Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World

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WORKSHOP PROCEEDINGS

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Executive Summary

Since the earliest days of the Islamic community, philanthropic giving has been a core value. Muslims are encouraged both by Scripture and tradition to distribute wealth to mitigate social inequality and injustice. This norm provides a critical foundation for Muslim societies and often constitutes the only source of support for their poorest members.

Muslim giving can take many different forms. Because it is not always labeled explicitly as charity, it can be hard to quantify. Meanwhile, despite the great wealth at the disposal of Muslim philanthropy, it is not clear that its potential is being maximized. To achieve a global impact, Muslim philanthropy must adopt new strategies and tactics.

The need is significant. Nations belonging to the Organization of Islamic Countries (OIC) bear a high burden of both communicable and noncommunicable diseases, and their infrastructure for health care remains weak. One of Muslim philanthropy’s greatest potential areas of impact would be ensuring sustainable health care delivery in OIC Muslim States, in particular, but globally as well.¹

For Muslim philanthropy to effectively promote sustainable health care delivery, a critical first step is to build a corpus of empirical data. A survey of philanthropy and giving behavior in Turkey, the first of its kind, can inform other quantitative studies. Broader attention to the existing philanthropic landscape in Muslim-majority countries may offer further insights.

In addition to general research on Muslim giving, participants in the meeting shared illuminating case studies from charities benefiting the health sector, including Pakistan’s Indus Health Network and Layton Rahmatullah Benevolent Trust, Egypt’s Resala charity organization, and Indonesia’s Muhammadiyah Health Network. Ultimately, improvement in sustainable health care delivery will be contingent on this kind of close collaboration between providers and funders, including philanthropists in the Muslim world.

1 Introduction

On December 1st and 2nd, 2016, a panel of experts assembled at the Harvard Medical School Center for Global Health Delivery in Dubai, United Arab Emirates, for a meeting entitled Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World.¹ The meeting was convened by Interactive Research and Development (IRD) with support from Harvard Medical School.

Each day of the meeting was divided into four sessions. The first day focused on global, national, and local perspectives about the context of Muslim philanthropy and health care delivery. Sessions on the first day addressed the magnitude of Muslim philanthropy and the challenges it faces, national perspectives on philanthropy and public health, and local and national case studies on philanthropy in public health. The second day featured consultations and discussions about the ways forward for research and policy around Muslim philanthropy and health care delivery.

Aamir Khan, Executive Director of Interactive Research and Development (IRD), opened the proceedings by welcoming the meeting.

¹The agenda for the meeting is provided in Appendix 1, and the list of participants is provided in Appendix 2.
participants and thanking the Harvard Medical School Center for Global Health Delivery for hosting. He outlined a set of aims and expectations for the meeting:

- To document and understand the role of health-directed philanthropy in Muslim majority countries, including best practice case studies from Pakistan, Egypt, Turkey, and Indonesia;
- To develop a framework for identifying opportunities and challenges of formalizing and tapping into existing and new flows for health, including zakat (the religious obligation of alms-giving, one of the “Five Pillars” of Islam), sadaqah (voluntary charitable contributions beyond the legally mandated amount), and waqf (religious endowments);
- To create a policy discourse to engage leading voices, policymakers, and practitioners resulting in policy recommendations supporting indigenously sustained health care.

Khan emphasized that the outputs of the meeting were designed to support sustainable health care delivery.

Khan provided an overview of IRD, which was founded in Karachi in 2002. Its headquarters in Singapore now runs a host of health delivery programs around the world, delivering surgical care, infectious disease care, and chronic disease care (Figure 1.1).

Figure 1.1. Interactive Research and Development

Source: Aamir Khan, Presentation at Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World 2016
IRD operations are funded by over $73 million in grants from global institutions for health care delivery in more than 20 countries annually. Sustaining this global footprint is, Khan said, a great responsibility, which also extends to exploring models of sustainable health care. Almost all funding comes from institutions based out of Geneva, including Global Fund and the Global Alliance for Vaccines and Immunizations (GAVI). The availability of funding from Geneva-based institutions is linked principally to the performance of North American and European economies, and the politics of global aid. In many MMCs, informal local charitable giving exceeds external aid, but the key challenge is its lack of organization. Very few institutional organizers have been able to earn the trust to channel the hundreds of millions and even billions of dollars in local funding. He emphasized the need for a practical vision about the future of that funding and about how to tap into the wealth that is circulating in MMCs to develop better systems of health delivery.

Khan closed with a verse from the Quran: “Those who spend in charity will be richly rewarded” (57:10). He reminded the group that charity is not simply the spending of money, but the spending of time.
2 Context of Muslim Philanthropy and Health Care Delivery

2.1 GLOBAL HEALTH DELIVERY: THE CHALLENGE FOR THE MUSLIM WORLD

2.1.1. Overview of Key Health Issues Faced by the Muslim World

Dr. Salmaan Keshavjee, Director of the Harvard Medical Center for Global Health Delivery - Dubai (United Arab Emirates), gave an overview of the Center’s scope of work. Its footprint spans 46 countries in the Middle East and North African (MENA) region, including most of the Muslim world. The Center’s mission is to create and nurture a diverse community of people committed to leadership in alleviating human suffering caused by disease; it contributes to this mission through its focus on gaps in the last phase of health care delivery. Keshavjee noted that suffering cannot be alleviated without a funding stream. Effective technologies for treating diseases such as TB, hepatitis, and diabetes exist, but they are simply not reaching patients in need.

Keshavjee explained the Center’s three-pronged approach: (1) Research to foster improved health care delivery; (2) Support for scholars, practitioners and policy makers to improve health care delivery; and (3) Training to drive an ecosystem of change in health care delivery. The Center focuses on delivery research, high-level workshops, policy impact, and global dissemination through published proceedings, working papers, and policy briefs. Keshavjee explained that the Center’s areas of focus are the biggest health problems faced by 46-country region: diabetes and obesity; surgical care; infectious disease; and mental illness, with particular focus on projects that protect women and children.²

2.1.1.1 Diabetes and Obesity

Diabetes currently affects 400-700 million people worldwide, with prevalence rates between 5-10% in most countries. The absolute number of patients is increasing and the demand for diabetes care will increase by an estimated 323% over the next 20 years. Many countries in the Center’s region have very high rates of diabetes (Figure 2.1). In Malaysia, for example, diabetes rates have climbed as much as 10% even though the country has a system of universal health care.

Obesity, which is strongly linked to diabetes, is also very prevalent in the Center’s 46-country region. Most countries in the region have obesity rates greater than 10%, and around 40% of Gulf Cooperation Council Countries (GCC) nationals are considered obese (Figure 2.2):

² Special consideration is given to projects that focus on the health of women and children.
Figure 2.1. Percent of population with diabetes in countries of the Center’s region


Figure 2.2. Estimated percent of adults who were obese in the Center’s region


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3 No data available for Palestinian Territories.  
4 No data available for Palestinian Territories.
Keshavjee noted that diabetes is a complex disease and a multi-sectoral problem. Its etiology is still being investigated, but possible causal factors include antibiotics in food that change the human microbiome, hormones ingested in food, and/or environmental pathogens. Like all chronic diseases, it is also a social disorder, heavily impacted by the conditions of daily life. While diabetes can be effectively controlled, outcomes for individual patients depend on the ability of the health care system to support their adherence to their treatment regimens. Studies\(^5\) have demonstrated that after one year, only 20% of people diagnosed with diabetes are still taking their medications. Keshavjee emphasized the huge cost of inaction in this area of health care. Diabetes is the leading cause of blindness worldwide and it leads to amputation of limbs,\(^6\) renal failure, heart disease, and infection.

**Figure 2.3. Annual value of lost economic output due to surgical conditions**

![Annual value of lost economic output due to surgical conditions](image)

Source: Alkire et al., 2015.

### 2.1.1.2 Surgical Care

Keshavjee explained that 28-32% of the global burden of disease is from surgical conditions—more than malaria, TB, and HIV combined—yet five billion people cannot access safe surgery when they need it. Worldwide, 25% of people have access to good surgical care and 75% have limited access to surgical care. Access is worst in lower- and middle-income countries (LMICs), where 90% of people cannot access basic surgical care from a trained surgeon and anesthesiologist within 2 hours. He noted that GCC countries have many state-of-the-art surgical facilities, yet access to care remains a problem.\(^7\) The demand for trauma care is predicted to rise by 227% over the next 20 years in the GCC, highlighting the importance of ensuring the capacity to meet the surgical burden. Regardless of a country’s income level, lack of proper surgical access is linked to a loss of about 1% of GDP, which is a significant problem for majority-Muslim countries (MMCs) with low income levels (Figure 2.3):

1. Donnan et al., 2002.
2. Saudi Arabia has one of the highest rates of foot amputation in the world.
3. Those countries spend more than $3 billion per year sending their citizens to other countries for surgical care.
2.1.1.3 Infectious Diseases

Keshavjee reported high levels of tuberculosis (TB) and hepatitis C virus infection in the Center’s region. Both TB and Hep C are preventable and curable diseases that serve as markers of poverty. WHO estimates that nine million people become ill with TB every year, but only six million are diagnosed and treated. One million among those infected are children of which only 33% get diagnosed. Because of this large delivery gap, the disease kills almost 200 million people each year. Of the three million people who become ill with TB but are not diagnosed or treated, 570,000 are likely to have drug-resistant TB. Every sick person who does not receive TB treatment can spread the disease to as many as 10 additional people each year.

The situation with MDR-TB is even grimmer: only 10% of the sick were estimated to have been diagnosed and treated in 2012. Most of the countries in the Center’s region have high TB burdens, with rates greater than 20 per 100,000 people8 (Figure 2.4).

Figure 2.4. Estimated number of tuberculosis cases per 100,000 people in the Center’s region

Keshavjee explained that Hepatitis C is also treatable and curable at a cost of $300 per person in India and slightly more in countries such as Georgia and Egypt. Lack of prevention measures such as inadequate sanitation in hospitals and other health centers can drive disease transmission because of the misconception that the disease only affects people who are hospitalized.

One in 50 people has hepatitis C worldwide (2% of the population), but rates are among the highest in South Asia (3.4%) and MENA (3.6%) (Figure 2.5).

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8The US, Canada, and most of the Western world have rates of 2-3/100,000.
2.1.1.4 Mental Health Disorders
Keshavjee explained that mental health disorders represent a significant burden of disability worldwide: mental and behavioral disorders are the leading cause of time lost to disability globally from all medical causes (26%).9 Lingering historical prejudice and stigma are key challenges, as well as presenting significant delivery gaps. For example, although general practitioners can diagnose some mental health conditions, there is a shortage of mental health specialists in most parts of the non-Western world.

2.1.2 Comparison of Health Issues Among OIC Member States
Keshavjee presented a comparison of health issues among Organization of Islamic Cooperation (OIC) member states along multiple dimensions and variables. The following thresholds were established to identify countries at risk:

- Per capita GDP <USD $10,000
- Rank <90 on the UN Human Development Index (includes GDP, education and health indicators)
- Maternal mortality >10 per 100,000 live births
- Child mortality >10 per 1,000 live births
- TB incidence >10 per 100,000 people
- Diabetes rate >5% of the population

Specific comparison data are provided in Appendix 3. Keshavjee reported that most countries are at high risk in every category of communicable and non-communicable diseases (Iran, Kazakhstan and Kuwait are outliers). Malaysia is at high risk in several areas, despite being a richer Muslim country; Saudi Arabia has invested heavily in health

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9 Insel, Collins & Hyman, 2015.
infrastructure but is still at high risk. He warned that billions of dollars will need to be mobilized and used properly to deliver care to people as the disease burdens continue to grow. On the UN Human Development Index (HDI), a composite index of development incorporating dimensions of health, education and living standards, Muslim-majority countries receive scores about half that of the rest of the world\(^\text{10}\) (Figure 2.6):

**Figure 2.6. UN Human Development Index trends**

![UN Human Development Index trends](image)


\(^{10}\)The same trends are evident on the UN Health Index, which measures life expectancy at birth and is expressed as a number between 0 and 1.
Keshavjee commented that discussions about capturing money need to be concurrent with discussions of how that money should be used. He explained that since the 1970s the fixation on ‘cost-effectiveness’ has driven a global push towards market-based health care provision. The Center is committed to changing the distribution mechanism to one based on a person’s health needs rather than economic status. He urged meeting participants to consider these crucial distribution gaps, the moral implication of suffering, and how to distribute money in the best possible way, observing: “people give money when they know it’s going to be used well.”

2.1.3 Discussion

Keshavjee was asked for his thoughts on Academic Model Providing Access to Healthcare (AMPATH), a partnership in Kenya between Moi University School of Medicine, Moi Teaching and Referral Hospital, and a consortium of North American academic health centers led by Indiana University. Initially the program focused on how to reduce HIV/AIDS rates; the partnership worked to build public health infrastructure and provide training for doctors from both universities. The latest version of the program situates private philanthropy in the public sector, with social workers going into the homes of Kenyans, taking censuses, and getting broader ideas of health care needs. Keshavjee noted that there is a mass of people putting social justice at the forefront of health delivery. His own work on TB was spent with Partners in Health (PIH) (whose motto is, “A preferential option for the poor”). PIH strives to bring health conditions to the fore, find their solutions, and deliver care equitably (groups like IRD and AMPATH also share those ideals). He remarked that such programs are sustained by relatively small sums of money, in comparison to the size of the public sector as a whole: PIH and AMPATH are both roughly $100 million organizations. This underscores, he said, the need to channel money to people directly involved with delivery, rather than subcontractors. He called for positioning such delivery-focused groups to serve as global social justice networks.

Rafiuddin Shikoh, Managing Director of DinarStandard, predicted that Islamic economies will soon create opportunities to connect region-specific Sharia-compliant financing with broader aims related to social impact and connectivity (e.g., the Sustainable Development Goals). For instance, Malaysia recently launched the first-ever sukuk (an Islamic investment vehicle) to fund beneficiaries working on environmental and social issues projects. Keshavjee in turn pointed to the Zero TB Initiative, a network of agencies (many of them municipal) seeking to eliminate TB entirely11 and suggested that appropriately structured social bonds may provide an opportunity for financing health care delivery.

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11 He noted that TB may be a relatively small problem compared to other health issues, but the project builds infrastructure that can be used to delivery other types of care.
3 Magnitude and Challenges of Muslim Philanthropy

3.1 QUANTIFYING PHILANTHROPY IN THE MUSLIM WORLD: CHALLENGES AND OPPORTUNITIES

Dr. Athar Osama, Interactive Research and Development, and Sahrish Qamar, of Technomics International Ltd and the Muslim World Science Initiative (United Kingdom) presented an overview of the challenges of quantifying Muslim philanthropy, and the potential contribution of such research.

3.1.1 Rationale for Quantifying Muslim Philanthropy

Osama explained that curbing inequalities and injustices in society is central to Islamic observance, which encourages the equitable distribution of wealth. The tradition of Muslim philanthropy dates back to the earliest days of the religion, but judging its scale is challenging given the myriad forms of Muslim giving worldwide. Osama explained the practical importance of quantifying Muslim philanthropy worldwide. While giving is mandated religiously, its impact is dependent on a shift to strategic philanthropy. He noted that philanthropy in general—as well as Muslim philanthropy—is gradually becoming more strategically rather than tactically oriented through the work of large global foundations with a renewed focus on research. However, he said, in the absence of appropriate systems and policies, philanthropic funds are still not being channeled toward the areas of greatest impact. The need for charitable support is growing at a time of widespread donor fatigue, so meeting the new demand will require innovative, systematic approaches. The objective of the present meeting, he said, is to work toward this goal by creating a prospectus on philanthropic support of public health projects that can be circulated in the Muslim world.

3.1.1.1 Evolving Development Flows

According to Osama’s presentation, the very limited corpus of studies about global philanthropy indicates that development flows are changing. The World Giving Index reported that 32.5% of people worldwide donated to charities in the previous year and private flows are outpacing official development assistance. In 2011, private capital investment, remittances, and philanthropy from the 23 donor countries in the OECD’s DAC Committee totaled around $577 billion, which was fourfold larger than official development flows that year. Worldwide, private flows have been increasing and charity is becoming more important as the proportion of official development assistance decreases. Globally, large donations exceed $24.5 billion (Figure 3.1).

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12 Osama noted that there are scientific/methodological/credibility issues with this index: for example, in 2015, two Muslim countries in Central Asia showed up as main givers, but it turned out that survey was done just after Ramadan and survey asked about actions over the previous month.
14 Hudson Institute, The Index of Global Philanthropy and Remittances 2013, Center for Global Prosperity, 2013.
3.1.2 Quantifying Muslim Philanthropy: Primary and Secondary Studies

Osama provided an overview (Table 3.1) of the existing primary and secondary studies that have quantified Muslim philanthropy. He noted that in the primary studies, numbers range widely and there are possible discrepancies. For example, the province of Punjab in Pakistan is reported to contribute $1.6 billion of the national total of $2.32 billion.

In the secondary studies, the range is even larger and more prone to discrepancies. For example, Turkey’s amount is much smaller than expected (Table 3.1):
### Table 3.1. Primary and secondary studies

<table>
<thead>
<tr>
<th>Primary Studies</th>
<th>Year</th>
<th>Amount (USD)</th>
<th>Type of study</th>
<th>Type of giving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pakistan</td>
<td>2010</td>
<td>$2.32 billion</td>
<td>Estimate</td>
<td>Philanthropy</td>
</tr>
<tr>
<td>Punjab (Pakistan)</td>
<td>2010</td>
<td>$1.6 billion</td>
<td>Survey</td>
<td>Philanthropy</td>
</tr>
<tr>
<td>Pakistan</td>
<td>2015</td>
<td>$54 million</td>
<td>Official figures</td>
<td>Zakat</td>
</tr>
<tr>
<td>Malaysia (14 states)</td>
<td>2008</td>
<td>$272 million</td>
<td>Mixed methods</td>
<td>Zakat</td>
</tr>
<tr>
<td>Turkey</td>
<td>2004</td>
<td>$2 billion</td>
<td>Survey</td>
<td>Philanthropy</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2012</td>
<td>$22 billion</td>
<td>Survey</td>
<td>Zakat</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2011</td>
<td>$85 million</td>
<td>Survey</td>
<td>Philanthropy</td>
</tr>
<tr>
<td>Malaysia</td>
<td>2010</td>
<td>$10 million</td>
<td>Estimate</td>
<td>Zakat</td>
</tr>
<tr>
<td>Malaysia</td>
<td>2014</td>
<td>$16 million</td>
<td>Estimate</td>
<td>Zakat</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Studies</th>
<th>Year</th>
<th>Amount (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muslim Countries</td>
<td>Annual</td>
<td>$250 billion-$1 trillion(^2)</td>
</tr>
<tr>
<td>Malaysia</td>
<td>2010</td>
<td>$411 million(^3)</td>
</tr>
<tr>
<td>Pakistan (36 districts)</td>
<td>2010-2011</td>
<td>$26,902(^4)</td>
</tr>
<tr>
<td>Pakistan</td>
<td>2006-07</td>
<td>$1.86024(^5)</td>
</tr>
<tr>
<td>Pakistan</td>
<td>2000</td>
<td>$1.4 billion(^6)</td>
</tr>
<tr>
<td>Turkey</td>
<td>2012</td>
<td>$93 million(^7)</td>
</tr>
<tr>
<td>Turkey</td>
<td>2012</td>
<td>$93 million(^8)</td>
</tr>
</tbody>
</table>

Source: Osama and Qamar, Presentation at Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World 2016

While some individual country estimates of varying validity exist, there are very few that cover the entire set of OIC member countries. Osama noted that the research team found only one study\(^{16}\) which provided a systematic estimate of potential zakat collection in all OIC member countries. This study used three different measures of the minimum asset level that triggers an individual’s legal obligation to pay zakat corresponding to different interpretative schools in Islamic jurisprudence. The authors estimated the potential annual zakat collection in 2006 to be between $50-138B, and this would amount to be about $98-250B in 2014. Zakat represents only one of the three largest potential sources of philanthropy in the Muslim world, and the study includes only zakat estimates. In the absence of validation or any other studies, he argued, this is best estimate of zakat potential in MMCs. Dr. Shariq Siddiqui, Executive Director of the Association for Research on

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\(^{16}\) Shirazi & Amin, 2006, based on Kahf, 1989.
Nonprofit Organizations and Voluntary Action (ARNOVA) in Indianapolis, USA, contended that this study actually underestimates Muslim philanthropy.

Qamar provided a brief quantitative overview of philanthropy in four target Muslim countries: Pakistan, Indonesia, Egypt, and Turkey (to be expanded later by individual country experts).

3.1.2.1 Philanthropy in Pakistan
Qamar explained that the first national study in Pakistan by the Aga Khan Foundation estimated giving at $815 million in 2000.\textsuperscript{17} Data from the first provincial survey in Pakistan (covering about 2000 urban and rural households in Punjab province) reported individual giving of $546 million and zakat proceeds of $206 million in a single year (2009-2010).\textsuperscript{18}

Official zakat collection in Pakistan was reported as $54 million in 2015; however, official figures do not incorporate non-governmental information sources. The Edhi Foundation collects 16% of zakat in Pakistan and the SKMHRC collects PKR $12 million annually.\textsuperscript{19} Qamar suggested that official government sources in most countries fail to fully capture the full magnitude of zakat collection, primarily because of the lack of trust in the government but also because of the injunction that makes it the religious obligation of every Muslim to ensure that zakat is given to eligible poor and destitute individuals.

