CFIIM PRACTITIONER PLAYBOOK · NO. 1

Governance Architecture

for Islamic Healthcare Private Markets

CFIIM
Capital Formation Institute in Islamic Markets

Capital Formation Institute in Islamic Markets

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Foreword

This playbook exists because sophisticated investors keep saying no — or not yet — to opportunities they find genuinely attractive.

The research behind this document points to a consistent explanation: the constraint is rarely appetite or economics. It is institutional ambiguity — uncertainty about governance, process, and accountability that makes trust difficult to extend. In Islamic private markets, that ambiguity is compounded by a further layer: Shariʿah framing that asserts compliance without demonstrating it.

This document is a practitioner tool grounded in an active research programme. It sits deliberately at the intersection of empirical inquiry and actionable guidance — designed to be used in investment committees, advisory board meetings, LP conversations, and due diligence processes. It does not tell you what to invest in. It tells you how to build the institutional conditions that allow capital to move with confidence.

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Executive Summary

Capital hesitates in healthcare private markets. Among Muslim investors and values-aligned allocators, it hesitates further. The reason is not weak appetite, insufficient product availability, or excessive risk aversion. The reason is governance opacity — uncertainty about accountability, process, and decision rights that rational investors do not overlook.

An exploratory practitioner survey (n=50, January 2026) suggests that governance credibility and ethical ambiguity are the dominant constraints on capital commitment — rated consistently above fundraising approach, translator scarcity, and time-horizon mismatch. The survey is exploratory in design and scope; the frameworks it grounds are interpretive rather than definitively proven. Among Muslim and Shariʿah-aligned respondents (n=32), one finding proved particularly consequential: Shariʿah labelling without documented governance process appears to increase hesitation rather than confidence. Seventy-eight percent agreed. The label, absent the process, functions as a warning signal rather than a trust anchor.

The Muslim investor population addressed here is not monolithic. GCC sovereign and institutional capital, family offices, Islamic banks, and diaspora investors operate under materially different mandates, liquidity constraints, and regulatory environments. The frameworks in this playbook apply across these audiences — but with different weights and timelines for each. Where distinctions are material, the text notes them.

This playbook translates those findings into a practitioner framework. It covers governance architecture, the GETA capital formation sequence, capital stack design, ethical guardrails, a structured due diligence framework, and implementation pathways. The appendices are working documents designed to be used, not referenced.

PART I

The Commitment Latency Problem

What keeps sophisticated investors from committing — and what actually unlocks them

1.1 What Is Commitment Latency

Commitment latency is the tendency for investors to delay capital allocation decisions after substantive evaluation has already occurred. It is not rejection. It is not indecision. It is a rational strategy for managing institutional ambiguity in environments where the cost of a wrong commitment extends beyond financial loss.

In healthcare private markets, commitment latency presents as a recognisable pattern: the investor who has completed multiple diligence cycles, remains engaged, asks for more information, attends follow-up meetings — and still does not commit. The sponsor interprets this as a relationship problem or a pricing problem. It is usually neither.

Commitment latency reflects uncertainty about governance, accountability, and operating mechanisms — not about the underlying opportunity. When investors cannot assess how decisions will be made under adverse conditions, delay becomes the rational choice. Waiting preserves flexibility without incurring irreversible exposure.

This distinction matters because it implies a different solution. If hesitation reflects weak return expectations, the remedy is better economics. If hesitation reflects governance opacity — which the founding survey consistently suggests — the remedy is governance clarity, not improved projections.

> *The survey findings are consistent on direction: 70% of healthcare-sector respondents reported delaying rather than deciding when uncertainty remained; only 9% committed despite unresolved uncertainty. The dominant response to ambiguity is information-seeking, not permanent withdrawal — which means the capital is available. The question is what institutional conditions unlock it.*

1.2 The Six Frictions Framework

Commitment latency is not caused by a single factor. Open-ended responses in the founding survey — followed by iterative practitioner review — consistently pointed to six structural frictions that make trust difficult to extend in healthcare private markets. They are distinct but mutually reinforcing, and they do not operate with equal force. Addressing secondary frictions before resolving primary ones is consistently insufficient.

1
PRIMARY

Governance Credibility

Constraint: Decision authority and accountability are unclear under stress scenarios. Investors face uncertainty about who decides when things go wrong, how conflicts between investors and operators are resolved, how valuations are determined in illiquid conditions, and how accountability is enforced when performance deviates from plan.

Remedy: A concise governance summary, explicit decision-rights mapping, and documented conflict-resolution and valuation policies — in place before the investment conversation, not after.

2
PRIMARY

Operating-Model Opacity

Constraint: Investors cannot link operational actions to economic outcomes. Value creation is described in abstract terms — “operational improvement,” “platform synergies,” “margin expansion” — without a clear mechanism connecting clinical operations to financial results.

Remedy: A plain-language operating-model bridge document that specifically articulates how staffing models, payer dynamics, referral networks, and clinical protocols translate into performance.

3
PRIMARY

Ethical & Reputational Ambiguity

Constraint: Downside includes professional and reputational exposure beyond financial loss. For clinicians and values-aligned investors, association with care quality failures, workforce mistreatment, or misaligned priorities creates exposure that many investors weigh heavily.

Remedy: Explicit ethical guardrails, documented non-negotiable practices, and clinical governance structures with independent authority.

4
SECONDARY

Fundraising Culture Mismatch

Constraint: Urgency-driven solicitation conflicts with professional decision-making culture. Pressure-based engagement — artificial timelines, artificial urgency signals, compressed decision windows — is interpreted as evidence of misaligned incentives rather than deal attractiveness.

Remedy: Education-first sequencing and explicit separation of the learning process from the commitment decision.

5
SECONDARY

Translator Scarcity

Constraint: Few individuals communicate fluently across clinical, regulatory, and financial domains simultaneously. Without credible translation between clinical operations and investment mechanics, sophisticated investors rely on reputational proxies rather than substantive analysis.

