا أَطِيعُوا اللَّهَ وَأَطِيعُوا الرَّسُولَ وَأُولِي الْأَمْرِ مِنكُمْ

"O you who believe, obey Allah, and obey the Messenger, and those in authority among you" (Quran 4:59).

Compliance with travel restrictions and public health directives therefore constitutes obedience to Allah when motivated by the intention to protect life and prevent harm [22].

The concept of social distancing also appears in the conduct of the companions. Umar ibn al Khattab maintained a respectful distance from Muaiqib, who suffered from leprosy, instructing him to sit at the distance of a spear. He did so not out of fear or disdain but to prevent transmission [24]. In another incident, when a woman afflicted with leprosy circumambulated the Kaabah, Umar advised her to remain at home so as not to cause harm to others.

Jurists of the Shafi'i school upheld this approach, considering it permissible and at times obligatory to prevent those with contagious illness from joining communal gatherings. Their rulings were grounded in the Quranic maxim that the prevention of harm takes precedence over the acquisition of benefit. In the context of pandemics, the benefit of unrestricted movement or collective worship is outweighed by the danger of mass infection [25].

During the recent global pandemic, international fatwa bodies applied these very principles. They cited the preservation of life and the prohibition of harm as the primary justifications for restricting travel, suspending pilgrimages, and limiting cross border movement. These measures echo prophetic guidance and the precedent of the early companions, ensuring continuity between classical jurisprudence and contemporary public health governance[26].

Travel restrictions therefore represent neither secular intrusion nor violation of faith but a legitimate manifestation of divine guidance. By limiting movement, Islam preserves life, contains harm, and affirms the collective responsibility of believers toward one another. The believer who abides patiently under these conditions follows the Sunnah and participates in communal mercy.

Balancing Individual Rights and Collective Welfare

The tension between individual rights and collective welfare lies at the heart of pandemic ethics. Islam recognises individual autonomy as a divine trust but situates it within the moral framework of communal responsibility. The principle of *maslahah 'ammah*, or public interest, anchors this balance by ensuring that the freedom of one person does not endanger the welfare of others. In times of epidemic, the duty to preserve life, *hifz al nafs*, supersedes personal liberty, as the wellbeing of the ummah constitutes a higher objective of the divine law [27].

During the COVID-19 pandemic, scholars and fatwa bodies across the Muslim world revisited these principles when assessing the permissibility of suspending congregational worship and Friday prayers [28] Their rulings drew upon the same Quranic and prophetic foundations that guided earlier Muslim generations during outbreaks of plague [13]. The reasoning centred on several interrelated principles, namely the obligation to safeguard life, the prohibition of self harm and harm to others, and the requirement that governmental action be guided by maslahah.

Allah Most High commands in the Quran,

وَلَا تُلْقُوا بِأَيْدِيكُمْ إِلَى التَّهْلُكَةِ

*"Do not throw yourselves into destruction by your own hands" (*Quran 2:195).

Although the real context of the mention verse is to reprimand those who neglect the obligation of Infaq & Zakat, the same verse is among the most frequently cited in discussions of epidemic control. It forbids

negligence and obliges believers to take preventive action when harm is foreseeable. In the sprit of Syariah which is to avoid harm, the individuals and communities have to comply with measures that prevent infection, including temporary restrictions on public worship. The suspension of Friday prayer is therefore not a violation of faith but an enactment of the divine command to avoid destruction [29].

The same reasoning is reflected in the legal maxim *tasarruf al imam manut bi al maslahah*, which states that the conduct of the ruler over his people must be based on public interest [30]. When governments limit gatherings or close mosques to contain contagion, such decisions are valid provided they aim to protect life. The ruler acts as a guardian, *wali al amr*, whose mandate is to prevent harm rather than to restrict devotion arbitrarily [31]. The Quran instructs believers,

يَا أَيُّهَا الَّذِينَ آمَنُوا أَطِيعُوا اللَّهَ وَأَطِيعُوا الرَّسُولَ وَأُولِي الْأَمْرِ مِنكُمْ

"O you who believe, obey Allah, and obey the Messenger, and those in authority among you" (Quran 4:59).