3.1.2.2 Philanthropy in Indonesia
Indonesia has the highest rate of religiously motivated charitable giving in the world (98%).\textsuperscript{20} The country’s zakat potential was estimated to be around $22 billion (3.4% of GDP) in 2012, based on household surveys and qualitative analysis and data from the National Board of Zakat.\textsuperscript{21} The National Board of Zakat collected between $6 million and $97 million over a seven-year period (2002-2008).\textsuperscript{22} A comparison of Islamic philanthropic organizations with the highest income from fundraising in 2006 and 2011 reported that the income of the 28 largest charities almost tripled from $30 million (2006) to $85 million (2011).\textsuperscript{23}

3.1.2.3 Philanthropy in Turkey
A 2004 survey of Turkish philanthropy reported almost $2 billion in total income from charitable contributions, with 80% of the public participating.\textsuperscript{24} Turkish high-net-worth individuals have a well-entrenched philanthropic tradition, with several large foundations active in individuals’ names. A Turkish economic journal reported that a total of $93 million was donated by the top 50 philanthropists in 2012.\textsuperscript{25} A repeat survey in 2015-2016 reported single year donations totaling around $4.5 billion, representing 0.8% of Turkey’s GDP in 2014.\textsuperscript{26} The more recent survey revealed a decline in charitable giving in Turkey (44% of people donating to charities in 2004; 34% of people in 2015), which Qamar suggested might be attributable to unfavorable economic conditions, peoples’ distrust of others, and a broader unwillingness to contribute to civil society and social groups.

3.1.2.4 Philanthropy in Egypt
Qamar reported the results of a large 2004 survey of Egyptian institutions and individuals.\textsuperscript{27} Local philanthropic contributions were estimated to reach up to $1 billion, with 62.1% of adult Egyptians practicing philanthropy, 85% of them making a donation categorized as zakat but traditionally given at
the end of Ramadan observances, and 42% of them paying a donation categorized as zakat reserved for wealthier individuals, on their total property holdings. Most local charitable organizations depend on individual giving, with donor agencies representing only 1.9% of their annual budgets. A subsequent survey of public donations in 2010, which likely captured only a subset of all charitable givers, suggested that 37.9% of the total adult population donated in all.

Qamar presented a graphic representing findings from World Philanthropic Index, a survey conducted in 144 countries using three basic indicators to investigate giving trends (Figure 3.3).

**Figure 3.3. Top 10 OIC countries on philanthropic index**

![Top 10 OIC countries on philanthropic index](source: Author’s Compilation, Charities Aid Foundation (2015)).

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28 People were asked whether they had helped a stranger or someone they didn’t know in past month; donated money to a charity; or volunteered their time.
Box 3.1 Philanthropy in Muslim Majority Countries: Current Understanding

- Very little is known about the magnitude and nature of giving in Muslim majority countries and the limited available data is outdated and unverifiable.
- *Zakat* and *sadaqah* could be potentially large and sustainable sources of philanthropy, but little is known about how many people actually practice these religious obligations.
- Important differences exist in the motivations and dynamics of philanthropy across countries.
- *Waqf* potentially represents another powerful tool of philanthropy, but knowledge about it is limited.
- Philanthropy in Muslim majority countries is dynamic and evolving: research is urgently needed to understand emerging philanthropic trends.

*Source: Osama and Qamar, Presentation at Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World 2016*

3.1.3 Discussion

Aamir Khan asked for comments on the reliability and scope of the statistics from Turkey, which are the best available. Dr. Ali Carkoğlu, Acting Dean of Koc University, Turkey and the Principal Investigator of the Turkish Philanthropy Study, noted that the survey by the Turkish economic journal presented gathered data from businessmen, who represent the largest charitable donors. His own surveys concentrated on laymen on the street. He explained that the scope is very different in the top tier of Turkey’s (or any country’s) society, with businessmen reluctant to distinguish between their own personal investments and their acts of “corporate social responsibility.” To illustrate, he described a top-ranking philanthropist who took individual credit for his entire company’s “social responsibility” project; other philanthropists were dismayed and asked to be removed from the ranking. While gathering better information about top-tier philanthropic giving is important, he remarked that there are also serious methodological and privacy issues to address. Further, although businesses must declare their charitable donations to the government, the information is not a matter of public record in Turkey. Osama concurred that a key challenge for data collection is the reluctance to declare income/charitable giving due to the potential for association with religious extremism, for example. He stressed that creating effective strategies will require a more precise understanding of giving behavior and motivations.

Saquib Hameed, Chief Executive Officer of Leyton Rehmatullah Blindness Trust (LRBT), remarked that there is an increasing trend among multinational companies towards aligning business interests with corporate social responsibility and/or social investments (which are not actually charity). Hameed wondered if there might be a similar trend among Muslim businesses. Shikoh replied that leading corporations and larger conglomerates (e.g., Nestle) are aligned with global best practices, which include CSR practices. He suggested that even if those organizations’ motivations for giving are aligned with business interests, at least they are making positive contributions.

3.2 CHALLENGES AND OPPORTUNITIES OF MUSLIM PHILANTHROPY: RESEARCH AND POLICY AGENDA

Dr. Shariq Siddiqui (of ARNOVA) opened his presentation with a reference to the dismissal of religious philanthropy over the past 100
years: “We’re having these conversations about philanthropy and how to do it better, but at the same time we’re discarding and not bringing into the equation religious philanthropy, because it’s always considered to be backward and insignificant.” Siddiqui commended the workshop and its participants for taking religious and cultural contexts into account, as well as the work of the World Congress of Muslim Philanthropists (among others) in elevating of philanthropy and this conversation within Muslim community.

### 3.2.1 Civil Society, Philanthropy, and Public Policy

Siddiqui’s presentation centered on the intersection of civil society, philanthropy, and public policy. He remarked upon the global trend toward a “shrinking space for civil society” across the developing world, and majority-Muslim countries in particular.29 He noted that civil society and philanthropy are related concepts, but public policy increasingly discourages civil society efforts, while at the same time philanthropy is increasingly encouraged and viewed as a proxy to fulfill certain traditional governmental responsibilities. In the United States, philanthropy began to assume some governmental roles under Reagan’s administration after systematic government disinvestment from the public sector. The non-profit sector grew rapidly and was driven by the belief that philanthropy and “third-sector” organizations were better equipped for this type of work than the government. In 2016, Saudi Arabia loosened laws to make it easier to set up endowments and foundations, which has been encouraging for donors in Saudi Arabia, where the government is looking to philanthropists for assistance meeting public obligations. In China, civil society is generally discouraged but the government is looking towards philanthropy for economic reasons. The OIC-Islamic Development Bank (OIC-IDB) is examining best practices of waqf, with a view towards enacting laws and recommending best practices for endowments, foundations, and increasing philanthropic resources within Muslim world. The United Nations Human Rights Council is also discussing a fund to “capture” zakat for use in UN work. After a recent strategic planning process, the Gates Foundation will begin work in the Gulf States and Saudi Arabia to investigate strategies for expanding Muslim philanthropic giving. Siddiqui summarized that philanthropy is increasingly being considered as a source of available funds to help solve society’s problems more effectively than is possible by reliance on government expenditure.

Siddiqui underlined a variety of potential approaches. The first is to pursue increased funding for the ‘third sector.’ If governments make it easier for individuals to donate to philanthropic foundations, nonprofits will benefit. The second approach is to create space for civil society actors. Nonprofits integrate philanthropy and volunteerism, which builds social capital and indirectly increases space for civil society actors. The third approach is to provide greater opportunity for corporations and individuals to influence or impact social issues. Saudi Arabia, for example, recently announced an initiative to train one million volunteers over the next four years, build capacity, and fund research to measure impact.

### 3.2.1 Philanthropy through Privatization: Opportunities and Challenges

Siddiqui argued that the increased global push for privatization could provide an important opportunity to leverage public assets by broadening the “philanthropic pot.” When public assets are privatized, the proceeds of sale are transferred to the government and can be spent immediately. Siddiqui suggested that those assets could be turned into a quasi-philanthropic foundation, not unlike a waqf, with their income supporting public services in

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29 Based on data conducted by Civicus Monitor (https://monitor.civicus.org) and a recurring theme in recent Association for Research on Civil Society in Africa (AROCSA) meeting.
perpetuity. He noted that this is a new concept that needs further research, but work along these lines is already underway in cities across the world.30

According to Siddiqui, this nontraditional approach may demonstrate that philanthropists are better than governments at stewarding public assets. However, the approach is fraught with potential challenges. Using the United States under the Reagan administration as an illustration, he showed that the initial influx of government money into nonprofit organizations was huge but, over time, nonprofits received less and less money to perform the same services. Research on contracting practices by Alan Abramson and Lester Salamon has demonstrated that if a government provides health care and then cuts it, citizens will protest. However, if a government provides health care through a nonprofit organization and stops (or gradually reduces) its funding, then “there’s less accountability and less of a connection between you and that nonprofit organization... so it allows government to pass the burden to a nonprofit but also sheds accountability.”31

Federal spending places the burden on the nonprofit sector to provide the existing level of services rather than adding services, and the nonprofit sector is less accountable to the public than the government is to the public. This makes it easier for the government to reduce the footprint of public services over time. Another challenge is that the nonprofit becomes less independent of government, and the government has greater control while expending fewer resources. This is a concern, according to Siddiqui, because their independence is the major reason nonprofits do their work well. When government funds go to nonprofits, it brings this monetary dependency to the forefront. Research shows that this can crowd out philanthropic donations.

3.2.2 Challenge: Philanthropy vs Civil Society

“...If we believe that philanthropy is an individual part of the public ecosystem which can take on roles that government and other parts of the sector would otherwise perform, we may be overpromising and under-delivering in the long term. We have to build a philanthropic infrastructure as part of a larger ecosystem that deals with delivery. Philanthropy works well only within a whole ecosystem which includes business and government as well.”

—Dr. Shariq Siddiqui, ARNOVA

Siddiqui explored the conflict between philanthropy and civil society, highlighting the tension between a short-term solution and a long-term challenge. In the short term, philanthropy is being leveraged where civil society raises concerns, resulting in resources flowing into the sector. While this will ultimately build social capital, the problem is that nonprofit sectors will soon confront the lack of sufficient resources. In the United States, he explained, half of nonprofit funding is governmental, less than 20% comes from individual philanthropy (the largest philanthropic source), and even less comes from corporate and foundation sources.

The nonprofit sector is receiving funds in the short term, but the upshot is that civil society becomes less active and less engaged in public policy, which is crucial for holding the government accountable. Siddiqui reiterated that attention must be paid to the overall ecosystem. While there are things that hospitals and nonprofits do better than government, the government must be held

30 He cited Lester Salamon of Johns Hopkins University as a key proponent.
31 Abramson, Salamon, and Steuerle, 2006
accountable so that its resource contribution does not diminish.

3.2.3 Research Agenda

To leverage philanthropy most effectively, Siddiqui called for greater investment of resources for research. This research should not be limited to measuring impact and determining scope. Rather, philanthropy and accompanying research can serve as laboratories of public policy innovation. The research agenda can serve as a “rallying cry” to make the case that Muslim philanthropy is significant; a key first step is to quantify it by gathering annual baseline data on giving in the Muslim world. For example, baseline data in the “Giving USA” report can be used to predict giving based on GDP and to guide fundraisers’ decisions and strategies. It demonstrates that in the U.S., individuals are more important philanthropic actors than corporations and the religious sector is the largest recipient of individual philanthropy.

The research agenda can also open the door to public policy changes to facilitate philanthropic giving, direct government investment in research, and guide government investment in building the nonprofit sector’s capacity. Siddiqui explained that baseline research is expensive but critical, because it will allow philanthropy to fulfill its most important historical role as “a laboratory of innovation.” According to Peter Drucker, the management specialist whom Thatcher credited with coining the term “privatization” in the 1960s, philanthropy is the most entrepreneurial social sector (including business), because it can take risks without worrying about economic returns. Nonprofits are operating in innovative ways that government and business cannot.

3.2.4 Discussion

During the discussion, Keshavjee underscored the idea that a vibrant civil society is one of the pillars of liberalism (“making a thousand flowers bloom, as it were”). He wondered whether Siddiqui’s model runs the risk of state capture or over-centralization that could impede innovation. Keshavjee noted that most philanthropic donations are currently being spent in a decentralized way, and, in fact, groups like the Indus Health Network might not have emerged in Pakistan if decisions about its establishment had been made centrally.

Siddiqui responded that the question of accountability poses a challenge. In considering philanthropy in the Muslim world, what concerns him is the metrics-driven agenda and the pervasive focus on accountability by stakeholders from major foundations and governments in the Muslim world. The “accountability piece,” he argued, undermines civil society. It runs counter to the entrepreneurship “which really makes our [nonprofit] sector work.” Siddiqui underscored the difficulty of conveying to potential funders the inherent value of entrepreneurship, and explaining the ways in which models with strict accountability measures and restrictions inhibit innovation.

3.3 DONOR-DRIVEN HEALTH CARE DELIVERY: WAYS FORWARD FOR MUSLIM GIVING

3.3.1 Status of Health Care in OIC Member States

Dr. Tariq Cheema, founder of the World Congress of Muslim Philanthropy (U.S.A.), reflected on the status of health care in OIC member states, juxtaposing the increasing disease burden with the widening state service gap. Many member countries do not have homogenous economies because they are at different levels of economic development. Nonprofit sector contributions are on the rise and face increased pressure, because many OIC countries are falling behind on providing important services and fulfilling urgent health care needs. OIC member countries have high burdens of communicable and non-communicable diseases; average life expectancy, child mortality, and nutrition are

32 However, philanthropy must demonstrate social impact, which is harder to measure.
critical issues. Average life expectancy at birth in some of the OIC member countries is still below 55 years; under-five mortality rates are not satisfactory. Undernutrition is still prevalent among children in OIC states, with 36% of children under the age of five recorded as stunted and 22% recorded as underweight during 2010-2011.

3.3.2 Trends in Muslim Giving
Cheema characterized Muslim giving as generous but spontaneous: they wish to give well, but lack interest in partnering or measuring impact. Further, Muslim giving is largely engaged in filling service gaps caused by state inefficiencies and in ‘firefighting’ for manmade or natural disasters. This means that philanthropists typically ignore the question of sustainability. It “leaves very little actually for us to invest in the communities; to invest in our today and tomorrow.” Cheema explained that the legal framework for giving is very restrictive and not donor friendly in many countries. This must be improved to promote philanthropy. Moreover, in the last 10-15 years, laws intended to halt financial flows to terrorist organizations have rendered cross-border giving increasingly difficult. Cheema reiterated the lack of data and research in this area, emphasizing the importance of tapping into the rich resource stream, worth many millions of dollars, from Muslim faith-based giving.

3.3.4 Charitable Health Care: Leading Challenges
Cheema explained that charitable health care is heavily donor dependent and overstretched in terms of human and financial resources. The overreliance on conventional fundraising techniques coupled with the lack of endowments or other social financing instruments highlights the need for innovation, especially related to sustainability. He suggested that hospitals and health care systems may be reluctant to make the shift from a “charity” model to a “social business” model, because they are acculturated to think of themselves as a charity.

3.3.5 Nonprofit Health Care Trends in US
Cheema explained that health care delivery cannot be supported by philanthropy alone. There is no successful model of system driven only by philanthropy in the developed world. About 60% of hospitals and health care systems across the United States have non-profit status and can link their genesis to philanthropy. Furthermore, most hospitals rely on philanthropy to support future capital projects. More than 80% of non-profit hospitals in the United States have a foundation that raises funds in support of the parent hospital or system. However, shrinking hospital operating margins present a major challenge. Medicaid and Medicare in the United States represent a far larger share of GDP than Pakistan’s public health spending, for example. Cheema maintained: “We don’t need to look toward the West. We need to really see and find homegrown answers to our own problems.”

3.3.6 Public-Private Philanthropic Partnerships to Build a Sustainable Health Care Ecosystem
Cheema emphasized that “health care...is not just about dispensing the medicine. It’s about improving the health status of a community.” A holistic, community-focused approach can improve a wider variety of health-related factors, such as sanitation, the environment, and basic education. He argued that investment in and by the community as a whole is a necessity because the best medicines in the world might not work if basic sanitation and health practices are not in place. Philanthropy alone is no longer enough to make a lasting impact. Traditional corporate-responsibility efforts do not address the root cause of the problem either, and free medicines are only part of the solution. He noted that charity rarely goes toward protecting the rights of patients, nor does it instill government accountability or push legislators to increase health care funding. He recommended that donor money should go
toward delivering health at the patient level but also toward advocating for those patients. Volunteering is also an important asset to be leveraged.

Cheema emphasized the urgent need to develop public-private-philanthropic partnerships to build a sustainable health care ecosystem. He offered a set of concrete recommendations:

• Advocate policies that promote a sustainable health care ecosystem;
• Revamp the business model: “sustainability is the key”;
• Shift from sub-standard “free” health care to “subsidized quality care”;
• Introduce social finance instruments;
• Take health awareness seriously;
• Invest in human resources;
• Create long-lasting solutions for global health through a combination of philanthropy, zero profit, and social ventures.

3.3.7 Discussion

Keshavjee suggested that the shift advocated by Cheema away from a “charity mindset” should constitute a move to the social justice mindset, i.e., creating a human obligation toward each other. He expressed concern about the proposed business model, given evidence that although user fees may improve health clinics, they affect the poor disproportionately (mortality increases and outcomes deteriorate when user fees for the poor are imposed). Cheema replied that the proposed business model would not employ interventions that place the financial burden on the patients. Rather, it would aim to create endowments and other social ventures that do not rely on user fees. He referred to various existing models that address how a health care system can be sustainable, but not at a cost to the patients. Osama asked Cheema to speak about the mindset of Muslim donors. Cheema suggested that in the Muslim world, funding should be directed toward the root causes of regional conflicts—and finding amicable solutions for them—rather than focused only on alleviating misery among the poor.

Siddiqui quoted a comment made by Cheema at the Global Donor Forum in Turkey: that conflict cannot be solved, but what can be solved is philanthropy being given to the symptoms of the underlying cause. He suggested that philanthropy should be going toward more strategic missions. Cheema replied that the focus should be placed on the diversification of giving, with emphasis on the future as well as the current situation. He stressed the importance of educating donors about the best ways to manage and direct giving.

Cheema concluded by inviting the group to work with World Congress of Muslim Philanthropists to advance the agenda of health care directed philanthropy.
3.4 MOBILIZING WAQF AS A PILLAR OF PHILANTHROPY: INNOVATIVE CASE STUDIES AND DEVELOPMENTS

“This growing broader trend is the Muslim spending power is being recognized as a category and being recognized as an element that has [a] values-driven component to it. [DinarStandard] is mapping the global landscape of waqf worldwide and its growing applicability towards philanthropy and social impact. We’re vehemently a proponent of a financially sustainable, profitably driven, philanthropic or equitable society model.”

−Rafiuddin Shikoh, DinarStandard

3.4.1 Overview of DinarStandard

Rafiuddin Shikoh of DinarStandard (U.S.A. based with Dubai Branch office) presented his organization as a global leader in Islamic economic growth strategy consulting. DinarStandard works with investment firms, funds, and industry players from key sectors of the Islamic economy. His team is currently engaged in a project to map the global landscape of waqf foundations, with a view to helping them maximize their philanthropic and social impact.

In the most recent Fortune 500 ranking, Shikoh observed, only five companies were located in OIC member states (which represent more than 20% of the global population). None of the top 100 global brands and innovations (e.g., phones, cars, televisions, etc.) are from the Muslim world. He emphasized the importance of building profitable major enterprises in the Muslim world because the potential power of the revenue from such enterprises:

“Today, enterprises have a significant role in philanthropy, and so building our enterprises is a big part, we believe, of social justice, social impact, within our communities.”

3.4.2 State of the Global Islamic Economy Report

Shikoh presented select findings from an annual report on Muslim consumer spending, “State of the Global Islamic Economy.” It focuses on trends in the Muslim lifestyle market, which typically coincides and overlaps with Islamic values. Muslim consumerism plays a very strong role in certain sectors with core products that are directly affected by Islamic law (e.g., Halal food, travel, fashion, and finance). Muslims spent $1.17 trillion in food and beverages worldwide in 2015, which is about 17% of spending in the global market. Within that larger sector, Halal-certified food and beverages were valued at $415 billion in 2015. The value chain of this space is worldwide, Shikoh argued, with 85% of meat and food imported into Islamic countries from non-Islamic countries. He noted that the global healthy and organic food trend is beginning to coincide with the halal food space in an exciting way. For example, the U.S. Saffron Road brand was the most successful new product introduction for Whole Foods, the world’s largest organic foods retailer, and raised the standard of the other Whole Foods suppliers. Muslim spending on travel in 2015 was significant ($151 billion) and the sector is growing. Travel is also affected by Islamic law, he explained, especially in the post-9/11 environment. Muslims are making travel decisions based upon certain preferences.