Remedy: Credible clinical-financial bridge figures and physician leadership at the GP level (the general partner, or fund manager) — not as a branding decision but as a structural one.

6
SECONDARY

Time-Horizon Mismatch

Constraint: Healthcare transformation requires sustained investment; incentive structures appear misaligned. Investors worry that short-term extraction incentives will

override the long-horizon commitments that clinical quality and workforce stability require.

Remedy: Clear articulation of investment horizon and exit philosophy, and incentive structures that align management compensation with long-term value creation.

Constraint hierarchy: Governance credibility, operating-model clarity, and ethical ambiguity form the primary cluster. All three must be addressed before secondary frictions become the binding constraint. Resources devoted to fundraising communication yield lower returns than equivalent investment in governance transparency.

1.3 Why Healthcare Amplifies These Frictions

Healthcare is not simply another private equity sector. Four characteristics make institutional ambiguity particularly costly in this context.

Regulatory exposure — Healthcare investments are subject to extensive regulatory oversight across federal, state, and payer frameworks. Governance failures in healthcare carry regulatory consequences that generic private equity does not face.

Clinical outcomes risk — Value creation in healthcare depends on operational decisions that directly affect patient care. Early decisions have lasting effects on clinical quality, workforce stability, and institutional reputation. Investors who understand this weigh governance quality accordingly.

Ethical scrutiny — Healthcare private equity operates in a sector where financial incentives and patient welfare can conflict visibly and publicly. This creates a layer of ethical scrutiny that amplifies reputational risk for all investors associated with a platform.

Long capital cycles — Healthcare platform building — workforce development, clinical standardisation, payer relationship management — requires sustained investment over timelines that strain typical PE fund structures. Time-horizon mismatch is a structural challenge, not an incidental one.

PART II

The Islamic Finance Dimension

Why standard approaches fail to mobilise Muslim capital — and what the evidence shows actually works

2.1 The Labelling Paradox

Islamic finance has built substantial institutional infrastructure over the past four decades: Shariʿah-compliant products, supervisory boards, certification frameworks, regulatory standards. Yet Muslim capital — particularly among U.S. diaspora communities and GCC-linked high-net-worth families — remains persistently under-deployed in professionally managed private markets.

The standard diagnosis attributes this to product scarcity or investor conservatism. The evidence does not support either explanation. Many Muslim investors who decline pooled private equity simultaneously accept substantial risk through direct real estate, concentrated operating businesses, and informal lending — activities with illiquidity and volatility equal to or greater than diversified private market funds. The puzzle is not whether Muslim investors accept risk. It is why they accept certain forms while declining others that may, in institutional terms, be safer.

The answer is trust and control. Investors prefer assets they can see, touch, and influence — even when those assets are economically riskier. When institutional conditions feel unsafe — ethically, informationally, or in terms of governance — non-participation becomes the rational choice.

2.2 Why Shariʿah Labelling Without Governance Increases Hesitation

This is the finding that most directly challenges the standard Islamic finance capital formation assumption. Among Muslim and Shariʿah-aligned respondents in the founding survey (n=32), Shariʿah labelling without documented governance process was associated with increased hesitation rather than confidence. Seventy-eight percent agreed with this framing. Documented Shariʿah process, by contrast, was associated with stronger confidence: 88% agreed, with a mean of 6.00 on a 7-point scale. The difference was statistically significant (paired t=2.63, p=.013). These findings are exploratory — the sample is limited and the population is not uniform — but the direction is consistent across sub-groups.

The finding operates on three levels simultaneously. From a behavioural perspective, ethical certainty asserted too strongly generates doubt — sophisticated investors who understand that Islamic finance involves genuine deliberation are sceptical of products that present compliance as settled when it is not. From an institutional economics perspective, past governance failures have created a credibility overhang — new initiatives inherit scepticism regardless of their intrinsic quality. From a social capital perspective, symbolic capital derived from religious framing is discounted in proportion to the absence of substantive institutional backing.

> *The implication is direct: investing in Shariʿah branding before establishing documented governance process is counterproductive. Governance first. Branding follows.*

2.3 What Actually Builds Confidence

The survey findings point consistently in one direction. Institutionalisation matters more than community affinity: 91% agreed (mean 5.84). Documented Shariʿah process is associated with increased investor confidence: 88% agreed, with a mean score of 6.00 out of 7. Transparency in handling non-compliance events matters: 88% agreed (mean 5.91). Scholar independence matters: 84% agreed (mean 5.53).

The institutionalisation finding is the most consequential. Ninety-one percent of values-aligned respondents agreed that institutional rigour matters more than communal relationship. Capital follows demonstrated accountability, not communal affinity. Governance infrastructure must exist first. Shariʿah framing, when introduced on top of credible governance, functions as a trust multiplier. Introduced before governance is established, it appears to amplify scepticism.

These patterns hold across the GCC institutional, family office, and diaspora sub-populations in the sample — though the weights differ. GCC institutional investors place greater emphasis on regulatory compliance and auditor credibility; family offices weight scholar reputation more heavily; diaspora investors weight transparency and operational track record. A governance framework that serves all three audiences must be strong on all dimensions, not optimised for one.

2.4 The GETA Sequence

The capital formation pathway consistent with the survey evidence follows four stages in a fixed sequence. Inverting this sequence produces the rational hesitation the data describe. A necessary caveat: the GETA sequence addresses what practitioners can control. It does not account for macroeconomic conditions, liquidity cycles, regulatory constraints, institutional mandates, or geopolitical risk — all of which operate independently and can delay or prevent allocation regardless of governance quality. The sequence is a necessary condition for capital formation, not a sufficient one.

G
GOVERNANCE

Credibility must be established first. This means independent documentation of process, conflict policies, and oversight structures — reviewed by a credible third party and published openly. This is the foundational condition without which all subsequent engagement is undermined.

