Promoting Muslim Community Health and Wellbeing: An Outline

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Preamble

Numerous verses in the Qur'an and authentic traditions of the Prophet, may Allah's peace and blessings be upon him, make it clearly incumbent upon the Muslim community to take good care of the not-so-fortunate members of the community, via formal (such as *zakat*) and informal (such as psychological support for the ill) mechanisms. By sincerely fulfilling this *wajib*, we are seeking to be dutiful to Allah, SWT, and to improve the bonding and strengthening the social fabric of our community. As our community evolves into further strength, compassion, and mercifulness, it will embody Allah's description of our Ummah as "*the best nation produced for mankind, enjoining what is right and forbidding what is wrong and believing in Allah,*" and will certainly be inviting for others to see what our faith really is and hopefully join it "*in multitudes*." As a relatively newcomer to Philadelphia, I see the community, with its impressive ethnic, cultural, and ideological diversity, as a microcosm of the worldwide Muslim Ummah. This uniquely representative makeup of our community adds an inescapable global dimension to the community improvement efforts that take place here, in such a way that ideas and initiatives the Muslim community collectively undertakes in Philadelphia may become a model for the Ummah elsewhere.

On the flipside, the repercussions of falling short of observing our collective duty, *fardh kafa'i*, to take care of our community have been lingering before our own eyes for years. Community fragmentation, bitter disagreement and exchanging blame amongst community groups, have led to declining social and economic conditions, for us all and especially for our brothers and sisters struggling to make their ends meet. This is letting alone that this internal disorder and failure to come together for the common good has created a not-so-positive community image in the mind of the larger society we live in, which is the primary subject of our *da'wah*.

In the following lines, I sketch out a long-term community improvement idea, premised on the social protections of our faith and centered around promotion of health and wellbeing. From my perspective, I think this effort, with sincerity and diligence, could trigger the kind of positive momentum we would like to see in our community. This momentum offers a hope to break out of this vicious circle of community inaction, resultant social, economic, and popular decline, and further tearing of the community social fabric, making community action even more difficult. In the following, any good is from Allah, SWT, and all the errors are mine.

The Problem

As of the 2012 data from the Household Health Survey of Southeastern Pennsylvania, two thirds of Muslims in the Region live in the City of Philadelphia, two in three Muslims are African American, and only one in three is immigrant. The Muslim community is relatively young, about 75% of Muslims are less than 45 years old. About 60% of Muslims live in or around poverty, with

total annual family income of less than $40,000, with high rates of reliance on public programs, such as food stamps and Medicaid. About 25% of Muslims have no health insurance, 30% report cost as a barrier to healthcare access, and about 20% have no access to healthcare whatsoever. About 30% of Muslims rely on the healthcare safety net, such as emergency departments and community health centers, to get the medical care they need. These numbers are much larger than the regional averages. Except for smoking which is more prevalent in the Muslim community, health indicators and prevalence of chronic conditions seem to be similar among Muslims relative to the rest of the region. These numbers should be understood in the light of data limitations (e.g. small sample size).

Overall, these numbers, besides our own anecdotes, tell us that there is a concentration of poverty and disadvantage in the Muslim community. Extensive research evidence has consistently shown us that poverty, financial strain, poor physical and social environment in the household and the neighborhood, and low community social capital and cohesion do in fact get under the skin and trigger poor health outcomes in individuals and populations. These "fundamental" risk factors, together with lack of access to culturally sensitive, well-coordinated medical care, promise even worse health outcomes. These factors are precisely the kind of conditions our not-so-fortunate brothers and sisters live through. With this broader understanding of the social determinants of health, we can readily see that health problems (such as heart disease, diabetes, psychiatric illnesses, etc) in the community are manifestations of the root social, economic, behavioral, and environmental problems. It stands to reason, then, that improving the health of our community in general and that of the brothers and sisters in our care in particular takes a concerted effort that is beyond mere provision of medical care. Besides improving our current health status, addressing the social determinants of health carries the added value of improving health outcomes for the future generation: our children and theirs.

