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Zakat-Based Islamic Philanthropy Supporting Maternal Health Equity Among Urban Poor Women in Banjarmasin

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ABSTRACT

This study examines how zakat-based Islamic philanthropy supports maternal and reproductive health equity among urban poor women in Banjarmasin, with particular reference to the Klinik Pratama Gratis Dhuafa Tersenyum. Employing a qualitative single-case study design, data were collected between March and June 2024 through semi-structured interviews with seven informants – comprising foundation staff, a certified midwife, and service users – supplemented by overt non-participant observations across multiple field visits and systematic review of program documents and service records. Data were analyzed using manual thematic analysis, with source, method, and time triangulation applied to enhance credibility. The findings indicate that zakat, infaq, and sadaqah (ZIS) financing enables the provision of free antenatal care, delivery-related support, and modern contraception services, thereby reducing affordability barriers for underserved populations. Nevertheless, contraceptive uptake remains constrained by prevalent sociocultural misconceptions and low health literacy among beneficiaries. Furthermore, program sustainability and accountability are limited by fluctuating ZIS collection revenues and the absence of standardized reporting frameworks. These findings suggest that ZIS-funded health services hold meaningful potential to complement public healthcare provision; however, realizing this potential requires strengthened collaborative governance, systematic referral coordination, and transparent financial reporting aligned with Sustainable Development Goal 3 targets, particularly in the context of improving local maternal health indicators.

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INTRODUCTION

The United Nations Maternal Mortality Estimation Inter-Agency Group (UN MMEIG), in collaboration with WHO, UNICEF, UNFPA, and UNDESA, estimated that in 2020 approximately 800 women died daily from preventable causes related to pregnancy and childbirth – equivalent to one death every two minutes. Global maternal mortality remains critically elevated, with the MMR recorded at 223 per 100,000 live births in 2023, of which nearly 95% of cases occurred in low-income countries. Indonesia ranks among the six countries reporting between 5,000 and 10,000 maternal deaths annually, alongside Pakistan,

Afghanistan, Chad, Kenya, and the United Republic of Tanzania (World Health Organization, UNICEF, UNFPA, World Bank Group, 2023). These figures collectively indicate that progress toward Sustainable Development Goal (SDG) 3.1 – which targets a reduction in the global MMR to below 70 per 100,000 live births by 2030 – remains insufficient, and that coordinated, cross-sectoral investment in reproductive health access is urgently required.

Contemporary scholarship increasingly frames maternal mortality not as an isolated clinical failure, but as a systemic outcome of structural inequity. Preventable maternal deaths are substantially shaped by the three-delays model – encompassing delays in deciding to seek care, delays in reaching an appropriate facility, and delays in receiving timely, respectful, and effective treatment – as well as by broader social determinants including poverty, educational attainment, and entrenched gender norms (Marmot, 2005; Thaddeus & Maine, 1994). Furthermore, recent evidence underscores that quality of care – particularly respectful maternity care and health system responsiveness – is now as determinative of maternal outcomes as service coverage alone (Bohren, 2015; Kruk et al., 2018). Collectively, these perspectives position maternal mortality within broader debates on health equity and governance performance, suggesting that the attainment of SDG 3.1 necessitates not only the expansion of service access but also substantive reform of the structural and institutional conditions that perpetuate avoidable maternal death.

At the national level, Indonesia's maternal mortality ratio (MMR) has followed a sustained downward trajectory over three decades, declining from 390 per 100,000 live births in 1991 to 189 per 100,000 live births in 2020, notwithstanding transitional increases recorded in 2010 and 2012 (Indonesian Demographic and Health Survey [IDHS]; 2015 Intercensal Population Survey [SUPAS]; National Medium-Term Development Plan [RPJMN]; (Chart 1). Nevertheless, this aggregate improvement obscures pronounced subnational disparities: provinces such as South Kalimantan continue to report elevated MMRs and inconsistent skilled birth attendance rates, despite sustained policy commitments at the national level. These disparities reflect persistent structural deficits in financial protection mechanisms, referral system functionality, and sociocultural barriers to reproductive healthcare access. To meet both the RPJMN 2029 target and the SDG 3.1 benchmark of 70 per 100,000 live births by 2030, accelerated intervention – encompassing policy reform, expanded community-level service delivery, and targeted financing – is therefore urgently required.

Regarding skilled birth attendance, national-level data indicate that coverage has

remained broadly on track with SDG benchmarks (Dashboard sdgs index, 2025). However, subnational variation persists, and aggregate progress at the national level should not be interpreted as uniform achievement across all provinces and population groups. The data suggest that closing remaining equity gaps will require governance reforms that address both supply-side constraints – including health workforce distribution and facility readiness – and demand-side barriers rooted in poverty, geographic remoteness, and cultural norms surrounding maternity care.

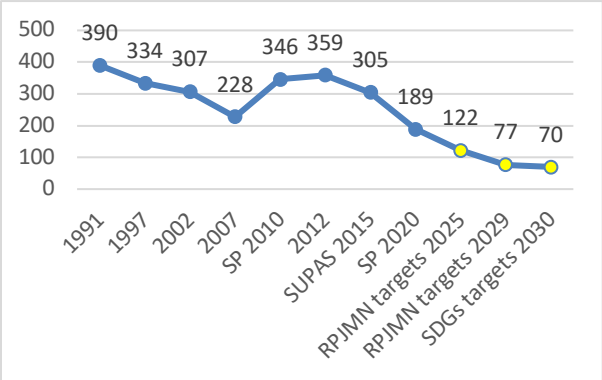

Figure 1. Maternal mortality ratio Trends in Indonesia 1991-2030

Source : Data collected from SDKI 1991-2012 (Kementerian Kesehatan RI, 2024), SUPAS 2015(Badan Pusat Statistik, 2016), SP 2020 (BPS RI, 2020), RPJMN (Lampiran II Peraturan Presiden RI No 12 Tahun 2025, 2025)