- *Governance is sufficiently established when all documentation exists, has been independently reviewed, and is available to prospective investors without being requested.*

E
EDUCATION

Non-transactional. Public-facing. Decoupled from any allocation ask. Not product education — institutional education. Deliberate exposure to how professional allocators think about risk, governance, liquidity, and accountability.

- *Education has served its function when prospective investors can articulate the basis for their interest independently.*

T

TRUST

Trust emerges from the sustained interaction between credible governance and transparent education. It cannot be accelerated through persuasion. It accumulates through consistency, restraint, and demonstrated competence. Public forums function most effectively as epistemic spaces, not as quasi-roadshows.

- *Trust formation is sufficient when unsolicited inbound enquiries replace outbound solicitation as the primary mode of engagement.*

A

ALLOCATION

Allocation follows when the investor has sufficient institutional confidence to commit voluntarily. The investor requests diligence materials. The allocator responds to expressed interest rather than soliciting commitment. This inversion of initiative profoundly affects trust dynamics and the quality of committed capital.

- *Allocation is healthy when investors who commit can articulate governance quality, operating philosophy, and ethical boundaries independently — not because they were told, but because they learned.*

> *Inverting this sequence produces exactly the rational hesitation the data describe — not a persuasion problem, but a sequencing one.*

PART III

Governance Architecture

The minimum governance standard for healthcare platforms seeking institutional and values-aligned capital

3.1 Minimum Governance Structure

The GETA sequence establishes that governance must come first. This section specifies what that means in practice. The following architecture represents the minimum standard for a healthcare private market platform seeking to attract institutional and values-aligned capital. Partial implementation is insufficient — sophisticated investors assess governance holistically. In the founding survey, no governance dimension rated as unimportant.

Investment Committee

Minimum three members with genuine decision authority. Clear quorum requirements and voting procedures. Documented conflict-of-interest recusal protocol. Written investment policy statement covering mandate, concentration limits, and prohibited activities. Minutes maintained and available to LPs upon request.

Independent Advisory Oversight

Advisory council with members serving in individual capacity — not as representatives of commercial entities. Explicit charter defining scope of authority, meeting cadence, and reporting obligations. Diversity across clinical, financial, Shariʿah, and operational expertise. Compensation disclosed. Conflicts disclosed.

Compliance Infrastructure

Designated compliance function — not a job title appended to another role. Written compliance manual covering regulatory obligations, LP reporting standards, and escalation procedures. Annual compliance review with findings reported to advisory council.

Clinical Governance Layer

Healthcare platforms require a clinical governance structure independent of financial governance. Clinical advisory committee with authority to flag care quality concerns. Documented ethical guardrails that cannot be overridden by financial considerations. Mechanism for clinical leadership to escalate concerns without retaliation risk. Care quality metrics tracked and reported independently of financial performance.

3.2 Decision Rights Mapping

Ambiguity about decision rights is the most common governance failure in emerging healthcare platforms. The following mapping addresses the four domains where clarity is most frequently absent.

Clinical Strategy — Who decides: Physician leadership at GP level, with clinical advisory committee input. What requires escalation: Changes to care quality standards, new clinical service lines, workforce composition affecting clinical delivery. What cannot be delegated: Clinical ethical boundaries.

Capital Allocation — Who decides: Investment committee. What requires LP consent: Material changes to investment mandate, follow-on investments above concentration thresholds, related-party transactions. What is disclosed proactively: All investments, fee arrangements, carried interest calculations.

Risk Management — Who decides: Investment committee with compliance function input. What triggers mandatory review: Regulatory inquiry, material adverse clinical event, key-person departure, covenant breach. What is reported to LPs: Material risk events within defined timeframes — recommended 30 days.

Shariʿah Review — Who decides: Independent Shariʿah supervisory board — not a single scholar. What requires board approval: All new investment structures, material amendments, non-compliance events. What is disclosed: Review process, scholars' identities and independence status, dissenting positions, non-compliance events and resolution.

3.3 Transparency Standards

Ongoing transparency and reporting quality were the single most frequently cited drivers of hesitation in the founding survey — rated above governance structure, operating model clarity, and ethical concerns.

> *Transparency is not a disclosure obligation. It is a capital formation strategy.*

Operating Model Disclosure — Provide a plain-language document that traces the connection between operational actions and financial outcomes. Answer specifically: How does staffing model affect margin? How does payer mix affect revenue stability? How does clinical protocol standardisation affect scalability? Investors who can answer these questions can underwrite the opportunity.

Portfolio Construction Philosophy — Document in writing: sector concentration limits, geographic parameters, co-investment rights, follow-on investment criteria, and LP notification thresholds. Publish to all LPs simultaneously. Update when policy changes.

Downside Governance — Document your downside governance plan: how underperformance is defined, what triggers a governance review, who has authority to remove management, what protects LP capital in a wind-down scenario. Sponsors who answer this question clearly are demonstrating exactly the governance credibility that accelerates commitment.

Capital Deployment Sequencing — Provide a written capital deployment plan covering deployment pace targets, concentration milestones, reserve policy, and the conditions under which deployment pace would be adjusted. When the plan changes, investors expect to be told promptly.

3.4 Governance Maturity Self-Assessment

Use this checklist to identify where your platform currently sits against the minimum governance standard. Address gaps in priority order. Governance is investor-ready when all elements are fully documented and available to prospective LPs upon request — not upon commitment.

Elements to assess: Investment committee charter · Decision-rights mapping · Conflict-of-interest policy · Valuation methodology document · LP reporting schedule and format · Compliance manual · Clinical governance structure · Ethical guardrails document · Shariʿah supervisory board charter · Downside governance plan · Capital deployment sequencing plan · Advisory council charter.

PART IV

Capital Stack Design

Structuring Shariʿah-aligned healthcare platforms — and the governance implications of each layer

4.1 The Four-Layer Capital Stack

Once governance architecture is in place, the next institutional design question concerns the capital structure through which healthcare platforms are financed. Healthcare infrastructure investment in Islamic markets requires a layered capital architecture that aligns different capital sources with their appropriate risk profiles, return expectations, and governance requirements.

