

Lance D. Laird

Boston University School of Medicine

Wendy Cadge

Brandeis University

Negotiating Ambivalence: The Social Power of Muslim Community-Based Health Organizations in America

This article analyzes three ways in which groups of socially and politically marginalized first-generation Muslim immigrants used the power of nongovernmental organizations (NGOs) to advance their interests in the United States. Specifically we examine the founding of nine Muslim community-based health organizations (MCBHOs) in Chicago, Detroit, Houston, and Los Angeles. We argue that MCBHOs (1) offer a vehicle for the expression and enactment of personal piety and self-fulfillment in ways that link traditional Islamic charitable values with American voluntarism, (2) mobilize middle-class Muslim values in American civil society in ways that normalize the difference of being Muslim in an Islamophobic environment, and (3) enable founders to mobilize the social and cultural capital of faith-based organizations to defensively enact American Muslim citizenship and belonging. Muslims, particularly those of immigrant origins, strategically deploy positively valued faith-based charitable and professional group identities through these NGOs to counteract their publicly stigmatized religious group identities. [Muslim-Americans, NGOs, religious organizations, citizenship, professional identity]

The Inner-City Muslim Action Network (IMAN, Arabic for “faith”) occupies a smartly renovated storefront on a busy street on the south side of Chicago. A group of Muslim students, community members, and leaders formed IMAN in the mid-1990s to respond “to the pervasive symptoms of inner-city poverty and abandonment” (IMAN n.d.). Led by a dynamic young director, Rami Nashishibi, the organization aims to be a “vibrant space for Muslims in urban America . . . inspiring the larger community towards critical civic engagement exemplifying prophetic compassion in the work for social justice and human dignity” (IMAN n.d.). Complementing IMAN’s activities in community organizing, Dr. Sherene Fakhran organized a clinic that offers free medical care to an underserved South Side community, in the name of Islam. Volunteer physicians and assistants, drawn from a pool of highly educated, middle-class, first- and second-generation immigrant professionals, provide access to basic primary care for all in the context of a complex U.S. health care system. Speaking about what she pointedly described as Islamic values of human dignity and worth, one medical student volunteer also described to us the collective Muslim

values of care and compassion she sees enacted when Muslims come together as Muslims to offer healthcare for all through this organization.

A growing body of anthropological literature describes the often ambiguous positions of nongovernmental organizations (NGOs), like IMAN, that provide services for poor and marginalized groups while simultaneously buttressing – or at least not challenging – neoliberal systems that keep people poor and marginalized. Examples from around the globe show NGOs filling gaps as they provide alternatives to fragmented states and plug holes in existing social service provision while simultaneously undermining the capacity of states to govern or to expand social service provision in ways that would challenge existing inequalities (Fisher 1997; Richard 2009; Schuller 2009). A wide range of case studies focus on how NGOs function as ambiguous actors in these situations as they mediate among the conflicting interests of local, national and international actors affiliated with and distant from such organizations (Bornstein 2003; Clark 2004; Karim 2001; Morsy 1988).

In the United States, many public services have been privatized and devolved as they are contracted to private third parties and spending decisions are transferred from federal to local levels (Marwell 2004). The role of religion in these organizations is also shifting with changing federal policies, as with Charitable Choice, and a number of recent court decisions (Sullivan 2009). In the health and medical sectors these processes are even more complex as public and private healthcare organizations are influenced by changes in national healthcare legislation, related state actions, and a patchwork of local organizations that seek to provide healthcare to people in need. Free health clinics like IMAN negotiate their own set of organizational ambiguities as they call attention to the failures of existing health care provision while simultaneously providing services to people in need. Some of their ability to provide these services depends on winning government contracts and securing funding from foundations in ways that give them little time (or impetus) to challenge broader structures of power (Weiss 2006).

This article focuses on the ambiguous position of one set of free health care organizations, Muslim community-based health organizations (MCBHOs). Encouraged by a movement during the mid-1960s in San Francisco, free health clinics in the “inner cities” provide services to the underserved through street, neighborhood, and youth clinics across the United States. While many organizations struggle to survive, Gregory Weiss estimates that there were 800 free clinics in the States in 2004 that, while providing health services, also called attention to the failure and gaps of the mixed-market, “health as individual responsibility” system that sets the United States apart from all other industrialized nations (Weiss 2006).

Muslim community health clinics are unique among free health clinics both in their religious dimensions and in the fact that they were started by a group of people, primarily first-generation Muslim immigrants, themselves subject to significant stigma in the United States. The motivations and marginalized position of the founders of MCBHOs led us to focus in this article on how these organizations serve the social, political, and cultural interests not of the people or contexts they serve – as is more common in studies of NGOs and power – but of the people who founded and work

in them. Specifically we focus on the leaders of these organizations to argue that the founders, staff, and volunteers in these organizations mobilize the power of NGOs to serve their own personal and communal interests in three ways.

First, MCBHOs offer a vehicle for the expression and enactment of personal piety and self-fulfillment, in ways that link traditional Islamic charitable values with American voluntarism. Charitable acts may be at the heart of Islam as these respondents argue, but charitable volunteerism has long been central to American civil society (Wuthnow 1998). Second, similar to Islamist clinics abroad, MCBHOs serve to mobilize middle-class Muslim values in American civil society in ways that normalize the difference of being Muslim in an Islamophobic environment. Third, MCBHOs provide the providers with access to power by mobilizing the social and cultural capital of faith-based organizations in order to defensively enact American Muslim citizenship and belonging. In other words, Muslims—particularly those of immigrant origins—strategically deploy positively valued faith-based charitable and professional group identities to counteract publicly stigmatized religious group identities. While MCBHOs may be in ambiguous positions vis-à-vis the American healthcare system broadly, this article demonstrates more narrowly how the organizations themselves provide strategies through which their founders and leaders negotiate their own identities as members of a marginalized group in the United States.