Obedience in this context is not blind submission but participation in collective protection. It fulfils the maqasid of preserving life and preventing social harm, aligning religious devotion with public order.

The juristic maxim la darar wa la dirar, meaning that there should be no harm and no reciprocating harm, further strengthens this rationale [23]. Allowing mass gatherings during an epidemic violates this principle by risking transmission among worshippers and the wider community. Another maxim, that the prevention of harm takes precedence over the acquisition of benefit, requires that the temporary suspension of public worship be accepted when it averts greater injury. The spiritual reward of communal prayer cannot outweigh the physical and moral consequences of spreading disease.

Prophet Muhammad (peace be upon him) himself established the precedent for containment through his statement,

إِذَا سَمِعْتُمْ بِالطَّاعُونِ بِأَرْضٍ فَلَا تَدْخُلُوهَا، وَإِذَا وَقَعَ بِأَرْضٍ وَأَنْتُمْ فِيهَا فَلَا تَخْرُجُوا مِنْهَا

"If you hear that plague is in a land, do not enter it, and if it occurs where you are, do not leave it" (Sahih Muslim 2219).

Vaccination, Collective Immunity, and Precision Medicine

Islamic medical ethics places prevention at the heart of faith. Preventing harm is an act of mercy and responsibility. Vaccination represents one of the most successful expressions of this principle and can be seen as an early form of what is now known as precision medicine. Both seek to prevent disease by understanding human biology while remaining aligned with divine purpose [23].

The Prophet Muhammad, peace be upon him, said:

تَدَاوَوْا فَإِنَّ اللَّهَ لَمْ يَضَعْ دَاءً إِلَّا وَضَعَ لَهُ دَوَاءً

"Seek treatment, for Allah has not created a disease except that He has also created its cure".
(Sunan al Tirmidhi 2038) [32]

This hadith establishes the foundation for all medical interventions. Precision medicine builds upon this principle by using genomics, molecular science, and artificial intelligence to match the right intervention to the right individual at the right time. It continues the prophetic understanding that healing occurs when treatment aligns with the disease by Allah's permission [33].

Vaccination, once focused mainly on population level immunity, has evolved

through precision medicine into a more refined science. The study of individual immune responses and genetic variation reflects the Quranic command for justice and excellence [34].

إِنَّ اللهَ يَأْمُرُ بِالْعَدْلِ وَالْإِحْسَانِ

"Indeed, Allah commands justice and excellence". (Quran 16:90)

Justice in healthcare means providing care that fits individual biological needs while ensuring fair access for all. Tailoring vaccines and preventive strategies according to risk and response fulfills both adl and ihsan [35].

From the perspective of *maslahah*, precision vaccination secures benefit and reduces harm [36]. By identifying those who benefit most and those at higher risk of adverse effects, it serves the preservation of life in its most accurate form [37]. Advances in genomics, particularly during the COVID 19 pandemic, demonstrated how knowledge can rapidly protect humanity through targeted vaccine development [38]. This reflects the Quranic encouragement to pursue beneficial knowledge.

قُلْ هَلْ يَسْتَوِي الَّذِينَ يَعْلَمُونَ وَالَّذِينَ لَا يَعْلَمُونَ

"Say, are those who know equal to those who do not know?"
(Quran 39:9)

The ethical legitimacy of vaccination and precision medicine is firmly rooted in fiqh. Preserving life is an obligation, and whatever is required to fulfill that obligation becomes obligatory. Scholars such as Imam al Ghazali and Imam al Shatibi placed the protection of life among the essential objectives of the shariah. Preventive medicine clearly serves this aim [39].

When refusal of vaccination risks harm to others, the principle that preventing harm takes precedence over acquiring benefit applies. Individual autonomy is respected but remains bounded by responsibility to the community [40].

Precision medicine relies heavily on personal data, particularly genetic information. This data is an amanah and must be protected with integrity and confidentiality [41].