This stack is presented as a target architecture, not a description of current market practice. Waqf deployment at institutional scale in healthcare remains nascent in most markets. Healthcare-specific Sukuk issuance outside a handful of GCC jurisdictions is still limited. DFI co-investment typically requires sovereign or near-sovereign sponsorship and carries approval timelines of 18–36 months that must be factored into any realistic implementation plan. The framework describes what a mature Islamic healthcare capital market looks like — and what practitioners should be building toward. Partial versions of the stack — physician PE plus a single DFI instrument, or Sukuk plus a Waqf operating subsidy — are viable intermediate structures.

Layer 1 — Waqf (Concessional Quasi-Equity)

Nature: Perpetual charitable endowment. Capital contributed as Waqf generates returns from an invested corpus, deployable as operating subsidies or concessional financing for underserved populations. Role in stack: First-loss absorber — the concessional layer that makes the overall stack viable where commercial returns alone are insufficient. Governance requirement: Waqf functions as intended only under independent trust governance — a purpose-specific trust with professional investment mandate, accountable trustees, published accounts, and an independent Shariʿah supervisory board. Ministry-administered Waqf models have historically underperformed in healthcare contexts, because administrative control without an active investment mandate tends toward capital preservation rather than productive deployment.

Layer 2 — Sukuk (Senior Debt)

Nature: Asset-backed Islamic financial certificates generating returns through ownership or lease arrangements rather than interest. Structures include Ijārah Sukuk — sale-and-leaseback of facility real estate, appropriate for hospital and clinic construction — and Murābaḥah structures — cost-plus-profit, appropriate for equipment acquisition. Role in stack: Senior capital instrument providing long-duration, asset-backed financing without interest obligation. Governance requirement: AAOIFI Shariʿah Standard compliance, independent Shariʿah board sign-off, and — for sub-sovereign issuers — DFI credit enhancement before accessing international markets. Practitioners should note that DFI approval timelines of 18–36 months must be factored into implementation planning.

Layer 3 — Physician-Led Private Equity (Operating Layer)

Nature: Equity investment with physician leadership at GP level. Role in stack: Operational control, clinical governance, value creation — the layer that makes the capital stack credible to GCC institutional investors and values-aligned allocators. Governance requirement: Physician GP leadership is a structural requirement, not a branding decision. Healthcare infrastructure investment carries clinical risks and operational complexities that financial-only sponsors are ill-

equipped to underwrite. Evidence from U.S. physician-led healthcare platforms suggests measurably different operational priorities than non-physician-owned entities — stronger orientation toward clinical quality metrics and care coordination outcomes. This structural difference is the basis for differentiated investor confidence.

A governance tension inherent in this structure deserves explicit acknowledgment: physician GPs occupy three roles simultaneously — operator, investor, and decision-maker — and these roles can conflict. A physician GP with a financial interest in a portfolio company may face pressure to approve investment decisions that benefit the financial position at the expense of clinical standards, or vice versa. The structural response is mandatory: independent clinical governance with authority that operates outside the investment committee's control; conflict-of-interest recusal requirements for investment decisions involving entities the physician directly operates; and advisory council oversight with genuine authority to escalate. Platforms that acknowledge this tension explicitly and build structural responses to it are demonstrating exactly the governance depth that sophisticated allocators are looking for.

Layer 4 — DFI Co-Investment (De-risking)

Nature: First-loss coverage, guarantee instruments, and concessional co-financing from development finance institutions. Institutions with active mandates in MENA healthcare infrastructure include the International Finance Corporation (IFC), Islamic Development Bank (IsDB), and U.S. International Development Finance Corporation (DFC). Role in stack: Critical de-risking mechanism that reduces the risk profile of the overall stack sufficiently to unlock conservative GCC institutional capital. Governance requirement: DFI co-investment carries its own governance obligations — reporting standards, impact measurement requirements, and compliance frameworks — that must be integrated into the platform's governance architecture from inception.

