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Original Research Article

Environmental health and patient safety in Indonesian sharia hospitals: A critical normative–empirical synthesis toward a maqasid-based governance framework

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Abstract: Sharia hospitals in Indonesia are rapidly evolving under Fatwa No. 107/DSN-MUI/X/2016 and MUKISI/SIRSMA standards; however, governance remains focused on contractual, financial, and halal compliance, leaving environmental health and patient safety underrepresented as measurable outcomes. This study synthesises normative and empirical evidence to assess the integration of these domains and proposes a maqasid al-shariah-based framework to render them operational. Utilizing a normative–empirical narrative synthesis, the research triangulated Indonesian regulatory and fatwa documents, certification standards, four domestic case studies, and comparative literature from Malaysia and Gulf countries. Results reveal that while environmental health and infection control are not entirely absent from current standards, their requirements remain fragmented across national accreditation and environmental regulations. Furthermore, case evidence highlights persistent gaps in halal supply chains, Sharia Supervisory Board engagement, and standardized safety indicators, whereas mature international models successfully embed these elements as core maqasid-linked components. Ultimately, Indonesian sharia healthcare governance possesses sufficient foundations to explicitly integrate environmental health and patient safety, where a unified maqasid-based indicator set would significantly enhance accountability, compliance, and overall safety performance.

Keywords: sharia hospital; patient safety; environmental health; hospital governance; Indonesia; maqasid al-shariah; hospital accreditation

INTRODUCTION

Patient safety and environmental health are now recognised internationally as core, measurable dimensions of hospital quality, driven by concerns over healthcare-associated infection, hazardous medical waste, antimicrobial resistance, and uneven governance capacity in low- and middle-income health systems. Indonesian hospitals, serving the world's largest Muslim population, face these pressures alongside a distinct institutional development: the emergence of the sharia hospital (rumah sakit syariah) as a formally certifiable category of care.

The normative foundation of this model is Fatwa No. 107/DSN-MUI/X/2016 of the National Sharia Board–Indonesian Ulema Council (DSN-MUI) (2016), which sets out contractual (akad), service, and product requirements for hospitals operating on sharia principles. This fatwa is operationalised through two parallel certification tracks: the Majelis Upaya Kesehatan Islam Seluruh Indonesia (MUKISI) certification instrument, first piloted in 2014 and now comprising several dozen standards and more than 150 assessment elements across management and service domains (Majelis Upaya Kesehatan Islam Seluruh Indonesia (MUKISI), 2018, 2023), and, for Muhammadiyah-owned hospitals, the Standar Islami Rumah Sakit Muhammadiyah-

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'Aisyiyah (SIRSMA), issued by the Majelis Pembina Kesehatan Umum (MPKU) of Pimpinan Pusat Muhammadiyah (Sukaca et al., 2019). By 2024, MUKISI reported approximately 79 hospitals certified or in the certification pipeline, out of roughly 500 member institutions, with several government-owned general hospitals also seeking sharia certification (Majelis Upaya Kesehatan Islam Seluruh Indonesia (MUKISI), 2023; Wildani et al., 2026).

Existing discourse on these instruments—both in policy documents and in the growing body of Indonesian thesis and journal literature—concentrates heavily on contracts, halal product certification, sharia financial governance, and religious-administrative compliance. Environmental health (clean water, sanitation, waste segregation, ventilation, disinfection, food safety, hazardous-material handling) and patient safety (incident reporting, medication safety, infection prevention, emergency preparedness) appear, when they appear at all, as secondary or implicit considerations rather than as core, measurable performance domains.

This is a consequential gap. A hospital can satisfy administrative indicators of sharia compliance—an akad framework, a halal-labelled pharmacy vendor, a zakat-infaq-sadaqah mechanism—while its environmental sanitation, waste handling, or incident-reporting culture remains underdeveloped. These domains are not separable in practice: unsafe medical-waste handling compromises the clinical environment for every patient regardless of religious identity; incomplete halal assurance in the hospital kitchen or pharmacy is simultaneously a supply-chain and a food-safety issue; and an undefined Sharia Supervisory Board weakens not only religious oversight but also the general accountability structure needed to enforce sanitation and safety standards.