Goals

In my view, which I hope we all would be sharing by now, improving Muslim community health can be achieved by addressing both medical care access and, more importantly, the fundamental, social determinants of health, as a long-term goal. Specifically, we need to build two inter-connected, horizontally reaching institutions to tackle this long-term goal:

I. A Muslim Social Services Unit, whose function would be to provide:
   a. Direct financial (and in-kind, such as food and clothes) assistance and counseling, from *zakat* and *sadaqat*, for eligible, indigent families. This function may be already provided by the Masajid. Providing this service within the Social Services Unit may offer more efficiency and also create the initial pool of clientele for the Unit.
   b. Job-related assistance, such as assistance with building resumes, career advice, and training in starting small businesses, building business models, and entrepreneurship,
   c. Assistance to sign up for public programs, such as unemployment benefits, food stamps, energy assistance, Medicaid and CHIP insurance, and other public benefits they may be eligible but not signed up for,
   d. Professional family and marital counseling, provided by specialized individuals who would also hopefully have Islamic knowledge

e. Foster care coordination for Muslim children who may have been separated from their biological parents (such as creating a network of Muslim families willing to take on Muslim foster children)
f. Assistance to refugee families
g. Activities to further enhance and support community integration and efforts to bring the community together.

II. A Muslim Mercy Clinic, which would provide:
a. Primary medical care and referral to specialists
b. Forge agreements with local hospitals and specialists to provide charitable care
c. Referral to and coordination with the Social Services Unit to address social and behavioral issues

These two institutions would work in tandem and each one can serve as the receiving end for the other, depending on the nature of services, though for primary prevention, we should be aggressively pursuing the Social Services mission. It is important to realize that although we might build on existing resources in our communities, such as federally qualified health centers (community health centers), the proposed model of service provision is distinct in two important ways:

- It emphasizes faith both as a conscious motivation and as a possible procedural component. For example, faith-based counseling should be an integral component of family counseling and health behavioral coaching (e.g. for smoking cessation and coping with stress). Even patients who get hospitalized may be targeted with faith-based visits by a special team of brothers/sisters, if they wish to receive this kind of support.
- It will rest on a horizontally branching network throughout the community, with Masjids as anchors for service provision. An example of this emerging structure would be to select (say) three primary Masjids (for example those located in areas of high need). These Masjids are the hubs for service provision (both health and social services) for their communities and also for neighboring communities. All other Masjids will have designated individuals who can receive, manage, and route cases to the closest "hub" Masjid.

Approach

It is clear by now that such ambitious goals require a host of tangible and intangible resources to be achieved. Here is a number of domains of action that I think we should think through and start working on:

- Needs Assessment: it is imperative to pursue a deliberate, systematic needs assessment to identify "hot spots" that need priority intervention and the frequency of these interventions. This assessment can be made more reliable through finer data collection.
- Community Survey: conduct a community-wide survey (starting with a pilot at Majidullah, for example) asking community members about the services they wish to see provided in the community and the frequency of these services. This survey can also have questions to assess more finely health status, healthcare access, and social and economic challenges in our

community. In addition to helping with needs assessment, this survey can help us define our target clientele and the package of services we should at least start with.

- Existing Efforts: Characterize, coordinate with, and help expand existing efforts, such as Al-Shifaa Health Screenings and Dr Farooq's Health Camp. One relevant way of expanding these efforts may be to have a volunteering social worker or public health specialist join their teams (I do have a Muslim volunteer who is willing to do so). After developing a list of preliminary sources of help with social issues, this person may be able to counsel people who attend the health screenings about their behavioral and social issues and possibly refer them to an appropriate source of help.
- Partnerships: successful, multi-stakeholder partnerships (that are not competitive nor exploitative) are critical for long-term viability of this effort. One central type of partnership is collaboration with other Masjids around the city, which can be gradually built as this effort expands and evolves over time. Further, we will need to build partnerships with other stakeholders and organizations that can help us better accomplish our goals, such as the local health department, community health centers, specialist offices, hospitals, police department, etc, as the need arises.
- Workforce: not surprisingly, in addition to medical care staff, we need to work with individuals ranging from local Imams and resident scholars to persons trained in social work and public health and bring them *all* up to speed on the mission and approach of this effort.
- Training: this is related to the workforce issue. In addition to having individuals who are knowledgeable of the subject matter related to their contribution (for example doctors providing screening, social workers providing counseling on social issues, persons signing people up for Medicaid or Obamacare), we need to train them on how to compassionately and nonjudgmentally work with our struggling brothers and sisters. Developing materials for our specific needs is thus an important undertaking.
- Learning from Other Experiences: Numerous communities around the country are building a culture of health in their local settings, with efforts similar to the one proposed here. It is important to learn from those experiences and use them as a guide for the planning and implementation of this project.
- Timeline: After thinking about these, and certainly other issues that I may be missing here, we need to come up with a timeline with milestones and concrete deliverables to follow, so that we do not lose track of what we are doing.

As a concluding remark, please feel free to comment on or critique these ideas. I sincerely ask Allah, SWT, to guide us all to the best for our community and use us and not replace us.