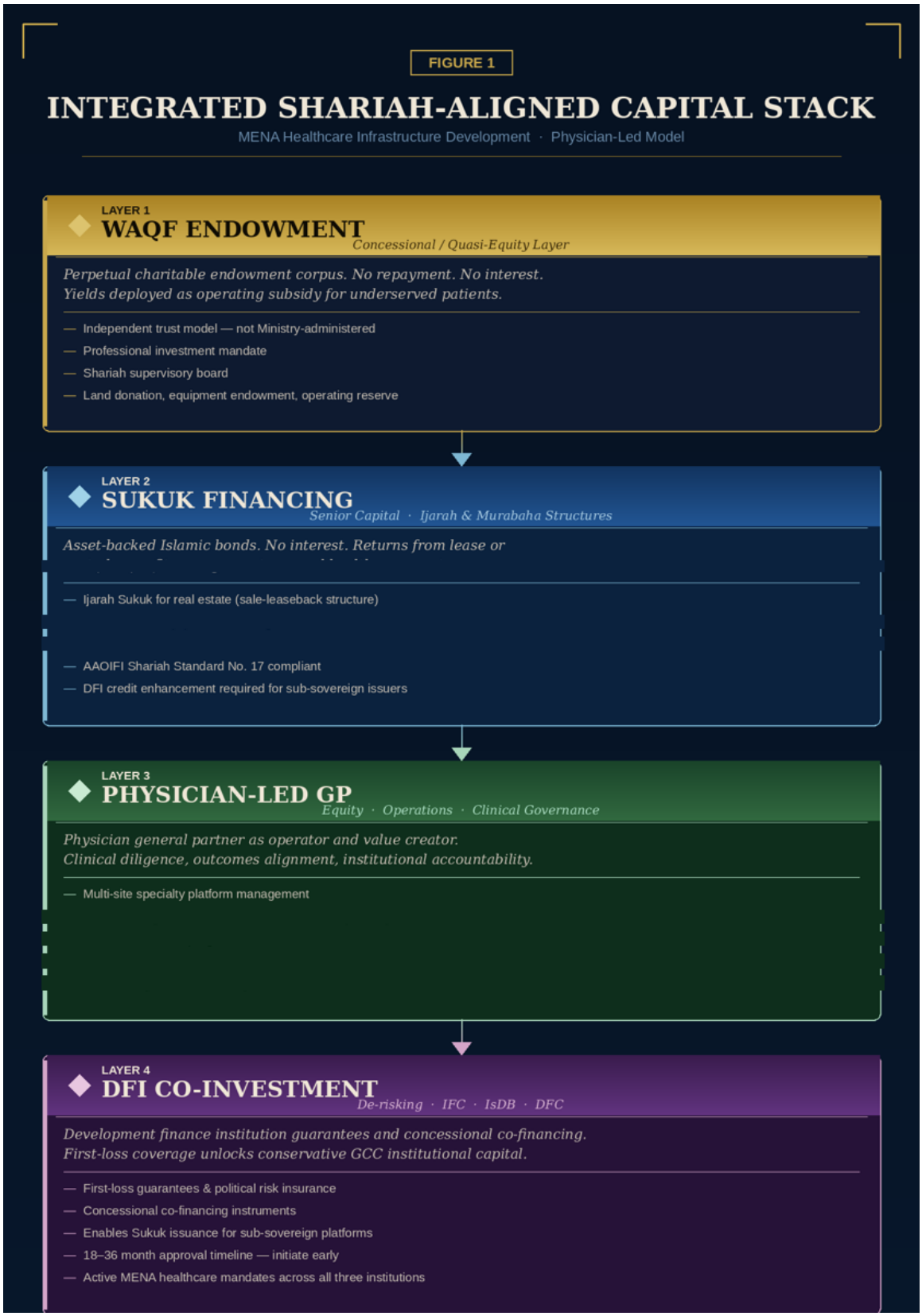

Figure 1. Integrated Shariʿah-Aligned Capital Stack — MENA Healthcare Infrastructure Development

4.2 Risk Allocation Across the Stack

Waqf absorbs first loss on concessional operations. It generates endowment yield with no repayment obligation, and governance authority rests with the independent Waqf trust board.

DFI co-investment absorbs first-loss on the senior tranche in some structures. Returns are concessional or below-market, and DFI reporting and compliance requirements apply throughout.

Sukuk absorbs credit risk on asset-backed obligations. Returns take the form of periodic rental or profit payments, under the authority of an AAOIFI-compliant Shariʿah board.

Physician PE absorbs equity risk and is last in. Returns are carried interest and management fees, with authority exercised jointly by the investment committee and clinical governance.

4.3 Governance Safeguards in Layered Structures

Layered capital structures introduce governance complexity that single-source capital does not. The following conflicts are predictable and should be addressed in writing before capital is committed.

Waqf and PE incentive misalignment — Waqf trustees have a fiduciary obligation to the endowment corpus and its beneficiaries. PE GPs have a fiduciary obligation to LP investors. These obligations can conflict when concessional pricing for underserved populations reduces platform-level returns. Document the pricing framework and subsidy mechanism before the structure is in place.

DFI and commercial LP reporting conflict — DFI co-investors require impact measurement reporting that commercial LPs may regard as administrative burden. Establish a unified reporting framework that satisfies both obligations from inception.

Sukuk covenant and clinical governance tension — Ijārah Sukuk covenants typically require the underlying asset to remain in operation for the duration of the lease. Clinical governance decisions — including platform consolidation or service line changes — must be assessed against Sukuk covenant obligations before execution.

Shariʿah board and commercial timeline pressure — Shariʿah supervisory board review takes time. Build Shariʿah review into the deal execution timeline — not as a final step.

PART V

Ethical Guardrails

Aligning financial incentives with clinical integrity — and managing reputational risk proactively

5.1 The Maqāṣid Framework Applied

Islamic jurisprudence identifies five higher objectives — maqāṣid al-Shariʿah, literally the objectives or purposes of Islamic law — that governance frameworks in Islamic finance must serve. Two are directly relevant to healthcare investment.

Ḥifẓ al-nafs (Preservation of Life) — Healthcare investment that degrades care quality, restricts access for underserved populations, or subordinates clinical decision-making to financial incentives fails this objective regardless of its Shariʿah compliance certification.

Ḥifẓ al-māl (Preservation of Wealth) — This objective implies not merely protection of assets from loss but the active creation of conditions under which wealth can be deployed responsibly and productively. When governance failures make institutional conditions unsafe, capital that could serve maṣlaḥa — the broader public interest — remains idle. The governance-first model is an expression of this objective applied to private market participation.

> *A healthcare platform with credible Shariʿah certification but degraded care quality fails the maqāṣid test. A platform without Shariʿah certification but with strong clinical governance, transparent operating model, and genuine commitment to underserved populations is closer to the maqāṣid objectives than the inverse. Certification follows substance, not the reverse.*

5.2 Clinical Integrity and Financial Incentives

Four structural mechanisms protect clinical integrity in healthcare private market platforms.

Independent clinical governance — A clinical advisory committee with authority independent of the investment committee. The ability to flag care quality concerns, escalate to the advisory council, and — as a last resort — go public without retaliation risk. This authority must be genuine, not nominal.

Documented ethical boundaries — Written statements of practices that are non-negotiable regardless of financial pressure: minimum staffing ratios, care quality floors, access commitments for underserved populations, workforce treatment standards. These must be in the LP agreement, not only the marketing materials.

Outcomes measurement from inception — Clinical outcome metrics embedded in the governance framework before the first investment is made. Not retrospectively added to demonstrate impact — built in from the beginning. Platforms that measure clinical outcomes behave differently from platforms that measure only financial returns.

Whistleblower protections — Formal, documented protections for clinical staff who report care quality concerns. The absence of whistleblower protections in a healthcare investment platform is a governance red flag.

