

Caring for our Neighbors

How Muslim Community-Based Health Organizations are
Bridging the Health Care Gap in America



A REPORT BY

**Institute for Social Policy
and Understanding**

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Executive Summary

Muslim community-based health organizations have a history that spans at least two decades in the United States. This study is the first to closely examine how Muslim community-based health organizations (MCBHOs) have developed and are providing free or low-cost primary care services to low-income communities in four cities with large and diverse American-Muslim populations: Chicago, Detroit, Los Angeles, and Houston.

This analysis of 10 prominent MCBHOs in these cities opens a window into the state of American-Muslim public health service. With these health organizations, American Muslims are following in the tradition of other religious minorities, including Catholics and Jews, in initiating a new wave of institution building that had in decades past concentrated on mosques and schools. The rise of MCBHOs in recent years can be seen as an indication of the American-Muslim community's growing civic and public service role in the cultural mainstream and the emergence of a new American-born generation of Muslims dedicated to serving the only country they have ever known.



Key Findings

Just over half of MCBHOs were initially started by American Muslims to serve particular ethnic and immigrant communities. This included providing Muslim patients with culturally and often linguistically appropriate care. But other MCBHOs, such as Los Angeles' UMMA Community Clinic, from the beginning, emerged in response to a universal commitment to serve urban populations that lacked access to insurance and health care. Today, the majority of MCBHOs serve the broader community, both Muslim and non-Muslim. Notably, at three major institutions, Muslim patients represented less than 5 percent of the population served.

American-Muslim health providers are motivated by a desire to “give back.” Most of the organizations in the study were founded by first-generation American-Muslim physicians who were motivated by a desire to “give back” to society, in keeping with the Islamic tenets of serving those in need. The emergence of MCBHOs also represents the emergence of a new American-born generation of Muslims that has successfully established roots and financial stability and is seeking to provide public service to underserved communities. Many of the MCBHOs were providing community-based health care well before 9/11, yet most leaders acknowledged that the current climate has strengthened their sense of urgency, purpose and commitment to providing — through these health initiatives — a highly visible manifestation of “what Islam is all about.”



Health organizations' “Muslimness” is largely incidental, though values of Islam may inform commitment to public service. Many who provide health care services in MCBHOs do not distinguish themselves from other free clinics or networks and describe their organization's Muslim identity as mostly derived from the nominal identification of the majority of providers. Although the organization may have been founded and/or run by Muslims or affiliated with an Islamic center, all medical services are “open to everyone.”

MCBHOs provide a critical, cost-savings safety net. Because they rely largely on volunteers (and, in some cases, private donations), MCBHOs likely provide better health care at less cost than many other forms of primary health care providers. These clinics are likely to be particularly good at locating and providing health care to the underserved, especially low-income communities who live in urban areas who might not otherwise access health care services.

Funding for MCBHOs mirrors those of other community-based health organizations and clinics. Nearly all clinics studied receive grants from city, county, state or federal government sources and rely on non-Muslim charitable foundations, in addition to donations from local and national American-Muslim groups.

Methodology

This pilot study was based on 43 interviews with individuals representing 10 Muslim community-based health organizations in four cities identified as having American-Muslim populations above 50,000: Chicago, Detroit, Los Angeles and Houston. The study also included a review of relevant literature and on-site visits of the health facilities. The research was approved by the Institutional Review Board at the Boston University School of Medicine.

Abstract

This report describes the history, development, organizational models, and identity components of 10 Muslim community-based health organizations in four cities (Chicago, Detroit, Los Angeles and Houston) and of the populations they serve. It is based on a review of historical materials, site visits, and interviews with 43 individuals affiliated with these organizations. Since 1990, these organizations have provided free or low-cost primary care services to Muslims and non-Muslims in their cities. They were, for the most part, started as organizations through which American Muslims could give back to their communities and were oriented in a range of ways around Islamic values. They have negotiated and evolved to meet challenges related to nonprofit management, funding, physical space, staffing and the recruitment and retention of volunteer physicians. We explore the implications of these new organizations on local and state public health efforts, future Muslim community-based health organizations and the American health care landscape as a whole.

Introduction

Individuals in the United States address their health care needs through a wide range of organizations (Starr 1982). In 2004, more than half of all adults (56.7 percent) visited a primary care physician, 7.5 percent of adults visited an emergency room, and 7.8 percent of people over the age of one were admitted to a hospital (NCHS and CDC 2006). Although some of these health care institutions were religiously affiliated, many more of the hospitals were influenced historically by religious people and organizations. These include nursing homes, free clinics, substance abuse facilities and other organizations [where people were treated in 2004]. In the 19th century, health care moved from the home to hospitals, and the number of American hospitals expanded. Religion shaped the process, as Catholic and Jewish hospitals opened to accommodate patients not treated well in other facilities and doctors and nurses who could not find work in them (Rosenberg 1995; Vogel 1980; Lazarus 1991). These religiously affiliated hospitals were open to everyone and, until the mid-20th century, cared for more than one quarter of all hospitalized patients (Numbers and Sawyer 1982).

Free health care clinics have a particular history in the American health care landscape, first emerging in the mid-1960s in San Francisco (The Haight-Ashbury Free Clinic), Seattle, Cincinnati, Detroit, and other U.S. cities. Street clinics, neighborhood clinics and youth clinics provided health care services to racial and ethnic minorities, youth, drug users, the uninsured and others not well served by existing health care organizations. Though many clinics struggled to survive and were often short of funds, they increased in number through subsequent decades. In 2004, there were an estimated 800 free clinics in operation. Some of these clinics have been supported by religious leaders and volunteers, and some have had close connections with area religious, particularly Christian, organizations, while others have been completely secular in their origins and mission statements (Weiss 2006).

This report details the emergence of a relatively new set of organizations on the American health care and religious landscape, Muslim community-based health care organizations. For the purpose of this study, we defined these organizations as those that provide ongoing professional physical or mental health care in their local communities and publicly identify their organizations as being Muslim, being led by Muslims or having developed out of Muslim teachings or traditions.

These organizations first started in the U.S. in the early 1990s and currently number approximately 10 in the four cities where we conducted this research (Chicago, Detroit, Los Angeles, and Houston). Additional Muslim clinics have started in other American cities, and this report provides a description of existing organizations and an analysis of their diverse characteristics, placing them in the context of non-Muslim, faith-based health organizations. This report also provides guidance for clinics in formation.

After a short description of our research methodology, we outline the history of these clinics, their organizational models and their approaches to questions of Muslim identity before noting the lessons learned through the history and development of these clinics and their implications for clinics in formation and the American health care context.

Research Methodology

This pilot study was designed to investigate how Muslim community-based health organizations in four cities with large and diverse Muslim populations (Chicago, Detroit, Los Angeles and Houston) are responding to the needs of patients outside “traditional” hospitals and medical facilities. The central research questions were the following:

- How have Muslim community-based health initiatives developed and evolved in the U.S. cities with the largest Muslim populations?
- How do the ways these initiatives develop differ between cities, with differing resources and communities to serve?
- How do these American-Muslim health initiatives reflect the values and tenets of the Islamic faith, and how do they compare with other historically faith-initiated health organizations in this country?
- Given how these initiatives developed, what can they teach others who are in the process of starting or would like to start similar projects, and how might they inform the structure and provision of care within the broader health care system in this country?