إِنَّ اللهَ يَأْمُرُكُمْ أَنْ تُؤَدُّوا الْأَمَانَاتِ إِلَى أَهْلِهَا

"Indeed, Allah commands you to render trusts to whom they are due". (Quran 4:58)

Islamic law supports both collective and individualized approaches to health. Community measures such as vaccination protect society, while precision medicine refines care for each individual. The Prophet encouraged both community protection and individualized treatment, demonstrating that the two are not in conflict but complementary [42].

Faith and science in Islam move together. The Prophet's instruction to tie one's camel and then place trust in Allah captures this balance [43]. Vaccination and precision medicine represent taking all available means before placing reliance upon Allah [44].

In conclusion, vaccination is both a prophetic legacy and a living expression of precision medicine. It reflects Islam's enduring commitment to preserving life through knowledge, justice, and compassion. Every advancement that protects life becomes an act of worship and a fulfillment of sacred trust.

وَمَنْ أَحْيَاهَا فَكَأَنَّمَا أَحْيَا النَّاسَ جَمِيعًا

"Whoever saves one life, it is as if he has saved all of mankind". (Quran 5:32)

Islamic law recognizes privacy as a divine right. The Qur'an commands believers to

respect the dignity and confidentiality of others:

يَا أَيُّهَا الَّذِينَ آمَنُوا لَا تَدْخُلُوا بُيُوتًا غَيْرَ بُيُوتِكُمْ حَتَّى تَسْتَأْنِسُوا وَتُسَلِّمُوا عَلَى أَهْلِهَا

"O you who believe, do not enter houses other than your own until you have asked permission and greeted their inhabitants." (Quran 24:27)
and further warns:

وَلَا تَجَسَّسُوا وَلَا يَغْتَب بَعْضُكُم بَعْضًا

"Do not spy on one another, nor backbite each other." (Quran 49:12)

These verses establish the sanctity of personal privacy and forbid unwarranted intrusion into others' affairs. Yet the same shariah that upholds privacy also recognizes the principle of darurah (necessity) and maslahah amma (public welfare). When concealing information endangers life, disclosure becomes not only permissible but necessary [45,46].

The Prophet Muhammad (peace be upon him) articulated the moral compass that governs this balance:

لَا ضَرَرَ وَلَا ضِرَارَ

"There should be no harm and no reciprocating harm."
(Sunan Ibn Majah 2341)

This maxim serves as the ethical cornerstone for public health policies, including disease surveillance, contact tracing, and genomic monitoring. During an epidemic, these measures prevent greater harm by identifying, isolating, and treating infected individuals while preserving the wider community's safety.

Islamic jurists agree that the duty of confidentiality in medicine is not absolute. The physician's obligation to protect patient privacy is conditioned by the prevention of harm to others. Imam al Nawawi, in his commentary on al Majmu', stated that if nondisclosure would lead to harm for another person, it becomes obligatory to disclose relevant information to prevent that harm [47].
This is consistent with the legal maxim *izalat al darar al amm muqaddamah ala izalat al darar al khass,* meaning that the removal of public harm takes precedence over the removal of private harm [48]. A physician, public health officer, or laboratory scientist who discloses infection data to prevent transmission acts in accordance with shariah [49,50].

The Qur'an supports this through its command to enjoin good and forbid harm:

وَلْتَكُن مِّنكُمْ أُمَّةٌ يَدْعُونَ إِلَى الْخَيْرِ وَيَأْمُرُونَ بِالْمَعْرُوفِ وَيَنْهَوْنَ عَنِ الْمُنكَرِ

"Let there arise from among you a group inviting to all that is good, enjoining what is right and forbidding what is wrong." (Quran 3:104)

Preventing the spread of communicable disease is an act of amr bil ma'ruf (commanding good) and nahy anil munkar (forbidding harm).

Contact tracing exemplifies how individual information can serve collective welfare. By identifying those exposed to infection, public health authorities interrupt chains of transmission and protect vulnerable populations. During the time of the Prophet Muhammad (peace be upon him), early forms of contact tracing were practiced. The Prophet instructed:

لَا يُورِدَنَّ مُمْرِضٌ عَلَى مُصِحٍّ

"The sick should not be brought near the healthy." (Sahih al Bukhari 5771; Sahih Muslim 2221) [51]
This guidance implies an obligation to know who is infected and who is not, and to act upon that knowledge to prevent harm. In modern terms, it authorizes the controlled sharing of infection data for epidemiological purposes.