This paper asks: to what extent are environmental health and patient safety already embedded in Indonesian sharia hospital governance instruments, and how can a maqasid al-shariah-based framework make these domains explicit, measurable, and central rather than incidental? Unlike a purely rhetorical critique, this synthesis explicitly tests—and, where the evidence warrants, revises—the common assumption that environmental health is simply absent from sharia hospital governance. The paper has three aims: first, to establish, through primary-source verification, what environmental-health and patient-safety content already exists across the fatwa, MUKISI, and SIRSMA instruments and where it is fragmented rather than absent; second, to synthesise Indonesian case-study evidence on implementation gaps with plausible safety consequences; and third, to propose a maqasid-based framework and curriculum implications for hospital administration (MARS) education.

METHODS

Design

This is a conceptual, normative–empirical synthesis paper. It does not report new primary fieldwork; instead it triangulates primary regulatory and certification texts with published Indonesian case-study literature and comparative regional evidence, following a critical-interpretive rather than a systematic-review logic, consistent with prior maqasid-based critical syntheses in Islamic health-services research (Ismail et al., 2018).

Sources and search strategy

Three categories of evidence were used. First, primary normative sources were retrieved and read in full or in relevant part: Fatwa No. 107/DSN-MUI/X/2016, the MUKISI sharia hospital certification standard and its public descriptions (Majelis Upaya Kesehatan Islam Seluruh Indonesia (MUKISI), 2018, 2023), the SIRSMA standard issued by MPKU PP Muhammadiyah (Sukaca et al., 2019), Government Regulation No. 42/2024 on Halal Product Assurance (2024), Ministry of Health Regulation No. 11/2017 on Patient Safety, and the Ministry of Environment and Forestry's medical-waste regulations (Permen LHK No. P.56/2015 and No. 6/2021) (Permen LHK No. P.56/2015 and No. 6/2021) together with Ministry of Health Regulation No. 18/2020 on region-based medical-waste management. Second, Indonesian empirical case-study literature on sharia hospital implementation was identified through targeted searches

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(Indonesian and English terms combining 'rumah sakit syariah', 'DSN-MUI 107', 'MUKISI', 'SIRSMA' with 'implementasi', 'akuntansi', 'pelayanan') and verified at source; four studies meeting relevance and verifiability criteria were retained for detailed synthesis (Badan Penyelenggara Jaminan Produk Halal, 2025; Ismail et al., 2018; Mahmudah & Hafni, 2022; Wildani et al., 2026). Third, comparative regional literature on sharia/Shariah-compliant hospital governance and patient safety in Malaysia, Oman, and Saudi Arabia was retrieved to contextualise the Indonesian case within a wider Muslim-majority health-systems literature (Al-Azmi, 2022; Al-Jabri et al., 2021; Jamaludin et al., 2025; Kaud et al., 2021; Sulistiadi et al., 2025).

Analytic approach

A thematic synthesis approach was used across four intersecting domains: governance, environmental health, patient safety, and competency/curriculum readiness. Because the original conceptual draft on which this manuscript is based asserted that environmental health is largely absent from sharia hospital governance, a deliberate critical-appraisal (red-team) step was added: every primary certification and regulatory source was re-examined specifically for environmental-health and infection-control content before that claim was accepted, revised, or rejected.

Limitations of the design

As a narrative rather than systematic synthesis, this paper cannot claim exhaustive coverage of the Indonesian sharia hospital literature, most of which consists of unpublished undergraduate theses of uneven methodological quality. The four detailed case studies are single-site, qualitative, and not generalisable in a statistical sense; they are used here as illustrative, verified instances of a recurring pattern rather than as a representative sample. Comparative material from Malaysia and the Gulf states reflects different regulatory architectures (e.g., SIRIM's MS 1900:2014 quality-management standard) and cannot be assumed to transfer directly to the Indonesian DSN-MUI/MUKISI/SIRSMA architecture.

Ethical Clearance

The authors declare that this study was conducted in accordance with scientific ethical standards and is free from fabrication, falsification, plagiarism, and data manipulation. Informed consent was obtained from all participants, and the confidentiality of their identities and data was strictly maintained. The authors also confirm that there is no conflict of interest regarding the conduct and publication of this research.

RESULTS AND DISCUSSION

Results

Governance architecture: layered, not absent, but poorly integrated

Indonesian sharia hospital governance is not a single instrument but a layered architecture: a religious-legal fatwa [1], a cross-institutional certification standard (MUKISI) with 50–51 standards and roughly 160–200 assessment elements spanning management and service groups (Majelis Upaya Kesehatan Islam Seluruh Indonesia (MUKISI), 2018, 2023), and, for Muhammadiyah-owned hospitals, an internal denominational standard (SIRSMA) covering management, human-resource, building/physical, and service domains (Sukaca et al., 2019). Layered on top of both is the mandatory national hospital accreditation system administered by KARS/LAFKI, within which Ministry of Health Regulation No. 11/2017 sets seven patient-safety standards and defines reportable adverse events.