We investigated these questions by identifying the complete population of Muslim community-based health organizations (MCBHOs) in Chicago, Detroit, Los Angeles and Houston. We also attempted to locate such organizations through multiple channels in New York City, without success. These metropolitan areas were chosen based on Muslim adherent estimates above 50,000 from the Association of Religion Data Archives (Association of Religion Data Archives 2006). For the purposes of this project, we defined Muslim community health care organizations as organizations that 1) provide ongoing, professional physical or mental health care in their local communities and 2) publicly identify their organizations as being Muslim, being led by Muslims, or having developed out of Muslim teachings or

traditions. We excluded from our sample organizations that did not meet both of these criteria.

Through the Association of Muslim Health Professionals (AMHP) Web site, listserv, and board of directors’ recommendations; Internet searches; academic contacts in each of these cities; and snowball sampling (asking each organization to name others); we identified 10 organizations for this particular study. These organizations were located in Chicago (two), Detroit (three), Los Angeles (three), and Houston (two). We visited each city and interviewed, individually and in groups, individuals (between one and 10) who were involved with each organization in a range of capacities. A total of 43 people representing these 10 organizations were interviewed.

Interviews generally followed the interview guide (attached as Appendix A) and were designed to investigate how these MCBHOs developed, what obstacles they faced, and how they integrated Islam and Muslim identity into their organizations and patient care. Interviews were tape recorded, transcribed and coded to identify and analyze common themes. By visiting each of these organizations, we were also able to gather relevant literature, see the facilities and neighborhood contexts and in some cases, attend relevant fundraising and outreach events. This research was approved by the Institutional Review Board at the Boston University School of Medicine and funded by the Institute for Social Policy and Understanding (ISPU) in collaboration with the Association of Muslim Health Professionals (AMHP) Foundation.

Historical Development of Muslim Community-Based Health Organizations

A Brief History of American Muslims in the U.S.

The Muslim population of the United States is often estimated to be around 6 million (Ba-Yunus and Kone 2004), with the recent ISPU/Pew national study reporting a more conservative 2.35 million, out of which Arabs make up approximately 24 percent, African-Americans 20 percent and South Asians another 18 percent (Pew Research Center 2007). Although Muslims reside in every U.S. state, their population density is greatest in the major cities of 11 states, including California and Texas in the West, Illinois and Michigan in the Midwest, and seven East Coast states from Florida to Massachusetts (Ba-Yunus and Kone 2004).

While the early story of African Muslims in the United States is still being unearthed by historians, the African-American Muslim movements nascent in the 1930s assumed prominence in U.S. public life in the 1960s and 1970s. The immigration of Muslims from other parts of the world to the U.S. occurred in several waves, beginning with Ottoman Arabs and South Asians in the late 19th century. The largest wave of Muslim immigration, however, occurred after the Immigration Act of 1965. This policy shift, coupled with the political and economic conditions of their home countries, has, over the past four decades, spurred Muslims from throughout the Middle East, Asia and Africa to immigrate to the U.S., where they have joined African-American co-religionists and increasing numbers of Anglo, Hispanic and Native American converts.

Muslim immigrants from the post-World War II era through the early 1970s were often urban and well educated, many arriving in the U.S. to pursue graduate studies in the sciences, medicine and engineering. Muslim immigrants began organizing mosques in the Midwest as early as the 1920s, and a Federation of Islamic Associations emerged by the 1950s. Mosques, Islamic schools and, later, Muslim professional associations were the focus of institution building, while additional philanthropic giving often concentrated on home-country charities. Recent studies indicate that many mosques, especially African-American mosques, are positively involved in community social services and outreach. Most efforts are, however, limited in both scope and infrastructure (Bagby 2004).

Muslim Community-Based Health Organizations: The Beginning

Muslim involvement in community-based health has a history that spans at least two decades in the United States. Early projects in which Muslim health care providers played an active role were organized to serve particular ethnic communities, for instance, the ACCESS Community Health and Research Center in Dearborn, Michigan, which began operation in 1988 to focus on medical, public health and mental health initiatives and research relevant to the burgeoning Arab community. Similar organizations formed in other cities, like Hamdard Center in Chicago, which formed in 1992, largely to provide physical, emotional and psychological health services to South Asian, Middle Eastern and Bosnian communities in Illinois.

Of the Muslim community-based health organizations in this study, the earliest to emerge were:

- NISWA (Arabic for “women”), which formed in 1990 to assist with the mental health, domestic violence and social service needs of Muslim families in Los Angeles.
- University Muslim Medical Association (UMMA) Community Clinic, the most well-known Muslim organization to offer medical services, which emerged in South Central Los Angeles in 1996.
- Shifa Clinic Houston, which began providing primary health services in the region in 1997.
- Muslim Family Services (MFS) of Detroit, originally founded by the Islamic Circle of North America (ICNA) in New York, which began providing marital counseling and psychotherapy for Muslims in 1998.

Several other Muslim community-based health organizations have emerged steadily since the turn of the century, including Al-Shifa Clinic in San Bernardino (2000), the Ibn Sina Foundation Clinic in Houston (2001), Inner-city Muslim Action Network (IMAN) Health Clinic in Chicago (2002), the Compassionate Care Network (CCN) in Chicago (2004) and the Health Unit on Davison Avenue (HUDA) Clinic in Detroit (2004). Organizations like Zaman International in Detroit, dedicated to providing humanitarian relief as well as culturally competent end-of-life care and women’s shelters, are slowly emerging. Other Muslim-initiated community health programs are developing in Chicago, Baltimore, Northern Virginia, Las Vegas, Buffalo and elsewhere, building on the models established by these pioneering organizations.

Giving Back: The American-Muslim Community Comes of Age

Many interviewees explained the rise of MCBHOs in the past few years as a sign that the American-Muslim community is coming of age. Several interpreted the emergence of UMMA, for instance, as indicating the emergence of a new American-born generation of Muslims dedicated to serving the only country they have ever known. The story of the UMMA Community Clinic, organized by second-generation American-Muslim activist medical students, represents one trajectory in the emergence of these MCBHOs, one shared in significant ways with HUDA and IMAN. For instance, Dr. Faisal Qazi, who served as a young resident in Detroit, is frequently mentioned as the driving force behind the creation of HUDA, which followed the UMMA model.

Nevertheless, the Muslim Physicians of Greater Detroit, an organization composed largely of older, first-generation American clinicians, also played a role in organizing and funding the initiative. African-American Muslim social workers and community organizers like Mitchell Shamsuddin also partnered with these immigrant Muslims in the creation of HUDA, and the Muslim Center of Detroit now provides the space for the clinic. The IMAN Health Clinic is the

“I see us as Americans. This is our home, not a home away from home. We chose to come here; we chose this country as our country. America is our country. We were given chances here for education, business; we were allowed to be who we are. Now it’s time for us to pay back the country that accepted us with open arms.”

—Rodwan Saleh, Islamic Society of Greater Houston president

“I don’t have one hundred million dollars. If I did, I don’t know if I’d donate it. But I do have ... my sensibilities and I do have the capacity to treat people, and I’m licensed to do that. So that’s what I wish to do.”