33 DinarStandard has locations in New York, Dubai, Cairo, Istanbul, Kuala Lumpur, and Jakarta.
34 For example, Walmart’s annual revenue is greater than the GDP of Egypt, Pakistan’s GDP, or Malaysia; Toyotas annual revenue is greater than Pakistan’s GDP.
35 A collaboration of Thomson Reuters, DinarStandard, and the Dubai Islamic Economy Development Centre (DIEDC).
37 The Quran usually refers to halal and tayyab together (tayyab means ‘pure’ or ‘healthy’).
38 It provides hand-slaughtered halal frozen meat from grass-fed animals raised under organic conditions without use of antibiotics.
such as halal food availability and friendliness to Muslim families. In another sector directly affected by Islamic law—modest fashion—spending exceeded $200 billion in 2015. Figure 3.4 explicates the state of the Global Islamic Economy Report.39

![Figure 3.4. State of the Global Islamic Economy report](image)


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Shikoh reported that the overall size of the halal Islamic food and lifestyle sector was $1.9 trillion in 2015 and the market size is projected to reach $3 trillion by 2021, at an 8% compound annual growth rate. Total Islamic finance assets are projected to increase from more than $2 trillion (2015) to $3.5 trillion, at a 9.5% compound annual growth rate.

These trends, argued Shikoh, represent a major global demographic shift that is likely to have a significant impact on the global economy. The youngest population in the world resides in Islamic countries, including the Arab region as well as Indonesia, Malaysia, Pakistan, and Turkey. Shikoh remarked: “It’s a very exciting, this market...and what we’ve been able to contribute to this... is to put a business case around it in a way that investment entities and the global entities can relate to and a language that they understand.” The upshot is keen interest in this market sector from investors and industry players. The largest halal food provider in the world in 2016 was Nestle, and the modest fashion category is gaining momentum among clothing retailers.

The 2015 State of the Global Islamic Economy report included a special brief on health care. It estimated Muslim health care spending at $435.6 billion in 2015, accounting for 5.7% of total global spending on health care (around $7.7 trillion). Global spending on health care includes public (government) spending, out-of-pocket expenses, and private spending on insurance and health care services. Shikoh explained that health care spending trickles down the value chain and affects the whole ecosystem of health care services.

3.4.3 Need and Context of Waqf Development

Shikoh defined waqf (pl. awqaf) as a category of endowment under Islamic law to provide social benefits on a perpetual basis. In Arabic, waqf is related to the verb waqqafa, meaning “to restrain, to detain, or to stop.” One widely cited source for the legal basis of waqf is a statement by the Prophet Muhammad as quoted by a canonical book of traditional narratives (hadith). When the future caliph ‘Umar bin al-Khattab asked for advice about the disposition of a valuable piece of property, the Prophet instructed him: “You may keep the corpus intact and give its produce as sadaqah.” The practice of endowing property as waqf was widespread under Islamic rule in the centuries that followed, giving rise to modern ecosystems of awqaf that include self-funded networks of mosques, schools, hospitals, stores, and residences.

Given that waqf have such a rich heritage of social impact across Islamic countries, Shikoh called for a revival in their use. Estimates of the potential market size range from $105 billion to more than $1.5 trillion worldwide. Today, the waqf landscape is very opaque, lacking formal data, evidence-based impact assessment, or operational efficiency benchmarks. In addition, there is little transparency with regard to the financial health, performance, and social usage of waqf assets. As a result, those assets are not being utilized for the maximum social good. Awqaf already play a strong role in Turkey, Indonesia, Pakistan, and India, but their productivity and utilization are “dismal” when benchmarked to conventional global foundations and endowments worldwide.
3.4.4 State of the Global Awqaf: Select Findings

Shikoh described how DinarStandard has been working in a strategic capacity with the executive office of His Highness Sheikh Mohammed bin Rashid Al Maktoum, Vice President and Prime Minister of UAE and Ruler of Dubai, after Sheikh Mohammed announced a vision for innovating in the space of endowments and awqaf. A new initiative was announced in early 2016 and a new center was launched—the Mohammed bin Rashid Global Centre for Endowment Consultancy (MBRGCEC). The Center has four pillars, one of which is to conduct research on awqaf and other endowments at a global level to develop expertise in this area. Approximately 80% of waqf proceeds in Dubai currently benefit mosques, but the center will advocate for a new vision and strategy which seek to move the focus toward productive social enterprises in health care, education, and other areas.

3.4.4.1 Comparison of Global Awqaf Versus Global Foundations: Geography, Recipients, and Purpose

Shikoh presented a comparison of the geographical distribution of global awqaf versus global endowments (Figure 3.5). As expected, the concentration of endowments is in the U.S., North America, and Europe, with very little in other regions:
To illustrate the priority on health for global conventional endowments, Shikoh listed the top five foundation recipient categories in the U.S. and Europe (in order): health; education; human services; public affairs/society benefit; and arts and culture. U.S.-based foundations applied for 82% of grants for five main purposes: health (22% of grants made); education (22%); human services (16%); public affairs/society benefit (12%); and arts and culture (10%). In Europe, the top five foundation recipient categories include: health; social services; international development and relations; arts and culture; and education and initial job-related training.

European foundations spent most on health and social services (around 50% combined).

As evident by the Dubai’s example on waqf foundations current and planned asset distribution, most funding across most Islamic countries Waqf goes to religious and faith-based activities, including masajid (spaces for Islamic worship) Islamic training institutions, or educational institutions in general. However, there are other areas of increasing focus beyond religious and faith-based activities. As GCC economies look to diversify, government
budgets are becoming increasingly restricted and they are turning to private-sector philanthropy to contribute in the delivery of social services. Thus, governments have a pragmatic incentive to move \textit{waqf} funding toward social service needs at the community level. Health is at the top of the list for planned future spending, so the timing is ideal to engage with \textit{waqf} foundations around the funding of health delivery.\footnote{The Mohammed bin Rashid Global Centre for Endowment Consultancy (MBRGCEC) is in the process of creating a database that maps social needs across all of the Arab markets, per country and in aggregate (obesity and diabetes came up as some of the biggest social needs in UAE; the second biggest cause of medical severity is diseases and death caused by indoor air pollution).} For example, obesity and indoor air pollution are rampant in the UAE, and should be urgently addressed by philanthropic endowments, including awqaf.

### 3.4.5 Innovative Waqf Applications: Case Studies

Despite encouraging work in the \textit{waqf} space, Shikoh noted, a recent study found that awqaf are “falling behind the conventional counterparts” in asset management, investment, and utilization. To better support the development of innovative applications of \textit{waqf}, DinarStandard has identified and benchmarked notable case studies from among over 200 \textit{waqf} foundations that exemplify multiple perspectives of \textit{waqf} management, asset management, beneficiaries, and ecosystems. The Global Wakaf Foundation (Indonesia), part of the ACT Foundation, focuses on non-traditional disaster-related recovery and social services that uses a component of crowd-funding. Its Global Water Program (now in 15 towns) is a very productive \textit{waqf}-based social initiative; there are also programs through which single cattle can be purchased for poor families in need, and programs through which orphans can run grocery stores. Hamdard \textit{Waqf}, a renowned foundation in South Asia and India, focuses on herbal, pharmaceutical, and Eastern aspects of medicine as well as funding research and development, education, scholarly publication, medical services, and student scholarships. Shikoh commended it as productive, sustainable, and socially impactful. The IHH Humanitarian Relief Foundation (based in Turkey) provides urgent relief support in 135 countries. It led the Humanitarian Flotilla initiative, provides much support work for Syrian refugees, and focuses on humanitarian diplomacy, which is unusual for a \textit{waqf}.\footnote{It helped to mediate the peace process between the government of the Philippines and the Moro Islamic Liberation front in 2012.} More than 90,000 children in 56 countries (including the Palestinian territories) are supported by its orphanage program and its health program provides support of various kinds to expatriate health care workers. Tabung Wakaf Indonesia, a subsidiary of Dompet Dhuafa, is an innovative program focused on taking \textit{waqf} properties and using them productively—for example, by building hospitals on recovered land. The Dubai Endowment Sign campaign began with a new \textit{waqf} and endowment-focused initiative in Dubai. An endowment is being established that will enable organizations in Dubai to conduct part of their business as a \textit{waqf}. As part of this program the Road and Transport Authority has committed a certain number of taxis to be dedicated as awqaf (with a special logo) to fund special causes.

### 3.4.6 Ways Forward for Sustainable Muslim Philanthropy

Shikoh reflected on possible ways forward for sustainable Muslim philanthropy. First, he reiterated the tremendous potential for awqaf to have social impact in Islamic countries. The MENA region, East Asia, South Asia, Central Asia, and Sub-Saharan Africa account for only 10% of the total conventional endowment assets worldwide. By contrast, these five regions, which contain most of the OIC countries, account for 97% of global \textit{waqf} assets. Therefore, Shikoh concluded: “In order to access foundation money in the markets of the Islamic countries, awqaf are the means.”

There is an emerging focus on \textit{waqf} growth and development across the OIC markets and the OIC-IDB has a program to advise governments on setting regulations. \textit{Waqf} foundations are beginning the needed shift in future focus to health. While religious services
and education are currently the top social needs being served by awqaf, health services were reported as the most urgent need by foundations surveyed. He suggested that Harvard Medical School Center for Global Health Delivery - Dubai should engage with the new Mohammed bin Rashid Global Centre for Endowment Consultancy (MBRGCEC) in connecting foundations to the most needed projects related to health services, and in building a database of projects to present to foundations. Finally, the emerging trend of innovation in waqf fundraising needs to be further bolstered and supported by innovative think-tank solutions aimed at developing sustainable funding for health services; he cited Fintech as an example.

3.4.7 Discussion

With respect to local awqaf, Abdul Bari Khan, the Chief Executive of Indus Hospital Network, asked whether all mosques were classified as assets. Shikoh replied that they are, alongside other religious assets, cash waqf assets, and physical assets. He noted that India has more than $23 billion in waqf assets that are managed, monitored, and controlled by a special government committee. Pakistan is more opaque about the size of waqf assets, and there is minimal awareness or engagement with asset management or financial institutions. Shikoh stated that a future goal is to bring asset management players and the Islamic asset management space together to elevate waqf asset management to the level of top-tier endowment foundations. His organization’s survey of 259 waqf institutions gathered useful data about the waqf assets’ estimated production, fund management strategies, governance, deployment, returns of funds, and institutional satisfaction.

Dr. M. Amr El Tayeb, a Professor of Neurosurgery at Cairo University and CEO of Smart Medical Services (Egypt), and former director of the medical division of the Resala Charity Organisation of Egypt, asked about the legal framework for private-public philanthropic cooperation in waqf foundations, for example, could companies undertake waqf as a partnership inside a public company, with a guarantee of proper management and returns. Shikoh responded that government regulation is an important issue, and awqaf differ from conventional endowments in their perpetuity and irrevocability. In the Maliki school of Islamic jurisprudence, waqf can be revocable if the purpose changes but this does not hold true in other schools of Islamic thought. The UAE have adopted a practical Maliki stance, under which a waqf to benefit refugees, for example, does not need to be endowed in perpetuity. El Tayeb highlighted a key legal challenge related to waqf: they can be registered, but the legal process of challenging them is murky and not well regulated. Concerns about waqf ahli (family waqf) are driving the development of a regulatory framework for dealing with challenges. This will also benefit public waqf regulation. The legal structure is still in its infancy in many Islamic countries, although the OIC-IDB is advising countries about how to develop a regulatory framework with state banks, central banks, and religious entities. Shikoh drew parallels with historical issues surrounding Islamic finance, in which Islamic banks were getting taxed twice and regulation was put in place to streamline it.

Hilman Latief, of the Muhammadiyah Network, noted that land awqf remain very popular in many Muslim countries, but cash waqf is growing in urban areas. However, the practice of using these two forms of waqf together in endowments so that better management of the waqf can be ensured is not yet well organized. Consequently, the land holdings of awqaf are often ill-managed, abandoned, and unproductive. Latief asked for examples of efforts to bring together the private sector and the awqaf to directly support health care. Shikoh replied that there are not many. He referred to the South Asian Hamdard Waqf.

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44 Such as fundraising by television, “Educare” waqf fundraising projects and waqf crowdfunding platforms (e.g. WaqfWorld in Singapore).
45 Land is the most common form of waqf assets.
46 There is some activity in Turkey along these lines, but it is minimal.
and the Saudi Rajhi Foundation Waqf, but noted that they do not strategically respond to health issues. It is possible that many awqaf have small components addressing health care (e.g., Tabung Wakaf Indonesia using land to set up a nonprofit hospital). However, none are dedicated to health care in their entirety.

Carkoğlu described some complexities from the Turkish perspective. The Directorate of Foundations in Turkey is responsible for managing all mosques remaining from Ottoman period, many of which are of very high value but have not yet been formally assessed. Transnational connections come into play because many prominent Ottoman families have foundation assets in other countries (e.g., Egypt, Bosnia, Iraq, and Syria) that remain in the status of private family foundations today and are run with funds received from abroad. He asked if there is any precedent for multi-founder foundations organized as shareholder enterprises. Shikoh had seen foundations set up in partnership but not a multi-founder shareholder system, although he thought it would make sense as a strategy for combining resources.

Shikoh noted that, as with any investment vehicle of this kind, administrators are reluctant to spend down the principal of waqf endowments, so that the income potential from smaller awqaf is limited. He emphasized that there must be wider pool to effectively support projects and promote productivity.

Carkoğlu asked whether waqf impedes innovation because it protects accumulated assets. He observed that unless it is productive and competitive, it impedes the development of capital. Thus, evaluating how assets are managed is extremely important. Shikoh replied that conventional endowments have demonstrated great productivity with well-documented rates of return, growth, and increase. This comparison to conventional peers demonstrates that waqf should not stifle innovation because their study was benchmarked against the setup, management, and governance of conventional endowments.

The management of public awqaf should achieve a level of sophistication on par with running a profit-driven fund, but with proceeds going to a social cause.

Hameed asked about the range on the assets of waqf endowment funds and Osama questioned the cumulative asset value. Shikoh estimated the cumulative asset value of awqaf at $403 billion worldwide, and noted that it may be possible to define ranges broken down by country. He cautioned that this is just an initial attempt at quantification because there is so little available data, and any study may consequently be limited.

Hameed asked whether the movement channeling waqf income toward education and other humanitarian causes is really feasible. Shikoh replied that foundations surveyed reported a shift in focus from religious giving toward social issues, but the foundations will require assistance in transition and management. Unfortunately, there are no good waqf asset management entities and financial management infrastructure for awqaf is lacking. When foundations give money as waqf for masajid (prayer spaces), for example, there is no expectation of future growth. Decisions about donating to a hospital, research, or medical care require assessing its management and how the “fruits of the corpus” will be generated and supported.

Siddiqui noted a parallel debate in the U.S. about whether the “5% payout rule” (a legal requirement for private non-operating foundations to distribute five percent of the value of their net investment assets annually in the form of grants or eligible administrative expenses) should allow a lower level of payouts to offset inflation, permitting foundations to pursue their missions indefinitely. Similar calculations cannot be made in the waqf market because of provisions in Islamic law mandating that people to pay off everything they earn from investments each year. Shikoh replied that such calculations may be possible, especially if the existing corpus of Islamic law there is no such system. Everyone involved in the governance of a foundation has an equal say regardless of the proportion of endowment that they have contributed. This commonly causes governance conflicts.
for cash awqaf that require adjustment for inflation and currency fluctuation. However, current financial management for Islamic endowments is not even at an amateur level. Siddiqui noted that trustees can make rules that 10% of earnings be reinvested back into a waqf, but cash awqaf are generally so small that their returns will not sustain them.

Siddiqui proposed a community foundation model for waqf management in cases where there is money to start a perpetual foundation, but the founders are reluctant to hire a manager.
4 National Perspectives on Philanthropy and Public Health

4.1 PHILANTHROPY AND GIVING BEHAVIOR IN TURKEY: EVIDENCE FROM TURKISH PHILANTHROPY SURVEY

Dr. Ali Carkoğlu of Koç University in Istanbul presented data on philanthropy and giving behavior in Turkey, based on a survey carried out in partnership with S. Erdem Aytaç (Koç University) with support from the Third Sector Foundation of Turkey (TÜSEV). Its findings were published in the 2016 report, “Individual Giving and Philanthropy in Turkey.” The 2016 study is the second wave – with some improvements - of an earlier survey carried out in 2004. Carkoğlu noted that the Turkish Study is one of the most extensive national surveys of philanthropy in the Muslim World and could be used a template for other countries. However, this will require identifying potential funding sources.

Box 4.1. Individual Giving and Philanthropy in Turkey

TÜSEV has been working to improve the legal, financial and operational infrastructure of the not-for-profit sector in Turkey since 1993. In that 23 years, it has given increasing attention to generating and sharing knowledge with its partners and civil society. The vision of a stronger civil society has motivated a search for solutions to common problems experienced by the civil society organizations in Turkey. Under TÜSEV’s Research and Publications program, it conducts research and publishes reports to shed light on important questions about civil society in Turkey, in areas such as the enabling environment, philanthropy, and social entrepreneurship.

Donations and philanthropy play a vital role in the financial sustainability of the not-for-profit sector. TÜSEV has been working to generate up-to-date data on philanthropy in Turkey and to develop the infrastructure for sharing it. In 2006, it published the first comprehensive report on the subject, Philanthropy in Turkey: Citizens, Foundations, and Pursuit of Social Justice. The most recent report, Individual Giving and Philanthropy in Turkey (2016), updates and expands the information on individual giving while reporting on giving trends and public perceptions of civil society and philanthropy. TÜSEV firmly believes that the most efficient way for increasing the level of knowledge about philanthropy in Turkey will be achieved through dedicated research.

Source: Carkoğlu, 2016

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4.1.1 Perceptions of Philanthropy and Philanthropic Activities

Carkoğlu explained that the research was carried out in 2015 among 2,495 people in 68 Turkish provinces.\(^{50}\) Findings were compared with those from the 2004 survey (published in the 2006 report). Compared to the 2004 sample, a smaller proportion of people were married and families were smaller, with implications for household per capita income.

Carkoğlu also pointed out that the number of university graduates had nearly doubled and that Kurdish people seemed more willing to identify their nationality in 2016 than in 2004 (Figure 4.1):

**Figure 4.1. Characteristics of sampled populations, 2004 and 2016**

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Number of Interviews</strong></td>
<td>2,495</td>
<td>1,536</td>
</tr>
<tr>
<td><strong>DATES OF THE FIELDWORK</strong></td>
<td>August 29 - November 29 2015</td>
<td>February 18 - March 11 2004</td>
</tr>
<tr>
<td><strong>NUMBER OF PROVINCES RESEARCH WAS CONDUCTED IN</strong></td>
<td>68</td>
<td>20</td>
</tr>
<tr>
<td><strong>WOMAN (%)</strong></td>
<td>50.2</td>
<td>49.4</td>
</tr>
<tr>
<td><strong>MARRIED (%)</strong></td>
<td>67.1</td>
<td>72.6</td>
</tr>
<tr>
<td><strong>AGE (AVERAGE)</strong></td>
<td>41.6</td>
<td>39.4</td>
</tr>
<tr>
<td><strong>MEDIAN AGE</strong></td>
<td>36</td>
<td>37</td>
</tr>
<tr>
<td><strong>NUMBER OF PEOPLE IN THE HOUSEHOLD (AVERAGE)</strong></td>
<td>3.5</td>
<td>4.3</td>
</tr>
<tr>
<td><strong>UNIVERSITY GRADUATE (%)</strong></td>
<td>14.8</td>
<td>7.5</td>
</tr>
<tr>
<td><strong>PRIMARY SCHOOL OR BELOW EDUCATION (%)</strong></td>
<td>39.5</td>
<td>60</td>
</tr>
<tr>
<td><strong>URBAN RESIDENT (%)</strong></td>
<td>81.2</td>
<td>65</td>
</tr>
<tr>
<td><strong>KURDISH-SPEAKING (%)</strong></td>
<td>14.8</td>
<td>12.6</td>
</tr>
<tr>
<td><strong>HOUSEHOLD INCOME (MONTHLY AVERAGE, TL)</strong></td>
<td>1,739</td>
<td>675</td>
</tr>
<tr>
<td><strong>HOUSEHOLD INCOME (MONTHLY AVERAGE, USD)</strong></td>
<td>602</td>
<td>511</td>
</tr>
<tr>
<td><strong>HOUSEHOLD INCOME PER CAPITA (MONTHLY AVERAGE, TL)</strong></td>
<td>659</td>
<td>219</td>
</tr>
<tr>
<td><strong>HOUSEHOLD INCOME PER CAPITA (MONTHLY AVERAGE, USD)</strong></td>
<td>228</td>
<td>166</td>
</tr>
</tbody>
</table>

Source: TUSEV, 2016 and 2006.

