Rule of Law Studies Journal

Contextualizing Community Health Practices within Islamic Legal Norms and Government Regulation: A Field-Based Inquiry from Rural Indonesia

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Received: 5 May 2025 | Revised 06 June 2025 | Accepted: 22 July 2025

ABSTRACT:
Background: In remote regions of Indonesia, public health centers remain essential yet frequently struggle with service delivery challenges. Islamic legal traditions, which emphasize the protection of life and well-being, offer a complementary framework to evaluate such services alongside state-mandated regulations.
Aims: This paper explores how healthcare services at the Negara Ratu Health Center comply with Indonesia's Ministerial Regulation No. 75/2014 and investigates whether those services align with the ethical imperatives of Islamic jurisprudence.
Methods: The study uses an empirical legal research approach. Data were obtained through interviews with minority shareholders in three companies, supported by doctrinal analysis of statutory provisions and legal theories on protection and effectiveness.
Results: The study found that core aspects of the service—such as reliability and responsiveness—met regulatory expectations. However, gaps remain in areas like comfort, clarity of communication, and continuity of care. Islamic legal assessment affirmed that the services generally reflect the principles of maqashid al-shariah, especially in promoting human dignity and safeguarding health.
Conclusion: Bridging state health policy with Islamic ethical values contributes to a more inclusive framework for public healthcare improvement. Targeted efforts to enhance patient satisfaction and system responsiveness are crucial in ensuring both legal compliance and moral accountability.

Keyword:
Community healthcare; Islamic legal ethics; Maqashid al-shariah; Ministry of Health Regulation No. 75/2014; Rural health services

Cite this article: Yanti, A, W., Alamsyah, A., Karini, E,. (2025). Contextualizing Community Health Practices within Islamic Legal Norms and Government Regulation: A Field-Based Inquiry from Rural Indonesia. *Rule of Law Studies Journal*, *1*(2), 127-140.

INTRODUCTION

Delivering healthcare to communities in remote areas remains a persistent concern in many developing countries, including Indonesia. While the government has established community health centers (Puskesmas) to expand access, various limitations still hinder service quality. These range from insufficient infrastructure and staffing to administrative delays that affect patient satisfaction (Amankwah et al., 2022; Hussein et al., 2025). In practice, patients often experience long wait times and a lack of responsiveness, despite the availability of services. Many of these issues stem from structural and resource-related problems that are common in rural healthcare (Getnet et al., 2021; Watanabe & Totsu, 2025). Regulation alone does not always guarantee quality; local context plays a significant role. In such settings, a deeper understanding of both systemic and sociocultural dimensions becomes essential. A holistic evaluation must therefore consider not just policy compliance, but also the community's expectations and lived experiences.

Beyond regulatory standards, religion plays a central role in shaping societal norms in Indonesia, particularly in Muslim-majority regions. Islamic teachings are deeply embedded in the everyday values of many Indonesians, especially concerning matters of health, care, and human dignity. The framework of maqashid al-shariah, which highlights the preservation of life, intellect, and well-being, offers a powerful ethical lens (Wardi et al., 2023). In healthcare contexts, this framework promotes compassion, justice, and collective responsibility for the vulnerable. It positions health not just as a right, but as a moral duty to be fulfilled both individually and institutionally. Consequently, public services that reflect Islamic ethical values may foster greater trust and legitimacy among service users (Jawad et al., 2021; Mulyawan, 2024). When these values are absent or neglected, disconnects can emerge between policy intentions and community reception. Thus, including Islamic perspectives in healthcare evaluation is not only relevant but necessary in Muslim-majority settings.

The Negara Ratu Health Center in North Lampung is a useful example of this intersection between policy and culture. Situated in a rural subdistrict, the center provides both outpatient and inpatient services for residents of fifteen surrounding villages. Although it meets many administrative standards outlined in national health regulations, patient satisfaction has been mixed (Alawode & Adewole, 2021; Alderwick et al., 2021). Complaints frequently relate to staff responsiveness, service delays, and physical conditions of the facility. On paper, the center may appear compliant, but in practice, service quality remains uneven. This highlights a crucial distinction between formal performance indicators and perceived quality. Community members may evaluate healthcare not only based on efficiency, but also based on how well it aligns with their moral and cultural expectations (Ettenberger & Calderón Cifuentes, 2022). Understanding these perceptions is vital for improving healthcare outcomes at the grassroots level.