—Dr. Azam Kundi, *Shifa Clinic Houston*

brainchild of Sherene Fakhraan, then a Northwestern University medical student, who enlisted two young South Asian-American physicians, Drs. Rima and Ahsan Arozullah. The latter also cite UMMA as part of their inspiration. The larger IMAN organization itself is the product of collaboration between second-generation Arab-American and African-American Muslims.

Most of the organizations in our study were actually begun by first-generation American, older Muslims or a combination of older and younger physicians. Many of these physicians also articulated a motivation of “giving back to this society” or “we’re here [in the U.S.] to stay.” Several suggested a “new role of the American mosque” or a new wave of institution building in the Muslim community, which in decades past has concentrated on mosque and school building and is now increasingly interested in establishing public service organizations in the health care sphere. Notably, Rodwan Saleh, president of the Islamic Society of Greater Houston addressed the Shifa Clinic Houston fundraiser, saying, “I see us as Americans. This is our home, not a home away from home. We chose to come here; we chose this country as our country. America is our country. We were given chances here for education, business; we were allowed to be who we are. Now it’s time for us to pay back the country that accepted us with open arms.”

Organizations like NISWA and Al-Shifa Clinic in Southern California, CCN in Chicago, MFS in Detroit and Shifa Clinic and Ibn Sina Foundation Clinic in Houston owe their origins to older, first-generation American-Muslim physicians, many of whom arrived in the United States for graduate medical training in the late 1960s and 1970s. Dr. Ayesha Sultana described how she had developed a passion for serving the underinsured while in her regular practice, but it took the arrival and convergence at the Muslim Community Center in Chicago of first-generation American activist clinicians Dr. Azher Quader and Dr. Mohammad Gafoor for the idea of CCN to germinate and take root. Dr. Quader’s daughter, Asfia, who is also a physician, is now organizing volunteers for CCN screenings.

She described CCN’s emergence as the product of a generation of Muslim physicians who had succeeded in establishing their families, households and Islamic centers and now had a desire to give back: “I think a lot of first-generation American professionals, when they came to this country, the focus was on ... establishing some sort of stability financially, because if you have that, then your housing is stable, then you can start to build a community.” Similarly, the largely first-generation American founders of Al-Shifa Clinic in San Bernardino met at the local mosque and began brainstorming about ways they could provide services to improve the image of Islam in their adopted country. As one Al-Shifa Clinic board member described, “We always felt obligated to do something for the community and that was the main motive behind it all. Back then there was also a lot of, unfortunately, stigmatizing about the Muslim community being ... either passive or sometimes an offensive side, a hostility issue that was raised a lot of times in the past. And we thought the minimum we can do is to proceed and establish a project like this one and not only to clean that image but to actively get involved in the community.”

It is interesting to note that NISWA emerged from school psychologist Dr. Shamim Ibrahim's experience with other first-generation Americans at the Islamic Center of Southern California who were facing the challenge of accessing culturally and religiously appropriate care for their marital and mental health needs. Similarly, MFS in Detroit emerged from the convergence of first-generation Ghanaian-American Shaykh Ali Suleiman's experience with immigrant Muslims in the mosque and the work of the now well-established Islamic Circle of North America in these immigrant Muslim communities. Shifa Clinic and Ibn Sina Foundation Clinic in Houston both emerged from first-generation American-Muslim physicians' observations of problems in insurance and health care access in immigrant and other minority communities in the area.

Perhaps the majority of the clinics we studied, then, were initiated by groups of professionally and financially established older Muslim physicians that met in established Islamic centers or Muslim professional associations associated loosely with the Islamic Medical Association of North America, the Association of Pakistani Physicians of North America, or other networks. The interplay between the visionary second-generation American and indigenous organizations and the initiatives of first-generation American physicians is symbiotic, mutually reinforcing and cross-fertilizing. Each trajectory represents the emergence of Muslims into public health activism in a visible way, a movement gaining both momentum and coordination in the past decade.

"I've been in practice like 30, 35 years. I know the plight of the uninsured. I used to work at Columbus Hospital and Catholic Hospital. ... That clinic used to see people uninsured, a lot of Mexican migrant farm workers used to come there, uninsured. We charged them what they can afford. ... And a lot of them went free. So I like that; I used to go to the church from there with them to do screening and just help."

—Dr. Ayesha Sultana, CCN secretary

"The founders had seen a need to serve the indigent – medically indigent population of Los Angeles, and the underlying ... backdrop behind all of this was the Muslim faith. In Islam we were taught that you're supposed to basically serve the underserved and provide them with the [necessities] that they're not provided with. And with the medical education it just seemed like a perfect fit that you ... use your training to help those who can't afford medical care. ... That was probably the ideology behind starting a clinic. I mean just at a very basic level to help those in need."

—Dr. Raziya Shaikh, former UMMA Community Clinic manager

The majority of these organizations arose organically as Muslim professionals aimed to use their personal assets in ways that addressed the unmet needs of others.

Their awareness emerged from their experiences as Muslims in the United States as well as from the challenges in their regular medical practices and professional networks that were related to the mushrooming numbers of uninsured and underserved people. They share motivations to “give back” that derive from Islamic values and immigrant success, as well as a desire to put professional skills to use for the common good in the name of Islam.

Financial Support

In terms of financial support, nearly every MCBHO described here received grants from city, county, state or federal government sources and has relied on non-Muslim charitable foundations in addition to donations from local or national Muslim organizations. Many began with donations from local Muslim organizations and moved towards business plans that require grants from state and other organizations as well as limited fees for service or memberships.

The most successful organizations, such as UMMA and Ibn Sina, have diversified funding streams. UMMA, for example, was initially funded by a university and then through a U.S. Department of Housing and Urban Development grant and donations from the Muslim community. Today both UMMA and Ibn Sina receive funds from grants, third parties, private donors, managed care groups and government contracts.

In recent years, these two clinics have progressed toward designation as Federally Qualified Health Clinics (FQHC). A designation as a FQHC “Look-Alike” clinic means that the clinic is eligible for Medicare and Medicaid reimbursement, may purchase drugs at reduced prices, may receive vaccinations for children and may qualify for other federal grants. Designation as a full-fledged FQHC brings in PHS 330 grant funding, up to \$650,000 (Rural Assistance Center 2007). Such success in securing public funding may, however, come at a price to the religious identity of the organization, as discussed below.

“I am not a medical professional. I’m a business professional. ... Not just the Muslim community, but our community needs it. You know, 45 million of my brothers and sisters are uninsured, and I have an opportunity to help them. A little way. Just a little way. If I help five people a week, I am delighted.”

—*Rafique Jangda, Shifa Clinic Houston director*

“The story of UMMA is basically ... ‘Hey, there’s a need out there in underserved communities!’ We as American Muslims need to make a difference. We want to make a difference.”

—*Dr. Rumi Cader, UMMA Community Clinic medical education director*

Services Offered and Organizational Models

The 10 MCBHOs described here are based on a range of vision and mission statements. Just over half were started by Muslims to, at least initially, address health care needs within Muslim communities.