At the regional level, subnational disparities in maternal mortality remain pronounced. South Kalimantan Province recorded an MMR of 224 per 100,000 live births – exceeding the national average – while facility-based delivery rates similarly fell below the national benchmark, albeit with a consistent upward trend observed between 2021 and 2024 (Badan Pusat Statistik, 2024; BPS Provinsi Kalimantan Selatan, 2024, 2025). Notably, skilled birth attendance figures in South Kalimantan exhibited year-on-year fluctuation, including a documented decline in 2022 (Badan Pusat Statistik, 2022);While these data indicate that the majority of women in the province retain access to skilled attendant-assisted delivery, they simultaneously reveal persistent deficits in the broader reproductive health system – particularly with respect to modern contraceptive access (Development & Agency, n.d.) and service equity for economically, socially, and culturally marginalised populations. In Banjarmasin City specifically, government-administered public health facilities have not yet achieved sufficient penetration among the most vulnerable communities, underscoring the structural limits of state-led provision alone.

The health financing literature pertaining to low- and middle-income countries consistently demonstrates that out-of-pocket payment systems exacerbate health inequities,

whereas risk-pooling and pre-payment mechanisms substantially improve financial protection (Kakwani et al., 1997). Concurrently, debates on provider pluralism have established that non-state and faith-based organisations can meaningfully expand access in underserved areas; however, they also risk fragmenting care pathways and eroding system-wide accountability (Olivier, J., & Wodon, 2012; Olivier et al., 2015). These debates foreground a critical governance question: under what conditions do non-state actors successfully integrate with – rather than operate in parallel to – public health systems?

Within Indonesia's national policy architecture, reducing maternal mortality has been designated a strategic priority under Presidential Regulation No. 12 of 2025, which establishes the National Medium-Term Development Plan (RPJMN) 2025–2029 (Kementerian Sekretaris Negara, 2025). The regulation targets an MMR reduction to 183 per 100,000 live births through three complementary pathways: strengthening maternal health service infrastructure, increasing facility-based delivery coverage, and accelerating the clinical management of pregnancy complications (Lampiran II Peraturan Presiden RI No 12 Tahun 2025, 2025). At the global policy level, Presidential Regulation No. 59 of 2017 – which governs Indonesia's implementation of the SDGs – explicitly recognises philanthropic organisations, academic institutions, the private sector, and civil society as formal stakeholders within the National SDG Implementation Team (Yoshida et al., 2023)(Peraturan Presiden Republik Indonesia Nomor 59 Tahun 2017, 2017). This regulatory framing confers strategic institutional legitimacy on philanthropic actors as co-contributors to maternal health outcomes, particularly in reaching population segments that public service systems have structurally failed to serve.

Islamic social finance – encompassing zakat, infaq, and sadaqah (ZIS) – is conceptually and institutionally distinct from secular philanthropy. Rooted in religious obligation, governed by legally defined beneficiary categories (asnaf), and embedded in frameworks of moral accountability, ZIS instruments operate under normative constraints that fundamentally shape their resource mobilisation, targeting logic, and distribution mechanisms (Ahmed, 2004; Mohieldin & Rostom, 2011). These structural characteristics suggest that Islamic philanthropic health interventions may produce equity outcomes and sustainability profiles that diverge systematically from those of general charitable health programmes – a distinction that existing health financing literature has yet to adequately theorise.

One institutional exemplar of Islamic philanthropic engagement in the health sector

is the Dhuafa Tersenyum Foundation, which operates Klinik Pratama Gratis Dhuafa Tersenyum in Banjarmasin. The Foundation mobilises ZIS funds to finance reproductive health services for economically vulnerable populations, thereby addressing gaps in public service provision that government-administered facilities have been unable to close. By integrating religious obligation, social welfare, and primary healthcare delivery within a single institutional model, the Dhuafa Tersenyum Foundation represents a substantive case of Islamic philanthropy operationalised as a maternal and child health access mechanism in an urban Indonesian context. Its operational model further exemplifies the SDG partnership principle of "Leave No One Behind," demonstrating how faith-based non-state actors can function as active co-implementers – rather than passive complements – of national health policy.

The existing literature on Islamic philanthropic institutions and the SDG is predominantly concentrated on economic welfare outcomes, particularly contributions to SDG 1 (no poverty) and SDG 2 (zero hunger) through zakat-based poverty alleviation and food security programmes (Aziz et al., 2020; Hasan, 2020; Herianingrum et al., 2024; Intezar & Zia, 2020; Isman & Amalia, 2023; Laurens & Putra, 2020; Singh et al., 2025; Syamsuri et al., 2022a, 2022b; Wasalmi, 2024). Beyond this economic focus, the OECD Centre on Philanthropy (2024) reported that while philanthropic funding directed at gender-related issues has grown, the majority of such funding remains gender-blind and does not explicitly target improvements in maternal or reproductive health outcomes (OECD, 2024). Similarly, studies examining foundation-led maternal and child health financing – such as those documenting the IBU Foundation's media fundraising and NGO partnership model (Hafdhallah & Arisjulyanto, 2018) – have yet to establish empirical linkages between philanthropic contributions and population-level indicators such as the MMR or facility-based delivery coverage rates.

Notwithstanding this growing body of interest, rigorous empirical evidence connecting Islamic social finance to maternal and reproductive health outcomes remains limited. The preponderance of existing research continues to prioritise poverty and hunger indicators (SDG 1 and SDG 2), with comparatively little attention directed toward how zakat-funded service delivery interacts with public maternal health systems or influences key performance indicators – including skilled birth attendance rates, modern contraceptive prevalence, and maternal mortality. This evidence gap is consequential: while national policy narratives in Indonesia and across the Muslim-majority world increasingly assign Islamic

philanthropy a formal role in SDG advancement, local-level empirical evidence – particularly concerning contributions to SDG 3.1 (maternal mortality reduction) and SDG 3.7 (universal reproductive healthcare access) – remains systematically underdeveloped. The present study directly addresses this gap by examining how one ZIS-funded institutional model engages with maternal health system indicators at the subnational level, thereby generating evidence at the intersection of Islamic social finance, health equity, and SDG implementation.