The Ambiguous Power of NGOs

Much recent anthropological research considers the ambiguous power of secular and religious NGOs around the globe. Drawing on the work of William Fisher (1997), Mark Schuller (2009) recently argued that NGOs in Haiti provide the “glue” for globalization, functioning as intermediaries between multinational funders, decision makers, and development experts, on the one hand, and, on the other hand, the local communities whose interests they ostensibly serve. Schuller (2009) argues that, in the name of humanitarian development assistance, NGOs fill gaps and provide alternatives to fragmented states, thereby undermining those states’ capacity to govern; he also points to how NGOs can reproduce inequalities by employing a transnational middle class, also constructing buffers or institutional barriers to local participation. Similarly, Analiese Richard (2009) describes the ambiguities of Mexican rural development NGOs as both local and transnational, allowing them to “circumvent states to enact their own programs of change” and often to legitimate neoliberal restructuring and downsizing of social service. Lamia Karim (2001) likewise demonstrates how microcredit NGOs in Bangladesh deploy a rhetorical “politics of the poor” while introducing new systems of patronage and instruments of control of poor women through social and financial obligations. Rather than empowering the poor, these and NGOs like them may serve the interests of the state and tie the lives of the poor to the maintenance of the NGO (Karim 2001).

Religious NGOs are in similar structurally ambiguous positions. In a carefully nuanced ethnographic portrait, Erica Bornstein (2003) analyzes the intersection of religious motivations and discourse with the social practices of international development in Zimbabwe, setting up local and transnational conflicts and power relations

that in many ways reinforced neoliberal economic policies. Related to the substantive topic of this article, Soheir Morsy (1988) examined the emergence of Islamic charitable medical clinics in Egypt, arguing that rather than providing an alternative to biomedicine they merely provided a “cultural elaboration of biomedical hegemony” (355). Like the examples from Haiti, Mexico, and Bangladesh, Islamic clinics in Egypt provide a component of the social welfare package that the state cannot fully provide. While closely supervised by the state, the charitable clinics help Islamist groups, in Morsy’s words, “gain legitimacy in, and affirm the legitimacy of, the social system” (360). Similarly, Janine Clark (2004) argues that Islamist clinics in Egypt do not mobilize the poor clientele or challenge state structures but rather expand and strengthen middle-class networks and their connections with state bureaucrats.

In the United States, NGOs face challenges similar to those described in Haiti, Bangladesh, and Egypt. These challenges are made more complex as privatization and devolution increasingly lead community-based NGOs to mediate between the state and needy citizens (Marwell 2004). Both secular and religious organizations do this mediating particularly since Charitable Choice legislation and the creation of a presidential Office of Faith-Based Initiatives allowed domestic social welfare services to be channeled, in the form of public funds, to charities and religious organizations which are permitted to retain more of their religious identities in social service provision than in the past (Cadge and Wuthnow 2006; Leve and Karim 2001; Wuthnow 2004).

As Robert Wuthnow (2004) argues in *Saving America*, religious organizations have long played a central role in social service provision and civil society more broadly in the United States. How religion has been present in organizations has varied significantly, however, as is evident in several recent studies. In her study of four HIV/AIDS-related faith-based organizations in New York City, for example, Susan Chambre (2001) shows how what she calls the “meaning of religion” changed over time with shifts in funding, clientele, leadership, and community stakeholders. While two of the organizations she studied became “secularized,” two others adopted what she describes as a “highly ecumenical and personalized form of faith that reflects trends in the nature of religion in contemporary American society” (Chambre 2001:435; see also Wuthnow 2004). More broadly, Thomas Jeavons (1998) outlines the diversity of faith-based organizations on the global and domestic scene by providing a rubric for examining the multiple ways that “faith” intersects with the organizations. He considers the relevance of faith in the organization’s self-identity, the mix of participants, the sources and nature of its material resources, its products and their delivery, its decision making, its distribution of power, and its primary partners within the organizational field (Jeavons 1998).

Most studies of faith-based organizations in the United States have concentrated attention on Protestant, Catholic, and to a lesser extent Jewish organizations. Relatively little attention has focused on religious identity in U.S.-based healthcare organizations, a surprise given the fact that many major hospitals, nursing homes, free clinics, substance abuse facilities, and other organizations that address basic healthcare needs today were founded and influenced by religious people and organizations. Religion

shaped the process of American hospital expansion in the nineteenth century, for example, as Catholic and Jewish hospitals opened – in part – to accommodate patients and health practitioners who experienced mistreatment or exclusion from mainstream, predominantly Protestant institutions (Lazarus 1991; Rosenberg 1995; Vogel 1980). Similarly, little attention has focused on religious healthcare organizations outside of those that are Protestant, Catholic, and Jewish. In the current climate of federal funding for faith-based social services generally and some healthcare organizations more specifically, it is vital to consider the experience of minority religious organizations and how they locate themselves in the context of faith-based organizations appropriating the power of NGOs for broader purposes. While the MCBHOs we analyze here may be considered both religious and ethnic organizations, we focused only on those that identified in religious terms as Muslim. We briefly note the role of ethnically oriented but not Muslim-identified health clinics below.

The Ambiguity of Being American and Muslim

To understand how MCBHOs serve the social, political, and cultural interests of their founders, staff, and volunteers it is essential to situate those individuals – mostly first-generation Muslim immigrants – in the historical development of Islam in the United States. Earlier foundations of Islam in America were laid with the arrival of slaves from Africa during the seventeenth and eighteenth centuries, through the nineteenth-century migration of Arabs from the Ottoman Empire and the post-World War II recruitment of students and scientists to the United States (Austin 1997; Diouf 1998; GhaneaBassiri 2010). Today, first-generation immigrant Muslims and their families represent approximately 65 percent of the estimated 2.35 million Muslims in the United States (Pew Research Center 2007). Most arrived from Arab and South Asian countries (later from Iran, Europe, and Africa) after changes in the immigration laws in 1965. These immigrants joined native-born Muslims, the majority of whom are African American but who also include Anglo, Hispanic, and Native American converts (Pew Research Center 2007).