Government efforts to regulate health services are primarily framed through national policy instruments like Ministerial Regulation No. 75/2014. This regulation outlines operational standards for community health centers, including service scope, staffing, infrastructure, and accountability mechanisms (Kesale et al., 2022; Sitienei et al., 2021). It aims to ensure equity and quality in public health delivery, particularly in underserved areas. However, these top-down standards often fail to capture the complex realities of local communities. Service users may hold expectations that are rooted in cultural or religious worldviews rather than administrative benchmarks (Mohammad et al.,

2021; Suleman, 2023). As a result, even well-intentioned policy may not resonate if it is perceived as culturally dissonant. The effectiveness of healthcare delivery, therefore, depends not only on policy design but also on its cultural congruence. Bridging this gap calls for an approach that integrates legal compliance with ethical legitimacy drawn from local belief systems.

Islamic legal ethics provide such a framework, emphasizing human welfare, dignity, and responsibility in both personal and institutional conduct. Health, in this view, is not merely a functional issue but part of a divinely mandated obligation to protect life and prevent harm (Nampewo et al., 2022). These principles can guide both policy formulation and service delivery, offering direction in contexts where religious norms remain influential. In the hands of health workers, Islamic ethics can shape how care is administered—with empathy, sincerity, and respect for patients' spiritual and physical needs. Likewise, communities that see their values reflected in public services may show higher levels of trust and cooperation. This synergy between ethical expectations and institutional behavior can enhance healthcare quality beyond technical efficiency. Recognizing these dynamics allows for more meaningful engagement with communities. It also offers pathways to improve public satisfaction through culturally grounded service models.

In the case of the Negara Ratu center, the religious and cultural fabric of the local population cannot be ignored. Residents, most of whom identify strongly with Islamic traditions, often view healthcare through a moral lens (Abu-Ras et al., 2022; Penney, 2022). They expect respectful communication, appropriate gender interactions, and ethical conduct that aligns with their beliefs (Keddie et al., 2023). When these expectations are not met, dissatisfaction may arise, even if the technical quality of care is adequate. Health services that disregard such ethical dimensions risk being seen as alien or untrustworthy. Evaluating the extent to which care delivery adheres to both religious and regulatory frameworks becomes critical. It not only helps assess existing gaps but also informs improvements tailored to the community. Therefore, understanding local moral frameworks enhances the relevance and acceptance of healthcare interventions.

To explore these dynamics meaningfully, a context-sensitive research design is required. Relying solely on quantitative metrics may obscure the nuanced ways in which people experience and judge healthcare (Castelnovo et al., 2022; Kiviat, 2023). Qualitative approaches—such as interviews, field observation, and narrative analysis—are better suited for capturing social meanings and ethical tensions (Knott et al., 2022; Krause, 2021). In this study, such methods were applied to gather insights from staff, patients, and administrators at the Negara Ratu center. These data points were then interpreted through both state policy and Islamic legal lenses. This dual framework allows for an evaluation that is not only comprehensive but also culturally attuned. It reveals not just what services are delivered, but how they are experienced by those who depend on them. Such understanding is crucial for designing more responsive and morally grounded health systems.

Finally, this research extends beyond a single rural clinic; it speaks to broader challenges faced by healthcare systems in culturally diverse societies (Coombs et al., 2022; Khatri & Assefa, 2022). When state regulations are developed without sufficient attention to local moral orders, implementation gaps may persist. In regions where religion informs daily life, integrating ethical and cultural values into public services is essential (Anderson et al., 2021; Currier et al., 2023). The insights gained from this study suggest that harmonizing religious ethics with regulatory frameworks

can enhance the overall legitimacy of healthcare systems. It also opens possibilities for more participatory governance, where communities feel acknowledged and respected. Such an approach does not undermine state authority but reinforces it through local legitimacy. Therefore, exploring the compatibility between Islamic values and government health policy is not only academically relevant but practically urgent. It offers a roadmap for more inclusive, trusted, and sustainable healthcare in Indonesia and similar contexts.