A central debate in philanthropy scholarship concerns whether faith-based and philanthropic initiatives complement state efforts – by reducing structural barriers and crowding in public investment – or, conversely, substitute for state responsibility by generating parallel service systems that ultimately weaken institutional accountability (McGoey, 2015; Reich, 2018). This debate has received scant empirical attention within Indonesia's maternal and reproductive health context, and remains particularly underexplored at the subnational level where service delivery gaps are most acute.

This study contributes to these debates by examining how a ZIS-funded philanthropic provider – the Klinik Pratama Gratis Dhuafa Tersenyum, a free primary care clinic operated by the Dhuafa Tersenyum Foundation – operates within the maternal health ecosystem of Banjarmasin. Specifically, it assesses whether philanthropic financing functions as a complement to government maternal health programmes by improving service access, cultural acceptability, and referral integration, or whether it operates as a structurally parallel system with limited articulation to public accountability mechanisms. In doing so, the study positions the Foundation's model as an empirical lens through which to interrogate the complement-versus-substitute debate as it manifests within an Islamic social finance framework and a subnational Indonesian health governance context.

In light of these debates, this study aims to examine the role of zakat-based Islamic philanthropy in expanding access to maternal and reproductive health services among urban poor women in Banjarmasin. It further explores how such services reduce financial and socio-cultural barriers to care, and how collaboration between philanthropic institutions and government actors contributes to local efforts toward achieving maternal health-related SDG indicators.

THEORETICAL FRAMEWORK

This study is grounded in Islamic Social Finance (ISF), particularly zakat, infaq and sadaqah (ZIS), as a socio-religious mechanism of redistribution that can function as

community-based social protection. From a population and reproductive health perspective, barriers to maternal care and modern contraception among the urban poor are closely linked to affordability constraints and administrative exclusion, which shape service coverage and contribute to persistent disparities in maternal and reproductive health outcomes. In this context, zakat is increasingly discussed not only as charity but as a development oriented financing instrument that can support sustainable development outcomes beyond poverty alleviation, including health and population related goals (Hasan, 2020). The productive zakat approach further distinguishes short term relief from longer term, capability enhancing distribution that can strengthen access to essential services, including maternal and reproductive healthcare (Herianingrum et al., 2024). Operationally, zakat institutions may act as social intermediaries by translating socio religious obligations into targeted support for vulnerable women thereby lowering barriers to service utilization and strengthening linkages between community needs and formal health systems (Haneef et al., 2015). Normatively this role also aligns with Islamic welfare objectives that prioritize the protection of life and family well-being.

To explain why maternal and reproductive health disparities persist among urban poor women, this study draws on health equity perspectives and the social determinants of health, which emphasize that maternal risks are shaped by structural constraints such as poverty, education, transport, and unequal availability of services across the continuum of care, from antenatal care (ANC) to delivery and postpartum family planning (FP). The three delays model further clarifies how delays in deciding to seek care, reaching appropriate facilities, and receiving timely and adequate treatment can turn preventable complications into maternal deaths, particularly when women face financial barriers, administrative exclusion, and weak referral pathways (Thaddeus & Maine, 1994). Beyond access, evidence on mistreatment and disrespect during childbirth highlights that women's experience of care including interpersonal treatment, stigma, and communication affects service utilization and safety (Bohren, 2015). Consistent with the High- Quality Health System (HQSS) perspective, advancing SDG 3.1 requires health systems that deliver not only accessible services but also competent, respectful, and accountable care making quality of care and equity sensitive governance central to maternal health improvement (Kruk et al., 2018).

To analyze how zakat-funded clinics operate within local maternal and reproductive health systems, this study applies perspectives on welfare/provider pluralism and hybrid governance, which recognize that public, private, and faith-inspired providers often coexist

in mixed health systems. Provider pluralism can expand access for underserved communities, yet it may also produce fragmented care pathways and weaken system-wide accountability when coordination mechanisms are limited, especially across referral chains linking ANC, delivery care, and postpartum family planning FP (Olivier, J., & Wodon, 2012). Building on this, collaborative governance theory explains how public agencies and non-state actors coordinate through shared decision-making, face-to-face dialogue, trust-building, and jointly designed institutional arrangements. The Ansell and Gash framework highlights conditions for effective collaboration, balanced participation, facilitative leadership, clear rules, and a shared problem orientation, which are relevant for examining whether zakat-funded services complement government programs through referral coordination, reporting practices, and alignment with local health priorities, or instead operate as parallel services with distinct accountability dynamics (Ansell & Gash, 2008).

Integrating these lenses, this study conceptualizes zakat-funded maternal and reproductive health services as an ISF-driven equity intervention whose effects depend on governance and system alignment. ZIS financing enables program resources and targeting through social intermediation (reaching urban poor women facing affordability and administrative barriers), while health equity frameworks clarify how barriers across the continuum of care (ANC–delivery–postpartum family planning) and quality of care (including respectful treatment) shape utilization and safety. Within a pluralistic health system, collaborative governance arrangements determine whether zakat-funded services complement public programs through referral coordination, reporting, and alignment with local priorities, or instead operate as parallel services with weaker accountability. Therefore, the study focuses on equity-relevant pathways (affordability, administrative access, referral functioning, and respectful care) and program-level outputs (e.g., ANC visits, delivery support, and modern contraceptive services) as observable indicators of how zakat-based financing may support progress toward SDG 3 goals without claiming direct population-level effects on maternal mortality.