Political scientist M.A. Muqtedar Khan (2003) describes the historical development of American Muslim identity in terms of a transition first from an internal then to an external focus. Muslim immigrants first concentrated on their internal community dimensions, organizing mosques in the Midwest as early as the 1920s. A Federation of Islamic Associations emerged in the 1950s. This group and the Muslim Student Association of the 1960s strove to maintain their identities in an increasingly multicultural environment through building mosques, Islamic centers, schools, and educational programs. Muslim immigrants from the post-World War II era through the early 1970s, who were often urban and well educated, also built mosques as they arrived in the United States to pursue graduate studies in the sciences, medicine, and engineering (Bagby 2004).

Physicians were an important part of the post-1965 wave of Muslim immigration. The creation of Medicare and Medicaid in 1965 changed U.S. healthcare in ways that led American-born physicians to establish private practices in wealthier suburbs, leaving a major gap in inner-city and rural areas. The federal government sought to fill this

gap by encouraging immigration of medical professionals from other countries. By 1972, 46 percent of all new licensed physicians in the United States were trained abroad (Ginzberg 1982). By 1974, one-fifth of all U.S. physicians were international medical graduates (IMGs), as were one-third of all hospital resident trainees. Many of these IMGs came from India, Pakistan, Syria, Lebanon, and Iran; a large number of them were Muslim.

Muslim medical professionals, along with engineering and science graduates, began forming associations for Muslim professionals and scholars in various fields. In the 1980s, the Islamic Society of North America and Islamic Circle of North America encouraged an enormous increase in mosque building, focusing on institutions that serve the internal needs of Muslim communities. There are now an estimated 1,200 mosques across the United States, with the highest concentrations in New York, Illinois, California, and New Jersey, though the majority of American Muslims do not attend mosques regularly (Ba-Yunus and Kassim 2004). Recent studies indicate that increasing numbers of mosques, especially African-American mosques, are positively involved in community social services and outreach, though these efforts are limited in both scope and infrastructure (Bagby 2004). Immigrant Muslim physicians have frequently taken the lead in organizing, funding, and even providing religious leadership for these mosques, schools, and larger American Muslim organizations.

Following a focus on internal organizing and identity work, and particularly in light of world events, Muslims in the United States focused significant attention in the last twenty years on their external image projected to the world. In the early 1990s, Arabs and Muslims worked against biased images in school textbooks and media coverage, for example, and they experienced significant levels of harassment and hate crimes as the U.S. mobilized the first Gulf War in Iraq. M.A. Muqtedar Khan (2003) argues that by the 1990s influential Muslim groups, buoyed by the success of first- and second-generation immigrants, began to engage in American society with a public, activist, and political approach. The Council on American-Islamic Relations became a significant watchdog organization to combat prejudice and discrimination against Muslims through action alerts and civil rights education. Muslim Student Associations also began to focus on raising public awareness of Islam on college campuses, and Muslim Internet sites proliferated. Major Muslim organizations also began forming political action committees and encouraging Muslims to participate in political parties and to run for public office. The Muslim Public Affairs Council in Los Angeles emerged in 1988 to provide a Muslim voice on international and domestic political issues, and the American Muslim Council began in 1990 to lobby for Muslim values in Washington, DC (Khan 2003).

Several scholars note the broad challenges faced by Muslims in the United States because of the convergence of U.S. foreign policy and military interventions in the Middle East and other predominantly Muslim regions, on the one hand, and the politically or religiously inflected racism experienced by Muslims in the U.S., on the other hand. Nadine Naber (2000) notes the rise of political racism or anti-Arab attitudes and behaviors that had their roots in politics, particularly after the Arab-Israeli War of 1967. Naber describes the conflation of the terms Arab, Middle Eastern,

and Muslim that are rooted in a systematic process of neocolonialism, whereby a new monolithic category is constructed as essentially different from and inferior to the white American – a threatening difference that justifies U.S. intervention. She calls this the “racialization of religion” for Muslims in the United States (Naber 2000). Similarly, Sherene Razack (2005) demonstrates how the war on terror and Samuel Huntington’s thesis of the clash of civilizations produced blatant racism against Muslims in the post-September 11 period.

Since September 11, 2001 and the passage of successive versions of the U.S. PATRIOT Act, Arab and Muslim Americans have been targeted for registration, surveillance, interrogation, and investigation by law enforcement officials at the federal, state, and local levels. Immigrants from Arab and Muslim countries have been arrested, detained, and interrogated in large numbers on the pretext of immigration violations. Legal immigrants from Muslim or Arab countries have been singled out for special registration and fingerprinted under the National Security Exit Entry Registration System (NSEERS). The FBI and local police departments have also monitored and investigated Muslim religious leaders, community activists, and mosques for possible terrorist activity. Additionally, numerous Muslim charities have been investigated, their assets confiscated, and/or their leaders charged with providing material support to terrorists (CAIR 2005; Tirman 2006). Sally Howell and Andrew Shryock (2003) argue that government and popular reactions to the post-9/11 event coerced even assimilated Arab and Muslim American citizens into a double consciousness like that what W.E. Du Bois described for African Americans or like the divided loyalty suspicion experienced by Japanese, Italians, and Germans in the United States during World War II (see also Shryock, 2002). It is against this backdrop that MCBHOs were started, and we analyze the claims their founders, volunteers, and staff made – especially about the complex ambiguities of belonging, as Muslims, in this context in the United States.

Research Methods

Social scientists knew little about the approximately 25 MCBHOs that emerged in the United States over the past two decades when we began this project in 2007. Our central research questions focused on the reasons Muslim physician founders decided to start Muslim identified community-based health clinics rather than clinics that were ethnically (e.g., Pakistani community health clinics) or professionally (e.g., physicians’ community health clinics) focused – and on how those organizations had developed since their founding.