Case-study evidence shows that even hospitals with long-standing sharia identity and full (paripurna) national accreditation continue to show incomplete alignment across these layers. At Fastabiq Sehat PKU Muhammadiyah Pati—accredited paripurna by KARS since 2018 and operating as a self-described Islamic hospital since 2015—a 2026 juridical–empirical case study

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found that 9 of 11 DSN-MUI management instruments and 10 of 13 service instruments were met, while halal-certified pharmaceutical/food/cosmetic products, full partnership with Islamic financial institutions, a definitive Sharia Supervisory Board, systematic use of MUI fatwas on contemporary medical issues, and a written patient fiqh-of-worship guideline remained unmet (Wildani et al., 2026). At RS Muhammadiyah Lamongan, a paripurna-accredited type-B hospital certified as sharia-compliant by DSN-MUI since 2018, a case study of the accounting and finance domain found the hospital met MUKISI's financial standards but had not yet completed SIRSMA certification, partly because of pandemic-era disruption, illustrating that the two certification tracks can diverge in timing and completeness even within the same hospital (Mahmudah & Hafni, 2022).

Environmental health is present in the instruments, but fragmented and unevenly enforced

A central finding of the critical-appraisal step is that the claim 'environmental health is absent from sharia hospital governance' should be revised. MUKISI's certification framework explicitly includes a 'Sharia Standard for Infection Prevention and Control', requiring hospitals to maintain an infection prevention and control programme as one of its named assessment groups (Adams, 2019). SIRSMA likewise contains a dedicated management domain for hospital buildings and physical facilities (manajemen bangunan dan fisik) alongside its management, human-resource, and service domains (Sukaca et al., 2019). What is fragmented, rather than absent, is the integration of these elements with the environmental and occupational-health regulatory system that governs Indonesian hospitals generally: medical and hazardous (B3) waste management is regulated separately, under Ministry of Environment and Forestry rules requiring segregation, licensed storage, incineration or autoclaving, and biannual reporting to the environment ministry, and, since 2020, under a region-based Ministry of Health medical-waste management regulation intended to help local governments coordinate shared treatment facilities. None of the sharia-specific instruments (fatwa, MUKISI, SIRSMA) currently cross-reference these environmental regulations as sharia-relevant obligations in their own right, even though improper handling of infectious or hazardous waste is arguably a more direct threat to hifz al-nafs (the protection of life) than an unresolved halal-certification gap in a supplier contract.

Patient safety: implicit in service standards, not yet an explicit indicator set

Patient safety appears in sharia hospital instruments mainly through service-quality, non-discrimination, and spiritual-care provisions rather than through a dedicated set of measurable safety indicators comparable to Ministry of Health Regulation No. 11/2017's seven national patient-safety standards. The Fastabiq Sehat and RSU Fastabiq case study explicitly linked non-discriminatory, professional service delivery to maqasid al-shariah and to the hospital's 'IKHLAS' internal work-culture programme, but did not report hospital-specific incident-reporting or infection-rate data as sharia-relevant outcomes (Wildani et al., 2026). This is consistent with a broader pattern identified in Sulistiadi and colleagues' 2025 analysis of sharia hospitals as a source of new economic growth in Indonesia, which frames sharia hospital development primarily in market, financing, and halal-industry terms rather than in clinical-safety terms (Sulistiadi et al., 2025), and with Ismail, Rahman, and Ahmad's earlier account of the Indonesian sharia hospital 'journey', which similarly foregrounds governance, certification process, and institutional identity over measurable safety performance (Ismail et al., 2018).

A critical case: symbolic compliance and legitimacy risk

The 2026 Fastabiq Sehat case study also documents a cautionary counter-example relevant to red-team scrutiny of the sharia hospital model: a 2019 controversy at a government-owned regional hospital (RSUD Tangerang), which drew national media criticism for religious symbols and rules perceived as potentially discriminatory toward non-Muslim patients and in tension with the neutrality expected of public healthcare providers (Wildani et al., 2026). This episode illustrates that symbolic or administrative markers of sharia identity, applied without a clear

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underlying safety-and-equity rationale, can generate legitimacy risk rather than trust—reinforcing, from the opposite direction, this paper's core argument that measurable safety and non-discriminatory care, not visible religious symbolism, should be the primary evidentiary basis for sharia hospital legitimacy.