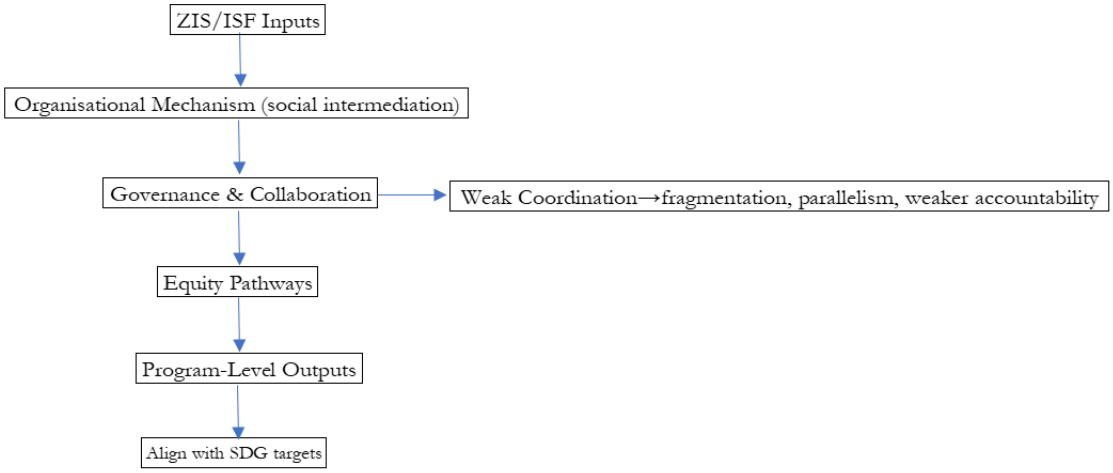

Figure 2. Conceptual framework of ZIS-funded services, governance, and equity pathways leading to program-level maternal and reproductive health outputs.

Figure 2 summarizes how ZIS financing, organizational mechanism, and governance arrangements shape equity pathways that lead to program-level maternal and reproductive health outputs. It also indicates that weak coordination may generate fragmentation and parallel service arrangements with weaker accountability.

METHODS

This study employed a qualitative descriptive design, operationalised through an instrumental case study of the Dhuafa Tersenyum Foundation in Banjarmasin, Indonesia. It examined the contributions of Islamic philanthropic institutions to population health indicators, with particular attention to reductions in maternal mortality and improvements in maternal health service coverage. Fieldwork was conducted over four months (March–June 2024) at Klinik Pratama Gratis Dhuafa Tersenyum – a primary healthcare unit administered by the Dhuafa Tersenyum Foundation (Jl. Sungai Jingah, North Banjarmasin, South Kalimantan 70122, Indonesia).

Data were generated through semi-structured, in-depth interviews with seven purposively selected key informants. Staff selection criteria included decision making or operational roles in financing, reporting, or service delivery and knowledge of referral/coordination practices. Patient criteria included age ≥ 18 years, having used at least one maternal or reproductive health service at the clinic, and willingness to be interviewed. We interviewed seven informants (foundation leadership (AA), finance staff (WP), operations staff (N), clinic midwife (E), and three patients (M, DL, S). Informants were

selected on the basis of their direct roles in the provision or utilisation of zakat-funded maternal health services. Complementing the interview data, participatory observation was undertaken to document health service delivery activities and community outreach practices. Secondary data sources comprised institutional programme reports, zakat disbursement records, the municipal demographic profile of Banjarmasin City, official maternal mortality statistics, and facility-based delivery coverage figures.

Data were subjected to thematic analysis following the six-phase framework of Braun and Clarke (2006). The analytical process was initiated through data familiarisation, achieved via iterative reading of interview transcripts, field notes, and institutional documents. Open coding was subsequently applied to identify meaningful units pertaining to zakat-based funding utilisation, maternal health service delivery, and healthcare access among urban poor women. The emergent codes were systematically grouped into broader categories and developed into five key themes: ZIS fund utilisation mechanisms, institutional collaboration structures, service delivery pathways, socio-demographic barriers to reproductive healthcare access, and governance accountability. To establish the credibility and trustworthiness of the findings, methodological triangulation was employed across interview data, observational records, and institutional documentation. The analysis proceeded iteratively, enabling themes to be progressively refined and interpreted against the theoretical frameworks of Islamic social finance, health equity, and collaborative governance.

RESULTS AND DISCUSSION

The research begins with an overview of the demographics of Banjarmasin City, the achievements of reproductive health service programs, the mechanisms for utilizing ZIS funds, and institutional collaboration with local governments. The research results are compiled from interviews, observations, and foundation program reports.

Table 1. Demographic and Reproductive Health Conditions of Banjarmasin City

Indicator	**Value**
Population	666,442
Total Fertility Rate (TFR)	2,11
Median Age at First Marriage (years)	22,1
Number of Family Planning Clinics	88
Number of Family Planning Acceptors	90,305
Number of Contraceptive Acceptors	67,726
Number of PUS who are not KB participants	15,559

Childbirth in Health Facilities(%)	89,44
Delivery Assisted by Health Workers (%)	96,72
Percentage of Poor Population (%)	4,58
Provincial Maternal Mortality Rate (per 100.000 KH)	224
Stunting Prevalence (%)	26,5

Source : Kota Banjarmasin dalam Angka 2025 (Badan Pusat Statistik Kota Banjarmasin, 2025) Dashboard Siperindu (BKKBN, 2025); BPS (BPS Provinsi Kalimantan Selatan, 2024)

Banjarmasin City is the most populous urban centre in South Kalimantan Province, with a registered population of 666,442 and a total fertility rate (TFR) of 2.11 – approaching the demographic replacement threshold. The median age at first marriage stands at 22.1 years, indicating that the majority of women in the city enter union during early adulthood, a pattern with implications for the timing and spacing of pregnancies and associated maternal health risks.