To answer these questions we visited all MCBHOs in four cities with Muslim adherent estimates above 50,000 according to the Association of Religion Data Archives – Chicago, Detroit, Houston, and Los Angeles. We focused only on Muslim-identified health clinics, specifically defined as those that provide ongoing professional physical or mental healthcare in their local communities and publicly identify their organizations as Muslim, led by Muslims, or having developed out of Muslim teachings or traditions. We located organizations in each city through listings and referrals from a related professional organization – the Association of Muslim Health

Professionals – as well as through Internet searches, academic contacts in each city, and snowball sampling. We identified the complete population of nine organizations in these cities: two each in Chicago, Detroit, and Houston – and three in greater Los Angeles. We also attempted to locate such organizations through multiple channels in New York City, without success.

Between April and June 2007, we personally visited each city and interviewed – individually and in groups – staff and volunteers (between one and ten interviewees in each location, adding up to a total of 41 informants) who were involved with each organization in capacities ranging from founders to physicians to office assistants. Interviews followed a semistructured guide designed to gather information about how each organization was started and developed, what obstacles it faced, and how it integrated Islam and Muslim identity into its organization and patient care.¹ By visiting each of these organizations, we were also able to gather relevant promotional literature, see the facilities and neighborhood contexts, and, in some cases, attend fundraising and outreach events. We worked together to identify common themes and coded interview transcripts and fieldnotes following modified principles of grounded theory in which key themes were identified inductively and then refined through the course of the analysis (Strauss and Corbin 1990). Much of the material presented here emerged from discussions with founders about how and why their organizations were established and how they have developed over time.

The Mobilization of Power in MCBHOs

Background

While we focus on Muslim-identified health organizations here, it is important to first note that the earliest related projects in which Muslim healthcare providers played an active role were not Muslim identified and were organized to serve particular ethnic communities. For instance, ACCESS – the Arab Community Center for Economic and Social Services Community Health and Research Center – in Dearborn, Michigan, opened in 1988 to focus on medical, public health, and mental health initiatives and research relevant to the burgeoning Arab immigrant community. Similar organizations formed in other cities – like Hamdard Center in Chicago, which started in 1992 largely to provide physical, emotional, and psychological health services to South Asian, Middle Eastern, and Bosnian immigrant communities in Illinois. The MCBHOs are distinct from ACCESS and Hamdard because they have religious rather than ethnic identifications. It is also important to note that despite the history of medical science within the Muslim tradition, almost none of our respondents mentioned or drew from this tradition, implicitly asserting, in contrast, the norms of the biomedical frame within which they work (see Morsy 1988).

The Muslim-identified organizations we located fall into two groups in terms of how they are organized. The majority are free-standing health clinics designed to offer free or low cost primary healthcare for needy individuals, particularly those who cannot afford health insurance. Some clinics are physically located on the grounds of a mosque, while others are located in stand-alone commercial facilities or sections of larger social service centers. While some charge nominal fees for services, others

accept no fees from patients, relying instead on public or private grant funding and donations to cover operating costs. While a few offer services primarily for Muslims, all provide services for all people – and most make their commitment to services for all evident in their public messages and publicity materials. The second, less frequent organizational model is the network model which aims to connect clients with service providers in their existing practices at no- or low cost but does not include the creation of a separate clinical facility. Participants who join these networks pay a monthly fee, are assigned a network provider, and agree to pay another fee to the provider for each visit.

Primary care is the main focus for all of the MCBHOs providing medical services, with particular emphasis on treatment for diabetes, hypertension, and cholesterol – as well as, in some cases, immunizations, eye exams, and dental care. Some clinics have also accumulated diagnostic service capabilities and use these for patient convenience. Most of the clinics have either a formal arrangement with pharmaceutical companies, whose patient assistance programs provide free medications, or informal relationships with Muslim clinicians who donate samples (for more information, see Laird and Cadge 2008).

Fulfilling a religious duty

In describing the founding of these clinics, respondents articulate three distinct ways they mobilized the power of the NGOs to serve their own personal and communal interests. First, MCBHOs offered a vehicle for the expression and enactment of personal piety and self-fulfillment, in ways that link traditional Islamic charitable values with American voluntarism. Founders, staff, and volunteers at MCBHOs, in other words, spoke about how their work in the clinics enabled them to develop their identities and anchor themselves as Muslims in the United States. They emphasized making services available to all people according to Muslim teachings, not just as individual Muslims, but through Muslim-identified organizations. Many spoke of how important it is for them, as Muslims, to give back not just to their Muslim community but to all.

Speaking of “Islamic teachings of giving back” and the importance of “giving back to my community,” respondents framed their comments in terms of general and specific Muslim teachings about universal service. In addition to providing domestic violence services to Muslim women and their families, for example, NISWA also provides services and shelter to non-Muslims as resources allow: “support will not be just limited to our own community.” The staff of Muslim Family Services in Detroit, the other organization focused largely on Muslims, made similar arguments. In the words of one Muslim counselor, “I want to help Muslims and the general community . . . we want non-Muslims to feel like they can come to us also and seek the same services or get the same services.” Echoing others, this counselor rooted the importance of serving all people in general Muslim teachings.

Other respondents spoke more specifically of teachings about charity, service, and *zakat* (almsgiving, purifying wealth). In the words of a representative from IMAN, “Islamic traditions and beliefs” include providing “compassion to those who are

underserved” and to those who are in need and disadvantaged. “Part of Islam” proclaimed a HUDA Clinic representative, “is to give back, to help the needy.” Just as Christians follow Jesus, another explained, Muslim means “one who submits to the will of God” which especially includes giving back, “because we have much.” Respondents from a range of groups viewed charity to others as a tenet of the Muslim tradition: “part of our Islamic teaching” is to “help humanity.”

Representatives from the University Muslim Medical Association (UMMA) also spoke about charity specifically in terms of zakat, one of the five pillars of Islam. As one respondent said, “Part of our religion, part of Islam is, as you know, is the five pillars. Charity is one of the big ones. Zakat is there and charity along with it.” This respondent explicitly linked the work of UMMA to zakat explaining:

I link it with zakat, you know I think there’s a Hadith or Qur’an, I’m not sure which one it is, which goes along the lines of “to save a life is to have saved all of humanity, to take a life is to have harmed all humanity.” And you know, along those lines, to help the poor community treat their diabetes, their bronchitis, whatever it might be, is a huge thing, religious wise, what more can you ask for in terms of good deeds than helping people with their health, helping people get better? And I think that’s where we all come from, and that’s why it’s such a heartfelt thing to work at UMMA.