NISWA was formed “to address the welfare needs of the Muslim community,” specifically responding to the lack of adequate shelter and counseling for South Asian and Middle Eastern immigrant women who were victims of domestic violence. This organization has since expanded to address foster care, adoption, refugee resettlement, interpreter services, and youth and senior services in a broader range of immigrant communities, predominantly but not exclusively Muslim (NISWA 2007). MFS similarly aims to serve the unique needs of Muslims by “building strong family structures, promoting healthy marriages, helping reduce divorces, eradicating domestic violence, and providing emergency assistance” (Muslim Family Services 2007). Located in an economically depressed African-American neighborhood in inner-city Detroit, the agency provides emergency assistance and basic counseling for many non-Muslims as well.

Houston’s Shifa and Ibn Sina clinics and Chicago’s CCN also emerged within ethno-religious enclaves to address the lack of health care access and insurance amongst their own communities, but they each envisioned expansion to serve all underinsured and uninsured populations from the beginning. Dr. Muhammad Gafoor, vice-president of CCN explains the large percentage of Muslim patients in the network by remarking, “[The Islamic centers are] where we had our screening thing. ... We go there, we find out the people don’t have any insurance. They are trying to get by with their daily living. But they don’t have the insurance, they cannot afford it.” MCBHOs like these emerged organically from physicians whose contact with newer immigrants in their own Muslim communities led them to find immediate practical solutions; later, these groups evolved into full-fledged public health initiatives for the broader community.

The remaining organizations in the sample, UMMA, Al-Shifa Clinic of San Bernardino, IMAN Health Clinic, and HUDA, were started as Muslim organizations but served predominantly non-Muslim patients from the very beginning. As UMMA medical education director, Dr. Rumi Cader explains, “The story of UMMA is basically ... ‘Hey, there’s a need out there in underserved communities!’ We as American Muslims need to make a difference. We want to make a difference. We want to show that American Muslims care about our local folks that are not as, you know, well off.” He drives this point home by exclaiming that the doctor-to-patient ratio in South Central LA is lower than in most of Africa. After the Los Angeles riots of 1992 exposed the economic disparities, ethnic divisions, and health crises in this part of the city, local Muslim medical students felt called to respond with the talents, training and resources they had available. All of the organizations in this sample now serve Muslim and non-Muslim patients, with the fraction of non-Muslim patients ranging from an estimated 10 to 20 percent at MFS in Detroit to 95 percent at UMMA in Los Angeles.



Table 1: Basic Overview of Organizations

Name	Year Founded	% Patients Muslim	% Providers Muslim	Hours/Days Open	Services Offered
NISWA (Harbor City, California)	1990	Most	Most	As Needed	Helpline, domestic violence shelter, advocacy
University Muslim Medical Association (UMMA) Community Clinic (Los Angeles, California)	1996	Less than 5%	Mixed	9am-5pm Tue-Sat	Primary care/some specialties, health education, pharmacy assistance program
Shifa Clinic Houston (Houston, Texas)	1997	80-90%	90%	10am-3pm Sat	Primary care, eye care, health education
Muslim Family Services (Detroit, Michigan)	1998	Most	100%	Unknown	Mental health counseling, marital counseling, education, foster parenting, advocacy, financial assistance
Al-Shifa Clinic (San Bernardino, California)	2000	Less than 5%	100%	20 hours/week	Primary care/some specialties, dental and eye care services, health education
Ibn Sina Foundation Clinic (Houston, Texas)	2001	52%	80%	Main: 9am-6pm Mon-Fri, 9am-1pm Sat Clear Lake: 4-9pm daily	Primary care/some specialties, health education, diagnostic/laboratory services, pharmacy assistance program
Inner-city Muslim Action Network (IMAN) Health Clinic (Chicago, Illinois)	2002	Less than 5%	100%	11am-3pm Sun	Primary care, health education
Compassionate Care Network (Chicago, Illinois)	2004	70%	90%	Varies	Medical screening, referrals to doctors in network, access to affordable prescription services
Health Unit on Davidson Avenue (HUDA) Clinic (Detroit, Michigan)	2004	Less than 10%	Most	10am-2pm Sat	Primary care, outpatient screenings, health assessments, social services
Zaman International (Detroit, Michigan)	Unknown	Unknown	Unknown	As Needed	Relief services, infant burial services, end-of-life care

In addition to variation in their patient populations, these organizations vary in the types of services they offer to patients. Some offer a narrow range of specialized mental health services (MFS and NISWA), relief and infant burial services (Zaman International) or primary care/dental referral options (CCN). Most offer a wider range of primary health care services, though the larger clinics include additional services. For instance, UMMA Community Clinic emphasizes adult family medicine but also offers complete lab services; HIV tests; medications; and specialty clinics in pediatrics, ophthalmology, gynecology and dermatology (UMMA Community Clinic 2007). Ibn Sina Foundation Clinic offers the widest range of specialty clinics, including cardiology, ophthalmology, dermatology and podiatry; and additional services, such as digital X-rays, echocardiograms, stress tests, ultrasounds, weight loss management, birth control, complete lab services, mammograms, eye exams, sports physicals, drug tests and electromyography (Ibn Sina Foundation 2007).

Primary care is the main focus for most of the MCBHOs providing medical services, with emphasis on treatment for diabetes, hypertension and cholesterol as well as, in some cases, immunizations, eye exams and dental care. Negotiating diagnostic testing, pharmacy services and specialty referrals has required a great deal of creativity and management skill at many clinics and has happened often after the clinic has been in operation for a few years. Ibn Sina, for example, has accumulated a number of diagnostic service capabilities and uses these for patient convenience. Since personnel costs are low, Ibn Sina can offer these diagnostic services to the community at a lower cost than that of its competitors, thus attracting more business and helping to subsidize its basic primary care services.

Most of the clinics have either a formal arrangement with pharmaceutical companies, whose patient assistance programs (PAPs) provide free medications, or informal relationships with Muslim clinicians who donate samples. PAPs require considerable administrative coordination to ensure continuity of supply to patients with chronic conditions, and some clinics have employed or recruited volunteers from local pharmacy schools to administer these programs. Others rely on volunteers to solicit drug sample donations from local physicians; though maintaining consistent supplies remains a significant challenge.

Different Service Models

The first model is the free-standing clinic model: UMMA, IMAN Health Clinic, HUDA, Ibn Sina, Shifa Clinic Houston and Al-Shifa Clinic in San Bernardino offer either free or considerably reduced-cost health care for the needy, targeting particularly those who cannot afford health insurance. These clinics differ in terms of their physical location: HUDA, Shifa Clinic Houston and Al-Shifa Clinic in San Bernardino are on the grounds of a mosque; UMMA and Ibn Sina are located in stand-alone commercial facilities; MFS and IMAN Health Clinic are part of larger service centers. They differ in the degree to which they serve a Muslim clientele: Ibn Sina and Shifa Clinic Houston have larger proportions of Muslim patients than the others. And they differ in the business models they have adopted. Ibn Sina, for example, requests a \$25 fee for a primary care visit and \$35 to \$40 for a specialist, while Shifa Clinic Houston requests an optional \$20 donation. Both clinics will waive the fee or donation if the patient is unable to pay.

Others, like Al-Shifa in San Bernardino, insist on no fees or donations from patients, seeking public and private grant funding and donations to cover operating costs. Nevertheless, providing referrals to specialists or to diagnostic services often means that patients must rely on insurance or public assistance, or pay out-of-pocket to other health care providers in the private or public system.