Evaluating public health services in predominantly Muslim areas requires not only adherence to formal regulations but also sensitivity to local ethical frameworks. Mohamad et al.(2025) emphasize that decisions around medical care should reflect Islamic values to ensure community confidence. This argument is echoed by Lubis et al.(2025), who underscore the importance of aligning institutional behavior with religious ethics to maintain credibility. Novita et al.(2025) further illustrate how Islamic conflict resolution principles shape community expectations of fairness, which also influence how health services are perceived. Fakhyadi et al.(2025) highlight the significance of combining customary practices with Islamic law to strengthen social resilience, offering parallels for improving localized healthcare delivery. Ebrahimi & Ghodrati, (2025)show how interpretations of Islamic legal standards differ across nations, pointing to the necessity of contextual approaches. From a different angle, Rezaee et al.(2025) stress the value of patient narratives in understanding healthcare experience within cultural contexts. Institutional decisions influenced by religious ethics are also visible in the financial sector, as demonstrated. The study by Adriansyah et al.(2025) explores the ethical responsibilities of institutions in digital economies, relevant to evolving health systems. Lastly, Aydın & Cevherli,(2025) revisit al-Shāṭibī's jurisprudential legacy, showing how classical Islamic thought can inform practical reforms, including in health service ethics.

In many rural regions of Indonesia, public healthcare facilities continue to encounter systemic and ethical challenges that influence their ability to deliver responsive services. Although national policies like Ministry of Health Regulation No. 75/2014 provide a formal structure for community health centers, these policies may not fully resonate with the lived realities and cultural expectations of local populations. Particularly in Muslim-majority settings, health is not merely a service matter—it is also seen as part of a religious and moral obligation. The Islamic legal tradition, especially the framework of maqashid al-shariah, positions the preservation of life, dignity, and well-being as essential goals that guide personal and institutional conduct. When healthcare systems operate without acknowledging these values, a disconnect may occur between what is legally required and what the community perceives as morally acceptable. Thus, integrating religious ethics into the evaluation of health services becomes a necessary step toward culturally grounded public health improvement. Yet, current policy evaluations rarely explore this dimension. A more inclusive analysis is needed to bridge the normative gap between regulation and community belief systems.

While previous studies have assessed various aspects of Puskesmas service delivery under national health standards, few have considered how these services align with religious norms held by the local population. Most evaluations tend to focus on technical compliance, infrastructure readiness, or statistical performance, overlooking ethical perspectives rooted in Islamic law. Moreover, little attention has been paid to how community members interpret the quality of care through the values of maqashid al-shariah, which emphasize protecting life and upholding human

dignity. In the case of rural areas like Negara Ratu, this gap becomes more evident, as religious values strongly influence how people engage with and respond to public institutions. The absence of integrated studies that compare regulatory fulfillment with ethical alignment leaves a blind spot in current health policy literature. Addressing this issue is crucial to build a more responsive, trusted, and value-aligned healthcare system.

This research seeks to explore the extent to which the health services provided by the Negara Ratu Community Health Center comply with the operational standards outlined in Ministry of Health Regulation No. 75/2014. More importantly, it aims to examine whether those services reflect the ethical values derived from Islamic legal principles, particularly the objectives emphasized in maqashid al-shariah. Through this dual-lens analysis, the study intends to uncover how state-driven healthcare delivery is perceived in a religiously conscious rural setting. By identifying areas of alignment and disconnect between legal frameworks and ethical expectations, the study aspires to offer practical insights for improving healthcare quality. The findings may also contribute to developing policy models that are not only administratively sound but also culturally and morally resonant with the communities they serve.