Not only are charity and service important in a general way in Islam, according to this respondent, they are core obligations one has to God. A board member of Al-Shifa Clinic remarked, “I would go as far to say that the service to the underserved would be a form of worship. And to your own benefit, to raise your bad deeds and shortcomings perhaps.” The act of zakat, dedicating to the service of the community a portion of one’s wealth, in the view of these respondents, purifies the remainder. These two physicians cast their acts of giving not just in terms of an obligation to humanity, but a pure or purifying obligation to God. “It may sound kind of kooky,” a physician from IMAN explained, “but it [the clinic] really isn’t about the people receiving the services. It is about giving people [the staff and volunteers] the chance to fulfill their responsibilities.” If Muslims as a community are not giving, she explained, they are in trouble. This giving back is what they are supposed to do, based on the teachings of their tradition.

By linking their service to religious values and teachings, respondents made clear that the acts of giving they valued were not individual acts of volunteering in the community or participating in mosques or existing secular service organizations. Rather, it was the opportunity to enact Muslim teachings through Muslim-identified organizations that enabled these respondents to tap into communal power not present when one Muslim physician acts alone. Charitable acts may be at the heart of Islam, as many of these respondents argued, but it is putting them into practice that connects them to the long tradition of American voluntarism and civic participation. As Robert Wuthnow argues in *Loose Connections* (1998), even as civic participation changes it continues to play a central role in the American democracy generally, and through religious organizations more specifically, which these respondents tap in to through MCBHOs.

Social mobilization of middle-class Islamic values in civil society

In addition to allowing Muslims to enact what they understand to be their personal religious obligations in ways that serve a wide range of people, respondents imbue MCBHOs with power in speaking of the ways the organizations help to normalize their differences as Muslims in American society. Specifically, these organizations show that Muslims can have faith-based organizations – just like Protestants, Catholics, and Jews – that emerged in large part from middle-class professional networks. Just as cultural idioms about the importance of voluntarism and serving all people developed and were enacted in other religious traditions, these organizations provide space for similar themes to emerge and be enacted through Muslim organizations (Wuthnow 1988, 1994).

This normalization of difference was particularly evident in the emphasis given in interviews to the fact that the founders of many of these organizations met as medical school classmates, fellow Muslim student association members at a university, fellow attendees at a mosque, or colleagues in a local hospital. UMMA's founders cultivated their social networks with professors, medical school administrators, and city officials to procure the initial funding, physical facilities, and staff for the clinic. In a time of crisis, they turned to the Islamic Society of Orange County, where several had been raised, for donations to extend the life of the clinic. Similarly, Al-Shifa Clinic received initial support, including physical space, through local government officials in the social and professional network of physicians. The Compassionate Care Network began literally as a social network of middle-class physicians and has continued to develop as such.

All of these founding stories emphasize the middle-class positions of respondents and the professional networks through which connections were forged. The overlapping nature of the horizontal religious, social, and professional networks is also described as integral to the survival of these NGOs, as they provide the base from which largely middle-class volunteer labor, donors, and political mediation continue to be recruited. In contrast to the Islamic clinics in Egypt described by Janine Clark (2004), MCBHOs have power in their constitution as a movement that normalizes the symbolic and political needs of the larger Muslim community, or at the very least, meets the need of the organizers to play a role in promoting a positive image of Islam in the public sphere.² Rather than mobilizing the uninsured and underinsured clientele to challenge state structures, MCBHOs mobilize horizontal networks of middle-class physician volunteers in order to enact what they articulate as Islamic values of charity in American civil society.

Mobilizing NGO power for Muslim citizenship and belonging

Third, MCBHOs provide access to power by mobilizing the social and cultural capital of faith-based organizations in order to defensively enact American Muslim citizenship and belonging. In other words, Muslims—particularly those of immigrant origins—strategically deploy positively valued faith-based charitable and

professional group identities to counteract a publicly stigmatized religious group identity. This theme is evident in the fact that Islamic religious concepts of charity are, for many, enmeshed in a particular American immigration context. Minimally, it is a defensive assertion against the double consciousness of American Muslims in the post-9/11 context. As a Shifa Clinic Houston volunteer explained, charity “starts at home . . . It starts with your family, then your neighbor, then your city, then your community, then the state, then the country.” The founders of Shifa started by providing services to fellow Muslims and expanded over time, as another leader explained: “Whether you are an immigrant or American. . . we are doing [this] for America.” Andrew Shryock (2002) discusses the emergence of new visual and rhetorical forms intermingling Islam and patriotism among Detroit Muslims after 9/11. The articulation of American Muslim identity in the discourse of MCBHOs volunteers similarly reflects the emergence of such forms.

Several studies document the rising level of discrimination, harassment, and fear of Muslims in Western societies during the past seven years (Allen and Nielsen 2002; Commission on British Muslims and Islamophobia 1997; Council on American Islamic Relations [CAIR] 2005; Ibish 2003; Runnymede Trust. Commission on British Muslims and Islamophobia., et al. 2004; Sheridan and Sheridan 2006; Weller 2006). These external social forces have considerable weight in shaping the self-presentation of these American Muslim faith-based health organizations. The high-profile allegations and prosecutions against Muslim charitable organizations after 2001 significantly affected the MCBHOs. As one HUDA volunteer states:

I think there’s a taboo after September 11 with us, so when we go out trying to get some money outside of the community, that becomes a bit of a challenge. Certain organizations think . . . Islamic terrorist – Hezbollah coming to America. . . We don’t accept any money from overseas – totally zero. It has to be raising our own funds from the United States from communities. The Blue Cross giving us money and the Medical Society giving us money and the Detroit health department giving us money. They are realizing we are contributing to society.