The second model is the network model, represented by CCN and, to a lesser extent, by NISWA, which aims to connect clients with service providers at no or low cost but does not include the creation of a separate clinical facility. NISWA's services do include a domestic violence shelter, but most of its health services are based in a network of providers. CCN enlists a network of 83 health care providers who volunteer to set aside a certain number of office hours in their private practices in order to provide primary care services for CCN subscribers. Subscribers pay a monthly fee (\$5 individual, \$10 family); they are assigned a network provider, primarily based on geographical considerations; and they agree to pay \$25 to the provider for each visit.

CCN contracts with laboratory services and some diagnostic services for reduced costs to network members. A few of the providers in the network insist that they do not accept the fee for services. Others have reportedly complained that the distribution of patients among the network providers is uneven (the complaint often being that they receive none), a problem that may be partially explained by the geographical distribution of providers' offices. CCN provides regular preventive health screening and health promotion events in local mosques, Islamic centers, churches and community centers, at which time they recruit both providers and patients to the network. The financial advantage of the network model is that the costs of facility maintenance, liability insurance for providers and medical equipment and supplies are eliminated by relying on existing private clinics and clinicians. The service advantage is that, when brought up to scale, the network can serve a wider geographic area than a stand-alone clinic. The network itself remains rather invisible and can subsidize preventive health screening and public health advocacy.

Muslim Identity in MCBHOs

In addition to identifying the organizational aspects of these groups, we aimed to understand how the leaders identify their efforts as "Muslim" and the range of forms and axes along which their Muslim identity operates. Our qualitative data suggests that the majority of MCBHOs serve the primary health care needs of the general uninsured urban population in each city. They are, thus, fruitfully considered to be faith-based participants in the "primary health care for all" movement that includes a range of community health clinics and free clinics. Those with predominantly Muslim clientele have suggested that Muslim immigrants are much like other immigrant populations in the United States and face language, culture, insurance and other barriers to accessing mainstream health care.

The "culture match" between Muslim providers and Muslim clients nevertheless enables these MCBHOs to provide comfortable, culturally and often linguistically appropriate care for particular underserved populations. Several interviewees mentioned gender matching of provider and patient as well as respect for modesty as concerns of Muslim patients that their clinic or organization attempts to address. Leaders at NISWA and MFS expressed the need to help Muslim leaders and clients interpret Islamic traditions concerning marriage and gender relations, domestic violence and mental illness, in particular, and to work on ways to integrate psychological therapy and social services with traditional interpretations and practices. Those whose agencies primarily attended to physical health often expressed concern that Muslim immigrants and religious leaders needed to learn the value of preventive medicine and regular health maintenance.

Open to Everyone

In this respect, many who provide health care services in MCBHOs do not distinguish themselves from other free clinics or networks. They describe each organization's Muslim identity as largely incidental, deriving from the nominal identification of the majority of providers, and sometimes the clientele, as "Muslim." The organization may have been founded by and may be run by Muslims, Muslims may make up the majority of volunteers, and the services may be provided on the grounds of an Islamic center, but all of the medical services are "open to everyone."

Dr. Ayesha Sultana emphasized that CCN holds health screenings in Nigerian and Spanish churches and at the Indian-American Center where Hindus come, adding, "I think all religions say to serve another human person." Several physicians pointed out in various ways that their professional commitment and oath required the best service for everyone and the rejection of any form of religious exclusivism.

For instance, Dr. Azam Kundi of Shifa Clinic Houston remarked, "My health care advice is based on evidence-based medicine, purely. It has absolutely nothing to do with religion. None whatsoever.... I preach health care when I'm with a patient. I don't preach religion when I'm with a patient." Most MCBHO leaders also pointed out that many non-Muslims had served as volunteers for various aspects of their organizations' work. In order to emphasize their ecumenism, many of the physicians involved in MCBHOs cite their current or past professional affiliation with a Christian or Jewish hospital or clinic. Several Muslim physicians indicated that they had volunteered in Christian or Jewish clinics as well.

Catholic and Jewish Health Care Institutions as Models

One aspect of this discourse worthy of further attention is the frequent mention of Christian (especially Catholic) and Jewish health care institutions as models. Dr. “Shaykh” Ali Suleiman, director of MFS mentioned that Muslims in the Middle East and elsewhere do not have independent, faith-based social services and counseling. “So we say let us copy ... Christians and Jews. They have this, they [have established] these kind of services for long time. So we said, ‘let us do it.’”

The implication of many of these statements seems to be that the Muslim religious minority is now following in the footsteps of religious minorities who have joined the “mainstream” of American culture via their involvement in health care.

As Dr. Mohamed Aslam of Al-Shifa Clinic in San Bernardino expressed, “I think Muslim people feel that their participation in the local communities, to help the local communities, is also important. Not to remain isolated, [but] to become part of the mainstream.... When somebody invites you to come to a party, you have to bring something.” The theme of the Shifa Clinic Houston June 2007 fundraiser was “A clinic today, a hospital tomorrow,” a vision echoed by Dr. Rumi Cader of UMMA and others. Shifa founder, Dr. Moien Butt, sees the ecumenical approach of Christian hospitals as a blueprint for the future of his clinic. “The future growth of it is dependent on being [multicultural], multi-religious, multi-everything. St. Luke’s Hospital is called St. Luke’s Hospital. It doesn’t cater to Episcopalians [even though] it’s the St. Luke’s Episcopal Hospital in Houston. The Methodist Hospital doesn’t cater to Methodists only. And neither will Shifa Clinic cater to Muslims only. It should develop along those lines. You maintain an identity, which is absolutely fine, but that doesn’t mean that you exclude anyone else from it. ... I believe that’s the model that I would like to follow also in this clinic.”

Jewish and Catholic hospitals emerged during times when minority religious physicians were denied jobs in public and Protestant-dominated hospitals and when minority religious patients received substandard care. The story of their development may offer both contrast and comparison with the situation of Muslims in the United States today. While one could argue that culturally competent care for Muslims in mainstream institutions is inadequate and that the health effects of societal discrimination are little understood (Laird et al. 2007), Muslim physicians are employed in many prestigious mainstream public and private health care institutions today.

Several MCBHO leaders also hope to use their organizations to nurture a new generation of Muslim youth, from high school through medical residency. When we visited Shifa Clinic Houston, more than a half dozen high school students were greeting patients, working the computer and phone, organizing files, and guiding patients to exam rooms. The director, Rafique Jangda, commented, “We want it to be a place where we can serve the community but

“The future growth of it is dependent on being [multicultural], multi-religious, multi-everything. St. Luke’s Hospital is called St. Luke’s Hospital. It doesn’t cater to Episcopalians [even though] it’s the St. Luke’s Episcopal Hospital in Houston. The Methodist Hospital doesn’t cater to Methodists only. And neither will Shifa Clinic cater to Muslims only. It should develop along those lines. You maintain an identity, which is absolutely fine, but that doesn’t mean that you exclude anyone else from it. ... I believe that’s the model that I would like to follow also in this clinic.”