The city's socioeconomic profile reveals persistent vulnerability among a segment of its population: the poverty incidence rate stands at 4.58%, while the stunting prevalence among children under five is recorded at 26.5% – both indicators of underlying nutritional and welfare deficits that compound reproductive health risk. In terms of family planning infrastructure, 88 active family planning clinics currently serve the population. Of the 90,305 registered couples of reproductive age, 67,726 are active family planning programme participants, while 15,559 remain non-participants. This participation gap represents a substantive policy challenge, particularly with respect to improving uptake of modern contraceptive methods through targeted education and outreach – an area in which Islamic philanthropic institutions may serve a complementary facilitative role.

Regarding facility-based maternal health delivery, 89.44% of births in Banjarmasin were recorded as occurring in accredited health facilities, with the proportion of deliveries assisted by trained health personnel increasing from 96.72% to 97.78% between 2023 and 2024 (Badan Pusat Statistik, 2025). Concurrently, absolute maternal mortality cases declined from 15 in 2023 to 10 in 2024 (Dinas Kesehatan Kota Banjarmasin, 2025). Taken together, these trends indicate measurable improvements in city-level maternal health outcomes over the observed period. While these improvements cannot be attributed solely to ZIS-funded interventions, they provide important contextual evidence of broader maternal health progress within which philanthropic services may play a complementary role. Nevertheless, the data also suggest that aggregate progress may obscure persistent intra-urban disparities – particularly in the continuity and equity of reproductive health service access among

economically marginalised and socially excluded urban populations. It is within this subnational context that the institutional contribution of ZIS-funded providers such as the Dhuafa Tersenyum Foundation warrants analytical attention.

Profile and Services of the Klinik Pratama Gratis Dhuafa Tersenyum

Klinik Pratama Gratis Dhuafa Tersenyum was established in 2005 by Abi Audah, founder of the Dhuafa Tersenyum Foundation, as a flagship institutional programme designed to direct ZIS funds toward improving the reproductive health of economically vulnerable populations in Banjarmasin, South Kalimantan. The clinic was conceived as a concrete mechanism for ensuring that zakat benefits are systematically channelled to those who qualify under the asnaf categories – particularly the urban poor who are structurally excluded from formal health financing systems.

The clinic addresses documented unmet demand among low-income urban populations for accessible reproductive health services, encompassing family planning consultations, antenatal care, and facility-based delivery. In addition to clinical service provision, the clinic administers reproductive health education and psychosocial support for beneficiary populations. All services are delivered free of charge, removing the financial barrier that most commonly deters care-seeking among the urban poor.

The clinic's operational financing is structured on a ZIS fund hierarchy. Primary funding is drawn from zakat contributions remitted by muzakki (eligible zakat payers). When zakat receipts are insufficient to meet operational demand, supplementary financing is sourced from infaq and sadaqah collections, mobilised through donation receptacles distributed across a network of mosques, restaurants, minimarkets, pharmacies, and retail outlets in Banjarmasin and its surrounding areas. This tiered financing model reflects a deliberate institutional strategy for ensuring revenue continuity and service sustainability

The clinic's reproductive health programme is sustained through a structured cross-sector collaboration involving both government and philanthropic partners. At the government level, the clinic maintains a formal partnership with the Banjarmasin City Agency for Population Control, Family Planning, and Community Empowerment (Dinas Pengendalian Penduduk, Keluarga Berencana dan Pemberdayaan Masyarakat Kota Banjarmasin), through which it receives technical assistance, subsidised contraceptive supplies, and co-facilitated family planning education. At the philanthropic level, DT Peduli contributes supplementary operational funding and covers medical costs associated with

delivery services. This multi-actor governance arrangement enables the clinic to maintain structured, accountable, and geographically extended service delivery – reaching populations for whom both state and market mechanisms have proven insufficient.

Reproductive health services delivered at Klinik Pratama Gratis Dhuafa Tersenyum are organised across three core service modalities: family planning consultation, antenatal care, and facility-based delivery.

Family Planning Consultation

Family planning consultations are conducted by qualified midwives who administer structured counselling on available contraceptive methods, including oral contraceptives and injectable contraceptives. Counselling sessions systematically address each method's mechanism of action, clinical benefits, potential side effects, and correct usage procedures. Notwithstanding this structured approach, a proportion of patients remained reluctant to adopt contraception, primarily due to misinformation and perceived incompatibility with personal or religious values. This hesitancy was documented in patient testimony: As one patient said *"Awalnya tu ulun takutan makai KB karena banyak yang memadahi meulah gemuk. Tapi imbah dijelaskan bu bidan, ulun jadi lebih paham kalo efek sampingnya belain gesan tiap orang"* (at first, I was afraid to use birth control because many people who use it are fat. But after the midwives explained, I became aware that the side effects vary across individuals). She had initially avoided contraceptive use due to community-circulated beliefs associating contraception with weight gain, but that midwife-administered counselling had clarified that side effects vary significantly across individuals. This finding is consistent with broader evidence that sociocultural stigma and low health literacy – particularly among populations with primary-level educational attainment – constitute persistent demand-side barriers to modern contraceptive uptake, and that sustained patient education by trained personnel is a critical intervention point.

Antenatal Care

Antenatal consultations were conducted with the dual objective of monitoring maternal and foetal health status and enabling early identification of pregnancy complications that could pose risk to maternal or neonatal life. Examinations were performed by midwives using the clinic's available diagnostic equipment; however, the absence of advanced diagnostic infrastructure – including laboratory facilities and ultrasound technology – represents a substantive service-delivery constraint. Within these resource

limitations, midwives provided structured education on nutritional maintenance during pregnancy, recognition of obstetric danger signs, and birth preparedness planning. The data suggest that access to regular antenatal monitoring, even under resource-constrained conditions, supports informed pregnancy management and may contribute to the early detection of complications among populations who would otherwise remain outside the formal antenatal care system.

Facility-Based Delivery

Delivery services were administered by experienced midwives with documented competency in managing both routine and complicated births. As a precondition for service, patients were required to present their Maternal and Child Health record (Kartu Ibu dan Anak, KIA) and antenatal ultrasound report, enabling midwives to review complete obstetric history prior to delivery. In cases where obstetric complications were identified that exceeded the clinic's clinical capacity, established referral protocols were activated and patients were transferred to the nearest accredited hospital. This referral mechanism constitutes a critical linkage between the clinic's primary-care functions and the broader public health system, reflecting the collaborative governance model that underpins the Foundation's operational design.