\(^{50}\) Thirteen provinces were not included because they are relatively sparsely populated.
To capture survey participants’ general attitudes about societal relations, they were asked: “Do you think most people can be trusted? Or can’t you be too careful?” In 2015, 90% responded that one can never be too careful, compared with 88% in 2004. Carkoğlu remarked that this reveals the negative side of social capital, a type of parochial trust that does not help to breed tolerance or cooperation in society and thus is detrimental to philanthropic giving. He construed this as a Turkish cultural trait, which explains why responses did not change significantly since 2004.

Both surveys (2004 and 2015) asked participants about their perceptions of both personal and CSO influence in addressing society’s problems. Responses to the survey question “As a citizen, to what extent do you think you can have an influence in addressing existing problems towards creating a better society?”:

- Not influential at all: 2004, 9%; 2015, 7%;
- Not influential: 2004, 19%; 2015, 15%;
- Neither influential nor not influential: 2004, 25%; 2015, 36%;
- Influential: 2004, 41%; 2015, 36%;
- Very influential: 2004, 5%; 2015, 5%

Responses to the question, “To what extent do you think CSOs such as associations, foundations and other charity organizations can have an influence in addressing existing problems towards creating a better society?”:

- Not influential at all: 2004, 4%; 2015, 5%;
- Not influential: 2004, 9%; 2015, 14%;
- Neither influential nor not influential: 2004, 23%; 2015, 31%;
- Influential: 2004, 54%; 2015, 41%;
- Very influential: 2004, 10%; 2015, 7%.

Carkoğlu noted that people’s perceptions of their own influence and of CSOs’ influence in addressing society’s problems have both deteriorated since 2004. In 2015, people also reported that they did not think that CSOs are particularly influential in the Turkish policy making apparatus. Together with the decrease in social capital, these results do not paint a particularly optimistic picture for philanthropic giving in Turkey, he remarked.

Modern Turkish does not have a word that corresponds directly to ‘philanthropy,’ Carkoğlu said. The closest approximation in Turkish is a phrase that translates roughly to “help lovingness,” but this does not map closely onto the concept of philanthropy. Survey participants were asked: “What comes to your mind when you think of philanthropy?” It was an open-ended question that that could be answered in any way.

The following figure (4.2) captures the responses of the open-ended question about activities perceived by Turkish respondents to be philanthropic. Carkoğlu noted that interestingly, religious motivation was not at the forefront of the responses:

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51 Responses: not influential at all, 23%; a little influential, 49%; quite influential, 14%; very influential, 3%; don’t know / no response, 11%.
52 This question was not asked in 2004.
53 Until the 1920s, when Mustafa Kemal Atatürk nationalized the waqf foundations of Republican Turkey and launched a systematic campaign to root out Arab and Islamic influence from the Turkish language, the Arabic-derived term cemiyet-i hayriye was used in precisely the sense of ‘a philanthropy.’
Participants in 2015 were asked another open-ended question about what they thought were the most frequent philanthropic activities in Turkey. Most answered by referring to aid in the form of food, clothing, or fuel—nearly triple the number who thought that religiously motivated giving was the most common form. Health-related aid was only referred to by 2% of the sample (Figure 4.3):

**Figure 4.3. Perceptions of the most frequent philanthropic activities in Turkey**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aid in the form of food, clothing and fuel</td>
<td>78%</td>
</tr>
<tr>
<td>Giving zakat-sadaqa</td>
<td>3.7%</td>
</tr>
<tr>
<td>Religiously motivated giving</td>
<td>3.7%</td>
</tr>
<tr>
<td>Giving scholarships to students, building schools</td>
<td>3.3%</td>
</tr>
<tr>
<td>Helping the poor</td>
<td>7.4%</td>
</tr>
<tr>
<td>Giving cash donation</td>
<td>3.2%</td>
</tr>
<tr>
<td>Helping the refugees</td>
<td>3.8%</td>
</tr>
<tr>
<td>Donations to Turkish Red Crescent</td>
<td>2.8%</td>
</tr>
<tr>
<td>Natural disaster relief</td>
<td>2.9%</td>
</tr>
<tr>
<td>Health related aid</td>
<td>2%</td>
</tr>
<tr>
<td>Helping the disabled, sick and the elderly</td>
<td>1.4%</td>
</tr>
<tr>
<td>Food aid during Ramadan</td>
<td>1.4%</td>
</tr>
<tr>
<td>Helping the orphans</td>
<td>1.1%</td>
</tr>
<tr>
<td>Other</td>
<td>4.4%</td>
</tr>
<tr>
<td>DK/NR</td>
<td>13.9%</td>
</tr>
</tbody>
</table>

Source: TUSEV, 2016
4.1.1.1 Incidence and Magnitude of Individual Giving in Turkey

Data about the incidence and magnitude of individual giving represented the most important component of the report, said Carkoğlu. In both 2004 and 2015, participants were asked who they thought was primarily responsible for helping the poor. A key finding is that people perceive it to be the state’s responsibility, up to 44% in 2015 from 38% in 2004. Other common responses were that it is the responsibility of ‘well-endowed citizens’ (2004, 31%; 2015, 30%) or of ‘all citizens’ (2004, 21%; 2015, 19%). Less common responses included ‘civil society organizations’ (2004, 5%; 2015, 4%) and ‘religious citizens’ (2004, 4%; 2015, 2%).

A hypothetical question asked how people would donate if they had an available sum of money. Carkoğlu explained that the responses underscore the parochial nature of Turkish giving behavior which prefers giving to those individuals they know best rather than to community organizations. The most common responses were “to a relative in need” and “to a person in need, who lives in the same neighborhood” (Figure 4.4).

Figure 4.4. Preferred donation recipients

Source: TUSEV, 2016

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He attributed the increase in “a person in need who speaks the same language and is from the same culture as you” as the responses of nationalist Turks who do not want to help the Kurds.
4.1.1.1 Informal Direct Aid
Participants were asked if they preferred one-to-one direct giving (informal direct aid) or giving through a relevant organization. Given the parochial donating preferences, Carkoğlu noted, it is unsurprising that people predominantly preferred direct giving in both 2004 (87%) and 2015 (88%). There is no need for an intermediary institution when one is donating to friends or neighbors.

In 2015, participants were asked: “Would you prefer to donate (a) to those in need, (b) to a public institution or (c) to a civil society organization?” The predominant response was that it does not matter (39%), but those who expressed a preference preferred public institutions (34%) over CSOs (18%). Informal one-to-one direct help is an important cultural tradition in Turkey, noted Carkoğlu. However, the popularity of direct aid significantly declined between 2004 (44%) and 2015 (34%).

Another question focused on the socioeconomic determinants of direct giving behavior. According to the survey, primary school graduates (or less) and people with a monthly income no more than 1500 Turkish lira were significantly less likely to engage in direct giving. Those who said that they had donated were asked to provide a subjective estimate of the value of those donations. Most participants responded that they had donated less than 10 Turkish lira ($40 at the time) in the past year. Carkoğlu summarized that direct giving behavior in Turkey is infrequent, has a relatively declining incidence, and donations are relatively small in quantity.

The four most common reasons cited for informal direct giving, rather than giving to an organization, were:

- “The amount of my donation is small”: 2004, 53%; 2015, 52%
- “I do not give to organizations because I donate irregularly, only when I come across someone in need”: 2004, 21%; 2015, 26%
- “I recognize such organizations but I do not trust them”: 2004, 12%; 2015, 13%
- “I do not recognize such organizations”: 2004, 9%; 2015, 5%

There was an increase in the number of people who reported giving money to street beggars, from 45% in 2004 to 49.6% in 2015. Of those who did give money to beggars, most (57%) reported giving less than 10 Turkish lira per month.

He noted that religiosity does not seem to make a significant difference in direct giving behavior. In response to the question “Do you take religious obligations into account while determining the amount of your donation?” the preponderance of negative versus positive answers shifted between 2004-2015. The proportion of people who responded “yes” decreased from 51% in 2004 to 47% in 2015 even though the general perception of the degree of religiosity in the Turkish society, as expressed in their voting pattern and other overt behaviors, seems to have grown from 2004 to 2015. Carkoğlu interpreted this decline as signaling that something other than religiosity is at play in making giving decisions. The surveys lend some credence to the notion that, perhaps, with the exception of street arms, the majority of Turkish people view philanthropy from a civic responsibility rather than a religious lens. The evidence here is clearly non-conclusive and needs further examination and elaboration.
4.1.1.2 Religiously Motivated Donations

Another set of survey questions focused on religiously motivated donations. Participants were asked if they had given *sadaqah* in the previous Eid-al-Fitr (Ramadan Feast) and if they had given *zakat* in the previous year. The incidence of “yes” responses declined significantly for both *sadaqah* and *zakat*.

Carkoğlu explained that the *zakat* decrease can be attributed to economic stagnation in 2015, but the reasons for the decrease in Eid-al-Fitr giving is less clear (Figure 4.5):

![Figure 4.5. Sadaqah giving (left) and zakat giving (right)](image)

Source: TUSEV, 2016

4.1.2 Civil Society and Institutional Mediation in Donation Making

In both 2004 and 2015, participants were asked about their participation in CSO activities over the previous year, and participation in all four types of activities significantly declined (Figure 4.6):
In 2015, participants who reported having made donations were asked to name the recipient organization or institute. The two most common responses were to “mosque/Quran teaching courses/religious associations” (13.7%) and to the Turkish Red Crescent Association (12.6%). Carkoğlu reported that 16% of donations greater than 25 Turkish lira were made to religiously-motivated organizations, 24% to state-mandated and partially state-mandated organizations, and about 52% to CSOs. He noted that some of the state-mandated donations come from, for example, enforced collection in schools. Most participants estimated the value of the most recent donation as less than 100 Turkish lira (<50 TL, 39%; 51-100 TL, 29%). He noted that CSOs are more likely to receive donations if they are recommended by an existing donor and if they provide a “good giving experience.” Therefore, he emphasized the importance of knowing how to ask for donations in the most effective way.

Interestingly, most people did not express an opinion about how their donations should be used (2004, 65.7%; 2015, 51.2%). Around one-third of participants (2004, 35%; 2015, 32.5%) replied that they received reports from the recipient organization regarding its activities. Carkoğlu thought this result was likely too high to be believable, but he conceded that apparently some explanation is being given to donors. Participants also reported using new channels for giving in 2015: 7.5% used mobile giving (SMS); 1.9% used online giving; and 1.3% took part in crowdfunding.

The survey also asked, “What are the foremost foundations and associations that come to your mind among the ones active in Turkey?” The foremost foundation reported was Kızılay, the state Red Crescent organization (26.8%), but Carkoğlu attributed this to people remembering Red Crescent from their school days. The second most common reply was Losev, a private leukemia foundation (9.8%), which had had recent success in raising funds through TV commercials. Environmental associations were also commonly reported. The most trusted organizations were state-mandated
civil society organizations. Obligatory donations (e.g., to gain a child’s admission into a certain school) were much more prevalent in the 1990s, but have dropped from more than 15% to around 1% in 2015. Carkoğlu attributed this to the success of present government’s policy of increasing the funds allocated to public institutions.

4.1.3 Estimated Value of Turkish Giving

Moving on to the overall picture in 2015, Carkoğlu presented the estimated financial value of direct giving as well as donations made to organizations, in average per capita terms (Turkish lira):

- Beggars: 53.2
- Sadaqah: 41.9
- Zakat: 41.9
- Relatives: 41.1
- Others: 18.6
- Organizations: 16.7
- Neighbors: 12.9
- Obligatory giving: 2

Carkoğlu estimated the total annual value of donations in Turkey to be 13.7 billion Turkish lira (approximately $4.5 billion and 4.15 billion Euro). This amount is equal to 0.8% of Turkey’s GDP in 2014. He compared that total to the budget for select government ministries: Director of Religious Affairs, 6.4 billion Turkish lira; Ministry of the Interior, 4.6 billion Turkish lira; and Ministry of Health, 4.1 billion Turkish lira. Measured only in budgetary terms, then, the magnitude of philanthropy is very significant. In comparison to Western countries, Belgium and Spain, for instance, have about the same or lower percentage of their GDP in institutional donations. Turkey has a larger share of giving as a share of GDP than the UK, which is at the top of the European rankings. In other words, when direct informal giving is included in the total, Turkey devotes a larger percentage of its GDP to donations than any other European country. Carkoğlu noted that other countries do not collect data about informal giving, but this is, perhaps, because those countries generally do not have the same historical tradition of informal direct giving to help the needy, so the numbers are not likely to be as significant. He predicted that Turks may in fact be the greatest donors in Europe. He concluded by cautioning that this type of research is difficult to perform because the concepts involved are difficult to measure; more work is needed to collect and analyze the data. However, this report represents an important step in the right direction.

4.2 ISLAMIC PHILANTHROPY AND HEALTH CARE DELIVERY IN INDONESIA

4.2.1 State Regulation of Zakat in Indonesia

Dr. Hilman Latief, Universitas Muhammadiyah Yogyakarta (Indonesia) traced the history and current landscape of state regulation of zakat in Indonesia, home to the largest Muslim population in the world. At the national level, regulation began with a Presidential Letter in the 1970s. The president at that time, Suharto, wanted to regulate zakat and install himself as national Aamileen (zakat-collector), but this was not publicly accepted. The government issued Zakat Law, No. 39 Year 1999 in order to regulate the governance of zakat in Indonesia. This Zakat Law placed the government agencies and civil society organizations on relatively equal footing; however, a new or amended Zakat Law was issued in 2011 designed to give more authority to the government-sponsored agency called the National Board of Zakat (BAZNAS), which determines how to allocate zakat funds. In November 2016, BAZNAS implemented the

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56 He noted that the largest sum was given to beggars, and surmised that this could have arisen because the sum was calculated based on responses to the question of how much was given in the past month, which was multiplied by 12. (Giving over the past year was considered too difficult to estimate.) He offered the caveat that the calculations are predicated on assumption that people give the same amount every month.
new nationalized regulation of zakat based on the 2011 Zakat Law.

Before the new law was imposed, however, government agencies and civil society organizations collaborated in a revision to allow space for civil society organizations to run charities, including zakat. District- and provincial-level governments have also issued a zakat regulation (Perda Zakat). Civil servants are strongly encouraged to channel their zakat funds through government agencies. BAZNAS has authority to accept zakat donations from civil servants, and state-owned companies are required to channel zakat money through BAZNAS. However, efforts to collect zakat fund from state-owned companies are not always successful, partly because many state-owned companies prefer establishing their own zakat organizations, instead of giving the collected funds to BAZNAS.

In 2012, BAZNAS spent 31% of the zakat expenditure on medical and healthcare assistance, behind education and relief-humanitarian aid. In subsequent years, the percentage of zakat funds allocated for healthcare by Baznas decreased. Latief explained that zakat governance in Indonesia is not centralized.

### 4.2.2 Case study: Increase of Zakat Collection After Disaster

Latief used a case study from Indonesia to illustrate how zakat collection increases after a disaster. After the tsunami in Aceh in 2004, international agencies increased humanitarian assistance to the region which peaked at $1 billion in 2005. In the subsequent decade, those international funds decreased overall while zakat funding has continued to increase steadily, growing thirty-fold during the period (Figure 19). The disaster, Latief explained, also served as a point of departure for civil society organizations, Muslim charities and Muslim organizations more generally to revive “the zakat idea in society.” After the disaster, many Muslim organizations started collecting zakat again, and they are now registered with the government.

#### Figure 4.7. Total estimated zakat collected and international humanitarian assistance received

![Chart showing zakat collected and international humanitarian assistance](image)

Source: Stirk, 2015.

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57 Latief, 2014.  
58 Stirk, 2015.
4.1.3 Collection of Zakat and Sadaqah in Indonesia

Latief provided data from government-sponsored agencies in Indonesia about zakat and sadaqah collection. Based on a report that surveyed 155 zakat organizations,59 both civil society organizations (n=48) and government organizations (n=92) saw growth in the total amounts collected between 2009 and 2010:

- Civil society organizations: 52.3% growth (304,316 million IDR / 464,284 million IDR)
- Government-based organizations: 15.1% growth (317,832 million IDR / 365,724 million IDR)
- Total zakat and sadaqah collection: 33.5% growth (622,148 million IDR / 830,007 million IDR)

59 Mintarti et al., 2012.
60 Examples of the latter include financing micro-economies and income-generating projects.
61 There is a current debate about whether “productive zakat” is acceptable under Islamic jurisprudence.
62 He explained that these figures are underestimates because many zakat entities do not report to the government.

Indonesia divides zakat-supported programs into two categories: ‘consumptive’ (housing, education, health care, and infrastructure) and ‘productive’ (economic empowerment).62 The same survey report found that between 2009-2010, distribution of zakat to consumptive programs increased from 26% to 29% and distribution to productive programs decreased from 74% to 71%.61

4.1.4 Zakat Spending on Health Care in Indonesia

Latief presented data from the National Zakat Board’s Central Office about zakat collected between 2014-2015.62 He noted that 60% of Zakat in Indonesia is collected by the government, and the remainder is collected by civil society organizations (Table 4.1):

Box 4.2 Trajectory of Indonesian Zakat Development

Debates continue about how to regulate zakat after the enactment of Law No. 23 Year 2011. In response to this law, The FORUM ZAKAT (Association of Indonesian Zakat Organizations) discussed possible options for zakat governance, including:

- A non-state independent body (due to concerns about corruption and undermining civil society);
- An independent state-appointed body (such as a commission) allowing for indirect government involvement;
- The State’s agency under the auspices certain ministries, such as Religious Affairs or Finance.

Yet civil society and especially philanthropic organizations are facing problems, because the national government is attempting to take over and prevent civil society from organizing or collecting zakat, which would force all zakat to be channeled through a bank that lacks sufficient capacity.

Source: Latief, Presentation at Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World 2016
Table 4.1. BAZNAS annual zakat collection, 2014-2016

<table>
<thead>
<tr>
<th>Year/BAZNAS</th>
<th>Zakat collection nationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>2.77 trillion IDR (20.4 billion USD)</td>
</tr>
<tr>
<td>2015 (Projection)</td>
<td>4.22 trillion IDR (31.1 billion USD)</td>
</tr>
<tr>
<td>2016</td>
<td>8 trillion IDR (59.1 billion USD)</td>
</tr>
</tbody>
</table>

Source: Latief, Presentation at Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World 2016

According to data from the Indonesia Statistics Bureau, there is still a critical lack of health facilities in the country. In 2013 there were only 1725 general hospitals serving the population of 30 million people. In 2014, Indonesia’s total health expenditure as a percentage of its GDP was only 3.1%. Latief noted that zakat spending on health care projects decreased between 2002 and 2015. The reasons are unclear, but Latief surmised that a contributing factor may be the conception of poverty as strictly related to food aid, rather than its more sophisticated cross-sectoral and integrated understanding (Figure 4.8).

Figure 4.8. BAZNAS expenditures by category, 2012-2015

Source: Latief, Presentation at Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World 2016

He explained that zakat organizations are generally less focused on health care issues and only a few zakat organizations have set up permanent clinics, focusing instead on direct aid. This is despite the insufficient number of health care facilities and the fact that the Indonesian government’s expenditure on health care is smaller than other countries in Southeast Asia. However, Latief presented examples of civil society zakat organizations that are engaged in the health space in Indonesia. Dompet Dhuafa has health clinics providing services to 41,328 families, leads the Zero Tuberculosis Campaign, and partners with the government health insurance program. Rumah Zakat (RZ) manages integrated community development in 754 locations (villages). It provides free mother and children health services, clinics (general health services), health preparedness, baby nutrition, integrated services, and health promotion. Several other organizations
provide health care for the poor, including YDSF, Muhammadiyah Zakat Division, DPU Daarut Tauhid, Al-Azhar Peduli, and Pos Keadilan Peduli Ummat.\textsuperscript{63} Universal health coverage is gradually taking root in Indonesia. The government and insurance-based health care schemes (BPJS) have adopted promotive, curative, and preventive approaches and provide services such as primary health services, cataract surgery, maternity care, dentistry, surgery, and so on. Latief noted that although the schemes help many people, they have sidelined civil society (zakat organizations) in the health sector because of the excessive number of requirements small private clinics must fulfill to partner with government insurance. Many people now receive care in government-run hospitals rather than in small civil society-run clinics. A new trend has seen the private sector work with Islamic philanthropies and there are projects in the pipeline with financing from international or multinational companies. He noted that there are waqf philanthropic organizations in Indonesia, but they are primarily concerned with Islamic education and not health care issues.

4.2.5 Discussion

Latief was asked about the effectiveness of corporate zakat and about how stringently the Zakat Law is applied to corporations in Indonesia. He replied that that corporate zakat can be implemented but is subject to many requirements (e.g., that the CEO and shareholders are Muslim). The Zakat Law in Indonesia does not address corporations and even before it was promulgated in 2011, corporations had set up zakat agencies as a type of corporate foundation through which workers collected and distributed zakat. However, these internal foundations are not mandated by the Zakat Law or publicly listed.\textsuperscript{64}

4.3 THE LANDSCAPE FOR ISLAMIC PHILANTHROPY AND HEALTH CARE DELIVERY IN PAKISTAN

Robia Islam of Interactive Research and Development offered an overview of the landscape for Islamic philanthropy and health care delivery in Pakistan.