Another in the group added,

After September 11 there was a lot of negativity. This was called Islamic Charity Work Community Clinic. This was our original name. But we had to change it because the word became taboo. I met the board . . . I said, “Look, right now, if mainstream America hears the word Muslim we are done for.” So we changed the name to HUDA . . . Has the name change been successful? Yes. But again, it was something we had to do out of necessity.

The HUDA clinic, along with several others, dissociated itself from overseas donors in favor of local communities recognizing private and public funders. The clinic’s name change further helped the organization avoid the taboo of being too openly Muslim and was part of a strategy for seeking external funds. The new name and receipt

of these funds sends an important message about Muslims: they are contributing to American society.

Several narrators expressed their awareness that their clinic's work was representing what they described as "Muslims in general." While they rarely identified this as a primary motivation, many respondents emphasized that forming a clinic was one way to demonstrate that Muslims, and particularly immigrant Muslims, are a compassionate, local, healing presence. A UMMA volunteer cited the "responsibility of a new group that comes into a society . . . the first generation" to "do something to help the community . . . this is our home and we need to do something." A HUDA representative similarly stated that "one of our reasons for being is community involvement. You know we feel like the Muslim community should be more involved in revitalization of the community." Another commented, "[we wanted to] show that we are a greater part of American society. We [Muslims] 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."

Similarly, a speaker at a Shifa Clinic Houston fundraising dinner remarked:

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.

The repeated theme in this speech and the interviews of "being present over here" drives home the point of local loyalty and commitment, often contrasted with involvement in "homeland" or foreign causes. For instance, one physician at UMMA described the surprising contributions of the local Muslim community in Los Angeles that helped rescue the clinic from a financial crisis in 2000, adding:

I think in most first world countries, there are a lot of immigrants in the Muslim community, and the majority of charity money that they give . . . it goes toward the local orphanage in [my home country]. And generationally that has been a thing; you know, the Italian Americans traditionally donate to stuff out there. But to make [the local Muslim community] aware of a Muslim project right here in their backyard and have people donating money to that to a clinic where 98 plus percent of the patients are non-Muslims, that's a statement!

In a very similar vein, a board member from Al-Shifa Clinic in San Bernardino argued,

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 and I think this is, you'll have to come to something. When somebody invites you to come to a party, you have to bring something. . . .

I always think about what President Kennedy said: "Ask what you can do for your country, not what your country can do for you." So when, thinking about that one, that we are physicians, we are Muslims, we happen to be in this area. And the United States is the richest country, but poorest in healthcare. So this is a perfect opportunity which we can contribute for this society as a Muslim and being present over here. People go to all over the world, missionaries, yet there are a lot of things to be done right over here.

The opportunity to fulfill one's obligations to one's country, to do your job in contributing to American society as a Muslim, may resonate in amplified ways for immigrant professionals, who have adopted the United States as home. This commitment reflects social pressure likely experienced by some immigrant Muslims to justify and defend their Americanness by service to their country. In the words of one representative from HUDA, "Remember, this is our country now. We are all here. None of us are going back. So I feel it is important for us as American Muslims to do for our communities of this country. . . . Let everyone know what we are doing and hopefully they will look at Muslims as peaceful entities."

This theme resonates with Soheir Morsy's (1988) critique of Islamist clinics in Egypt when she argues: "Beyond the provision of biomedical services, contemporary health programs provide opportunities for the appropriation of power" (365). She further suggests that the religious symbolism of Islamic clinics provided a "placebo effect" that "affords the professional "providers" of Islamist health care the opportunity to share power as the state's ideological metamorphosis increasingly lends legitimacy to their efforts" (Morsy 1988). The alignment of cultural and governmental discourses about the appropriate involvement of religion in the public sphere offers opportunities to articulate and define immigrant Muslim citizenship and belonging in the United States in the midst of suspicion and hostility.

Conclusion

The MCBHOs analyzed here illustrate how one group of socially marginalized individuals, first-generation Muslim immigrants, utilize the social power of NGOs in the United States to advance their own personal and community interests. Much as Soheir Morsy (1988) argues that "religion can help individuals and groups gain legitimacy within existing power structures," the founders of MCBHOs utilized these organizations to express their piety, normalize their differences, and enact Muslim American citizenship in an Islamophobic context (375). They did this through biomedically oriented health NGOs primarily because those are the skills they had as a group. Had they more knowledge of Islamic health traditions or professional skills in other areas, they likely would have formed different kinds of NGOs through which to serve Muslim and broader communities in the United States.

The negotiations and ways these organizations utilized the social power of NGOs are not static but continue at the group level, especially as the organizations make decisions about receiving grants from city, county, state, or federal government sources,

some of which comes with strings attached. UMMA clinic, for example, was required to restructure its board in order to receive Federally Qualified Health Center (FQHC) status. The restructuring required that the majority of board members be drawn from the non-Muslim patient community served, rather than from the Muslim physician community providing the services. UMMA decided to make this transition, achieving this federal funding status in August 2008 (personal communication, June 29, 2009). 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, which they hope will not require a change in the religious composition of board members. The director is also reevaluating how this federal status could negatively affect their ability to sustain their present operational budget without a strong, private fundraising board (personal communication, July 13, 2009). State and local grants and connections with local politicians also remain an important part of staking their claim of belonging in Houston society and American society more generally, as negotiations continue.

The diverse choices MCBHOs directors make around operations, legal status, and the solicitation of public funds are, we argue, both pragmatic and about accessing social power in the political sense. Leaders participate in the larger movement of utilizing NGO power to articulate a sense of belonging and commitment to American society. This has been especially evident at the UMMA Clinic where leaders have assumed the mantle of representing Muslim Americans to political leaders from the city to federal level with alacrity, in the process becoming unabashed players in the game of identity politics in the United States. The UMMA promotional DVD, "Healing Our Community," opens with the dramatic title, "As the nation watches," then cuts to footage of the U.S. Congress. Another title appears, "History unfolds in the House of Representatives," as Los Angeles' Representative Maxine Waters reads an official commendation for the UMMA Clinic in Congress: "If you want to see what Muslim Americans truly represent, go to the UMMA Community Clinic, and you will see it there" (UMMA Clinic 2008).