Comparative regional evidence

Regional comparison suggests that more mature Shariah-compliant healthcare systems increasingly treat environmental control and patient safety as certifiable, maqasid-linked components rather than peripheral concerns. In Malaysia, the International Islamic University Malaysia's SASMEC@IIUM hospital pursued dual certification against ISO 9001:2015 and SIRIM's MS 1900:2014 Shariah-based quality-management standard, explicitly requiring that the hospital's physical environment, and not only its contracts and products, be 'adapted to Islam' (Al-Azmi, 2022). A 2025 consensus study using fuzzy Delphi and interpretive structural modelling with Malaysian experts identified ten core elements of a Shariah-compliant medical-services framework, in which spiritual-care infrastructure and an 'Islamic environment' were found to depend on—rather than substitute for—effective operational and clinical governance (Jamaludin et al., 2025). Outside the specifically Islamic-hospital literature, national patient-safety studies from two Gulf states illustrate what a maturity trajectory can look like: in Oman, a 2021 cross-sectional study of two tertiary hospitals found patients and healthcare professionals rated quality of care and patient safety highly against magnet-hospital benchmarks, following more than a decade of dedicated Ministry of Health quality-and-safety infrastructure (Al-Jabri et al., 2021); in Saudi Arabia, a 2021 qualitative study using Vincent et al.'s Measuring and Monitoring Safety framework identified 39 distinct national-level methods for measuring and monitoring hospital patient safety, indicating a comparatively dense, if still uneven, national safety-surveillance architecture (Kaud et al., 2021). No comparable Indonesia-specific, sharia-hospital patient-safety measurement study was found in this synthesis, underscoring a genuine—rather than merely rhetorical—gap in the Indonesian literature.

Discussion

From symbolic compliance to maqasid-based safety performance

The strongest and most defensible claim to emerge from this synthesis is not that environmental health is absent from Indonesian sharia hospital governance, but that it is present in fragmented, poorly cross-referenced form, and that patient safety has not yet been converted from an implicit value into an explicit, measurable performance domain. This distinction matters for both scholarly precision and policy design: a claim of outright absence invites a simple 'add a chapter' remedy, whereas a claim of fragmentation invites structural integration—cross-referencing MUKISI's infection-control standard, SIRSMA's physical-facility standard, national Ministry of Health Ministry of Health patient-safety regulation, and Ministry of Environment and Forestry hazardous-waste rules under a single, maqasid-anchored indicator set.

Environmental health and patient safety as maqasid-based practice

Maqasid al-shariah, particularly hifz al-nafs (the protection of life), provides a coherent normative bridge between Islamic ethics and modern hospital management, a linkage already articulated in the Malaysian Shariah-compliant hospital literature (Al-Azmi, 2022; Ismail et al., 2018; Jamaludin et al., 2025). Clean water and sanitation protect life and dignity; correctly segregated and treated medical waste prevents harm to patients, staff, and surrounding communities; systematic infection prevention preserves life and reduces avoidable injury; and halal-verified, safety-verified pharmaceutical and food supply chains protect both bodily welfare and institutional trust. Framed this way, environmental health and patient safety are not imported 'Western' managerial add-ons to sharia hospital identity; they are among its most direct operational expressions, arguably more central to hifz al-nafs than administrative markers such as contract terminology or religious signage.

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Why patient safety remains under-integrated

The recurring implementation gaps identified across the four Indonesian case studies—unresolved halal certification, absent or non-definitive Sharia Supervisory Boards, incomplete Islamic-financial partnership, missing written fiqh-of-worship guidance—suggest that many hospitals are still working through sharia governance via visible, document-based compliance items, a pattern consistent with a well-known risk in governance reform generally: administrative compliance can outpace operational and safety maturity. A hospital can hold a sharia certificate, a halal-labelled pharmacy vendor list, and a certification badge from MUKISI or SIRSMA, while its incident-reporting culture, sanitation audit frequency, and hazardous-waste compliance remain governed—and measured—entirely outside the sharia framework, by ordinary national accreditation and environmental law. This is not, on the evidence reviewed here, unique to Indonesia; the comparative Malaysian material shows that even a jointly ISO- and MS 1900-certified flagship hospital treats its 'Islamic environment' element as dependent on prior operational governance rather than as a free-standing achievement (Al-Azmi, 2022; Jamaludin et al., 2025).