Figure 3. A clinic beneficiary holding a sign indicating that delivery-related services were provided free of charge through ZIS-funded reproductive health programs at Klinik Pratama Gratis Dhuafa Tersenyum. The sign also indicates that the newborn is the clinic's 915th baby since the program began.

As shown in Figure 3, subsidized delivery services illustrate how ZIS-funded interventions can reduce financial barriers for low-income urban women and support equitable access to childbirth care.

Reproductive Health Service Utilisation and Programme Outcomes

Between 2023 and 2024, Klinik Pratama Gratis Dhuafa Tersenyum delivered reproductive health services to a total of 632 patients from low-income communities in Banjarmasin City. Disaggregated by service modality, 509 patients (80.5%) received modern contraceptive services – encompassing injectable and oral contraceptive methods – 111 patients (17.6%) accessed antenatal care consultations, and 12 facility-based deliveries (1.9%) were conducted by clinic midwives. All services were administered free of charge, financed exclusively through ZIS funds mobilised and managed by the Dhuafa Tersenyum Foundation. These figures indicate that the clinic functions primarily as a contraceptive access point for its target population, with antenatal and delivery services constituting a smaller but clinically significant component of overall service provision (Chart 2).

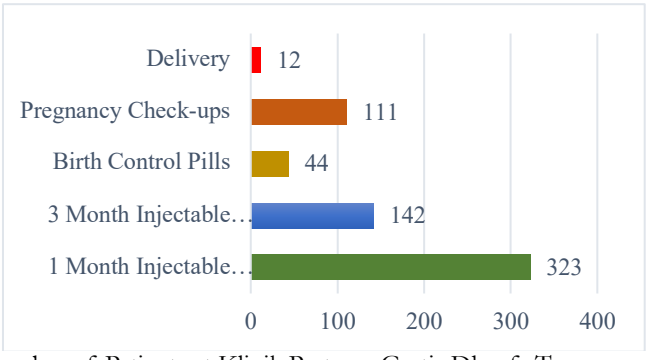

Figure 4. Number of Patients at Klinik Pratama Gratis Dhuafa Tersenyum 2023-2024
Source: Personal Data Collection

The predominance of family planning uptake within the utilisation profile is notable, yet the data also reveal persistent demand-side constraints that limit the programme's reach. A proportion of eligible women expressed reservations regarding contraceptive adoption, citing concerns about adverse side effects and, in several cases, family-level opposition rooted in perceived incompatibility between contraceptive use and religious or cultural values. These findings suggest that service utilisation cannot be adequately explained by access alone – sociocultural barriers, including intra-household gender dynamics and community-level health belief systems, continue to mediate contraceptive decision-making among the clinic's target population. Sustained behaviour change communication and community engagement strategies are therefore indicated as necessary complements to service provision, particularly in reaching women who remain outside the active family planning programme despite geographic proximity to the clinic.

ZIS Fund Utilisation Mechanisms and Institutional Financing Architecture

The Klinik Pratama Gratis Dhuafa Tersenyum is financed through a structured ZIS fund mobilisation model, drawing on zakat contributions from individual donors, community-level collections, and inter-institutional collaboration with DT Peduli. Mobilised funds are allocated across four expenditure categories: clinic operational costs, medical staff honoraria, procurement of medicines and medical equipment, and facility-based delivery expenses. This financing architecture enables the clinic to deliver maternal healthcare services entirely free of charge, without dependence on government budget allocations – a structural feature that distinguishes it from both public facilities and commercially operated private providers.

The clinic's patient administration system is deliberately designed to minimise documentation barriers while maintaining service accountability. Patients are required to present a patient registration card, national identity card (KTP), family registration card (Kartu Keluarga), maternal and child health record (KIA), and an antenatal ultrasound report. The requirement for prior ultrasound documentation serves a dual function: it ensures that delivery services are provided only to women whose pregnancies have been monitored from early gestation – thereby reducing the risk of undetected complications that may precipitate maternal mortality – and it constitutes an accountability mechanism for ZIS fund disbursement, ensuring that maternity services are directed toward patients who satisfy both medical and social eligibility criteria. Notably, while the KTP is required as a formal identification document, it is not applied as a proxy indicator of economic status, given that registered residential addresses frequently fail to reflect actual socioeconomic conditions among urban poor populations. This administrative approach, however, generates a significant structural constraint: it is incompatible with the BPJS Kesehatan verification system, which continues to rely on formal population registry data as the primary basis for beneficiary eligibility determination – thereby precluding formal financing integration between the clinic and the national health insurance scheme.

The persistence of this structural disconnect is situated within a broader global health governance context. According to the SDG Dashboards and Trends report (Sachs, J.D., Lafortune, G., Fuller, G., Iablonovski, 2025), SDG Goal 3 (Good Health and Well-Being) continues to be classified as facing significant challenges, with progress indicators stagnating and falling short of the trajectory required to meet 2030 targets. This global assessment is reflected at the subnational level: while measurable improvements in maternal health

indicators have been documented in Banjarmasin City, the data do not permit unambiguous attribution of these gains to ZIS-funded interventions specifically. Nevertheless, the evidence presented in this study suggests that philanthropic health services of this type make a substantive contribution to expanding care access among populations for whom financial and sociocultural barriers would otherwise preclude engagement with the formal health system. Interpreted through the productive zakat utilisation and collaborative governance frameworks, Klinik Pratama Gratis Dhuafa Tersenyum operates as a socio-religious innovation that functionally complements – rather than substitutes for – public maternal health programmes, addressing documented gaps in financial protection and sociocultural accessibility that state-administered systems have not resolved.