In the same vein, UMMA issued a press release in the fall of 2008:

On October 22, 2008, the White House Office of Faith Based and Community Initiatives hosted an UMMA clinic representative, the U.S. Surgeon General and national health leaders for a panel event titled, the "Compassion in Action Roundtable". UMMA clinic, representing the Muslim American contribution to charitable healthcare provision, was one of only three clinics in the nation invited to take part at the exclusive White House event. [University Muslim Medical Association 2008]

The press release went on to highlight the clinic's "strategic coalitions" with other local clinics and its "unique commitment to medical education" through which it "cultivate[s] a new generation of mission driven physicians." UMMA thus "is bolstering the regional safety net, and saving lives." The writer identifies the central theme of the White House forum: "faith based and community clinics like UMMA are indispensable in providing the affordable, qualified and culturally sensitive health services

low income and uninsured communities need.” It concludes with this statement: “As UMMA’s participation was indeed historic, we are hopeful that it represents a significant and positive step in advancing the dialogue between Muslim Americans and national policy makers.”

Although his statement preceded UMMA’s events in 2008, a dentist moderating a 2006 panel on MCBHOs remarked, “If we want to have participatory citizenship, we have to do this kind of service.” Founders of MCBHOs position their organizations within what M.A. Muqteder Khan (2003) calls the Muslim democrat discourse, maintaining careful collaboration but clear autonomy from larger Muslim religious organizations and religious authorities. These healthcare professionals thus stake their claim, as the UMMA press release suggests, to “represent American Muslims.” In so doing, MCBHOs redress Islamophobia and social marginalization of Muslims in the U.S. by claiming a place at the table of faith-based activism and the prestigious mantle of established charitable clinics in the United States.

As they stake their claims, MCBHOs navigate among ambiguous positions much like other NGOs around the globe. They mediate between the state or the medical system and the poor, uninsured, or underinsured citizens. At the same time, they attend to their own survival through cultivating access to political leaders who disburse public funds and to corporate leaders who control foundation funds in a competitive nonprofit organization market. They deliver an important aspect of social welfare services, but at the same time fill in the gap left by the neoliberal state’s failure to provide these services and instead to devolve and privatize them. As CBOs, they have the potential for organizing the community of clients for social change; and yet they focus efforts on organizing middle-class volunteerism and ideologies of charitable service within the American Muslim community. In navigating these ambiguities, MCBHOs simultaneously enable their founders, staff, and volunteers to utilize the power of NGOs in the American context. They provide Muslim physicians with an opportunity to discharge a religious duty in a public, professional setting outside the traditional institution of the mosque. By forming faith-based service institutions, Muslim physicians are able to participate in both the transnational moderate Islamist movement and the American civil society tradition of faith-based organization. They are able to show how Muslims are much like members of other religious traditions, who provide charity for all. Leaders also mobilize the social and symbolic capital of the faith-based clinic that serves everyone, articulating a new vision of Muslim belonging to counter Islamophobic assertions of a clash of civilizations. In response to the question of whose interests these organizations ultimately serve in the process, we argue both “the poor” and, “though it may sound kooky,” in the words of one respondent, MCBHOs serve to empower the middle-class Muslim providers, to resolve their and the American Muslim community’s position as “ambiguous insiders” (Naber 2000).

Notes

1. Interviews were recorded and transcribed with permission. The research was classified as human subjects “exempt” by the Boston University Institutional

Review Board. Narrators were offered anonymity if they wished. We recruited those identified by the organizations' leaders as having enough experience in the organization to give an overview of its work. This research study was funded by a collaborative grant from the Association of Muslim Health Professionals Foundation and the Institute for Social Policy and Understanding (ISPU), for which the authors were listed as research fellows.

2. The notion that these organizations form a Muslim social movement is further evident in the common answers given across cities and to the tight interpersonal networks among many leaders, staff and volunteers in different cities, networks in part supported through a broader organization, the Association of Muslim Health Professionals, that takes supporting these organizations as one of their many goals.

References Cited

- Allen, Chris, and Jorgen S. Nielsen
2002 Summary Report on Islamophobia in the EU after 11 September 2001. European Monitoring Centre on Racism and Xenophobia.
- Austin, Allan
1997 *African Muslims in Antebellum America: Transatlantic Stories and Spiritual Struggles*. New York: Routledge.
- Bagby, Ihsan
2004 The Mosque and the American Public Square. *In Muslims' Place in the American Public Square: Hope, Fears, and Aspirations*. Zahid H. Bukhari, Sulayman S. Nyang, Mumtaz Ahmad, and John L. Esposito, eds. Pp. 323–346. Walnut Creek, CA: AltaMira Press.
- Ba-Yunus, Ilyas and Kassim Kone
2006 *Muslims in the United States*. Westport, CT: Greenwood Press.
- Bornstein, Erica
2003 *The Spirit of Development: Protestant NGOs, Morality, and Economics in Zimbabwe*. New York: Routledge Press.
- Cadge, Wendy and Robert Wuthnow
2006 Religion and the NonProfit Sector. *In Handbook of NonProfits*. Walter Powell and Richard Steinberg, eds. Pp. 485–505. New Haven, CT: Yale University Press.
- CAIR (Council on American-Islamic Relations)
2005 *Unequal Protection: The Status of Muslim Civil Rights in the United States*. Council on American-Islamic Relations.
- Chambre, Susan J.
2001 The Changing Nature of "Faith" in Faith-Based Organizations: Secularization and Ecumenism in Four AIDS Organizations in New York City. *Social Service Review* 75(3):435–455.
- Clark, Janine
2004 Social Movement Theory and Patron-Clientelism: Islamic Social Institutions and the Middle Class in Egypt, Jordan, and Yemen. *Comparative Political Studies* 37(8):941–968.