Implications for MARS (hospital administration) education

For postgraduate hospital administration (MARS) programmes with a sharia orientation, the practical implication is to teach environmental health and patient safety as integral extensions of maqasid al-shariah rather than as separate, secular management topics appended to an Islamic-studies curriculum. Concretely, this means training future hospital administrators to read MUKISI's infection-control standard, SIRSMA's physical-facility standard, Ministry of Health Regulation No. 11/2017, and the medical-waste regulations as a single accountability chain, and to build institutional Sharia Supervisory Boards with the technical literacy to audit that chain, not only contracts and product certificates.

Limitations

This synthesis relies on a small number of verifiable, single-site Indonesian case studies and on regulatory texts rather than on hospital-level outcome data (infection rates, incident reports, waste-compliance audit scores); it therefore cannot quantify the size of the environmental-health or patient-safety gap, only its recurring qualitative pattern. The comparative Gulf and Malaysian evidence, while informative, describes different regulatory and resource contexts and should not be read as demonstrating that similar interventions would produce identical results in Indonesia. Finally, because much of the underlying Indonesian source literature consists of undergraduate or graduate theses rather than peer-reviewed journal articles, the evidentiary base—while triangulated and source-verified for this synthesis—remains methodologically heterogeneous, and future work should prioritise peer-reviewed, multi-site, mixed-methods studies that directly measure environmental-health and patient-safety indicators inside certified sharia hospitals.

Proposed Framework

Building on the evidence above, an integrated framework for Indonesian sharia hospitals is proposed, explicitly cross-referencing existing instruments rather than proposing new parallel ones:

Sharia governance and accountability

A definitive, technically literate Sharia Supervisory Board with an explicit mandate covering environmental-health and patient-safety audit, not only financial and contractual compliance (Fatwa Dewan Syariah Nasional-Majelis Ulama Indonesia No: L07/DSN-MUIIX/2016 Tentang Pedoman Penyelenggaraan Rumah Sakit Berdasarkan Prinsip Syariah, 2016; Sukaca et al., 2019; Wildani et al., 2026).

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Environmental health system

Integration of MUKISI's infection-control standard and SIRSMA's physical-facility standard with Ministry of Health Regulation No. 11/2017 and hazardous/medical-waste regulations into one monitored indicator set (Adams, 2019).

Patient safety system

Adoption of the seven national patient-safety standards—incident reporting, infection control, medication safety, safe procedures, emergency preparedness—as explicit, published sharia hospital performance indicators, not only implicit service values.

Halal-safe procurement

Full alignment with Government Regulation No. 42/2024 on Halal Product Assurance (2024) for pharmacy, food service, and medical-device supply chains, including hospital kitchens and compounding pharmacies (Badan Penyelenggara Jaminan Produk Halal, 2025).

Staff competence and safety culture

Training, supervision, and documentation that treat environmental and patient safety as maqasid-based religious obligations, reinforced through MARS curricula (Ismail et al., 2018; Jamaludin et al., 2025).

Maqasid-based performance monitoring

Hospital-level indicators explicitly linked to hifz al-nafs (protection of life), reported alongside conventional certification renewal cycles.

CONCLUSION

This synthesis finds that environmental health and patient safety are not wholly absent from Indonesian sharia hospital governance, as an uncritical reading of the discourse might suggest, but are fragmented across a fatwa, two overlapping certification instruments, national patient-safety regulation, and separate environmental law, without a unifying, maqasid-anchored indicator framework. Verified case-study evidence from Fastabiq Sehat PKU Muhammadiyah Pati, RS Muhammadiyah Lamongan, and the broader Indonesian sharia-hospital literature shows that even well-accredited, long-established sharia hospitals continue to carry unresolved halal-certification, governance, and documentation gaps with plausible, if unmeasured, implications for environmental and patient safety. Comparative regional evidence indicates that more mature Shariah-compliant health systems already treat these domains as measurable and certifiable rather than incidental. The principal recommendation is that Indonesian sharia hospital policy, accreditation practice, and MARS education explicitly integrate environmental health and patient safety as core, cross-referenced, maqasid-based outcomes—making the sharia hospital model more credible, more measurable, and more directly responsive to Indonesia's current healthcare-safety priorities.

DECLARATIONS

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take full responsibility for the accuracy, originality, and scholarly integrity of the final manuscript, consistent with ICMJE and COPE guidance on generative-AI disclosure.
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