From a health equity perspective, ZIS-funded interventions of this nature function as redistributive mechanisms targeting structurally disadvantaged populations – specifically those excluded from formal health financing systems through administrative, economic, or documentation barriers. In this regard, zakat-based financing constitutes an alternative access pathway that materially reduces care-seeking inequalities in contexts where both socioeconomic and bureaucratic barriers persist, and where state-administered systems have demonstrated limited penetration among the most marginalised urban populations.

This finding suggests that Islamic philanthropic financing contributes to improving access and supports progress toward SDG health targets, particularly in contexts where formal health systems face structural limitations – specifically SDG 3.1.1 (maternal mortality reduction), SDG 3.1.2 (facility-based delivery coverage), and SDG 3.7.1 (modern contraceptive prevalence). The clinic's integrated service model – encompassing structured antenatal monitoring, facility-based delivery, and contraceptive counselling – operationalises the continuum of maternal care framework in a resource-constrained urban setting where equivalent public provision remains inadequate. The elimination of user fees through ZIS financing directly addresses the cost barrier that the extant literature consistently identifies as the primary determinant of care-avoidance among low-income women (World Health Organization, UNICEF, UNFPA, World Bank Group, 2023). These findings collectively affirm that ZIS performs a dual institutional function: as an instrument of social redistribution and as a community health financing mechanism that addresses documented gaps in state service provision. This dual function is theoretically consistent with the social intermediation model of zakat, which conceptualises zakat institutions as structural intermediaries bridging socio-religious obligation with population health and demographic

outcomes (Haneef et al., 2015).

Notwithstanding these contributions, the findings also surface critical questions regarding the long-term sustainability and systemic positioning of philanthropy-based maternal health provision. Health equity theory establishes financial barriers as a primary structural determinant of differential access to maternal care, particularly among economically marginalised populations (Marmot, 2005), and the evidence presented here confirms that ZIS-based financing effectively mitigates this barrier for the clinic's beneficiary population. However, the model's dependence on voluntary donor contributions introduces an inherent dimension of financial precarity: service continuity is contingent on donor commitment rather than institutionalised public financing, rendering the model structurally vulnerable to fluctuations in philanthropic giving. This vulnerability exposes a fundamental tension within equity-driven philanthropy-based health interventions – namely, the conflict between the moral imperative to expand access and the structural fragility that voluntary financing entails. Resolving this tension likely requires the development of hybrid financing arrangements that preserve the redistributive targeting logic of ZIS while integrating more stable, institutionalised revenue streams.

From a provider pluralism and collaborative governance perspective, ZIS-funded health services of this type are best understood as constitutive elements of a mixed health system, in which non-state actors perform complementary functions alongside public providers (Olivier et al., 2015). The evidence from this study indicates that the clinic effectively reduces financial barriers and extends service reach among populations underserved by both state and market mechanisms. Nevertheless, its integration into formal health financing architectures – including the national health insurance system (BPJS Kesehatan) – and into government health information and reporting systems remains structurally limited. This integration deficit generates a tangible risk of service fragmentation, wherein philanthropic health initiatives operate in functional parallel to – rather than as systematically incorporated components of – national maternal health strategies. Left unaddressed, such fragmentation risks undermining system-wide accountability, duplicating service delivery efforts, and weakening the coordinated governance that sustainable progress toward SDG 3.1 requires (Reich, 2018). These findings therefore suggest that policy frameworks governing non-state health providers in Indonesia must evolve to enable structured integration of ZIS-funded clinics into national health governance architecture, without compromising the sociocultural and religious legitimacy that renders these services

accessible to populations that formal systems continue to fail.

With respect to scalability, the institutional model operated by the Dhuafa Tersenyum Foundation reflects a context-specific configuration shaped by local philanthropic capacity, established donor networks, and accumulated community trust. Consistent with the Islamic social finance literature, the effectiveness of zakat-based health programmes is contingent not solely on resource mobilisation but equally on institutional governance quality and social legitimacy within the served community (Haneef et al., 2015). While the model demonstrates replication potential in comparable urban settings, its transferability cannot be assumed: successful adaptation would require the presence of institutionally mature philanthropic organisations, sustained donor commitment, and governance structures capable of maintaining both ZIS accountability and community-level credibility. Contextual variations in socioeconomic conditions, administrative capacity, and inter-institutional relationships would therefore need to be systematically assessed prior to any replication effort.

A further dimension of the model's equity contribution concerns its capacity to reach populations structurally excluded from the national health insurance system. BPJS Kesehatan coverage gaps persist among low-income urban populations, driven substantially by administrative data inconsistencies rather than genuine ineligibility. A case documented during fieldwork illustrates this dynamic: a patient whose KTP registered the same address as their employer's residence was assessed as ineligible for subsidised coverage on the grounds that the registered address corresponded to a high-value property – despite the fact that the property belonged to the employer rather than the patient. This case exemplifies a broader systemic failure in which administrative proxies for socioeconomic status systematically misclassify genuinely vulnerable individuals, thereby producing exclusion errors that formal health financing mechanisms are structurally ill-equipped to detect or correct.

In this context, ZIS-based institutional financing functions as a targeted gap-filling mechanism, enabling rapid and locally responsive service access for populations that formal administrative systems fail to reach (Development & Agency, n.d.; Liyanto et al., 2022). Critically, the clinic's documentation requirements – including the KTP, family registration card, KIA record, ultrasound report, and antenatal monitoring history – should not be interpreted as administrative exclusion barriers. Rather, they constitute a maternal safety protocol designed to ensure that delivery services are provided only to women with documented antenatal histories, thereby reducing the risk of undetected obstetric

complications. This distinction is analytically significant: it demonstrates that philanthropic institutions can integrate socio-religious redistributive principles with evidence-based clinical governance – simultaneously extending access and maintaining service quality standards. Furthermore, this finding substantively extends the OECD (2024) critique of gender blindness in global philanthropic health financing. Where the OECD report identifies a systemic failure of mainstream philanthropy to explicitly target reproductive health outcomes, the Dhuafa Tersenyum model represents a contrasting case – one in which locally embedded, ZIS-funded provision constitutes a demonstrably gender-responsive philanthropic intervention, operationalising reproductive health equity through religiously mandated redistribution mechanisms.