4.3.1 Zakat Management in Muslim Majority Countries (2015)

Islam explained that zakat management falls into four categories in MMCs.\textsuperscript{65} The most common (23 MMCs, 49%) is informal management, where governance is outside the government’s purview and paying/receiving zakat is a matter of personal discretion. In a second model, formal zakat management is institutionalized by the state, but without mandatory collection and payment (10 MMCs, 21%). In a third model, mandatory zakat management is institutionalized by the state with compulsory zakat collection and obligatory payment. This is relatively uncommon (6 MMCs, 13%), however it is still practiced in Pakistan.

4.3.2 Context of Religiously Motivated Giving in Pakistan (2000)

Islam provided context for religiously motivated giving in Pakistan in 2000.\textsuperscript{66} Religious institutions and causes received 94% of the donations in comparison to other organizations and religious faith was cited as a motivation for giving for 98% of the donors. A substantial 65% of all monetary giving went directly to individuals, two-thirds of which was zakat. Somewhat unexpectedly (given the Islamic calendar), Pakistanis were largely spontaneous in their giving, preferring to donate time, goods and money as requested or as needed, rather than in relation to a specific event or time of the year.

\textsuperscript{63} Latief, 2010.
\textsuperscript{64} Latief, 2013.
\textsuperscript{65} Hasan, 2015. The zakat management system information was not available for 8 MMCs (17%).
\textsuperscript{66} Bonbright, 2000.
4.3.3 Zakat Fund Distribution to Health Care in Pakistan

Islam pointed out that relatively small percentage of government–directed zakat funds were distributed to health care in Pakistan. The same trend holds in most provinces, though Punjab distributed more to health care than Sindh or KPK (Table 4.2).

The government distributes health care funds in one of two ways: directly to a health institution or to a local district/zakat committee. In the latter case, needy patients are determined by local zakat committees; the patient then receives a certificate for free hospital treatment.

In both Sindh and Punjab provinces, the majority of government zakat funding goes to public health care institutions, as opposed to private health care institutions (Figure 4.9).

Table 4.2. Government–directed Zakat Fund distribution by sector (2014-15)

<table>
<thead>
<tr>
<th>Sector</th>
<th>Total funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guzara allowance</td>
<td>22 million (USD)</td>
</tr>
<tr>
<td>Education stipends</td>
<td>13 million (USD)</td>
</tr>
<tr>
<td>Health care</td>
<td>5 million (USD)</td>
</tr>
<tr>
<td>Marriage assistance</td>
<td>1 million (USD)</td>
</tr>
</tbody>
</table>

Source: Islam

She noted that most of the top-performing health care institutions that are recipients of zakat are private (in order of performance based upon publicly accessible data): Shaukat Khanum Memorial Cancer Hospital and Research Center; Indus Health Network; Layton Rehmatullah Benevolent Trust; Memon Medical Institute; and Gulab Devi Chest Hospital.
Table 4.3. Subsidized or free-of-cost health care institutions by types of beneficiaries

<table>
<thead>
<tr>
<th>Institution</th>
<th>Outpatients</th>
<th>Inpatient (Non-surgery)</th>
<th>Inpatient (Surgery)</th>
<th>Eye Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shaukat Khanum Memorial Cancer Hospital and Research Center (2015)</td>
<td>205,313</td>
<td>11,352</td>
<td>11,047</td>
<td>NA</td>
</tr>
<tr>
<td>The Indus Hospital (2014-15)</td>
<td>505,760</td>
<td>16,368</td>
<td>7,964</td>
<td>NA</td>
</tr>
<tr>
<td>Layton Rehmatullah Benevolent Trust (2014-15)</td>
<td>2,697,530</td>
<td>NA</td>
<td>NA</td>
<td>248,403</td>
</tr>
<tr>
<td>Memon Medical Institute (2013)</td>
<td>52,859</td>
<td>7,002</td>
<td>3,438</td>
<td>NA</td>
</tr>
<tr>
<td>Gulabi Devi Chest Hospital (2011-12)</td>
<td>239,466</td>
<td>469,626</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

Source: Islam

During 2015, Shaukat Khanum Memorial Cancer Hospital and Research Center distributed financial support to indigent patients as follows: pharmacy ($10 million); pathology ($7 million); surgery ($6 million); radiation therapy ($5 million); medical oncology ($4 million); radiology ($3.4 million); internal medicine ($2 million); nuclear medicine ($1 million); and ancillary health services ($0 million).

4.3.3 Key Findings

Islam summarized the key findings of the investigation: There is a lack of transparency and credibility with institutionalized government distribution of zakat in Pakistan. Regionally, the government of Punjab distributes the most (cumulative) zakat. A small fraction of government zakat is allocated to the health sector, of which most is allocated to public health care institutions. Zakat’s share, as a percentage of total revenue, in subsidized or free-of-cost health care institutions is minimal.

4.3.4 Discussion

Osama clarified that $2 billion is a rough estimate for Pakistan’s zakat collection, and that the government of Pakistan collects 2.5% of zakat, which is roughly 5 billion rupees. A.B. Khan noted that this used to be much higher, but the Supreme Court ruled that individuals could opt out of giving zakat to the government (Shi’ites opted out and Sunni were given an option to sign an affidavit to do so). At that time, zakat was only applicable to profit from banks and dividends from individual stock market investments. A.B. Khan noted that in Indonesia, there is a higher level of trust in the public zakat collection, the principal source of zakat financing. However, universal health care is making it difficult for NGOs with small clinics to utilize zakat, because patients can now receive free or subsidized care at hospitals. Hilman suggested that philanthropic organizations could provide a system for poor people to complete their documentation to access universal health care.

4.4 EGYPTIAN PHILANTHROPY: AN OVERVIEW

El Tayeb remarked that philanthropy is deeply entrenched in the Arab culture. A range of different terminology is used for waqf, but the underlying principle is the same. Egypt has a particularly rich heritage of philanthropic giving that is tied to both Christianity and Islam. During the Ottoman Empire most public services, including health care, were financed by awqaf. Today, NGOs continue to fill a huge public service provision gap. In 2011,
Egypt was estimated to have at least 30,000 NGOs and 700 foundations, but there may currently be closer to 45,000 NGOs. Most NGOs specialize in providing services to the community. In terms of the volume of giving, Bait Al Zakah has estimated the value at 10 billion Egyptian pounds on an annual basis. However, there are no formal statistics, there has been no accurate assessment, and there is no formal reporting. Other estimates range between 4.5-12 billion Egyptian pounds (252-672 million USD), but El Tayeb personally believes the annual amount to be around 10-12 billion Egyptian pounds (560-672 million USD).

4.4.1 Modes of Giving in Egypt: Religious and Secular

El Tayeb noted that Egypt is a very poor country that faces many health-related issues and a high disease burden (e.g., diabetes and conditions related to indoor air pollution). However, there is a keen focus on giving that has increased over the past 10 years. He explained that Muslim giving takes many forms, including zakat, sadaqah, and waqf among others. Christian giving also includes ushur or tithe (10% of wealth). Individuals tend to give very small donations, but also give regularly. There are many civil society organizations and charities affiliated with houses of worship (both mosques and churches) that serve to mobilize available resources. Secular civil society organizations also exist, and have been shifting away from charitable giving and towards implementation of development-oriented programs. Grant-making foundations include high-net worth families and corporate entities, such as corporate social responsibility and private sector multinationals. Socially responsible business is an emerging trend in Egypt as well.

4.4.2 Motives and Modes of Giving in Egypt

El Tayeb explained the Islamic concept of zakat, which is money that can only be dedicated to eight specific causes. He noted that this restriction raises ethical issues with respect to health care, because it can be difficult to morally justify giving assistance only to a certain type of person. People tend to be primarily interested in zakat giving through charitable direct cash donations. El Tayeb explained that “a waqf endowment is a form of ongoing public service that utilizes private wealth to establish projects of public benefit...[that allow you to] preserve certain revenue or property for religious or philanthropic purposes.” He noted that some of Egypt’s largest health care organizations started off as awqaf, such as Al Qasr Al Ainy. Today, Al Qasr Al Ainy remains one of the largest public health care providers in the country, yet it suffers from major financial sustainability and efficiency struggles. Most endowed properties and projects were nationalized in the 1950s. El Manial, now called Cairo University Hospital, was nationalized in 1950s after a large building was donated as a waqf to treat patients.

El Tayeb cited five motivations often given by Egyptians for practicing Islamic philanthropy:

- Fulfilling an Islamic obligation;
- Doing charity work;
- Eradicating poverty;
- Preserving society from feelings of envy between people of different social strata;
- Protecting God’s blessings of health, wealth, or children.

He noted that social inequality is a key driver of charitable giving, with richer people donating to help their conscience and feel that they have contributed to society in a positive way. He also explained that the motivation of God’s blessing is different than religious obligation. Rather, it is a perception that ‘what goes around comes around’: donating will come back in a good way to the benefactor’s family, and future generations will benefit from an improved society.

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74 Abdou et al., 2011.
75 Ibrahim & Sherif, 2008
El Tayeb also outlined six primary modes of giving in Egypt: religious charities; corporate foundations; development foundations; crowdfunded large-scale projects; venture philanthropy; and social entrepreneurship. These types of organizations serve as distribution channels, collecting money and then deciding how and whom to disperse it to (the last two are the least common).

4.4.2.1 Religious Charities
Religious charities in Egypt, which are always associated with a mosque or a church, must be legally registered, and this is the only way they can collect donations. Most of their donations are from individuals, with some support from the government or from other foundations. Typical activities include care of orphans; female education; medical care; support in the form of food, clothing, medicines; and care for the poor and disadvantaged. Some also support sustainable projects such as skills training. Examples of religious charities in Egypt are Gamia Mostafa Mahmoud and El Gamia El Sharia.

4.4.2.2 Corporate Foundations
The Mansour Foundation for Development was the first donor NGO to be fully funded by an Egyptian family. The Mansour family, a wealthy clan, wanted to institutionalize their giving with a focus beyond traditional giving to individuals with a broad-based focus on developmental goals. The focus of the foundation has shifted towards being an implementer and grant-maker.

4.4.2.3 Development foundations
Misr El Kheir is a comprehensive development foundation that funds and implements programs across the entire country. It is one of the largest foundations in Egypt, and has grown significantly. It was the first to popularize the notion of investing Muslim giving in development programs, as opposed to charitable giveaways, and it was backed by the country’s Grand Mufti.76

In the health care space, Misr El Kheir provides financial services for surgeries, program implementation, medicines, and more. It is not a religion-based organization, although much of the money donated is from zakat (Figure 4.10).

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76 The Grand Mufti is a senior Muslim cleric who is part of the government and manages issues concerning religion and religious administration. Source: (https://www.state.gov/documents/organization/238412.pdf)

77 Available at http://misrelkheir.org/en/#
4.4.2.4 Crowdfunded Large-Scale Projects
Existing NGOs and foundations started relying on mass-advertising and fundraising campaigns to raise large sums of money, starting with the 57357 Children’s Cancer Hospital Foundation. Television used to provide air time as a donation, which raised the price of air time for everyone at different times so the cost of the donation has increased. Small sums are raised from individuals and large sums from high-net worth individuals and companies. The effort has strong support from public figures and the government, and 57357 has successfully raised millions of pounds in this manner.78

4.4.2.5 Venture Philanthropy
Venture philanthropy uses practices of venture capitalists to provide funding and technical expertise to social enterprises, but requests results and accountability. El Tayeb explained that fundraising is a continuous process in venture companies. They are attractive from a donor standpoint because they must be accountable to donors and demonstrate progress. Venture philanthropy transfers strategic investment management practices to the nonprofit sector, with the goal of building organizations that can generate the highest rates of social returns. Only one regional foundation (Al Fanar) is working with Egyptian non-profits to enhance their efficiency and sustainability through the venture philanthropy approach.

The Magrabi Foundation79 is a health care charity that has explored an approach related to venture philanthropy. It was established in 1992 by Dr. Akef El-Maghraby, the founder of the Magrabi Medical Group, to promote affordable eye care services for everyone in Egypt and beyond. It is registered as a charitable organization under the governance of the Ministry of Social Solidarity and registered under the law of non-governmental organization and civil community foundation. It started its transformation to a social-business model in 2012, with the aim of developing scalable and replicable models to provide eye health care services to the poor, and is currently piloting and testing self-sustaining business models. It charges those who can afford it, and offers free services for those who cannot.

4.4.2.6 Social Entrepreneurship
Entrepreneurial mission-driven enterprises are also emerging, some of which focus on the health care sector. Several fatwas (Islamic rulings) have been issued advising Muslims to direct their zakat to rebuilding the economy and providing job opportunities for the unemployed. El Tayeb explained that the social entrepreneurship concept microfinances where money goes to promote the economy and, in turn, to improve the welfare of the underprivileged.

4.4.3 Volumes of Giving: Health Care
Although no accurate sector specific disaggregated data exists, health care is one of the main areas of investment in Egypt, in addition to aid and education. A study on corporate social investments reported that health care is one of the top three sectors targeted by corporations80 (Figure 4.11):

78 Available at https://www.57357.org/
79 Available at http://magrabi.org/about-us/
4.4.4 Philanthropy in Egypt: Challenges and Ways Forward

El Tayeb concluded by outlining current challenges and ways forward for philanthropy in Egypt. While a variety of models exist, there is minimal data on their actual magnitude and viability. Transparency and reporting by nonprofit organizations is minimal for a variety of reasons, including fear of prosecution and an overall lack of emphasis on accountability. In parallel, Egyptians continue to rely on and prefer informal, discrete channels of giving. Finally, the magnitude of giving across the country is not well understood, so efforts are often scattered, duplicated, and concentrated in urban centers. Institutionalizing zakat is under consideration, but faces issues due to the legal framework/institutions that collect the money and the lack of donor-driven accountability.

“How do we believe our developing countries are going to move forward? Through taking risks, through innovation and through creativity”
– M. Amr El Tayeb

The landscape and potential of philanthropy in Egypt provides an opportunity for maximizing its benefits, he reflected, but there is much room for improvement in terms of viability, geographic dispersion, experience sharing, and collaboration. Efforts should focus on finding ways to channel the substantial fundraising potential towards the highest impact. To determine whether to focus on treatment versus prevention, and how to maximize the substantial religious and social investment, more reliable data is urgently needed. He emphasized the need for Egypt to work on multiple fronts to reassess how the

81 Available at http://sdgfunders.org/sdgs/goal/good-health/country/egypt/lang/en/
system functions, address policy problems, engender financial accountability, and demonstrate quantifiable results.

4.4.5 Discussion

El Tayeb related the story of a wealthy Egyptian family that constructed a beautiful hospital for seven billion Egyptian pounds, which became nonfunctional, with no equipment and no revenue, due to their lack of expertise. In comparison, a private equity firm has bought many hospitals over the past five years that are generating good returns and net profit. If the family had collaborated, there would have been another hospital to care for patients and generate profits. A.B. Khan noted that the firm’s profit-making facilities are serving only people who can afford to pay, and that the family’s intention may have been to serve those who cannot afford to pay. The private equity firm’s approach may be financially smarter, but lacking in free or heavily subsidized care. El Tayeb replied that it would be difficult to make care completely free. People who are insured and can afford to pay will go to hospitals, but it could be possible to set up a system whereby one-third of patients could be treated for free (or be heavily subsidized) through the hospital’s profit. He reiterated the importance of consulting with experts, given that there are at least 25 hospitals he knows of that are incomplete or have poor (or nonexistent) management and inadequate standards.

Shikoh noted that El Tayeb’s examples of foundations were all private, and asked whether similar government-sponsored projects are effective. El Tayeb replied that the government and some public hospitals have started their own foundations. There is no mandatory zakat, but people can donate to government institutions. Siddiqui reported that a publication on religiously managed health care centers in four countries including Egypt found that while the poor are generally associated with being the primary recipients of religious philanthropy, religiously run health care centers were largely focused on the middle class. El Tayeb remarked that this is relevant because health care in general cannot be completely free; someone must pay the provider. There are families in Egypt that are not technically poor, but cannot pay for their medical expenses and deserve subsidies through zakat.
5 Local and National Case Studies on Philanthropy in Public Health

5.1 THE INDUS HEALTH NETWORK: A PAKISTANI HEALTH PHILANTHROPY CASE STUDY

A.B. Khan presented a case study about Indus Hospital and the evolving Indus Health Network, which is seeking to change the paradigm of health care delivery in the country. Its motto is “Excellence in health care for all to please Allah” and its aim is to provide quality care, free of cost. The following objectives are designed to realize its vision:

- To focus on creating an excellence-driven, comprehensive, compassionate free-of-charge, scalable health care system accessible to all.
- To be a not-for-profit entity, managed with the Islamic concept of waqf funded through donations, zakat and bilateral and multilateral public grants.
- To adhere to ethical best practices in all aspects of its operations, while following Islamic law and the law of the land.
- To empower its employees for their spiritual and professional growth.
- To enhance and build human capacities through quality education and research.

A.B. Khan traced the origin of the Indus Health Network from its humble beginnings in 2007-2008. It had 2,134 inpatients, 47,928 outpatients, $7.4 million in donations received, and 277 employees. Figures 5.1 and 5.2 illustrate the upward trends of funds received and patients served.

Figure 5.1. Funds received by the Indus Health Network (2008-2017)

Source: A.B. Khan, Presentation at Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World 2016
As of 2016, the network has received more than $130 million in funds and served over 3.2 million.

A.B. Khan reported that zakat funds received by Indus have increased steadily in recent years, from $1.63 million in 2010 to $16.9 million in 2016. Non-zakat funds received have spiked sharply since 2015 to include $37 million in international donor grants and $15 million in governmental grants (Figure 5.3):
5.1.1 Partnerships and Collaborations

A.B. Khan emphasized the crucial role of partnerships and collaborations for the Indus Health Network. At the outset, the Rufayddah Foundation merged with Islamic Mission Hospital to establish the Indus Hospital (TIH), which began collaborating with Interactive Research and Development (IRD) in 2006. TIH has since merged with the Children’s Cancer Hospital (CCH). The Al-Fakir Trust partnered with TIH by providing space for a dialysis unit and family medicine clinic. The Delhian Trust offered a mother and child unit to TIH in the year 2015; it was revamped and turned into an effectively run maternal and neonatal health care unit. When the Al-Ghazi trust dissolved, it offered the land and constructed a hospital for TIH, and the Government of Sind handed over Civil Hospital Badin under the Public Private Partnership Act. ICRC, CHAI Foundation, and TIH worked together to build Physical Rehabilitation Centers in Karachi, Lahore, and Muzzafargarh. In 2017, the Indus Health Network (IHN) was being formally rolled out, and individual TIH Hospitals and Centers would fall under the Network.

5.1.2 Indus Health Network (IHN) Hospitals and Centers

A.B. Khan described the Indus Health Network (Table 5.1) as of Dec 2016 to include eight physical sites. Five hospitals owned by the Indus Health Network were supported by private donation, while another three hospitals were funded by the Government under a Public Private Partnership agreement and were 100% managed by the Indus Health Network:

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Location</th>
<th>Year</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Indus Hospital (TIH) Korangi Campus</td>
<td>Karachi</td>
<td>Established 2007</td>
<td>150 beds</td>
</tr>
<tr>
<td>2. TIH - Al Fakir Trust Campus PIB</td>
<td>Karachi</td>
<td>Established 2014</td>
<td>20 beds</td>
</tr>
<tr>
<td>3. TIH - Children Cancer Hospital – FB Area</td>
<td>Karachi</td>
<td>Joined TIH 2012</td>
<td>50 beds</td>
</tr>
<tr>
<td>4. TIH - Shaikh Saeed Memorial Campus</td>
<td>Karachi</td>
<td>Joined TIH 2015</td>
<td>50 beds</td>
</tr>
<tr>
<td>5. TIH - Al Ghazi Trust Campus</td>
<td>Bhong</td>
<td>Joined TIH 2015</td>
<td>60 beds</td>
</tr>
<tr>
<td>6. Government Shahbaz Sharif General Hospital</td>
<td>Lahore</td>
<td>Joined TIH 2015</td>
<td>60 beds</td>
</tr>
<tr>
<td>7. Government Recep Tayyip Erdogan Hospital</td>
<td>Punjab</td>
<td>Joined TIH 2014</td>
<td>100 beds</td>
</tr>
<tr>
<td>8. Government DHQ Hospital</td>
<td>Badin</td>
<td>Joined TIH 2016</td>
<td>150 beds</td>
</tr>
</tbody>
</table>

Source: A.B. Khan, Presentation at Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World 2016

TIH Blood Centers: The vision of TIH’s blood center is to promote voluntary blood donation in Pakistan, ultimately eliminating paid and replacement donors and making blood donation completely voluntary. To date, 767 blood camps have been conducted across Karachi, with 20,100 bags of blood donated to various hospitals, health units, and individuals. The government of Punjab has agreed to fund ten regional blood banks in partnership with TIH’s blood center. Thus far, Sindh and Punjab each have two regional blood centers.

TIH Rehabilitation Centers: ICRC, CHAI Foundation, and TIH have collaborated to build physical rehabilitation centers in Karachi, Lahore, and Muzzafargarh. The centers provide orthotic and prosthetic limbs to patients, enabling them to become mobile again. Indus Karachi currently manufactures and fits about 2000-2500 devices per year.
coupled with assessment, counseling and training for physically disabled people to make optimal use of these devices.