—Dr. Moien Butt, Shifa Clinic
Houston founder

“We want it to be a place where we can serve the community, but also serve the volunteers here: offer them training as to how to act in a business environment, how to answer the phone, how to receive the patient. ... These young people need to learn these techniques, so when they go into the world ... they are prepared for it.”

—*Rafique Jangda, Shifa Clinic Houston director*

also serve the volunteers here: offer them training as to how to act in a business environment, how to answer the phone, how to receive the patient. ... These young people need to learn these techniques, so when they go into the world ... they are prepared for it.”

Jangda also seeks to integrate his clinic with a major medical school, like Baylor, as a part of the students’ residency rotation in community medicine. For UMMA Community Clinic, this integration is essential to their vision. Dr. Munaf Kadri, chair of quality assurance, passionately argues that “unless you are a part of a teaching institution, you become [merely another] clinic.” It may not be the most efficient way to run a clinic, but there is no future without “actively bringing in new people.” As part of their commitment to the mission of Muslim health organizations, UMMA and Shifa Clinic Houston leadership, as well as volunteers at CCN, expressed the desire to cultivate among Muslim students this sense of “giving back” by encouraging their participation in charitable work in the United States.

Muslim Community Health Organizations and Identity in the Post-9/11 Era

The issue of Muslim identity is particularly pressing for many organizations because of the current sociopolitical environment, which many referred to as “post-9/11.”

Many interviewees were quick to point out that involvement, whether their own or their MCBHO’s, in community-based health in the name of Islam predated 9/11. Most leaders maintained that the missions and visions of their MCBHOs were strictly health-related, nonsectarian and nondiscriminatory. At the same time, most acknowledged that providing a positive example of Muslim faith in action and “reaching out” to non-Muslims were among their motivations as well as an important side effect of the MCBHOs. In most cases, leaders articulated their explicit rejection of proselytizing, while expressly endorsing the idea that they and their organizations were “representing Islam” and providing a highly visible example of “what Islam is all about.”

“

I think a lot of people look at Muslims as coming here, benefiting but not giving anything back. Not really being integrated into society. They wanted to show that we are a greater part of American society. We are not some subculture or something like that. In order to do that, I think it is important to get involved in the nitty-gritty of society. You can't get any nitty-grittier than this.

”

—Yusuf Qamruzzaman, HUDA Clinic student volunteer

“

My health care advice is based on evidence-based medicine, purely. It has absolutely nothing to do with religion. None whatsoever. ... I preach health care when I'm with a patient. I don't preach religion when I'm with a patient.

”

—Dr. Azam Kundi, Shifa Clinic Houston

Different Expressions of “Muslimness”

The ways in which each MCBHO demonstrates or publicizes its Muslim identity vary quite widely among the organizations studied. One of the most striking contrasts, though certainly not the only one, is the one between UMMA and Al-Shifa of San Bernardino. The UMMA Community Clinic has “Muslim” in its name, prominently displayed alongside a crescent and star on the signage in its South Central Los Angeles neighborhood. The physical space inside the clinic is lined with quotations from the Qur’an and Sunnah in Arabic with English translation. Partly as a result of its success as a community medical center, however, the majority of the governing board is now non-Muslim, and all of the paid clinical staff, including the medical director, are non-Muslim.

In contrast, the stark white and green mobile unit that houses Al-Shifa stands on the grounds of a mosque that is home to a largely South Asian Muslim community in a predominantly Hispanic and African-American neighborhood. Besides the Arabic name, recognizable only to Muslims as a religious moniker, there is no indication inside or out that this clinic is a Muslim space. The board is entirely Muslim, and the physician volunteers are all Muslim, and they are very committed to maintaining the Muslim identity of the institution. Administrator Mr. Saab, however, disclaimed immediately, “We do not mention Islam here.” The physical space and personnel choices demonstrate subtle (and not so subtle) differences in how Muslim identity is expressed and maintained in these organizations.

Leaders often describe the “Muslimness” of the organizations as more circumstantial than intentional. The organizers utilize existing Muslim networks, from Islamic centers and regional councils of Islamic organizations to professional organizations (e.g. APPNA, IMANA, AMHP, and their local versions) for a number of reasons: to recruit volunteer clinical staff, to solicit donations and to recruit patients. A few of our interviewees admitted that they themselves were “not very religious,” while many others insisted that religious identity and practice was personal and not relevant to service in their organizations. Many insisted on the total independence of their MCBHO from any mosque or official Muslim organization, though some MCBHOs were subsidiaries to other Muslim organizations (e.g., IMAN Health Clinic, MFS, Shifa Clinic Houston). Even those who were adamant about their clinic’s professional autonomy nevertheless touted cordial and supportive relationships with particular imams or mosques that were crucial for their organizations’ success.

Role of Private and Public Funding

The other side of the identity issue is often raised when public or private funds come with strings attached. The restructuring of UMMA’s governing board was a requirement for receiving Federally Qualified Health Center (FQHC) status, in that the majority of board members had to be drawn from the community served rather than the “community” providing the services. Ibn Sina Foundation Clinic is also pursuing FQHC status; but through aggressive recruitment of patients from within a dense South Asian immigrant population in southwest Houston, the majority of their “community served” remains Muslim. The clinic also collaborates with the State of Texas to offer free pediatric services through Title V funding. As the ethnic and religious character of the patient population has begun to shift, however, the Ibn Sina Foundation, as its director explained, has already decided to export its model to other underserved communities in Austin, Dallas and Atlanta.

Public funding for the provision of social and clinical services by religious organizations is often associated with a differentiation between the “religious” and “secular” missions of an organization, a separation that is already present in many of these MCBHOs but not in others. It is interesting to note that Adil Najam, in his national study of the philanthropic giving of Pakistani-Americans, found that those religiously motivated to give financially or to volunteer for charitable organizations often preferred to give to nonreligious, issue-based organizations (Najam 2006).

“Our approach is that when we come to them we’re spiritual, we’re trying to heal them and treat them. ... We feel an obligation about it, to give back. To give to charities, to help the wayfarer, or those in need without their asking. And so that’s the motive.”

—Catherine Ziyad, HUDA Clinic social worker

“I think, based on the charitable nature of the people and charity being one of the tenets of our religion, we believe that we have to be charitable to [our] fellow human beings.”

—Rafique Jangda, Shifa Clinic Houston director

“I think it satisfies the spirit of Islam. Islam is ‘do good and don’t do harm.’ And that’s the main ... the core of the Muslim faith. ... We are doing exactly what the Muslim faith is asking us to do.”

—Dr. Yasser Slayyeh, Al-Shifa Clinic board member

“And I think that the board members – the people who came up with Compassionate Care Network – their own understanding of Islam has everything to do with the value of giving back to society and being ... somebody who focuses on doing good works for the society, and those good works are defined as activities and efforts that benefit the people around you. So you have to identify the needs of society and then apply some sort of remedies for those. You can’t just sort of walk on this earth and live your life and take and take and then that’s the end of it. Part of your responsibilities is to take care of the people around you. So I think that’s a very basic concept that kind of fuels a lot of the work.”

—Dr. Asfia Qaadir, CCN volunteer coordinator

Despite the disclaimers about how the services provided were not different from those of other professional health care organizations, many providers described how the voluntary nature of their service was shaped by Islamic moral values. By removing the financial incentives from patient care, many felt the freedom to practice a “purer” form of medicine, characterized by attention to the whole person and the absence of time pressures. Compassion, charity, honesty, and humility were frequently mentioned as Islamic values that distinguished their MCBHO from mainstream health care settings.