METHOD

Research Design

This study adopted a qualitative descriptive method to examine how healthcare services are delivered at the Negara Ratu Health Center, especially in relation to state regulations and Islamic ethical values. A single-site case study was chosen to allow detailed exploration of service experiences within a specific institutional and cultural setting. This design made it possible to observe real-life interactions and assess how policies are enacted on the ground. It also provided room to explore perceptions shaped by both formal health policy and religious norms. By using a descriptive lens, the study focused on capturing narratives, behavior, and contextual meanings rather than testing hypotheses. The approach was considered suitable due to the study's emphasis on values, beliefs, and interpretations. The design prioritized depth of insight over generalizability, aligning with the goal of understanding the health center's operations in cultural and ethical context. Ethical approval was obtained through informed consent, and participant anonymity was maintained.

Participant

Participants in this study were selected purposively to represent a range of experiences and roles within the health service environment. The group included medical staff, administrative personnel, patients, and the head of the health center. In total, ten individuals participated, all of whom had regular interaction with the Puskesmas and were considered capable of offering informed perspectives. Their selection was based on direct experience with healthcare provision or utilization at the site under study. The sample was diverse in age, gender, and occupation to ensure representation of varied viewpoints. All participants were informed about the study's purpose and gave their consent before taking part. Their identities were kept confidential, and participation was

entirely voluntary. This approach allowed the researcher to access insights that reflected both professional practice and patient experience within a shared religious and cultural setting.

Instrument

To collect data, the researcher used semi-structured interview guides containing open-ended questions tailored to the research focus. The guide covered issues such as service accessibility, staff conduct, perceived fairness, and consistency with Islamic moral expectations. Interviews allowed participants to express their views in their own words, while still following a thematic structure to maintain relevance across sessions. In addition to interviews, the researcher conducted direct observations of patient flow, staff-patient interactions, and facility conditions. Institutional documents—such as service protocols, feedback forms, and internal evaluations—were also reviewed to contextualize findings. This combination of sources helped improve the trustworthiness of the results. Interviews were conducted in the local language and recorded with permission for accuracy. Field notes supported the documentation of non-verbal cues and environmental factors that influenced service delivery.

Data Analysis

All collected data were processed through thematic analysis, beginning with a close reading of the transcripts and observation notes. Key phrases, ideas, and concerns raised by participants were identified and grouped into codes. These codes were gradually refined into categories that represented broader patterns, such as service efficiency, empathy, and alignment with Islamic values. A comparative reading was also done, contrasting the emergent themes with the content of Ministry of Health Regulation No. 75/2014 and the core aims of maqashid al-shariah. Patterns were interpreted to reveal areas of harmony or disconnect between regulatory demands and community expectations. The researcher maintained reflexive notes to monitor possible bias during analysis. Cross-checking data from interviews, observations, and documents supported the credibility of findings. The process concluded by synthesizing themes that responded to the study's core questions and reflected the lived reality of healthcare at the study site.

Figure 1. . Research Flowchart: Evaluating Healthcare Services through Islamic Legal Ethics and Government Regulation

RESULTS AND DISCUSSION

Results

This study produced three central findings drawn from interviews, on-site observations, and institutional documentation. The findings are grouped into: (1) adherence to health policy, (2) service experience as perceived by patients, and (3) alignment with Islamic ethical values.

• Observed Compliance with Regulation

Administrative data and managerial interviews suggested that the health center operates within the structural expectations outlined in the national health regulation, specifically Ministerial Regulation No. 75/2014. The availability of both inpatient and outpatient services, along with routine public health programs, was confirmed. Internally, procedural forms were in place, and staff were familiar with the regulatory framework. However, routine practices often depended on available personnel and fluctuating workloads. While documentation requirements were fulfilled, the consistency of actual service delivery varied. Some procedures were applied more mechanically than meaningfully. This indicates that legal compliance exists in form but sometimes lacks substance in execution.

• Patient-Reported Concerns and Expectations

From the perspective of service recipients, various challenges emerged that are not visible through formal documentation. Interviews revealed issues such as slow response during busy hours, limited privacy, and discomfort related to gender interaction in care settings. While some

respondents acknowledged receiving basic treatment, many raised concerns about emotional neglect or poor communication. To support these qualitative insights, a thematic count was conducted to determine how often each issue was mentioned across the interviews. The result is summarized in the chart below:

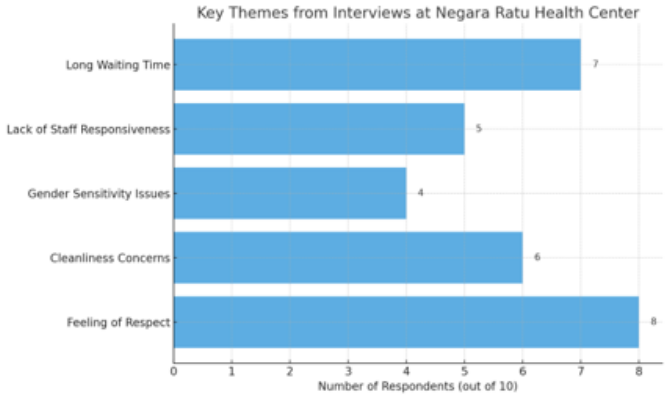

Figure 1. Key Themes from Interviews at Negara Ratu Health Center

The graph shows that most patients valued respectful treatment, but they also frequently brought up long waiting times, cleanliness, and gender sensitivity. The pattern reveals that while basic services were in place, the patient experience often did not meet expectations grounded in cultural and ethical norms.

- Ethical Fit with Islamic Legal Principles

When analyzed through the moral perspective of maqashid al-shariah, the health center's performance showed partial consistency. Many patients recognized the staff's intention to provide care with sincerity, which aligns with the Islamic value of preserving life (hifz al-nafs). Nonetheless, certain aspects—such as mixed-gender care and lack of privacy—fell short of community expectations rooted in religious teachings. Interviews with health workers acknowledged these limitations, with some expressing regret about being unable to accommodate religious preferences due to staffing shortages. Despite these shortcomings, patients continued to access the facility, pointing to a functional level of acceptance that may stem from necessity rather than satisfaction. This highlights the complex balance between institutional capacity and moral legitimacy in public service.

Discussion

The service implementation observed at Puskesmas Negara Ratu appears formally aligned with government regulations, particularly Permenkes No. 75/2014. However, structural adherence alone does not always reflect the quality of care as felt by the community. This finding supports the view of Mohamad, Hamdan, and Yusof (2025), who argue that ethical responsiveness must accompany legal compliance. In practice, procedural checklists were fulfilled, but patients often experienced inconsistencies in delivery. Some health workers followed the flow but lacked deeper understanding of ethical nuances. This suggests that service legitimacy in rural communities involves more than just

rule-following—it requires human engagement. Community members may tolerate weak systems due to habit or lack of alternatives, but that does not imply satisfaction. Therefore, evaluating healthcare performance must consider both institutional formality and relational depth.

Discontent reported by patients was not rooted in outright rejection of the system, but rather subtle frustrations. Common themes such as long queues, unclear communication, and limited privacy contributed to diminished service experiences. These concerns mirror insights from Lubis et al. (2025), who discuss how institutional ethics go beyond rules—they require a sense of sincerity and consistency in everyday encounters. When people feel neglected, their trust in public services may erode, even if technical indicators are met. At Negara Ratu, for instance, some patients continued attending only because there were no better options. Trust, in this context, became passive rather than affirming. Healthcare spaces must be not only accessible but also emotionally and ethically affirming. This distinction is critical in designing services that are both effective and accepted.

Several complaints centered on gender interactions, particularly from female patients who felt uncomfortable with male medical personnel. Although staff did not intentionally ignore religious preferences, resource limitations meant such issues could not always be addressed. This reflects what Novita, Sar'an, and Ridwansah (2025) found in their study on conflict and fairness—religious values strongly influence perceptions of legitimacy. In healthcare, that translates to expectations about modesty, respect, and privacy. When these norms are overlooked, patients may comply outwardly but disengage inwardly. Cultural congruence is thus not merely symbolic; it shapes trust, participation, and long-term system sustainability. Rather than viewing religious expectations as barriers, institutions could integrate them into service design. Such adjustments may be minor operationally but significant ethically.