5.1.3 TIH Strategies for Future Expansion

A.B. Khan described TIH’s strategies for future expansion include the evolution in the Indus Health Network, which will be focused on improving access to free health care for the poorest populations in Pakistan, and to improving health outcomes through high-quality and free primary, secondary and tertiary health care. He noted that provisions for clean water, sanitation, and nutrition are critical for promoting comprehensive health in addition to quality health care, and that the Indus Health Network would incorporate these services into its program. The partnership and collaboration model with IRD will be further expanded under the joint Global Health Directorate, and the Indus Health Network will continue to explore partnerships with likeminded people and organizations to become a force for social justice.

He illustrated the health care delivery pyramid of Pakistan with Figure 5.4:

Figure 5.4. Health care delivery pyramid of Pakistan

Source: A.B. Khan, Presentation at Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World 2016

At the level of primary care (basic health), the strategic focus is on early detection and prevention of disease. In cases where TIH is managing a major government hospital, it will encourage and lobby the government for permission to take over management of primary health care in the district to improve the general health indicators of the district’s populations. TIH may consider partnering with institutions with expertise in primary care, like SINA, the People’s Primary Healthcare Initiative (PPHI), and the Health and Nutrition Development Society (HANDS).

At the level of secondary-care hospitals, there are a number of fully funded but non-functional government and private sector hospitals in Pakistan which could be improved significantly with intervention from TIH. Plans are underway to partner with provincial governments and nonprofit institutions to manage fully funded hospitals that fulfill certain minimum criteria (e.g., quality of facility, availability of doctors and paramedical staff, etc.).

At the next level are tertiary-care teaching hospitals funded and managed by the Indus Health Network in each Pakistani province.
These hospitals will serve as TIH centers of excellence and model health care units in major cities. In Karachi, the expansion of the main hospital is in progress. In Lahore, there are ongoing discussions with Qarshi foundation to build a 500-bed hospital. In Peshawar, TIH has been allocated land by the KPK Government. In Quetta, land is being allocated to TIH to set up a tertiary care hospital by the Pakistan Air Force in Yonisabad.

### 5.1.4 The Indus Hospital and Religious Philanthropy

A.B. Khan reported that 40% of funds donated to TIH come from zakat, and 60% from donations. In the first five years of operation, however, zakat was the source of more than 80% of its funding. By the eighth year, the distribution was approximately 50% zakat and 50% donations (including from the government). Currently, more than 97% of its funding comes from within Pakistan. He explained that historically, zakat funding has not been used for the capital expenditures, equipment, or construction but it is used to pay 70% of the operational expenses. Donations are channeled into capital expenditure and expansion. Major challenges have included lack of human resources and how to most effectively manage growth.

TIH property and land are donated through waqf endowment (e.g., the Korangi location). He explained that any individual or organization having ownership rights of an asset can declare that asset as waqf. Assets can be in the shape of land, machinery, or cash. However, to be declared as waqf it has to fulfill certain conditions defined by Islamic scholars. Once the asset is declared as waqf, it could not be consumed and only its usufruct can be used to benefit the public at large. Over the last two years, he noted, TIH has been building its own endowment fund, The Indus Hospital Waqf, to ensure long term sustainability and lesser dependence on zakat and donations. It is a cash waqf created by the trustees of TIH, who are the irrevocable administrators of the waqf.

### Figure 5.5. Flow of funds in/out of Indus Hospital Waqf

![Diagram of the flow of funds in and out of the Indus Hospital Waqf](Source: A.B. Khan, Presentation at Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World 2016)

Keshavjee asked for clarification on how the money goes into two different awqaf. A.B. Khan explained that zakat money must be spent in the same calendar year, so religious scholars have provided a system for using the money. The Asle-Waqf is an endowment. For the Mamlook-e-Waqf, Indus collects zakat on behalf of patients as a type of advocate, which can be used for any deserving patients. Excess funding can be transferred to the waqf. Once zakat funds have been utilized by TIH hospitals for services rendered directly to the patient, those funds become available for different hospital expenses. Similarly, the hospital land

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It is a restricted fund (not a separate legal entity) and a distinct Shariah entity.
is waqf, although the building on the land is not waqf because waqf buildings cannot have their structure changed.

5.1.5 Discussion
Cheema pointed out that Indus did not have to raise money for their expensive land and structure, compared with the 700 million Egyptian pounds that had to be raised in the Egyptian case study, which illustrates the value and expediting power of donations. He commended Indus for leveraging that advantage effectively not just at their first site but also as a countrywide business model. A.B. Khan explained that they created the model in advance to prepare for the opportunity to influence policymakers. A.B. Khan now has influence as a board member for many government organizations, such as the drug regulatory authority and the Benazir Income Support Programme (BISP).83

El-Tayeb asked how Indus is managing decentralization and expansion, and especially the task of holding HR to the appropriate standards. A.B. Khan replied that Indus sends a trainer to a new site for six months. They also monitor staff performance in other hospitals in real time, through video surveillance. They are also able to receive spending and utilization data in an executive scorecard almost on a daily basis to ensure optimal utilization of facilities. Shikoh observed that many projects receive donations and then fail, because they are not able to execute properly. Indus was able to execute properly and is now an effective, efficient institution. He asked A.B. Khan what the key ingredient is. A.B. Khan replied by attributing it to finding the right people for the right job, and delegating appropriately. Carkoğlu asked about the primary cost centers; A.B. Khan replied that there are two: HR (42%) and consumables (45%). Most consultant-level staff work for about 25% of their private-sector earning potential.

5.2 MUHAMMADIYAH HEALTH NETWORK: AN INDONESIAN HEALTH PHILANTHROPY CASE STUDY
Dr. Syafiq Mughni, Indonesia Muhammadiyah Health Network, offered a case study of his organization. Muhammadiyah was founded in the city of Yogyakarta (Java) in 1912 by Ahmad Dahlan, an ‘Alim and entrepreneur’, who had studied in the Middle East and was inspired by reform movements in the area at that time. The Muhammadiyah follows the Sunnah, but is non-sectarian and not affiliated with a particular religious school of thought. The Muhammadiyah Health Network has multiple autonomous organizations and departments.85 People can become a member of Muhammadiyah in two ways. Limited members register formally and must pay a monthly contribution to the organization (from zakat, infaq, or sadaqah) or they are sanctioned as disloyal and they could volunteer and be part of one of its subsidiary organizations. Muhammadiyah has a core/limited member of about 15 million people.86 Organizational membership is around 35 million people, including employees of Muhammadiyah (e.g., teachers, doctors, social workers, and nurses) and people who support its activities but are not officially registered.

5.2 Muhammadiyah Health Network: Structure and Facilities
Mughni noted that the number of Muhammadiyah-owned facilities is growing: the network has 172 hospitals and clinics in almost all of Java’s districts and almost all other provinces87 (Table 5.2). A complex structure of internal partnerships spans faculties of medicine, pharmacy, nursing, and midwifery.

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83 He had recently proposed that people would not be eligible for BISP funding unless their children are immunized.
84 Women, youth, students, martial arts, scouts.
85 Health, tabligh, education, waqf, social services, economy, disaster management center, library-information, charity, research, social empowerment, law & human rights, public policy, financial auditing, international cooperation.
86 He commented that many Indonesian people will say they are Muhammadiyah members without registration.
87 North Sumatra (2); West Sumatra (2); South Sumatra (1); Lampung (1); Jakarta (5); West Java (5); Central Java (29); Yogyakarta (7); East Java (38); East Kalimantan (1); Central Kalimantan (1); South Kalimantan (1); South Sulawesi (2); Gorontalo (1); West Nusatenggara (2).
Table 5.2. Muhammadiyah-owned facilities (as of Dec 2016)

<table>
<thead>
<tr>
<th>Type of Facility</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher education</td>
<td>172 (including 47 universities)</td>
</tr>
<tr>
<td>Kindergartens</td>
<td>5,623</td>
</tr>
<tr>
<td>Elementary and high education</td>
<td>5,657</td>
</tr>
<tr>
<td>Orphanages/children centers</td>
<td>318</td>
</tr>
<tr>
<td>Senior citizens and disabled centers</td>
<td>54</td>
</tr>
<tr>
<td>Hospitals/clinics</td>
<td>103/373 (estimated 10,476 beds)</td>
</tr>
<tr>
<td>Mosques</td>
<td>11,198</td>
</tr>
<tr>
<td>For-profit companies</td>
<td>49</td>
</tr>
<tr>
<td>Cooperages (similar to Cooperatives)</td>
<td>492</td>
</tr>
</tbody>
</table>

Source: Mughni, Presentation at Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World 2016

All health care centers originate at the grassroots level (village or sub-district), often beginning with a small quorum of people interested in founding a mosque, school, clinic, or hospital. He likened Muhammadiyah to a pattern or process for developing facilities. The founders form the local Muhammadiyah board of leaders and facilities are owned by the Muhammadiyah association, managed by a board of directors, and implemented by the council/department of health. The managers of health facilities supervise the day-to-day operations of hospitals and are controlled by the health council. They report to the local board of Muhammadiyah leadership as well as the central board of Muhammadiyah (annually). This is an extremely efficient decentralized structure that allows for quick response to local needs as well as keeps the control nearest to the point of need, however, it also creates some challenges. For example, there is an ongoing problem with respect to data collection such as the unknown number of patients served by the network. The reason is the decentralization of the Muhammadiyah structure: as the hospitals and clinics develop, and there is no central repository of information.88

5.2.2 Health Network Programs and Support

The network has multiple health programs. Health promotion and education programs include the Sakinah Family Program (a project working to strengthen families) and the Qaryah Tayyibah program (an alternative school providing a broad opportunity for the learners to explore their talents and capacities).89 Treatment and rehabilitation programs are carried out in clinics, special hospitals, general hospitals, health care facilities, and rehabilitation centers. Support for the broad network comes from the government, international agencies, and companies. Specific health facilities are initially funded entirely by Muhammadiyah members but as they grow, they are funded by budget surplus as well as from reinvesting patient fees. All patients must pay for medical services and medicine prescribed in health centers. Some pay out-of-pocket, others have state or private insurance, and some poor patients receive assistance through lazismu. Lazismu are Muhammadiyah charity institutions that operate at the national, provincial, district, sub-district, and hospital levels. At the hospital level, the lazismu receive money to help support poor patients.90

88 A new partnership with Indus Hospital in Karachi, Pakistan is working to rectify this issue with data collection.
89 Both are supervised by the women’s section of Muhammadiyah.
90 Patients are supported either by directly paying the patient’s bill or by paying the patient’s national insurance. Lazismu is distributed
Box 5.1. Challenges for Sustainable Philanthropy in Indonesia

Mughni summarized key challenges for sustaining philanthropy in Indonesia. First, charity through lazismu is distributed to many different Muhammadiyah programs (e.g., humanitarian aid), not only to health care. A key problem for the Muhammadiyah is its lack of specific institutions working on charity for health care delivery. No charity institution is currently dedicated exclusively to health care. Further, there are many clinics, especially in rural and isolated areas, which must be subsidized for their survival; some clinics have closed down due to shortages in financing and staff.

Source: Mughni, Presentation at Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World 2016

5.2.3 Discussion

Keshavjee observed that one of the benefits of state engagement is that the state can use the power of taxation to reallocate money from the rich to the poor. Referring to Mughni’s comment on cross-subsidizing money that comes to the poor, he asked: “How do we leverage this use of philanthropy to actually get the state to do things better? Because I think if we end up doing things and the state doesn’t, we lose the strength of the state to look after the poorest and to actually set up systems that can cross-subsidize and get to far places. That’s the risk.” He asked how this observation lines up with the experience in Indonesia in terms of Muhammadiyah’s taking over the state’s role and compromising the way the state can contribute. Mughni replied that in his experience, the government appreciates Muhammadiyah’s work because it cannot serve all of its own people. Many believe that without NGOs and faith-based organizations, the Indonesian government could not accomplish all that it needs to do.

Aamir Khan remarked upon Muhammadiyah’s influence in terms of registered membership and historical context, noting that Muhammadiyah was in effect a social movement created to counter colonization (the Dutch occupation of Indonesia) and to conserve the culture and religious beliefs.”

Muhammadiyah has a high level of influence in the current government. When the national government selects a Minister of Health, Muhammadiyah is asked to nominate and advise on who the candidate should be; it also influences the Eid date for the country. He noted that Muhammadiyah, a true grassroots organization, has a level of influence in society and government that very few NGOs have, so helping them to strengthen their information systems represents a huge opportunity. In fact, Muhammadiyah has started a movement to centralize information and expedite the response to region-specific health challenges, such as TB and diabetes.

Keshavjee wondered how such systems and organizational experience could be leveraged to strengthen the state. In some countries, like Pakistan, the state functions poorly. In Indonesia, the state functions and can improve in function; for example, although Muhammadiyah may serve millions of people, the state should be serving many millions more. Latief agreed that this is a critical question, and was one of many asked about its future direction on the occasion of Muhammadiyah’s 100th anniversary. Private clinics and schools have collapsed due to lack of state support. Keshavjee suggested that the government may perceive Muhammadiyah

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more widely at subdistrict levels, to healthcare, education, orphans, or poor people.

91 Mughni explained that the Muhammadiyah always uses an astronomical calculation to set the date of Eid, which sometimes conflicts with the date set by the Indonesian government. The Muhammadiyah typically establishes its date earlier than the government, leading many people to follow the Muhammadiyah’s date instead.
as a rival, as is not uncommon in the relations between states and NGOs. He urged NGOs to employ these types of best-practice models to spur the state toward responsibility and accountability to its people.

5.3 Layton Rahmatullah Benevolent Trust: Pakistani Health Philanthropy Case Study

“I shall pass through this world but once. Any good that I can do or any help that I give to my fellow beings, let me do it now. Now; for I shall not pass this way again.”

–Stephen Grellet (1773 – 1855)

Najmus Saquib Hameed, of Layton Rahmatullah Benevolent Trust (LRBT) (Pakistan), explained that the Pakistani government spends less than 1% of its GDP on health and 45% of the population has no access to government eye care facilities. Service delivery is poor, and most Pakistanis are unable to afford private sector charges for eye care treatment. The monthly per capita income is just $130, whereas cataract surgery costs $162 for an adult and $333 for a child. LRBT was founded to address this issue of affordability, as stated in its mission: “No man, woman or child should go blind just because they cannot access or afford the treatment.” LRBT was founded in Tando Bago (in the province of Sindh) in November 1985; and as of 2016 it operates 19 hospitals and 55 clinics, with 68% of Pakistanis within a 3-hour bus ride to a LRBT facility. Its focus is on helping people living around the poverty line by building a network of hospitals in deprived areas with ineffective (or nonexistent) government facilities. They work to ensure that women get equal treatment, there is no discrimination on any basis and patients are all treated with compassion and dignity. Charity should not mean second-rate, so treatment is appropriate and state of the art.

Box 5.2. What is the size of the problem for the blind and visually impaired?

- Number of blind / visually impaired: 19.7 million (11% of the population; 2.6 million children);
- Number of blind: 1.7 million;
- Annual loss: Rs. 69 billion. ($700 million in loss of productivity);
- Rehabilitation: adds 0.8% (government spending on health = 0.9%);
- 80% of the blindness is curable;
- Prevalence of blindness 3 times higher among the poor vs. affluent;
- 2/3rd of the population earns less than $2/day. Food is 60% of their consumption basket.

Source: Hameed, Presentation at Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World 2016
5.3.1 LRBT Service Delivery Structure
The three-tier service delivery structure of LRBT includes 51 community eye health centers, four outreach clinics, 17 secondary hospitals, and two tertiary hospitals. OPD procedures and surgeries are carried out once a month by teams at partner hospitals in Balochistan (Gwadar, Turbat, and Sibi) and in Punjab (Khewra). Major issues among patients visiting the OPD include: refractive errors (34%); cataract (12%); glaucoma (2%); retinal diseases (1.6%); and corneal diseases (no data).

5.3.1.1 Female Blindness Programme
Women make up 48% of the Pakistani population, but there are 874,000 blind women representing 51.4% of the total blind population. Prevalence of blindness among women is 30% higher in all age groups except 30-39 years. In a male-dominated society, women are underserved or not served at all in Pakistan, so LRBT has a special focus on female blindness. Pakistan now has a significantly lower prevalence of female blindness than the average in other developing countries (64%).

5.3.1.2 LRBT Pediatric Programme
Around 2.6 million children are either blind or visually impaired, and 11% (297,000) of LRBT patients are children. LRBT runs school screening programs in Karachi, Lahore, and Quetta, where 30% of school-aged children are myopic. It has established two tertiary level pediatric clinics (Korangi and Lahore Hospitals) and three secondary level clinics (Mandra, Lar, and Quetta).

5.3.1.3 Glaucoma Screening Programme
Glaucoma was identified as one of the leading causes of blindness in the National Blindness Survey (2002-04). To address this, in 2006 LRBT decided to screen all patients over 35 years of age who visited any of their hospitals. All LRBT hospitals now provide glaucoma screening and treatment, and 6.9 million patients have been screened since 2006.

5.3.2 Quality and Efficiency
Despite the relatively low number of health care providers (1,226), more than 2.9 million patients have been treated by LRBT so far. Efficiency is also driven by a health management information system, and LRBT's administrative overhead (4.6% of operating expenditure) is very low.

Table 5.3. Private sector vs. LRBT procedure treatment costs (as of Dec 2016)

<table>
<thead>
<tr>
<th></th>
<th>Private sector charge</th>
<th>LRBT hospital cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rs.</td>
<td>USD</td>
</tr>
<tr>
<td>OPD</td>
<td>400</td>
<td>4.0</td>
</tr>
<tr>
<td>Cataract surgery (adult)</td>
<td>17,000</td>
<td>162</td>
</tr>
<tr>
<td>Cataract surgery (child)</td>
<td>35,000</td>
<td>333</td>
</tr>
<tr>
<td>Vitreo Retinal Surgery</td>
<td>55,000</td>
<td>524</td>
</tr>
</tbody>
</table>

Source: Hameed, Presentation at Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World 2016

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92 In addition to screening students, they also train teachers how to administer simple screening tests for myopia.
93 Other hospitals/CEHCs deal with refractive errors, minor eye problems, and Vitamin A deficiency.
LRBT has played a major role in reducing the prevalence of blindness by half, from 1.8% in 1989 to 0.9% in 2016. It has been the recipient of numerous recognitions and awards. The number of surgeries performed per year has increased steadily over time. Major surgeries have increased from 426 (1985-86) to 203,520 (2015-16); minor surgeries have increased from 120 (1985-86) to 56,596 (2015-16). The quality of surgical outcomes has also improved (Figure 5.6):

Figure 5.6. Quality of surgical outcomes

![Quality of surgical outcomes](source.png)

To promote human resource development, LRBT provides continuous medical education, offers postgraduate programs, and has established a school of paramedicine to train paramedics and ophthalmic technicians.

5.3.3 LRBT Donations and Zakat 2015-16

LRBT received Rs. 1,149 million ($10.96 million) in 2015-16 in donations/zakat. 86% of the total amount donated went towards operating expenditures, 12% was specifically reserved for capital expenditures, and 2% was for investment in the endowment fund. The donations/zakat were contributed by individuals (67%), NGOs (16%), corporations (11%), and the government (6%) both within Pakistan (84.3%) and outside Pakistan (15.7%). In the same time period, donations/zakat for operating expenses totaled Rs. 952 million ($9.08 million). In terms of sustainability, Hameed reported that income has covered expenses for the entire existence of LRBT. All patients who cannot afford the treatment whether, mustaheq (deserving) or not, are treated free of cost. Patients who can afford treatment are asked to donate enough to cover the costs. In 2015-16, these donations covered 20% of the operating expenses. The endowment fund is Rs 1.35 billion, and income in 2015-16 was Rs 119 million (covering 15% of cash operating expenses).

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94 This includes specific donations from affording patients (20%), donations (31%), and zakat (49%).
5.3.4 Future Plans for LRBT
Hameed outlined future plans for LRBT, which include:
• Establishing a cornea bank
• Commencement of diabetic screening, to be piloted at the Korangi (Karachi) tertiary hospital
• Expanding medical retina for treating macular (wet) degeneration DME
• Providing laser treatment for diabetic retinopathy in all 15 hospitals (currently available in 13)
• Expanding Lar (Multan) and North Karachi Hospitals (to be completed by March 2017)
• Constructing a purpose-built hospital at Chiniot to replace temporary facility (March 2018)
• Building new hospitals at Larkana/Dadu, Rahim Yar Khan, Gujrat, and Bannu (ten-year strategic plan)

5.4.5 Discussion
“Global health in general relegates people to their place in the global economy. If you are poor, you don’t get good health care. The LRBT model gives people high quality health care regardless of where they are in the global economy...When thinking about this in terms of how to use Islamic financing, part of it is to also be Islamic\footnote{See \url{www.resala.org}}: to be just, to be fair, and so on. It’s not only the money; it’s the mindset behind the system... to really treat other humans with dignity.”