5.3 Reputational Risk Management

Governance failures in healthcare destroy investor confidence with a speed and completeness that failures in other sectors do not. Healthcare failures are reported in clinical and professional communities, not only in financial media. For physician-investors and values-aligned allocators, a single documented care quality failure can end the capital relationship permanently.

Pre-investment reputational due diligence — Before committing capital to any healthcare platform, assess its prior care quality record, regulatory history, workforce treatment track record, and community relationships. These factors are as material as financial performance.

Ongoing monitoring — Establish reporting obligations that surface care quality and regulatory concerns in real time — not in annual LP reports. Material adverse clinical events should trigger immediate notification.

Crisis response protocol — Document in advance how the platform will respond to a public care quality event: who speaks, what is said, what remediation commitments are made, and how LP investors are informed. Platforms without crisis response protocols discover their approach under the worst possible conditions.

PART VI

Due Diligence Framework for Allocators

A structured framework for evaluating Islamic healthcare platforms — governance, operating model, and Shariʿah process

6.1 Governance Due Diligence

Use these questions in LP due diligence conversations. Unsatisfactory answers — or the absence of written documentation — are material findings.

Investment Committee and Decision Authority

Who sits on the investment committee, and what are their qualifications? What is the quorum requirement for investment decisions? How are conflicts of interest identified and managed? Can you provide the investment committee charter? Has any committee member had a conflict-of-interest recusal in the past three years?

LP Rights and Reporting

What are LPs' rights to remove the GP for cause? For no cause? What triggers mandatory LP notification? What is the reporting cadence, and what does each report contain? Are audited financials provided annually, and by whom? Are LP meetings held at a defined cadence, and are minutes circulated?

Downside Governance

How is underperformance defined in your governance documents? What is the process if the platform needs to wind down? What protections exist for LP capital in a liquidation scenario? Who has authority to remove portfolio company management? Has the GP ever had an LP request early exit or redemption, and how was it handled?

Advisory Council

Who serves on the advisory council, and in what capacity? What is the advisory council's mandate? Does the advisory council have access to LP reporting? Has the advisory council ever escalated a concern to LPs?

6.2 Operating Model Assessment

Value Creation Mechanism

Walk me through exactly how you create value at the portfolio company level. How does staffing model affect margin in your platform? What is your payer mix strategy, and how does it affect revenue stability? How does clinical protocol standardisation affect scalability? What is your operational track record at previous platforms?

Clinical Governance

Who has clinical governance authority, and is it independent of financial governance? What care quality metrics do you track at portfolio company level? What happens when financial pressure conflicts with care quality standards? Have there been cases where clinical governance decisions constrained financial returns, and how were they handled? Are whistleblower protections in place for clinical staff?

6.3 Shariʿah Process Verification

> *Do not rely on the label. Verify the process. You should be able to read a documented Shariʿah review process, identify the scholars involved, understand how interpretive disagreements are handled, and know what happens when a non-compliance event occurs — before you commit capital. If this documentation does not exist, the platform's Shariʿah compliance is a label, not a process.*

Shariʿah Supervisory Board

Who are the Shariʿah supervisory board members? Are they independent — no employment or financial relationship with the GP or its affiliates? How many boards does each scholar sit on simultaneously? What is the board's compensation structure? Can you provide the Shariʿah supervisory board charter?

Review Process and Ongoing Compliance

At what stage of the investment process does Shariʿah review occur? What documentation is submitted for Shariʿah review? Is the review process documented in writing? Are dissenting opinions recorded and disclosed? How are grey areas and interpretive disagreements handled? Has there been a non-compliance event? How was it handled and disclosed? Are annual Shariʿah compliance reports provided to LPs?

PART VII

Implementation Pathways

A practical starting point — whether building from inception or retrofitting an existing platform

7.1 Building a Governance-First Platform

For sponsors building a new healthcare investment platform, the sequence is fixed. Governance infrastructure must be established before capital formation begins.

Phase 1 — Foundation — Draft and adopt investment committee charter. Map decision rights across clinical, capital, risk, and Shariʿah domains. Appoint advisory council with genuine independence and cross-domain expertise. Engage Shariʿah supervisory board with clear charter and documented process. Draft governance disclosure template.

Phase 2 — Documentation — Complete operating model bridge document. Draft conflict-of-interest and valuation methodology policies. Establish clinical governance structure with independent authority. Document ethical guardrails and non-negotiable practices. Prepare LP reporting template and cadence.

Phase 3 — Education — Begin non-transactional public education programme. Publish working papers and thought leadership. Establish presence in institutional forums as an educator, not a fundraiser. Build small-group private engagement pathway for investors who self-select.

Phase 4 — Trust Formation and Allocation — Allow inbound enquiries to drive allocation conversations. Provide governance documentation proactively to interested investors. Structure allocation process around investor readiness, not fund timeline pressure. First close only when governance is fully documented and independently reviewed.

7.2 Retrofitting Governance in Existing Platforms

For sponsors with existing platforms, the governance maturity assessment in section 3.4 identifies the gaps. Address them in the following priority order.

Priority 1 — Immediate (within 60 days) — Any governance element with direct LP exposure: investment committee charter, conflict-of-interest policy, LP reporting format, key-person notification protocol. These should exist already. If they do not, LP relationships are at risk.

Priority 2 — Near-term (60–120 days) — Operating model bridge document, downside governance plan, clinical governance structure. These are the elements most frequently cited as capital formation constraints. Completing them materially improves LP confidence and shortens decision timelines for prospective investors.

Priority 3 — Medium-term (120–180 days) — Shariʿah governance documentation, advisory council charter, ethical guardrails document, whistleblower protections. These elements build long-term institutional credibility and are prerequisites for GCC institutional capital.