Partial alignment between Islamic legal ethics and health service practice was noted throughout this study. While efforts were made to deliver care sincerely, some actions fell short of community values. According to Fakhyadi et al. (2025), Islamic norms are flexible and adaptive, especially when integrated with local customs. In Negara Ratu, religious expectations were not rigid but required recognition and respect. Staff behavior was generally well-intentioned, yet not always consistent with patient expectations regarding dignity. These gaps highlight the need for ethical reflection alongside technical training. Embedding moral considerations into institutional routines could strengthen both legitimacy and effectiveness. The community's patience should not be mistaken for satisfaction—it signals unaddressed potential for improvement.

Legal scholars like Ebrahimi and Ghodrati (2025) have emphasized that Islamic frameworks can adapt across diverse policy environments. This adaptability opens space for reinterpretation in sectors like public health. Regulations can coexist with faith-based expectations if service design includes culturally aware protocols. One example is gender-appropriate scheduling or modesty arrangements, which require minimal resources but high sensitivity. Such practices demonstrate attentiveness and affirm ethical responsibility. Institutions that integrate these elements can foster a stronger bond with the community they serve. It is not about religiosity in form, but ethics in substance. Bridging regulatory frameworks with lived moral expectations can enhance both policy impact and public trust.

In addition to policy alignment, the way patients experience care shapes how they judge its quality. Rezaee and Ghaljeh (2025) highlight that perception, not just outcome, defines patient satisfaction. Interviews at Negara Ratu revealed emotional responses—such as discomfort, gratitude, or disappointment—that cannot be captured by standard forms. These expressions reflect how individuals interpret their dignity in medical interactions. A system that fails to listen misses crucial insight into its own effectiveness. Qualitative inputs thus complement quantitative audits, offering a fuller picture of institutional performance. Ethical care requires more than efficiency—it requires presence, attention, and understanding. These intangible elements are foundational to trust-building in healthcare.

The role of ethics in institutional decision-making extends to operational and financial choices. Nazwari and Madnasir (2025) argue that Islamic values can guide behavior beyond individual actions, including institutional conduct. At Puskesmas Negara Ratu, limited physical space and minimal staff diversity created ethical tensions that had practical consequences. Solutions do not always require more money but better alignment between priorities and community values. For instance, ensuring separate waiting areas or privacy screens can demonstrate care without incurring major costs. These small gestures carry symbolic weight in a value-conscious society. A health center that honors cultural expectations fosters loyalty and confidence. Ethical behavior, in this case, becomes a tool for community engagement, not merely religious obligation.

Ethical literacy must also be built into institutional training and leadership. In their study, Adriansyah et al. (2025) found that ethical preparedness was crucial for navigating uncertainty in digital workspaces. This principle applies equally to public healthcare, where frontline workers face moral dilemmas daily. In Negara Ratu, staff were aware of ethical tensions but lacked structured support to resolve them. Training modules often focus on technical competence without addressing interpersonal conduct. Including ethics in training would prepare workers to act with greater self-awareness and cultural fluency. This, in turn, would improve patient interactions and reduce moral discomfort on both sides. Institutions that invest in ethical development cultivate resilience, not just compliance. Long-term, this approach enhances institutional character and public perception.

Classical Islamic thought remains relevant for guiding contemporary institutional values. Aydın and Cevherli (2025) revisited the work of al-Shāṭibī to illustrate how ethical utility (maslahah) can inform social policy. In the context of healthcare, this concept supports actions that protect life, promote well-being, and maintain dignity. At Negara Ratu, some elements of this were present—especially in staff motivation—but implementation was inconsistent. Bringing ethical utility into health service planning could improve responsiveness to local needs. Rather than treating faith and policy as competing forces, integration may generate more balanced governance. Religious values need not be imposed but engaged thoughtfully within policy design. This kind of synthesis respects both legal mandates and moral legitimacy.

Overall, the study confirms that regulatory success must be paired with ethical awareness to truly serve communities. Government frameworks such as Permenkes No. 75/2014 provide structure, but lived experiences reflect whether that structure holds moral weight. Research by Mohamad, Lubis, Novita, and Rezaee all support the idea that ethical legitimacy is as critical as technical compliance. Patients may accept systems out of necessity but not out of satisfaction. When

care is delivered with respect and attentiveness to local values, it becomes more than a transaction—it becomes a shared social good. This insight offers a pathway for policy improvement that is both inclusive and sustainable. Ethical integration is not a luxury; it is a prerequisite for dignified public service. In this way, healthcare institutions can evolve into spaces of mutual respect, not just administrative function.