- Commission on British Muslims and Islamophobia
1997 Islamophobia: A Challenge for Us All. Runnymede Trust.
- Diouf, Sylviane
1998 *Servants of Allah: African Muslims Enslaved in the Americas*. New York: New York University Press.
- Fisher, William F.
1997 Doing Good? The Politics and Antipolitics of NGO Practices. *Annual Review of Anthropology* 26:439–64.
- GhaneaBassiri, Kambiz
2010 *A History of Islam in America: From the New World to the New World Order*. Cambridge: Cambridge University Press.
- Ginzberg, Eli
1982 The Future Supply of Physicians: From Pluralism to Policy. *Health Affairs* 1(3):6–19.
- Howell, Sally, and Andrew Shryock
2003 Cracking Down on Diaspora: Arab Detroit and America’s “War on Terror.” *Anthropological Quarterly* 76(3):443–462.
- Ibish, Hussain
2003 Report on Hate Crimes and Discrimination against Arab Americans: The Post September 11 Backlash. American-Arab Anti-Discrimination Committee.
- IMAN (Inner City Muslim Action Network)
n.d. Inner City Muslim Action Network: About Us (web page) <http://www.imacentral.org/about.html>, accessed September 24, 2010.
- Jeavons, Thomas
1998 Identifying Characteristics of “Religious” Organizations: An Exploratory Proposal. In *Sacred Companies: Organizational Aspects of Religion and Religious Aspects of Organizations*. Nicholas J. Demerath, ed. Pp. 79–95. New York: Oxford University Press.
- Karim, Lamia
2001 Politics of the Poor? NGOs and Grass-roots Political Mobilization in Bangladesh. *PoLAR: Political and Legal Anthropology Review* 24(1):92–107.
- Khan, M.A. Muqtedar
2003 Prospects for Democracy in the Muslim World: The Role of US Policy. *Middle East Policy Journal* 10(3):79–89.
- Laird, Lance and Wendy Cadge
2008 *Caring for Our Neighbors: How Muslim Community-Based Health Organizations are Bridging the Health Care Gap in America*. Clinton Township, MI: Institute for Social Policy and Understanding.
- Lazarus, Barry A.
1991 The Practice of Medicine and Prejudice in a New England Town: The Founding of Mount Sinai Hospital, Hartford, Connecticut. *Journal of American Ethnic History* 10(3):21–41.
- Leve, Lauren, and Lamia Karim
2001 Introduction Privatizing the State: Ethnography of Development,

- Transnational Capital, and NGOs. *PoLAR: Political and Legal Anthropology Review* 24(1):53–58.
- Marwell, Nicole P.
2004 Privatizing the Welfare State: Nonprofit Community-Based Organizations as Political Actors. *American Sociological Review* 69(2):265–291.
- Morsy, Soheir A.
1988 Islamic Clinics in Egypt: The Cultural Elaboration of Biomedical Hegemony. *Medical Anthropology Quarterly* 2(4):355–369.
- Naber, Nadine
2000 Ambiguous Insiders: An Investigation of Arab American Invisibility. *Ethnic and Racial Studies* 23(1):37–61.
- Pew Research Center
2007 Muslim Americans: Middle Class and Mostly Mainstream. Report, available as Electronic Document. <http://pewresearch.org/assets/pdf/muslim-americans.pdf> Accessed September 23, 2010.
- Razack, Sherene
2005 Geopolitics, Culture Clash, and Gender After September 11. *Social Justice* 32(4):11–31.
- Richard, Analiese M.
2009 Mediating Dilemmas: Local NGOs and Rural Development in Neoliberal Mexico. *PoLAR: Political and Legal Anthropology Review* 32(2):166–194.
- Rosenberg, Charles E.
1995 *The Care of Strangers: The Rise of America's Hospital System*. Baltimore: Johns Hopkins University Press.
- Runnymede Trust. Commission on British Muslims and Islamophobia., et al.
2004 *Islamophobia: Issues, Challenges and Action: A Report*. Stoke on Trent, UK; Sterling, VA: Trentham Books in association with the Uniting Britain Trust London.
- Schuller, Mark
2009 Gluing Globalization: NGOs as Intermediaries in Haiti. *PoLAR: Political and Legal Anthropology Review* 32(1):84–104.
- Sheridan, L. P., and Lorraine P. Sheridan
2006 Islamophobia Pre- and Post-September 11th, 2001. *Journal of Interpersonal Violence* 21(3):317–336.
- Shryock, Andrew J.
2002 New Images of Arab Detroit: Seeing Otherness and Identity through the Lens of September 11. *American Anthropologist* 104(3):917–922.
- Strauss, Anselm L. and Julie Corbin
1990 *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park, CA: Sage.
- Sullivan, Winnifred.
2009 *Prison Religion: Faith-Based Reform and the Constitution*. Princeton, NJ: Princeton University Press.
- Tirman, John
2006 *Immigration and Insecurity: Post-9/11 Fear in the United States*.

In Border Battles: The U.S. Immigration Debates (online essays), <http://borderbattles.ssrc.org/Tirman/> (Social Science Research Council), accessed September 22, 2010.

UMMA Clinic, University Muslim Medical Association

2009 UMMA Presents w/ U.S. Surgeon Gen. on White House Panel, <http://www.ummaclinic.org/news.php?id=48&PHPSESSID=4f25140afedc6b01a0e1d01313c207cb> (posted Thursday, October 30, 2008), accessed September 22, 2010.

Vogel, Morris J.

1980 *The Invention of the Modern Hospital, Boston, 1870–1930*. Chicago: University of Chicago Press.

Weiss, Gregory L.

2006 *Grassroots Medicine: The Story of America's Free Health Clinics*. Lanham, MD: Rowman & Littlefield Publishers.

Weller, Paul

2006 Addressing Religious Discrimination and Islamophobia: Muslims and Liberal Democracies. The Case of the United Kingdom. *Journal of Islamic Studies* 17(3):295–325.

Wuthnow, Robert

1988 *The Restructuring of American Religion: Society and Faith since World War II*. Princeton, NJ: Princeton University Press.

1998 *Loose Connections: Joining Together in America's Fragmented Communities*. Cambridge, MA: Harvard University Press.

2004 *Saving America?: Faith-based Services and the Future of Civil Society*. Princeton, NJ: Princeton University Press.