“There’s an inherent value and worth in every human being, regardless of his or her ideologies, beliefs, religion, and to serve those people – meaning all people – with the same quality of care is what I mean by incorporating Islamic belief and tradition. Especially those who are disadvantaged, special arrangements should be made for them in the Islamic tradition. ... Unfortunately, in the American health care system, I see ... the exact opposite. Those who have the money are able to afford the private insurance, etc., and get the care whenever and however they want it. But those who don’t, 45 million who are uninsured and even more are underinsured, can’t get the care that they want. And so that seems diametric to what Islam actually advocates. And so acting as Muslims in America who are able to actually form an organization that provides such care – [that] is what IMAN is trying to provide.”

—Hajira Saeed, IMAN Health Clinic student volunteer

Lessons Learned

Like free clinics in general, all of the MCBHOs described here have faced a series of challenges in their organization and operation. Several began as ad-hoc health screening activities in local mosques (e.g., CCN, Ibn Sina, Shifa Clinic Houston) and have struggled to learn the ropes of organizing professional health care services and navigating the world of nonprofit management. Clinic leaders have been challenged to find appropriate physical spaces, address staffing issues – particularly among volunteer physicians address liability issues, locate and maintain funding source and successfully partner with other organizations. The most successful organizations have networked effectively with other free clinics, with local political officials and academic institutions, and with other community- and faith-based organizations in order to develop effective business plans. The organizers of UMMA Community Clinic, for instance, utilized their affiliation with UCLA and Drew medical schools for community contacts, initial funding and management of the fledgling clinic. Board members visited the Venice Family Clinic and the LA Free Clinic to investigate models, and they received support from city councilors and congressional representatives for securing the physical space and the initial federal grant. All of these relationships have changed as the clinics have developed, but all continue to sustain the health of the clinics. Dr. Khowaja, director of the Ibn Sina Foundation Clinic, likewise drew on his experience with the Aga Khan Development Network in Pakistan for models of grassroots community organizing and fundraising. At Ibn Sina, relationships with key businesspeople in the local jama`atkhana (congregational worship center for Nizari Isma`ili Muslims) complement relationships with city officials and enable continued private and public funding for the clinic.

Particularly for the organizations operating in the clinic model, as is often pointed out by CCN founder Azher Quader, they demand physical space, dedicated staff and, usually, malpractice insurance. All the clinics have purchased or rented space, and many operated out of makeshift quarters for a considerable time. Shifa Clinic Houston, HUDA and IMAN Health Clinic now operate out of buildings that house larger Muslim service organizations, while UMMA, Ibn Sina, and Al-Shifa of San Bernardino have their own separate facilities. UMMA and Ibn Sina pay medical directors and some clinical staff while partially relying on volunteer physicians. The network model has significant advantages in this regard, as the space, staff and malpractice insurance burdens are borne by existing medical practices.

Recruiting and retaining volunteer physicians has been the single most consistent challenge among the organizations profiled here. Every organization we studied is fundamentally dependent on physicians to donate their time, skills and often other resources to the mission. The handful of physicians who set up an organization usually begin with their own religious and professional networks to recruit volunteers, and most meet with both interest and resistance. The Muslim Physicians of Greater Detroit is a significant source of HUDA volunteers; the Muslim Student Associations in LA have been a source of volunteers for UMMA; mosques in the San Bernardino area provide physician volunteer recruitment networks for Al-Shifa of San Bernardino; the Islamic Society of Greater Houston and the Muslim Health Professional Society provide support and volunteers for Shifa Clinic Houston; the local jama`atkhana supply nearly all the volunteers for Ibn Sina Foundation Clinic, etc. Nevertheless, several organizations reported that they had closed down for days or weeks due to lack of an attending physician; and most others have stretched their most committed attendings very thinly.

The retention of volunteer physicians has been negatively affected by a lack of organization and professionalism at some of the sites. Some organizations have struggled to make the transition from an ad-hoc group of well-intentioned physicians to an organization with a reputation for high quality care, reliable documentation, adequate supplies and well-trained support staff – a transition that has taxed the patience of some physicians. Leaders of Shifa Clinic Houston and IMAN Health Clinic speak frankly of their struggles to reorganize and streamline administration, as well as their problems with physician recruitment and retention. Other clinic leaders report that volunteer physicians are sometimes turned off when they perceive that insured patients are abusing the free or low-cost services.

Apart from their personal experiences at the clinics, one of the biggest obstacles for physicians providing volunteer medical services in a free clinic is fear of exposure to malpractice lawsuits. As different state laws govern malpractice insurance, the clinics we studied have a variety of arrangements for coverage, and some are still in the process of clarifying these.

One creative response to the limited supply of physicians has been to incorporate Muslim medical students and academic medical centers into clinic operations. UMMA Community Clinic began under the auspices of academic medical centers, and many of its founders continue in academic medical careers. Dr. Munaf Kadri emphasized that accountability to these institutions and to the education of medical residents has pushed UMMA to maintain the highest professional standards of care and documentation. Medical students and residents also play a less formalized role in HUDA Clinic and CCN, and Shifa Clinic Houston is aspiring to be a teaching affiliate. Again, the choice to affiliate brings an additional layer of regulation and the potential of greater involvement of non-Muslim providers in the efforts, involvement that most of these organizations welcome in principle.

Mentoring Muslim college students is one way to cultivate volunteers for the long-term stability of these charitable medical services. When the organization's services require highly professionalized care, computer systems and fundraising efforts, student volunteers may be more difficult to integrate, an issue with which UMMA's Dr. Cader is now wrestling. Ibn Sina has a highly efficient recruitment and training system for its volunteers in collaboration with the local Aga Khani (Nizari Isma'ili) jama'at khanas. While several organizations, like Al-Shifa of San Bernardino, remain entirely staffed by volunteers, most have opted to hire at least an administrator, and others have hired a medical director or nursing staff to ensure quality of care and continuity of coverage. Some organizations have initially financed these positions through specific grants or special allocations of state, county or local funds for medically underserved communities.

Broader Implications

The history and development of MCBHOs as outlined here has implications on numerous levels. For the founders, staff and patients of these organizations, this report helps to better situate individual organizations within the range that exists in these four cities and may point to strategies regarding staffing, physician recruitment, funding, identity negotiation and services offered that may inform future decision making. Organizations designed via the clinic model may identify ways to include aspects of the network model, perhaps via referrals to specialists, while organizations following the network model may see the benefits, perhaps in the range of services, of some of the clinic models.

Existing MCBHOs might begin to think about their challenges in funding, physician recruitment and the next generation of leadership as not their challenges alone but shared among a range of similar organizations. By recognizing the degree to which challenges like donor fatigue, volunteer fatigue, the shifts in public policy in relation to health care, insurance coverage for physicians and patients, and the changing relationship between government and faith-based organizations are shared not only by MCBHOs but by all free clinics, leaders of existing MCBHOs might further reach out and work with likeminded organizations when policy matters are being considered by local, state, and federal governments.