Implications

This study reveals how health service delivery in culturally rooted settings cannot be fully understood through administrative metrics alone. Beyond compliance with formal regulations, public trust depends on whether institutions reflect the ethical values held by their communities. In the case of Negara Ratu, alignment with Islamic principles was partial, indicating that state frameworks can benefit from moral contextualization. When ethical sensitivity is built into service routines, institutions not only perform better but also gain deeper public acceptance. These findings encourage policy designers to consider values like respect, dignity, and gender sensitivity as essential components of healthcare—not as peripheral concerns. Even small operational changes grounded in cultural awareness can generate meaningful improvements in perception and use. Moreover, embedding moral reasoning in service protocols can help bridge the distance between written policy and lived experience. The insights here point to a broader opportunity: aligning governance with shared community ethics fosters trust, sustainability, and accountability.

Limitations

While this research offers valuable insight, several boundaries must be acknowledged. The focus on a single case—Puskesmas Negara Ratu—means the results reflect one institutional setting and may not fully represent other regions. The qualitative method, while rich in depth, depends on subjective accounts from a limited number of participants. Although care was taken to capture multiple perspectives, themes could have evolved further with a larger and more diverse sample. Additionally, the study centered on user and staff experiences without including views from religious leaders or policymakers, whose insights might add new layers of understanding. Time constraints limited prolonged observation that could have revealed routine behavioral patterns in greater detail. The use of thematic interpretation also introduces a degree of researcher bias, despite efforts to remain reflexive. Lastly, the absence of quantitative indicators limits cross-validation with service data, such as wait times or staff performance records. These constraints suggest that findings are exploratory, not conclusive.

Suggestions

Further studies should explore health service delivery across multiple rural sites to identify whether similar ethical tensions arise in different cultural contexts. Including voices from religious leaders, female patients, and older populations could broaden the range of perspectives and reveal hidden expectations. Combining qualitative insights with quantitative measures—such as patient satisfaction scores or service completion rates—would offer a more balanced evaluation. Policymakers may consider developing training modules that equip staff with ethical sensitivity and cross-cultural communication skills. Simple environmental adaptations, like installing privacy curtains or separate waiting areas, can address many ethical concerns without significant costs. Future research could also examine how the principles of maqashid al-shariah might inform service

standards within state-run facilities. Collaborative planning with community stakeholders could help reframe service guidelines to better reflect both legal and moral obligations. Ultimately, public services must be designed not just to function efficiently, but to resonate meaningfully with the communities they serve.

CONCLUSION

This research set out to understand how healthcare services at the Negara Ratu Community Health Center function within the framework of national health regulations while responding to the ethical expectations of a predominantly Muslim community. Although administrative procedures appeared to follow official policy, patients' lived experiences often revealed a different story. Delays in service, lack of privacy, and limited gender sensitivity showed that technical compliance did not always translate into moral or emotional satisfaction. These gaps point to the importance of considering not just whether a service is available, but how it is delivered and perceived. In communities where faith plays a central role in daily life, healthcare must speak not only to physical needs but also to ethical and cultural values. The concept of maqashid al-shariah—preserving life, dignity, and public welfare—offers a useful compass for rethinking service quality beyond checklists. Rather than framing ethics and regulation as competing forces, this study suggests they can be aligned for greater impact. Moving forward, institutions that listen closely to community voices and engage moral perspectives may find themselves better positioned to earn lasting trust.

AUTHOR CONTRIBUTION STATEMENT

Author 1 (Andika Wanda Yanti) was responsible for initiating the research, collecting and analyzing the data, and preparing the manuscript draft.

Author 2 (Dr.Alamsyah, S.Ag.,M.Ag) and Author 3 (Eti Karini. S.H.,M.Hum) provided academic supervision, contributed to the refinement of the research design, and offered critical feedback during the writing and revision stages. Their guidance was essential in shaping the conceptual framework and ensuring methodological coherence.

All contributors reviewed and approved the final version of the manuscript prior to submission.

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