> *On communication: When you retrofit governance, tell your existing LPs what you have done and why. The narrative — "we have formalised what was always our practice" — is honest and strengthens relationships. LPs discovering governance documents they were not told about damages trust.*

7.3 Where CFIIM Fits

Research institutions like CFIIM contribute to capital formation in healthcare Islamic private markets through three distinct mechanisms — none of which involves product promotion or investment facilitation.

Governance Research — CFIIM produces governance frameworks, disclosure standards, and practitioner tools — like this playbook — grounded in empirical evidence and practitioner engagement. The research agenda does not tell allocators where to invest. It builds the institutional infrastructure that makes investment decisions more legible and more confident.

Investor Education — CFIIM's education programme is non-transactional. The goal is institutional literacy — exposing investors to how professional allocators think about governance, risk, and Islamic finance principles in private markets.

Institutional Dialogue — CFIIM convenes practitioners, scholars, allocators, and sponsors in structured dialogue about governance architecture. The outputs are public: frameworks, standards, and documented practitioner perspectives that advance the field rather than any specific participant.

Sponsors who adopt CFIIM governance frameworks and participate in CFIIM's institutional dialogue are demonstrating a commitment to field-building that sophisticated allocators recognise. This is how research institutions and practitioners create mutual value: the institution provides credibility infrastructure; practitioners demonstrate their governance commitments by using it.

Conclusion

Healthcare investment requires institutional trust infrastructure. Islamic private markets require that infrastructure to be explicit, documented, and credible.

Governance is not compliance. Compliance is the floor — the minimum required to operate. Governance is the architecture through which investors gain the confidence to allocate capital to a platform they cannot fully control, in a sector they find genuinely meaningful, through structures that reflect their values.

The evidence from CFIIM's founding research is consistent and actionable. Commitment latency is not irrational. It is a rational response to institutional ambiguity. Shariʿah labelling without documented process does not build confidence — it destroys it. Education precedes allocation. Governance precedes branding. Trust cannot be accelerated through persuasion; it accumulates through demonstrated accountability over time.

For sponsors, the implication is architectural: build the governance infrastructure first, then invite capital into it. For allocators, the implication is evaluative: govern your own due diligence as rigorously as you expect the platform to govern its investments. For the field, the implication is institutional: the gap in Islamic private markets is not product availability. It is governance infrastructure. Closing that gap is the purpose of this playbook, and the founding mission of CFIIM.

Appendix A — Governance Disclosure Template

This template provides a standardised framework for Islamic healthcare private market platforms to disclose governance arrangements to prospective and existing LPs. Complete all sections. Where an element is not yet in place, state this explicitly and provide a timeline for implementation. Incomplete disclosure is preferable to misleading disclosure.

Platform Name:
Legal name of the GP entity

Date of Document:
Date this disclosure was prepared

Version:
Version number — update and re-date when material changes occur

Section 1 — Investment Committee

Members (name, role, qualifications):
List each member with their relevant background

Quorum requirement:
Minimum number required to approve investment decisions

Voting procedures:
Unanimous vs. majority; how ties are resolved

Conflict-of-interest recusal protocol:
How conflicts are identified, disclosed, and documented

Minutes policy:
Confirm minutes are maintained and available to LPs upon request

Section 2 — Advisory Council

Members (name, capacity, expertise):
Including clinical, financial, Shariʿah, and operational representation

Charter summary:
Attach full charter — summarise authority and scope here

Compensation disclosure:
How advisory council members are compensated

Conflict disclosure:
Any commercial relationships between advisory council members and the GP

Reporting to LPs:
How and when advisory council findings are reported

Section 3 — Shariʿah Supervisory Board

Members (name, affiliation, other board seats):
Independence requires disclosure of concurrent engagements

Independence confirmation:
Confirm no employment or equity relationship with GP or affiliates

Review process summary:
Attach full process document — summarise stages here

Non-compliance handling:
What triggers a review and how events are disclosed to LPs

Annual compliance report:
Confirm issuance; attach most recent report if available

Section 4 — Clinical Governance

Clinical advisory committee members:
Including basis for appointment and independence status

Independence from investment committee:
Describe the structural separation

Authority to escalate care quality concerns:
Describe the escalation mechanism and to whom

Whistleblower protections:
Confirm written protections exist for clinical staff

Clinical outcome metrics tracked:
List metrics and reporting cadence

Section 5 — LP Rights

Cause removal provisions:
Specific triggers and process for GP removal for cause

No-cause removal provisions:
Threshold and process for LP-initiated removal

Key-person notification triggers:
Events requiring mandatory LP notification

LP consent requirements:
List transaction types requiring LP consent

Audit provider:
Name of independent auditor and frequency

Section 6 — Ethical Guardrails

Non-negotiable practices:
Practices that cannot be overridden by financial considerations

Care quality floors:
Minimum standards applying to all portfolio companies

Access commitments:
Commitments to underserved populations, if any

Crisis response protocol:
Confirm written protocol exists; attach or summarise

Appendix B — Investment Committee Charter (Model)

This model charter may be adapted by healthcare private market platforms. All bracketed fields require completion. Completed charter should be reviewed by counsel and approved by the GP's governing body before adoption.

1. Purpose

The Investment Committee (the "Committee") is responsible for all investment decisions made by [Platform Name] (the "GP") on behalf of its limited partners. The Committee exercises fiduciary authority over capital deployment, portfolio management, and exit decisions.

2. Composition

The Committee shall consist of not fewer than three and not more than five members. Members are appointed by [governing body] and serve until resignation, removal, or incapacity. The Committee shall at all times include at least one member with clinical healthcare expertise and at least one member with Islamic finance expertise.

3. Quorum and Voting

A quorum consists of [N] members. Investment decisions require [unanimous / majority] approval of a quorum. No investment decision may be approved without a quorum present. Proxy voting is not permitted.

4. Conflict of Interest

A member with a material conflict of interest in a proposed investment shall disclose the conflict in writing to the Committee chair before deliberation and shall recuse from the vote. Recusal shall be documented in the meeting minutes. The conflict-of-interest register shall be maintained by the compliance function and reviewed annually.