New and developing MCBHOs may see in these examples best practices, as well as practices and models they would prefer to avoid, based on their specific location, goals and resources. By recognizing the challenges around physical space, funding, physician and staff recruitment, donations of equipment and pharmaceuticals, etc., these newly forming organizations might learn from those before them and develop networks with these groups or with funders and other community partners early on in the process that will save them time and difficulty in the long run.

Local, state and federal health care policy-makers might first recognize in these organizations a new set of health care providers on the American health care landscape. In future policy analyses or when making decisions about funding, policy-makers might investigate how these organizations reduce the public financial burden of emergency room usage and other forms of primary care in the neighborhoods and cities where they operate. The cost effectiveness of MCBHOs might also be compared to the cost effectiveness of other religious and secular free clinics to determine what the most effective and efficient ways of providing services are. Because they rely largely on volunteers (and in some cases private donations), MCBHOs and other free clinics likely provide better health care at less cost than many other forms of primary health care providers, a possibility this research sets the stage to investigate further.

In addition to containing costs, policy-makers might consider analyses that would examine health outcomes among the people who use these clinics, perhaps most importantly those who receive screenings and other forms of preventative health services that they would not otherwise be able to afford. These clinics are likely to be particularly good at locating and serving the underserved, especially low-income people of color who live in urban areas and recent immigrants who might not otherwise access health care services. Not only is it likely that these organizations reach these individuals, but by being located in their neighborhoods, the organizations may also be able to establish a degree of rapport and trust that could, over time, lead to better health care usage and better health. For these reasons, states might consider working with these MCBHOs and other free clinics to provide low-cost primary care, screening services and pharmaceuticals, which might reduce Medicaid costs that influence state budgets. For more information about these general issues, see Weiss's study, *Grassroots Medicine: The Story of America's Free Health Clinics* (Weiss 2006).

Conclusions

The MCBHOs in Chicago, Detroit, Los Angeles, and Houston provide a significant window into American-Muslim activism in public health. In offering a range of models for providing care to underserved populations, both Muslim and non-Muslim, these organizations are following in the footsteps of faith-initiated hospitals and clinics that came before them. Pioneering MCBHO models, like NISWA's domestic violence shelter and services, UMMA and Ibn Sina's freestanding clinics and CCN's network of providers, have helped solidify American Muslims' civic role in their communities and are already being reproduced elsewhere. Each of these new organizations will face unique challenges in different local political, religious and medical environments – but they also bring unique assets to the table for improving care. Muslim health care professional organizations are already serving as networks for the discussion and dissemination of these MCBHO models throughout the country. Dialogue and coordination with other faith-based health initiatives and with policy-makers may enable greater success.

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Appendix A. Interview Protocol

We are asking approximately 60 Muslim health care leaders to participate in an in-depth interview lasting 60 to 90 minutes. If you agree, we will ask you questions about the development, mission, challenges and visions for your community-based initiative and how Islam or Muslim identity influences each of these.

Your participation is voluntary, and you may withdraw from the interview or the research project at any time, without penalty. You may opt to keep all or part of the information you provide during the interview confidential. With your approval, we will tape-record the interview. Please let us know if you would like to review the transcript for accuracy.

Background

1. To start, can you tell me about the history of your organization?
2. How was it set up as an organization and how has it evolved? (probe for organizational models; whose work or which organizations inspired you?)
3. What is the organization's vision statement? Goals?
4. How did you come to be involved in the organization and in what capacities?
5. How is the organization funded?

Relations with Muslim constituents

6. To what extent was the organization started as a response to the needs of Muslims v. non-Muslims?
7. In what ways does the organization associate with Muslim religious organizations (mosques, student associations, other groups) as part of its work? (e.g., Are these organizations funders, directors, outreach or treatment sites, or sources of patients?)
8. How has it responded to Muslim patients/physicians/health care workers v. non-Muslims in your geographic area?
9. What fraction of the organization's patients, staff, physicians are Muslim?
10. What kinds of physical spaces, personnel or programs does the organization have to specifically interact with the Muslim community? Why is it important for the organization to do this?

Organizational identity issues (i.e. Muslimness)

11. How do you think the needs of Muslim patients are similar to and different from the needs of non-Muslim patients?
12. How do these needs vary between Muslims in this community (ethnicity, sectarian affiliation, SES, immigration status, etc.)?
13. How has the organization tried to respond to these needs?
14. How have other non-Muslim groups in the area tried to respond to these issues, if at all?
15. As a Muslim organization, how do you operate differently from non-Muslim organizations (things you do and don't do because you are a Muslim organization)?
16. What does it mean to be a Muslim health care organization?
17. Is there something uniquely Islamic about the way health care is offered at your organization?

Conclusions

18. What have been some of the organization's biggest successes and failures?
19. With unlimited resources, how would the organization provide health care for the people it serves?
20. Would you consider your organization a model for other Muslim communities? Other health care institutions? Why or why not?
21. Have you seen any changes in how Muslims relate to each other or to the larger community since your work began?
22. AMHP's vision is "to be a leader in improving public health, through efforts inspired by Islamic tradition." How do you interpret what this statement means, in light of your own organization's experience?

About the Institute for Social Policy and Understanding

The Institute for Social Policy and Understanding (ISPU) is an independent and nonprofit organization committed to solving critical social problems in the United States through education, research, training and policy analysis. ISPU provides cutting-edge analysis and policy solutions through publications, public events, media commentary and community outreach. Major areas of focus include domestic politics, social policy, the economy, health, education, the environment and foreign policy. Since our inception in 2002, ISPU's research has worked to increase understanding of key public policy issues and how they impact various communities in the United States with an emphasis on issues related to the American-Muslim community.

U.S. society is far from being monolithic, whether culturally, socially or politically. It is therefore imperative that the thoughts and insights of each aspect of this heterogeneity play a contributory role in the discourse and debate of issues that affect all Americans. ISPU was established and premised on this idea – that each community must address, debate and contribute to the pressing issues facing our nation. It is our hope that this effort will give voice to creative new ideas and provide an alternative perspective to the current policy-making echelons of the political, academic and public-relations arenas of the United States.

ISPU firmly believes that optimal analysis and treatment of social issues mandates a comprehensive study from several different and diverse backgrounds. As social challenges become more complex and interwoven, ISPU is unique in its ability to bring this new approach to the human and social problems facing our country. Through this unique approach, ISPU will produce scholarly publications, incorporating new voices and adding diversity to the realm of ideas. Our multi-disciplinary work in partnership with universities and other research institutes serves to build understanding and create programs that effect lasting social change.

Further information about ISPU can be obtained from our Web site at www.ispu.org

About the Association of Muslim Health Professionals Foundation

The Association of Muslim Health Professionals (AMHP) Foundation is a nonprofit charitable sister organization of AMHP that is committed to increasing awareness of the importance of public health as a means to improving the overall health status of our communities. Established in 2007, AMHP Foundation strives to improve the health of Americans by identifying needs for research on the American-Muslim community. The organization seeks to collaborate with relevant organizations such as research institutions, academic centers, governmental entities, or policy-makers, in pursuit of its mission.

The views and opinion expressed in this publication do not necessarily reflect the position of AMHP Foundation and its Board of Directors.

For more information, please visit www.amhp.us



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