The historical incident of the plague of Amawas under the caliphate of Umar ibn al Khattab further illustrates this principle. When the plague struck Syria, Umar consulted the Companions and decided to withdraw the army from the affected area, saying, "We flee from the decree of Allah to the decree of Allah." (Sahih al Bukhari 5729) [21]

This action, informed by knowledge of exposure and risk, stands as a prophetic precedent for quarantine and contact tracing.

In the contemporary era, contact tracing has evolved through the integration of genomic epidemiology, the study of pathogen genomes to track the spread of infectious diseases. Whole genome sequencing allows scientists to determine how viruses and bacteria move between individuals, hospitals, and regions. This method, widely used during the COVID-19 pandemic, transformed outbreak management by providing precise, real time information about transmission networks.

From an Islamic ethical perspective, genomic epidemiology exemplifies hisbah, the moral responsibility to monitor and correct harm within society. When used transparently and ethically, it fulfills the Qur'anic principle of cooperation for righteousness:

وَتَعَاوَنُوا عَلَى الْبِرِّ وَالتَّقْوَى وَلَا تَعَاوَنُوا عَلَى الْإِثْمِ وَالْعُدْوَانِ

"Cooperate with one another in righteousness and piety, and do not cooperate in sin and aggression." (Quran 5:2)

The use of genomic data to protect life is a form of cooperation in righteousness, provided it respects human dignity and privacy. Data must be anonymized, securely stored, and used solely for legitimate maslahah. Any misuse of personal genetic data for discrimination, surveillance, or profit would constitute zulm (injustice) and violate the command of Allah:

وَلَا يَجْرِمَنَّكُمْ شَنَآنُ قَوْمٍ عَلَى أَلَّا تَعْدِلُوا اعْدِلُوا هُوَ أَقْرَبُ لِلتَّقْوَى

"Let not the hatred of a people lead you to injustice. Be just; that is nearer to piety." (Quran 5:8)

Therefore, ethical frameworks for genomic epidemiology in Muslim societies must ensure justice, equity, and transparency. The right to health protection belongs to all, but so does the right to privacy and respect.

In Islam, both privacy and public health are amanah entrusted to humankind. The Prophet Muhammad (peace be upon him) said:

كُلُّكُمْ رَاعٍ وَكُلُّكُمْ مَسْؤُولٌ عَنْ رَعِيَّتِهِ

"Every one of you is a shepherd, and every one of you will be asked about his flock." (Sahih al Bukhari 893; Sahih Muslim 1829)

This hadith establishes accountability for those in authority, including healthcare leaders and researchers. Public health officers act as shepherds whose duty is to protect the community from harm without violating individual dignity. Disclosure of medical or genomic data is thus permissible only when it prevents imminent harm, aligns with scientific necessity, and is implemented with proportional safeguards.

The principle *al darurat tubih al mahzurat,* meaning necessity permits what is otherwise prohibited, applies here. Revealing infection status or sharing genome data may ordinarily be restricted, but under the pressure of a public health emergency it becomes permissible, even obligatory, to prevent harm to others [52].

However, *al darurat tuqaddar bi qadariha,* meaning necessity must be limited to its extent, ensures that disclosure remains

narrowly focused and time bound. When the risk subsides, confidentiality must be restored [53]. This balance preserves trust between the public and health institutions, which is essential for effective outbreak control.

Precision public health builds upon these ethical principles by combining individual level data with population scale interventions. It uses genomic, behavioral, and environmental information to identify who is most at risk and to target prevention efficiently. In Islamic jurisprudence, this aligns with the *maqasid of hifz al nafs* (preservation of life) and *hifz al aql* (preservation of reason), since it relies on accurate knowledge and rational policy to protect lives.

When genomic surveillance identifies a new pathogen variant or reveals hidden transmission clusters, it fulfills the hadith of the Prophet Muhammad (peace be upon him): "If you hear of plague in a land, do not enter it, and if it occurs where you are, do not leave it." (Sahih Muslim 2219) [23]

The hadith reflects the same epidemiological reasoning that modern sequencing achieves through molecular tracing.