5. Authority

The Committee has exclusive authority over: initial investment approvals above [threshold]; follow-on investments above [threshold]; exits and partial dispositions; related-party transactions (subject to LP consent requirements); and material amendments to investment terms.

6. Meeting Cadence

The Committee shall meet not less than [quarterly] and additionally as required by investment activity. Meetings may be held in person or via secure video conference. Written resolutions may be used for time-sensitive matters below [threshold], provided all members confirm in writing.

7. Documentation

Minutes shall be maintained for all meetings and circulated to members within [five] business days. Approved minutes shall be retained for the life of the fund and made available to LPs upon request. Investment memoranda supporting each decision shall be retained in the same manner.

8. Reporting

The Committee shall report to LPs [quarterly / semi-annually] on: investment activity; portfolio performance; material risk events; and any conflict-of-interest recusals occurring in the period.

9. Amendment

This Charter may be amended by [unanimous / majority] vote of the Committee with [30 / 60] days written notice to LPs.

Appendix C — Shariʿah Governance Process Template

This template establishes the minimum documented Shariʿah governance framework for an Islamic healthcare private market platform. Complete all sections. Adopt by resolution of the GP's governing body. Make available to all LPs without being requested.

1. Shariʿah Supervisory Board

[Platform Name] maintains an independent Shariʿah Supervisory Board (the "Board") comprising [N] scholars. No Board member may have an employment relationship with [Platform Name] or its affiliates, hold equity in [Platform Name], or receive compensation other than disclosed scholar fees. Board members, their institutional affiliations, concurrent board seats, and signed independence statements are disclosed to all LPs annually.

2. Scope of Review

The Board reviews and approves: all investment structures before commitment; material amendments to existing structures; new financial instruments or product types; and any matter referred by the investment committee or management.

3. Review Process

Step 1 — Submission: The investment team submits a Shariʿah review memorandum to the Board not less than [15] business days before the required decision date. The memorandum includes transaction structure, economic terms, relevant fiqh analysis, and any areas of interpretive uncertainty.

Step 2 — Deliberation: Board members review independently and then convene to deliberate. Deliberations are documented.

Step 3 — Resolution: The Board issues a written ruling — approval, conditional approval, or rejection. Conditions are documented specifically. Dissenting positions, if any, are recorded.

Step 4 — Implementation review: For conditional approvals, the compliance function confirms that all conditions are satisfied before the transaction closes.

4. Interpretive Disagreement

Where Board members disagree, the disagreement is documented and the matter is resolved by majority vote. Dissenting positions are recorded and disclosed to LPs in the next periodic Shariʿah compliance report.

5. Non-Compliance Events

A non-compliance event is defined as any transaction or practice determined by the Board to be inconsistent with the approved Shariʿah framework. Non-compliance events are reported to the investment committee within [5] business days of discovery, disclosed to LPs within [30] business days, and remediated under a plan approved by the Board.

6. Annual Compliance Report

The Board issues an annual Shariʿah compliance report covering: all transactions reviewed in the period; any non-compliance events and their resolution; and the Board's assessment of the platform's ongoing compliance with its approved Shariʿah framework. The report is circulated to all LPs.

Appendix D — Investor Due Diligence Checklist

Complete this checklist when evaluating an Islamic healthcare private market platform. Rate each item: Satisfactory (S) / Needs Clarification (NC) / Not in Place (NP). Any NP is a material finding requiring resolution before commitment.

Governance

- ☐ Investment committee charter reviewed and understood
- ☐ Decision-rights mapping reviewed — authority clear at all four domains
- ☐ Conflict-of-interest policy reviewed — recusal mechanism credible
- ☐ Valuation methodology document reviewed
- ☐ Advisory council charter reviewed — independence confirmed
- ☐ LP rights reviewed — cause and no-cause removal provisions understood
- ☐ Downside governance plan reviewed — wind-down protections understood
- ☐ Reporting format and cadence reviewed — content meets my standards
- ☐ Auditor identified and independent

Shariʿah Governance

- ☐ Shariʿah supervisory board members identified by name
- ☐ Scholar independence confirmed — no employment or equity relationship with GP
- ☐ Scholar concurrent board seats reviewed — concentration acceptable
- ☐ Shariʿah review process documented in writing and reviewed
- ☐ Dissenting opinion handling confirmed
- ☐ Non-compliance event history disclosed and assessed
- ☐ Annual Shariʿah compliance report format reviewed

Clinical Governance

- ☐ Clinical advisory committee composition reviewed
- ☐ Independence from investment committee confirmed
- ☐ Care quality escalation mechanism reviewed and credible
- ☐ Whistleblower protections documented and reviewed
- ☐ Clinical outcome metrics reviewed — tracked from inception
- ☐ Ethical guardrails reviewed — non-negotiable practices documented

Operating Model

- ☐ Operating model bridge document reviewed — mechanism clear
- ☐ Payer mix strategy reviewed and understood
- ☐ Staffing model reviewed — margin implications understood
- ☐ Regulatory exposure reviewed
- ☐ Key-person dependencies identified

Capital Stack (if applicable)

- ☐ Waqf governance model reviewed — independent trust confirmed
- ☐ Sukuk structure reviewed — AAOIFI compliance confirmed
- ☐ DFI co-investment terms reviewed — reporting obligations understood

☐ Layer-by-layer risk allocation understood
☐ Inter-layer governance conflicts identified and documented

My Commitment Readiness

Before committing, I can confirm:

☐ I understand how value is created at portfolio company level
☐ I understand the governance structure and my rights within it
☐ I understand the Shariʿah compliance process — not just the label
☐ I understand the downside scenario and my protections
☐ I have had my questions answered in writing, not only verbally
☐ I am committing because I have sufficient institutional confidence, not because I was persuaded

A commitment made with all boxes checked is a commitment built on institutional trust. That is the kind of capital that sustains a platform — and a field.