–Salmaan Keshavjee

Keshavjee questioned whether user fees can sway an organization towards thinking like a business. Hameed noted that LRBT is Sharia-compliant and thus they must administer an 8-question zakat test created by its Sharia advisors. Zakat has a low ceiling of $550 per year, so many people just above the threshold also cannot afford to pay. Therefore, they treat everybody who says they cannot afford to pay. A.B. Khan commented that many individuals who receive free care go on to become regular donors when they can afford it. Keshavjee characterized this as a model of why to avoid labelling patients and to provide them with an opportunity to give back. El-Tayeb asked about LRBT’s system for managing decentralization and standardizing processes. Hameed replied that every hospital has well trained staff who adhere to established protocols for all processes and procedures. All sites are monitored regularly, virtually and physically, to ensure quality standards.

5.4 RESALA CHARITY ORGANIZATION: EGYPTIAN HEALTH PHILANTHROPY CASE STUDY
El Tayeb, Assistant professor of Neurosurgery at Cairo University and health care entrepreneur, provided the case study of the Resala Charity Organization. It began as a university activity to engage youth in volunteer work at a time when there was no future vision for a health care sector. One branch was donated in 1999, which became a formal NGO in 2001, and four new branches were established in 2004. There are currently 63 branches across Egypt, with more than 28 activities provided by 1.2 million volunteers offering services for 3 million beneficiaries.\footnote{See \url{www.resala.org}} The vision of Resala is to be a nonprofit organization providing professional integrated services to serve as a model others can follow, with volunteering bringing out the best in society. It is building an attractive model for donors, with several options for donations, an efficient administration, and data collection and sharing. Employees are provided with an attractive environment to promote
innovation and team work with investment in human capabilities. Volunteers have multiple opportunities to make a difference in patients’ and their families’ lives by promoting human values. Patients are provided with integrated, modern, state-of-the-art quality health care services with complete transparency and respect.

5.4.1 Resala Activities
El Tayeb emphasized Resala’s commitment to providing aid to the less fortunate, with activities that include:

- Care for more than 600 orphans, with around 10,000 volunteers;
- Housing repair;
- Provision of utilities for underprivileged areas;
- Marriage aid;
- Braille training for the blind (23,000 beneficiaries with 37,712 volunteers);
- Deafness support (25,000 beneficiaries with more than 20,000 volunteers);
- Care for the elderly (60,000 beneficiaries with 44,000 volunteers);
- Addiction treatment support (both financial and social);
- Development of villages and rural areas;
- Training center and development in soft skills and HR;
- Used clothes exhibitions (10,500 fairs with approximately one million beneficiaries);
- Financial aid for more than 300,000 families to cover education and health care needs;
- Food distribution: 680,000 meals.

Other medical activities include medical awareness campaigns and medical convoys providing outreach to underprivileged areas (178,000 volunteers with 351,000 beneficiaries). Many health care providers volunteer their time to treat patients with no access to health care. Blood bank and donation campaigns are carried out every week in collaboration with the national blood bank to address the lack of coordination between blood banks, especially outside of Cairo. Other activities include provision of cochlear and corneal implants, prosthetics, and laboratory and radiology services.

Financing comes either directly from Resala’s NGO, or fundraising by specific programs and facilities. Donations are mainly driven by intensive marketing and advertisements on television, billboards, and social media. There are also donations from high-net-worth individuals and corporations, as well as small individual donations through zakat, sadakah, and waqf.

5.4.2 Resala Health Care Facilities
El Tayeb explained that there was a shift in Resala’s focus in 2004 toward providing medical services rather than just paying for them. The Resala Medical Center Faysal (2004) started as a primary care facility with high-end consultants at a very low cost. There are now more than 20 other medical centers distributed over the country. They are completely decentralized and are financially independent, but take advantage of Resala’s shared expertise in the establishment and operation of medical facilities. The idea is that Resala branches must be independent financially and administratively, profitable, and sustainable while providing high quality care at relatively low cost; it is not a free service, and health care providers are paid (although they can donate it back).

The Resala Medical Center (2004), the original facility, maintains the highest standard of consultants and specialists. It is a small facility that provides all basic outpatient services in all specialties, as well as emergency services and complete lab, radiology, and dental services. Resala Hospital (2006) is a small hospital with 10 beds, an ICU, 3 operating theatres (including a specialized pediatric surgery unit), an emergency unit, and laboratory and radiology departments. It provides high-quality medical care through a highly qualified
staff and adheres to the best infection control methods. Its revenue is sustainable due to its high turnover and efficiency: 200 clinic sessions a week; more than 300,000 patients treated annually; and 5,135 surgeries performed (620 of those completely free).

The Resala Neonatology Center (2007) provides one of the most needed services for 1500 newborns annually through a specialized team of consultants, specialists, residents, and highly qualified nursing staff. Cardiac catheter services with conjunction with Abou El Reesh Children University hospital following the highest standards and protocols, as well as pediatric surgeries for neonates with specialized consultants from the university. The cost for services are minimal and subsidized or free depending on need.

The Resala Kanater El Khieria Medical Center serves high risk patients to the highest standard in an underprivileged area with all outpatient specialties and surgical referrals to Resala Hospital. It facilitates ophthalmological medical convos and surgeries with Magrabi Eye Hospital, and financing for the largest dialysis unit in the Kanater. It cooperates with the Rotary Organizations and other local NGOs, with plans for expansion and duplication in other areas underway.

The Resala Children’s Hospital—under construction as of 2016—is another specialized hospital and neonatology unit, with plans for free services. It will comprise outpatient clinics, 50 inpatient beds, a specialized pediatric surgical unit, a children’s ICU unit, and radiology and laboratory facilities. It will serve children of all ages from all over the country and act as a referral center for all specialties, with a focus on research and training as well as treatment. To mobilize resources efficiently, cooperation and synergy with other NGOs will ensure that services are not duplicated, and the infrastructure can reach maximum utilization. It will also provide hospital management assistance for NGOs that lack the operational capabilities.

El Tayeb concluded by explaining that Resala has more models in the pipeline, including community partnerships, community-public partnerships (financing public hospitals), and community-private partnerships. However, making a significant shift to efficient resource mobilization will require addressing all factors of financing, management, and cultural perceptions.

5.4.3 Discussion

When asked whether he thought the Resala model works well because it is decentralized, El Tayeb confirmed that every center and institute is allowed autonomy. Other facilities can obtain start-up capital funding from Resala if they can convince the Board of Hospitals that they are accountable. They must come with a clear plan to fundraise their own resources and eventually become financially sustainable and independent, e.g., by paying the funds they receive from Resala back to their own facilities. He said that the system is still a work in progress, however.

Participants discussed the suggestion that if a hospital that charges for care is turning a profit, then a second hospital should be opened that subsidizes patients with the first hospital’s profits. Siddiqui likened Resala as the philanthropy version of an accelerator. In the venture capital world, big companies go to accelerators for funds and the accelerator provides expertise on how to take business to market. Resala plays a similar role: people come to them with ideas, plans, and buy in money, and Resala provides funding and expertise.

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96 They tried to implement a patient health informatics system, but providers were resistant to it.
6 Consultations and Discussions on Ways Forward for Research and Policy

The second day of the meeting comprised consultations and discussions on ways forward for research and policy in sustainable Muslim philanthropy. The first session was open roundtable discussion, and the second session centered on the potential creation of a policy brief and a proposal for primary data collection across a small number of pilot countries as potential outputs of the meeting.

6.1 ROUNDTABLE DISCUSSION

Aamir Khan opened the session by asking the group to recalibrate and think through the potential for sustainable health care delivery utilizing zakat, sadaqah, and waqf as principal sources of financing. He also asked the group to delve into the best-case practices in MMCs and consider other models, such as social business and impact investment models for sustainable health delivery, in which funders invest money but then require repayment. This stands in contrast to MMC case studies, for example, in which a partial fee-based hospital system was initially established through charitable giving with no expectation of repayment.

He commented that there are systems of Muslim philanthropy that began a thousand years ago, but are still holding fast in the form of foundation assets. He attributed the very survival of the Muslim world to one of its strengths and sources of resilience: philanthropic organizations and systems such as mandatory zakat and waqf. Despite how poorly governed many Muslim societies are, these philanthropic systems should be better recognized for the significant role they play in those societies, especially for poor people. However integral to society those systems are, to health care and other domains, they must be updated per modern economic principles and in modern conceptual terms. Aamir Khan explained that the pre-meeting assumption was that the multi-country philanthropy survey should be an output of the meeting. He also suggested an intensive focus on best-practice case studies like the ones presented in the meeting, and asked for more examples of potential health-related case studies to be included in the project.

Siddiqui emphasized the importance of providing donors with sound-bite data that can be delivered quickly. Effective public policy requires this, and impacting social change and the policy level requires data to convince people to include philanthropy in their strategic initiatives. He predicted that survey data will be in huge demand among the many interested researchers, which will help bring discussions of Muslim philanthropy to the forefront of mainstream publications. Osama cautioned that bad data is worse than no data, referring his struggle with unverified and unsourced data and stressing that empirical understanding of giving behavior is a critical next step, he said. Hameed noted that robust data requires primary sources, which will be a challenge, and suggested investigating the behavioral aspects of giving and about maximizing the potential of unorganized, informal giving.

To orient the collective effort, Cheema sought clarity about the group’s objectives. One option is another comprehensive study on Muslim giving and philanthropy. Another is to find ways to leverage previously untapped instruments of Muslim giving for sustainable health delivery. A third option is exploring the move toward non-conventional methods. Latief commented that the group should also consider what kind of data to explore. For example, there is not sufficient information from the actors in thousands of philanthropic organizations, or about the patterns and priorities of Muslim giving for individuals and organizations.
El Tayeb commented that surveys will provide valuable data and insight into the current philanthropic situation that is needed, in addition to the case studies, to ensure transparency and convince donors to fund health delivery. He warned that future ideals must be empirically linked to the present situation, and only data can serve as that infrastructural bridge. A.B. Khan agreed that an emerging trend in philanthropy over the past 25 years is that donors now ask how efforts will be sustained. “We have to have the data in order to move forward,” he added.

Çarkoğlu suggested collecting data from a longitudinal perspective, because data collected under changing conditions will be much more powerful, but even ‘snapshot’ data is useful from many perspectives. He agreed about the importance of making initial strategic decisions how to use data, suggesting various options for the target group, such as laymen/mass population, waqf administrators and trustees (who are more difficult to reach), or the top-tier relatively wealthy population (a group that is difficult to define and even more difficult to reach). He noted that there are several important objectives that are not mutually exclusive. For example, focusing on the health sector requires comparison to other sectors and gathering more powerful multisectoral data. Institutional funder data will also need to be collected, as will cultural data (e.g., street beggars ask for money, but institutions do not). Increasingly donors require more accountability and put pressure on the institutions; questions about transparency could provide that institutional data. To understand motivation, he recommended against in-depth focus on religious motivations, because they are almost impossible to disentangle methodologically and is extremely sensitive for people. The question policy-wise is whether the anchoring in a religious argument makes people more or less likely to donate. The survey must also explore alternate motivations and ways of giving (e.g. by becoming part of a larger community such as the Muhammadiyah).

Aamir Khan focused on utilizing religiously motivated Muslim philanthropy for sustainable health delivery as the principal issue for further study, aiming to better understand the amount of money available and how much of it could be channeled into charitable health care. He asked whether interested groups from other sectors should be brought to the table (e.g., from education sector). Hamed cautioned about being too ambitious, because wider domains can result in a loss of focus. Aamir Khan clarified that understanding health giving must be contextualized with other non-health alternatives for giving. Asking questions only about health-focused giving sacrifices valuable comparison information about giving in other domains. Hamed suggested asking participants to rank choices for giving that have been exercised in the past.

Siddiqui remarked that to achieve the broad goal of unlocking a potential resource (philanthropy in the Muslim world) to improve health care outcomes, verifying that hypothesis is the next step. The fundamental role of philanthropy is not to assume the role of government or business, but to innovate and lead. The bulk of philanthropic funding comes from the masses, with a small percentage from large organizations like Gates Foundation, giving rise to the question of who should lead: taking the data from the masses and then going to large funders for leadership is problematic. Over the past thirty years, donors have become much more educated, given the availability of data and resources, and they request more transparency. Intersectoral analysis is critical for establishing the priority of health care, for example, and as an educational tool. He observed that although it is a good starting point for data collection, the focus

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97 He noted that this is a similar problem faced by philanthropy in the US in the 1970s and 1980s, when it was informal, nonstrategic, and nonformalized. Indiana University went to the Lilly Endowment and called for a new strategic vision and provided the data making the case to the leaders that the masses must be educated to affect change.
only on zakat, sadaqah, and waqf may be too restrictive because not all Muslim donors give through those channels. He suggested defining Muslim philanthropy to include anyone who gives time and money in MMCs.

Aamir Khan asked for clarification about how to define that type of giving, and Cheema suggested drawing the distinction between giving in general and giving as a faith-obligation; he noted that zakat is the only type that falls squarely into the latter category because it is heavily regulated and obligated, and the other types are essentially general giving. Siddiqui construed this as a branding issue: using the term sadaqah, for example, limits the scope of philanthropy. Çarkoğlu’s research demonstrates that religious motivation is difficult to diagnose and define. Two policy cases are being made, he suggested: a policy case to the government about the role of philanthropy in health care delivery, and a case for donors and organizational leaders to take a leadership role in the philanthropic sector. From this perspective, it is less important to understand peoples’ motivations for giving than understanding the fact that they give, the scope of that giving, and how it can be directed in certain ways.

Hameed asked for clarification about the purpose of the data-gathering exercise: to influence governments and legal structures, to help strategize fundraising, or something else? Each objective requires a tailored approach to data collection. Çarkoğlu responded that in his experience, it is very difficult to predict how and by whom data collected will be used. He advised presenting data, making a case, and then disseminating the findings. He emphasized that the person reading the data makes a unique determination about how to use it, so the outcome can never be predicted with complete accuracy. However, it is important to plan on a certain target groups and objectives, which drives the inclusion (and exclusion) of planned survey questions. Hameed continued that many governments in the Islamic world have low credibility, so it is unrealistic to expect them to be able to change the attitudes of donors; other groups are better suited to shape public attitudes and opinions.

Siddiqui noted that data are also important for quantifying philanthropy relative to a country’s GDP. If it is very high, it will require one level of policy analysis; if it is very low, the task is to encourage more philanthropy and engender a culture of generosity. Right now, the appropriate policy intervention is unknown. He suggested that some potentially publishable conclusions can be drawn: health care education is a social problem that has not been successfully addressed by MMC governments, and philanthropy provides an opportunity to influence outcomes, but there is a lack of data about its scope and impact. He suggested that a case statement should be made to help persuade donors.

Keshavjee asked, from a practical standpoint, whether the ultimate goal could be to create a trust fund, like those established by MSF and the Red Cross, where people feel comfortable giving to cause that they know will use their donation for good purposes. Aamir Khan responded that while this would be a desirable long-term outcome, and is not completely off the table, the aims of the current effort are:

- Generating outputs to better inform donors, governments, civil society organizations (CSOs), and the public and help them to strategize about Muslim philanthropy;
- Triangulating with best-practice case studies that have been able to capture informal giving;
- Learning more about high-net-worth donors and the scope of waqf donation.

Keshavjee noted that the same types of analysis would broadly apply to informing the creation of a trusted fund to channel funds for health delivery.

Cheema advised that data collection efforts must involve a broad spectrum of stakeholders, noting that there are parallel efforts taking place to quantify giving. In
Muslim society, health care is actually one of the largest recipients of donations from the public, but evidence is needed to link data to health care delivery. He suggested bringing expert advisors to the table to help tap into available resources that can be used to build sufficient capacity. However, he emphasized that data needs to drive decisions at every level of development.

Cheema noted that zakat is well regulated from the religious perspective, but it has the potential to be better organized, with funds collected, managed, and spent in ways that are both impactful and in keeping with religious restrictions. Keshavjee suggested that this idea of creating a large fund where people can direct their zakat for use in specific ways has great potential.

Aamir Khan elaborated on the idea of case studies, noting that they will require a very different type of structure and analysis than a national prevalence survey of individual giving. The Muhammadiyah organization, for example, has built its own ecosystem of internal giving that warrants research in a case study. He suggested that discussion of a "global fund" for Muslims is beyond the present scope of discussion, because it would require the difficult task of building a very high level of cross-cultural trust in MMCs. Siddiqui concurred that part of the survey’s focus, beyond the data, is the issue of trust. After 9/11, philanthropic giving in the Muslim societies came under heavy scrutiny and there was a major loss of trust in philanthropic institutions. Creating a large global zakat fund has been under consideration by several organizations. However, this will require donor education and trust. While this may be possible, the existing fundraising in each region is based on local trust, and a global effort may undermine that process.

Keshavjee remarked that transcending these challenges will require targeting a specific subsection of zakat money from donors just below the top-tier high net-worth individuals who wish to promote the strengthening of MMCs and diaspora populations living in the West that may want to give back to their communities in the Muslim world.

Cheema suggested that social innovation is key to accessing those donors toward the top of the pyramid and convincing them to invest among many other options. The problem is that donors are not getting the return on investment of their charitable giving in terms of driving real change, which has led to donor fatigue and frustration. To ensure eventual autonomy in service delivery, a multi-donor fund must be inclusive, rather than being region-, religion-, or donor-specific. Muslim multi-donor funds are possible, he remarked, but they must be innovative, evidence-based, and 'human-centric.' Funders now have a business mindset and are looking for low-cost, high-impact targets for their donations. Examples of existing such funds include the $20 million Hassana fund (focused on hunger and food security), in which a major donor provided 25% seed money and the remainder came from smaller pledges. Another example is the $28 million Higher Education Fund for displaced Syrian youth in which the government of Qatar provided $8 million, Holland provided $14 million, and the remainder came from Turkey.

Aamir Khan asked whether there are any such funds raising larger amounts of money (e.g., $500 million). Cheema pointed to the Global Fund, but Khan countered that those are very different mechanisms. A better example, according to Khan, would be groups such as MSF, which raises $1.5 billion from smaller individual donations every year. Cheema replied that such entities take a very long time to build a track record of on-the-ground delivery that is well established enough to generate that level of funding. Keshavjee suggested remediying this by creating a fund that does not actually provide delivery, but with a framework that links funding to entities that have been delivering socially just and effective care on the ground for decades.
(such as Indus, IRD, PIH, or Muhammadiyah). Cheema suggested that a better strategy would be to find known, successful change-makers in the health care space and create a model based on this strength for fundraising, which will differ from country to country.

Keshavjee reiterated his vision of a global fund of Muslim philanthropic contributions through which people could donate their zakat money and specify how they would like it to be used (e.g., food aid for the poor, an IRD recipient in Karachi, etc.). Siddiqui clarified that this would not be a fund, but a charity like Islamic Relief USA, which last year raised $250 million. Funds have a specific purpose (e.g. delivering a million immunizations) and the program ends when the money does. Funds also retain a principal, like an endowment.

El Tayeb noted that setting up a fund requires special expertise. Institutional and high-net-worth fundraising requires both proof of concept and proof of track record. Funds that look for social impact in terms of patient capital, for example, may invest in technology and innovation in health delivery with the expectation of ROI through the lifespan of the fund. El Tayeb noted that Keshavjee’s idea has been used for channeling individual zakat giving in Egypt, but most people tend to select the same option—orphans—as opposed to options such as ‘administrative activities.” However, creating a larger fund will require a proven track record of returns, sustainability, and impact. Keshavjee concurred with Siddiqui and El Tayeb that charity is the more appropriate term for his vision. He informed the group that an NGO has already been created that would serve as the ideal shell: Advance Access and Delivery. It is already linked to IRD and PIH, and has plans to link and funnel money to other NGOs that can deliver quality care to the poor in more than 25 countries. He suggested that the survey could include a question asking about the appeal of such an organization.

Aamir Khan agreed that the survey needs to be directly linked to specific aspirations, and suggested identifying the 3-4 top health delivery groups that are operating at scale in large MMCs and then asking in country-specific surveys about willingness to give to a global ‘holding’ fund that would support those specific health delivery groups. People in Pakistan, for example, tend to give only to regional or national organizations, not international ones. He also suggested that people could potentially be galvanized for disease-specific campaigns, which have been successful historically, but was concerned that less-common diseases might not garner as much interest.

Çarkoglu pointed out that leukemia is rare, but the leukemia foundation in Turkey has been very successful because they ask for money publicly and directly: the package is more important than experience with the disease. Siddiqui urged the group to bring the case studies to experts in the psychology of giving and related domains, in order to unlock their potential for others to give. For broader applicability, he suggested, the analysis of case studies should inform the development of survey questions to capture the motivation of giving, beyond its size and scope. This information could also be used to create culture-specific training modules for effective fundraising. He suggested partnering with expertise with their own funding mechanisms (e.g., Gulf Opinion Polls) to disseminate the survey instrument beyond the four target countries.