The findings also surface persistent challenges with respect to SDG Target 3.7.1, which concerns universal access to modern contraceptive methods. Field data indicate that misperceptions regarding family planning remain prevalent among the clinic's beneficiary population, with the primary obstacles comprising misinformation about contraceptive mechanisms and efficacy, and entrenched sociocultural norms that render open discussion of sexual and reproductive health socially transgressive – particularly among women from conservative religious communities (Development & Agency, n.d.). These compounding informational and cultural barriers sustain hesitancy toward modern contraceptive adoption even where services are available free of charge, confirming that demand-side constraints operate independently of financial access. In response, the clinic has institutionalised ongoing counselling and community health education as integral service components – an approach that simultaneously addresses biomedical needs and the sociocultural determinants of reproductive health disparities. The data suggest that this dual-register intervention model represents a meaningful adaptation to the specific access barriers facing low-income urban women in the Indonesian context.

These findings are consistent with and substantively reinforce the conclusions of Liyanto et al. who demonstrated that poor urban women in Indonesia systematically receive inferior maternal health services – in both quantity and quality – relative to non-poor women, despite the existence of a national social security framework (Liyanto et al., 2022). The present study confirms that this structural disparity between formal policy commitments and ground-level service access reality persists in Banjarmasin, and that it is not resolved by the BPJS Kesehatan scheme alone. The institutional presence of ZIS-funded providers such as Klinik Pratama Gratis Dhuafa Tersenyum is therefore analytically significant precisely

because it reaches population segments that the formal social security system administratively excludes or fails to adequately serve. The flexible ZIS financing model functions as an alternative maternal health financing mechanism for women who are ineligible for, or effectively excluded from, institutionalised public coverage – thereby addressing a structural gap that neither the state nor the market has resolved.

This study advances the existing literature in two analytically distinct respects. First, substantively, it reorients the dominant focus of zakat scholarship – which has historically centred on contributions to poverty alleviation (SDG 1) and food security (SDG 2) – toward zakat's direct and measurable role in reproductive health outcomes (SDG 3), an understudied dimension of Islamic social finance's development contribution (Singh et al., 2025). Second, methodologically, it integrates qualitative case study analysis with population-level health indicators – specifically the maternal mortality ratio and facility-based delivery coverage rates – to produce a socio-demographic assessment grounded in primary field data. Taken together, these contributions address a gap in the extant literature, which has predominantly examined zakat management at the macro-institutional level without investigating its downstream effects on population health indicators or its interactions with subnational health governance systems (Hafdhallah & Arisjulyanto, 2018). These findings should therefore be interpreted as context-specific, reflecting the institutional and socio-economic conditions of Banjarmasin rather than representing generalisable national patterns.

The findings of this study affirm that cross-sectoral collaboration constitutes a structural prerequisite – rather than a supplementary mechanism – for achieving the Sustainable Development Goals at the subnational level. Presidential Regulation No. 59 of 2017 provides a formal regulatory foundation for institutionalising partnerships between philanthropic organisations and local government actors; however, the operationalisation of this framework remains incomplete. A critical gap persists in the absence of systematic data integration and standardised reporting protocols that would enable ZIS-funded providers such as Klinik Pratama Gratis Dhuafa Tersenyum to be formally recognised within national health indicator monitoring and achievement recording systems. Without such integration, the substantive contributions of Islamic philanthropic health institutions to SDG 3.1.1, 3.1.2, and 3.7.1 remain invisible to national health governance architecture – and therefore excluded from evidence-based policy planning.

Furthermore, the findings point to an underutilised governance opportunity: the strategic alignment of zakat management institutions with the National Population and

Family Planning Agency (BKKBN) toward the co-financing of maternal health and family planning services for urban poor populations. Such alignment would leverage the complementary institutional strengths of each actor – the state's regulatory authority and programmatic infrastructure, and Islamic philanthropy's sociocultural legitimacy and administrative flexibility – in service of shared population health objectives. The ZIS-funded reproductive health service model examined in this study thereby demonstrates potential as a replicable instrument of equitable and sustainable population policy, provided that enabling governance frameworks are developed to support structured integration, mutual accountability, and coordinated service delivery between philanthropic and state health actors.

CONCLUSIONS AND SUGGESTIONS

This study demonstrates that ZIS-funded institutional provision, as implemented through Klinik Pratama Gratis Dhuafa Tersenyum in Banjarmasin, represents a meaningful mechanism for expanding maternal and reproductive health service access among economically marginalised urban women. By providing free antenatal care, modern contraceptive counselling, and facility-based delivery services, the model effectively reduces financial barriers that often hinder access to care.

Three key conclusions emerge from this study. First, Islamic philanthropic financing, when institutionally structured and governed with accountability, functions not only as a redistributive economic instrument but also as a socio-religious mechanism that supports health equity outcomes, particularly for populations excluded from formal social protection systems. Second, the ZIS-funded service model operates as a complement to, rather than a substitute for, public maternal health services, addressing gaps in financial access, sociocultural acceptability, and service continuity. Third, cross-sectoral collaboration between philanthropic institutions and government actors demonstrates potential to support progress toward SDG targets 3.1.1, 3.1.2, and 3.7.1 at the subnational level, provided that integration, data alignment, and accountability mechanisms are strengthened.

Despite these contributions, the findings should be interpreted within the limitations of a single-case qualitative design. The study does not establish causal relationships between ZIS interventions and changes in population-level health indicators, and its conclusions are context-specific. Future research should adopt comparative and mixed-method approaches to further examine the scalability, sustainability, and systemic integration of Islamic

philanthropic health models within broader national health governance frameworks.

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