Hence, genomic epidemiology becomes a tool of *maslahah,* transforming the principle of "no harm" into an actionable system of real time protection. It allows Muslim majority societies to fulfill the Qur'anic duty of preventing destruction.

Disclosure, contact tracing, and genomic epidemiology represent the evolving frontier of Islamic public health ethics. Each seeks to balance two sacred trusts: the privacy of the individual and the safety of the community. Islam neither absolutizes secrecy nor sacrifices dignity for control. It calls instead for measured transparency guided by amanah, adl, and maslahah.

When scientists and health authorities use genomic data with honesty, confidentiality, and fairness, they act as stewards of divine mercy. The believer who shares information truthfully for the protection of others fulfills the Qur'anic promise:

وَٱلْمُؤْمِنُونَ وَٱلْمُؤْمِنَٰتُ بَعْضُهُمْ أَوْلِيَآءُ بَعْضٍ ۚ يَأْمُرُونَ بِٱلْمَعْرُوفِ وَيَنْهَوْنَ عَنِ ٱلْمُنكَرِ وَيُقِيمُونَ ٱلصَّلَوٰةَ وَيُؤْتُونَ ٱلزَّكَوٰةَ وَيُطِيعُونَ ٱللَّهَ وَرَسُولَهُۥٓ ۚ أُو۟لَٰٓئِكَ سَيَرْحَمُهُمُ ٱللَّهُ ۗ إِنَّ ٱللَّهَ عَزِيزٌ حَكِيمٌ

"The believers, both men and women, are guardians of one another. They encourage good and forbid evil, establish prayer and pay alms-tax, and obey Allah and His Messenger. It is they who will be shown Allah's mercy. Surely Allah is Almighty, All-Wise." (Quran 9:71)

Thus, the integration of genomic science into Islamic bioethics reaffirms that faith and knowledge are not adversaries. They are partners in the sacred mission of safeguarding life, honoring privacy, and manifesting compassion. Through this harmony, precision public health becomes an act of worship and a fulfillment of humanity's trust before Allah.

Conclusion

Islamic jurisprudence provides a robust and principled ethical framework for the management of pandemics and communicable diseases. Rooted in the preservation of life, the prevention of harm, and the pursuit of public welfare, this framework affirms that protecting society from widespread disease is both a moral obligation and a religious duty. Quranic injunctions, Prophetic guidance, and juristic reasoning consistently prioritise the safeguarding of life when credible harm threatens individuals or communities.

Historical precedents from the early Islamic period demonstrate that measures such as quarantine, restriction of movement, and temporary suspension of communal

activities were understood not as violations of faith but as expressions of responsibility, compassion, and obedience to divine law. Contemporary public health interventions, including travel restrictions, suspension of congregational worship, vaccination programmes, and disease surveillance, represent extensions of these same ethical commitments when guided by scientific evidence and legitimate authority.

Islamic law does not endorse unrestricted state power in public health. The legitimacy of restrictive measures depends on necessity, proportionality, expert guidance, transparency, and temporal limitation. Actions that intrude upon personal liberty or privacy are ethically justified only when they prevent greater harm and are confined to what is required to achieve that purpose. This balance preserves individual dignity while maintaining the collective trust necessary for effective epidemic control.

Advances in vaccination, contact tracing, and genomic epidemiology further illustrate the compatibility of Islamic ethics with evidence based public health practice. When governed by justice, excellence, and trust, these tools serve the higher objectives of the shariah by preventing harm and preserving life. Disclosure of health information, though ordinarily restricted, becomes permissible and at times obligatory when nondisclosure endangers others.

In an era of recurring pandemics and rapidly advancing biomedical technologies, Islamic jurisprudence offers a proactive and ethically grounded vision for public health governance. It affirms that faith and science are not competing domains but complementary means of fulfilling humanity's responsibility to protect life. Public health measures guided by justice, compassion, and accountability thus become not only legitimate policy instruments but also expressions of moral responsibility and religious devotion.

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