6.2 PHILANTHROPY AND SUSTAINABLE HEALTH CARE DELIVERY IN THE MUSLIM WORLD

Osama collated and compared health indicators for Muslim majority countries (MMC)\textsuperscript{99} and reported key findings from his analysis. The vast majority of the disease burden comes from six high population countries: OECD, 13%, High Population Muslim

\textsuperscript{99} Including DALYs, life expectancy, infant mortality, risk of catastrophic expenditure for surgical care (% of people at risk), out-of-pocket health expenditure (% of private expenditure on health), public health expenditure (% of government expenditure), and total health expenditure (% of GDP).
Majority Countries (HPMMCs), 15%; rest of OIC, 9%; Conflict-Ridden Countries (CRCs), 1%; Gulf Cooperation Council (GCC), 0%; and rest of world, 62%.

He presented the following table demonstrating that High Population MMCs spend considerably less on health:

**Figure 6.1. Health spending in Muslim majority countries**

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>World</td>
<td>2513239.2</td>
<td>71.5</td>
<td>49.4</td>
<td>44.1</td>
<td>45.6</td>
<td>9.9</td>
<td>9.9</td>
</tr>
<tr>
<td>OECD</td>
<td>325093</td>
<td>80.3</td>
<td>3.8</td>
<td>12.9</td>
<td>73.0</td>
<td>72.4</td>
<td>9.1</td>
</tr>
<tr>
<td>OIC</td>
<td>611908.5</td>
<td>66.6</td>
<td>38.31</td>
<td>48.63</td>
<td>79.87</td>
<td>8.99</td>
<td>5.55</td>
</tr>
<tr>
<td>GCC</td>
<td>8972.70</td>
<td>76.2</td>
<td>8.48</td>
<td>15.11</td>
<td>63.20</td>
<td>7.62</td>
<td>3.68</td>
</tr>
<tr>
<td>HPMMC</td>
<td>370056.9</td>
<td>67.36</td>
<td>39.30</td>
<td>52.32</td>
<td>86.59</td>
<td>6.73</td>
<td>3.83</td>
</tr>
<tr>
<td>CRC</td>
<td>35005.9</td>
<td>67.8</td>
<td>30.6</td>
<td>48.8</td>
<td>99.9</td>
<td>7.0</td>
<td>5.5</td>
</tr>
<tr>
<td>Rest of OIC</td>
<td>197873.00</td>
<td>64.9</td>
<td>43.41</td>
<td>53.20</td>
<td>79.34</td>
<td>9.74</td>
<td>6.10</td>
</tr>
</tbody>
</table>

Source: WB, WHO, SESRIC data.

However, he noted that GCC achieves near-OECD standards of outcomes for half the health spending:

**Figure 6.2. GCC achieves near OECD standards of outcomes for half the health spend**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Saudi Arabia</td>
<td>5641.80</td>
<td>74.18</td>
<td>13.38</td>
<td>24.40</td>
<td>57.17</td>
<td>8.21</td>
<td>4.68</td>
</tr>
<tr>
<td>Bahrain</td>
<td>238.40</td>
<td>76.55</td>
<td>5.90</td>
<td>6.50</td>
<td>63.51</td>
<td>10.47</td>
<td>4.98</td>
</tr>
<tr>
<td>Qatar</td>
<td>339.30</td>
<td>78.42</td>
<td>7.20</td>
<td>25.80</td>
<td>48.15</td>
<td>5.83</td>
<td>2.19</td>
</tr>
<tr>
<td>Kuwait</td>
<td>546.80</td>
<td>74.47</td>
<td>8.10</td>
<td>14.00</td>
<td>90.54</td>
<td>5.77</td>
<td>3.04</td>
</tr>
<tr>
<td>Oman</td>
<td>692.80</td>
<td>76.84</td>
<td>10.00</td>
<td>10.50</td>
<td>56.49</td>
<td>6.76</td>
<td>3.55</td>
</tr>
<tr>
<td>UAE</td>
<td>1513.60</td>
<td>77.20</td>
<td>6.40</td>
<td>9.50</td>
<td>64.38</td>
<td>8.69</td>
<td>3.64</td>
</tr>
</tbody>
</table>

Source: WB, WHO, SESRIC data.
Further, he noted while that conflict-ridden countries such as Afghanistan, Iraq, Syria, and Libya do not (yet) perform much worse than rest of the world, high-population MMCs (Pakistan, Indonesia, Egypt, Bangladesh, Turkey, and Nigeria) significantly underspend and underperform on health.

**Figure 6.3. Muslim majority countries significantly underspend and underperform on Health Indicators**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pakistan</td>
<td>7732.30</td>
<td>65.96</td>
<td>69.10</td>
<td>75.2</td>
<td>86.78</td>
<td>4.72</td>
<td>2.61</td>
</tr>
<tr>
<td>Indonesia</td>
<td>72340.7</td>
<td>68.70</td>
<td>24.40</td>
<td>43.7</td>
<td>75.32</td>
<td>5.73</td>
<td>2.84</td>
</tr>
<tr>
<td>Egypt</td>
<td>24016.9</td>
<td>70.93</td>
<td>21.80</td>
<td>52.8</td>
<td>90.07</td>
<td>5.38</td>
<td>5.64</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>50765.8</td>
<td>71.25</td>
<td>33.50</td>
<td>73.6</td>
<td>92.89</td>
<td>5.65</td>
<td>2.81</td>
</tr>
<tr>
<td>Turkey</td>
<td>18378</td>
<td>74.90</td>
<td>13.20</td>
<td>4.9</td>
<td>78.71</td>
<td>10.50</td>
<td>5.41</td>
</tr>
<tr>
<td>Nigeria</td>
<td>127231.2</td>
<td>52.44</td>
<td>73.80</td>
<td>63.7</td>
<td>95.74</td>
<td>8.17</td>
<td>3.66</td>
</tr>
</tbody>
</table>

Source: WB, WHO, SESRIC data.

**Figure 6.4. Muslim majority countries compared to other groups of countries**

Source: WB, WHO, SESRIC data.
He emphasized the need to understand the specific structure and dynamics of each HPMMC to affect change, and that very little is known about philanthropy in MMCs.

Osama presented a possible framework for understanding health needs in the Muslim world:

**Figure 6.5. Framework for understanding health needs in the Muslim world**

<table>
<thead>
<tr>
<th>Country</th>
<th>Average SHE</th>
<th>Average DALY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morocco</td>
<td>$439</td>
<td>9962</td>
</tr>
<tr>
<td>Egypt</td>
<td>$742</td>
<td>790.3</td>
</tr>
<tr>
<td>Iran</td>
<td>$2068-154</td>
<td></td>
</tr>
<tr>
<td>Algeria</td>
<td>$571</td>
<td>39507</td>
</tr>
<tr>
<td>Iraq</td>
<td>$61.8</td>
<td>5059</td>
</tr>
</tbody>
</table>

Source: WB, WHO, SESRIC data.

He went on to suggest that inter-country transfer of philanthropy will require classifying countries according to their GINI coefficient and potential zakat collection (Figure 6.5):
### Figure 6.6. Inter-country transfer requires an assessment of generation and utilization

<table>
<thead>
<tr>
<th>High GDP (Wealth)</th>
<th>Average GDP: $20,634</th>
<th>Average GINI: 44.49</th>
<th>Nigeria</th>
<th>Qatar</th>
<th>Suriname</th>
<th>Turkey</th>
<th>Malaysia</th>
<th>Gabon</th>
<th>Morocco</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low GDP (Wealth)</td>
<td>Average GDP: $5,616</td>
<td>Average GINI: 34.9</td>
<td>Algeria</td>
<td>Kuwait</td>
<td>United Arab Emirates</td>
<td>Brunei Darussalam</td>
<td>Saudi Arabia</td>
<td>Bahrain</td>
<td>Oman</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average GDP: $8,333</th>
<th>Average GINI: 42.8</th>
</tr>
</thead>
<tbody>
<tr>
<td>High GINI (Income Inequality)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average GDP: $1,052</th>
<th>Average GINI: 33.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low GINI (Income Equality)</td>
<td></td>
</tr>
</tbody>
</table>

Source: WB, WHO, SESRIC data.

### 6.2.1 Policy Recommendations

Osama outlined a list of potential policy recommendations for the group at large to consider. They included recommendations for national governments, philanthropic organizations, and advocacy/research organizations.

#### 6.2.1.1 National Governments

- **Governments’ treatment and regulation of philanthropy** is an important policy lever that could be effectively used to enhance the quantum of philanthropy in the Muslim majority countries.
- **Government funding and philanthropy** are often the opposite ends of the same coin – or conjoined twins to use a somewhat unfortunate example – and there is a need to better conceptualize and theorize about this relationship and recast it in a different and more synergistic way.
- **A move away from centralized collection systems**, particularly for zakat, could revive a failing and ineffective system and may provide greater legitimacy to civil society organizations trying to fill in the service void left by government.
  - Philanthropy-funded health initiatives in Muslim majority countries must serve as laboratories for policy innovation and models that could be adopted, adapted, and replicated by governments.
  - Governments must take a fresh look at waqf (especially cash waqf) as a means to operationalize and make productive vacant assets and make available for social causes.

#### 6.2.1.2 Philanthropic Organizations

- Philanthropic organizations in the Muslim majority countries and those in the developed world must embrace new and innovative models of giving as well as disbursement.
- **Non-profit organizations and service providers** must use the entire range of
philanthropic instruments – not just zakat alone, but also sadaqah and, in particular, waqf – that are at their disposal to enhance the quantum collections.

- Organizations that tap into Muslim philanthropy must embrace transparency, integrity, and service excellence as key principles on which to build their operations.
- Muslim philanthropic organizations must embrace innovative organizational models of philanthropy in zakat and waqf-funded charities. There is also a need to further innovate to meet the changing needs of the time.
- Muslim philanthropic organizations must develop refined and differentiated fundraising strategies for different target markets – high net-worth, expatriate, and small donors – to diversify a sustainable source of charities through, perhaps, a MMC “health fund”

6.2.1.3 Advocacy and Research Organizations

- There is clearly a need for better understanding of philanthropy in the Muslim majority countries, not just at an intuitive level but in a fine-grained, rigorous, and empirical level.
- There is a need for creating a system for collecting and channeling philanthropic flows to places of highest needs, particularly in situations of disaster or health-related emergencies.
- By and large the underlying structure of Muslim philanthropic giving is “small, individual, and informal” and any effort to channel this must take into account the unique nature of this resource.
- There is a need for Muslim philanthropic organizations to work with and educate religious scholars to find ways to address current challenges.

6.3 FRAMING IS IMPORTANT – THE FIELD NEEDS TO BE FRAMED FROM CHARITY TO SUSTAINABLE PHILANTHROPY. DISCUSSION

According to Siddiqui, Muslim philanthropists should be expected to ‘step up’ in terms of vision, strategy, and leadership; policy recommendations should formalize that expectation. Keshavjee pointed out that Bill Gates, Warren Buffett, John D. Rockefeller, and other founders of prominent American charities are not regarded as “Christian” philanthropists. Siddiqui replied that this is precisely why the definition of Muslim philanthropy is so important; for example, the designation “Muslim Majority Countries” is geographic rather than religious, which is important because some Muslims do not want to identify as such. Osama noted that the designation “Muslim philanthropist” is needed because otherwise it would not capture zakat.

Keshavjee advised that the recommendations are not currently suitable for an HMS policy brief. The major conclusion of the workshop - that more data is needed about Muslim philanthropy - is not substantive enough for a policy brief, which often entails a set of specific recommendations endorsed by a large number of experts in the field. He, therefore, suggested that since this was still a work in progress, a HMS-Dubai Working Paper, along with an annotated briefing, might be an appropriate format for the findings of this workshop.

Siddiqui suggested submitting a set of policy briefs covering different issues to the Symposium of Public Policy and Nonprofits journal (partnered with the peer-reviewed Nonprofits Policy Journal). Siddiqui suggested addressing the following issues:

- Governments of those four countries (Pakistan, Egypt, Turkey, and Indonesia) need to have a better policy framework for philanthropy (requires a review of legal structures of those countries related to philanthropy and waqf/zakat management)
• Zakat systems (data exists for this through secondary research);
• Lack of data on Muslim philanthropy.

Keshavjee agreed, remarking that other issues could include better understanding the legal infrastructures in target OIC countries, or how to channel flows using specific models. He also suggested publishing such topics as working papers from the HMS CGHD-Dubai as a first step to gather feedback from others. Siddiqui commented that peer-reviewed publications are often more effective in convincing donors.

Çarkoğlu expressed concern over the lack of a conceptual discussion as to the different types of philanthropic activity that really take place in MMCs. Charitable giving, philanthropic investment, strategic philanthropy, and social entrepreneurship are all types of philanthropy, but most Muslim giving is charitable giving and the others are very rare. If the global trend is shifting toward the other three activities, then the fact that MMCs are focused on just one type is limiting their impact. Producing information—a public good—is strategic investment philanthropy, in that providing this data for people is in fact philanthropic work. Because this is not the tradition, the top-tier MMC donors are not used to paying for the cost of research as opposed to more traditional charity, so they will need to be convinced to invest in new types of philanthropic activity. He suggested that this recommendation is the most important to come out of this forum. Cheema noted that collecting and analyzing data is a type of strategic philanthropy that is part of the mission of the World College of Muslim Philanthropists. However, a challenge they have faced in doing so has been finding academic institutions with adequate capacity to carry out the research that can also engender trust in donors.

Aamir Khan observed that in other scenarios, the process involves identifying a problem (e.g., a disease area) and then finding the main contributors in the field to galvanize a core of individuals and partners to serve as a resource. The best data so far are from Çarkoğlu and his team in Turkey, who have a level of expertise from working on the surveys for more than a decade. He suggested that Çarkoğlu’s group could serve as a possible resource for the workshop efforts, particularly in terms of technical leadership and strengthening the capacity for organizations such as Muhammadiyah, for example, to carry out similar philanthropy surveys.

Cheema agreed that it is important to lead the charge toward better data collection, and ultimately bringing together the academic institutions carrying out the work in a moderated collective. He noted that UN agencies are interested in this area but facing major obstacles such as operating costs and the problem of earning the peoples’ trust. The workshop participants’ sphere of influence, good intentions, and sound integrity could be leveraged to avoid such problems. At the current stage, he warned against juxtaposing the collection of data with the collection of money. Fundraising is ineffectual without governance and accountability. Once the data has been collected, then the group can carry out more detailed analysis and planning. He suggested that the time is right to initiate these efforts because there are many people trying to enter this untapped market, but they do not have the same intentions as the researchers present at the workshop. Cheema reflected that there are many institutions in the Muslim world engaged in service delivery at least partially funded by faith-based giving that could be brought within the ambit of the project.

Siddiqui suggested that the philanthropy surveys can be carried out as a collaborative and decentralized activity whereby local coalitions and collaborations spring up to fundraise and carry out surveys as per a standardized global format. He suggested that such conversations may be initiated once the survey instrument has been created and opined that that once the initial proof of concept and value of the broader process is established, many countries (e.g. Gulf States) will come in self-funded and donors may line
up to fund others (e.g. poorer countries). GDF can also help to imbue countries with ownership.

Keshavjee reminded the group to collect data from Muslims in the United States and Britain as well, in order to better target activities. Also, to the question of social justice/social business, Keshavjee noted that there is much in the Quran about looking toward the poor and helping orphans, the sick, the aged, and so on, far more than the mention of prayer. He was struck by the question of what it is to be a Muslim, and suggested including a question in the survey instrument about what people think that faith-based giving is, and what it is linked to, to better capture peoples’ understanding.

Aamir Khan summarized the discussion and reiterated the group’s intention to focus on a set of working papers as future outputs of the group (rather than a policy brief), with the possibility for publishing one or more of the papers.

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Cheema said that out of 6236 verses of the Quran, ‘community’ is referred to in 14% of the verses and jihad is referred to in only 0.417% of verses.
Appendices

APPENDIX 1. MEETING AGENDA

Muslim Philanthropy and Sustainable Health Care Delivery in the Muslim World
Harvard Medical School Center for Global Health Delivery – Dubai
December 1st – December 2nd, 2016

Thursday, December 1st 2016; The Context of Muslim Philanthropy and Healthcare Delivery: Global, National, and Local Perspectives

Session 1: 8:30-09:30 Setting the Stage

Introduction and Expectations - Dr. Aamir Khan, IRD

Global Health Delivery: The Challenge for the Muslim World - Dr. Salmaan Keshavjee, Harvard Medical School Center for Global Health Delivery – Dubai

Session 2: 9:30-12:00 Quantum and Challenges of Muslim Philanthropy

Sizing Philanthropy in the Muslim World: Challenges and Opportunities – Sahrish Qamar, Technomics International Ltd & Muslim World Science Initiative, United Kingdom

Challenges and Opportunities of Muslim Philanthropy: Need for a Research and Policy Agenda – Dr. Shariq Siddiqui, ARNOVA and IUPUI, United States

Donor-Driven Healthcare Delivery: Trends, Challenges, and Way Forward for Muslim Giving - Dr. Tariq Cheema, World Congress of Muslim Philanthropy, United States

Mobilising Waqf As a Pillar of Philanthropy: Innovative Case Studies and Developments from Around the Muslim World - Rafiuddin Shikoh, Dinar Standard, USA and UAE

Lunch and Prayers: 12:00-13:00

Session 3: 13:00-15:00 National Perspectives on Philanthropy and Public Health

Philanthropy and Giving Behavior in Turkey: Evidence from Turkish Philanthropy Survey - Dr. Ali Çarkoğlu, Koc University, Turkey

Islamic Philanthropy and Healthcare Delivery in Indonesia – Dr. Hilman Latief, Universitas Muhammadiyah Yogyakarta, Indonesia

The Landscape for Islamic Philanthropy and Healthcare Delivery in Pakistan – Robia Islam, IRD, Pakistan
Session 4: 15:30-17:30pm Local and National Case Studies on Philanthropy in Public Health

The Indus Health Network: A Pakistani Health Philanthropy Case Study - Dr. Abdul Bari Khan, Pakistan

Muhammadiya Health Network: An Indonesian Health Philanthropy Case Study
– Dr. Syafiq Mughni, Muhammadiya, Indonesia

Layton Rahmatullah Benevolent Trust: A Pakistani Health Philanthropy Case Study – Najmus Saquib Hameed, Pakistan

Resala Charity Organization: The Change to Efficient Resource Mobilization Study
– Dr. Amr El Tayeb, Egypt

19:30 - 22:00 Dinner (Location: TBD)

Friday, December 2nd 2016: Consultations and Discussions on Way Forward for Research and Policy

Session 1: 08:30-10:30 Open Discussion on Day 1 Presentations
Led by Dr. Athar Osama and Dr. Aamir Khan

Session 2: 10:30-12:30 Discussion on Draft Harvard Policy Brief
Led by Dr. Aamir Khan, Dr. Salmaan Keshvajee, and Dr. Athar Osama

Lunch and Prayers: 12:30-14:00

Session 3: 14:00 - 15:30 Discussion on Proposal for Multi-Country Muslim Philanthropy Surveys
Led by Dr. Ali Carkoglu, Dr. Aamir Khan, and Dr. Athar Osama

Session 4: 16:00 - 17:00 Wrap Up and Next Steps
Led by Dr. Aamir Khan
APPENDIX 2. LIST OF MEETING PARTICIPANTS

1. Dr. Aamir Khan, Executive Director, Interactive Research & Development, Pakistan
2. Prof. Salmaan Keshavjee, Director, Harvard Medical School Center for Global Health Delivery – Dubai and Professor of Global Health and Social Medicine, Harvard Medical School
3. Dr. Shariq Siddiqui, ARNOVA and IUPUI, United States
4. Dr. Tariq Cheema, Founder and President, World Congress of Muslim Philanthropy, USA
5. Dr. Rafiuddin Shikoh, DinarStandard, USA and UAE
6. Prof. Ali Çarkoğlu, Koc University, Turkey
7. Hilman Latief, M.A., Ph.D. Chairman of Muhammadiyah National Zakat Board (LAZISMU). Email: h_latief@umy.ac.id
8. M. Amr El Tayeb, M.D., MRCS(Eng) CEO, Smart Medical Services Professor of Neurosurgery, Cairo University Email: Amr. eltayeb@smart-medicalservices.com
9. Prof. Abdul Bari Khan, Indus Health Network Pakistan
10. Prof. Syafiq Mughni, Muhammadiyah, Indonesia
11. Mr. Najmus Saquib Hameed, LRBT, Pakistan
12. Dr. Athar Osama, Policy Consultant, Interactive Research and Development, Pakistan
14. Ms. Sahrish Qamar, Technomics International Ltd & Muslim World Science Initiative, UK
## APPENDIX 3. COMPARISON OF HEALTH ISSUES AMONG OIC MEMBER STATES

Highlighting in the table represents a health issue in the country.

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<th>Organization of Islamic Cooperation (OIC) member state</th>
<th>GDP per capita (US$)</th>
<th>Human Development Index (HDI) 2014</th>
<th>HDI rank 2014</th>
<th>Maternal mortality ratio (estimate, per 100,000 live births) 2015</th>
<th>Child mortality under-5 (per 1,000 live births) 2015</th>
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</table>

*Source: Keshavjee presentation at December 2016 Muslim Philanthropy Meeting, hosted by HMS Center for Global Health Delivery-Dubai.
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