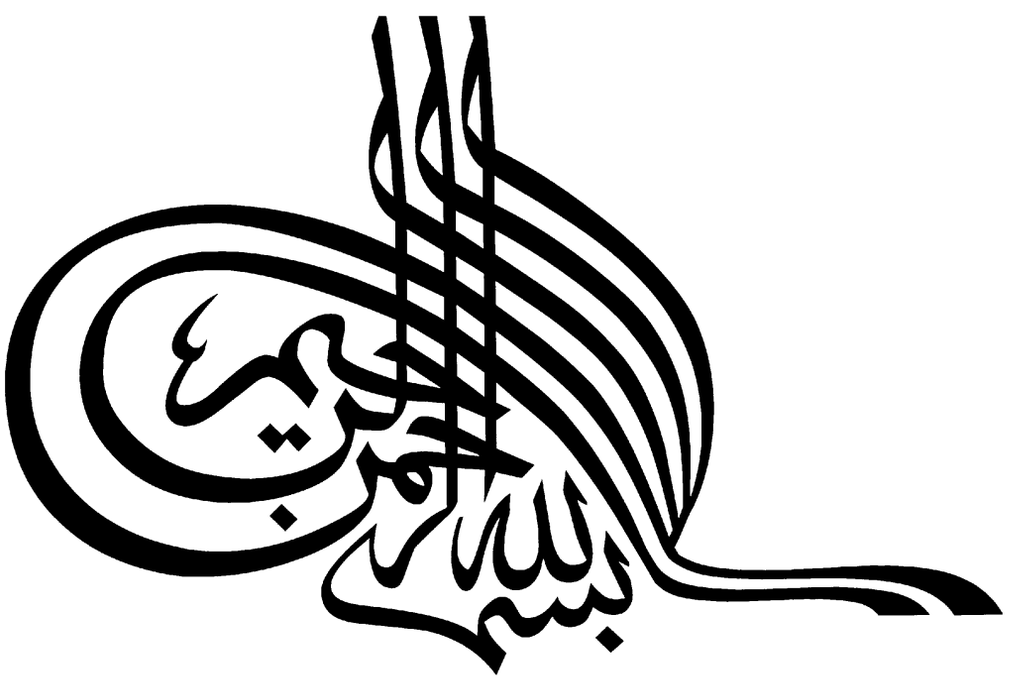
بسم الله الرحمن الرحيم

" .... ومن أحياها فكأنما أحيا الناس جميعاً....."

“ ... And if anyone saved a human life, it would be as if he saved the life of the Whole humanity... ”

Glorious Qura’n: Chapter 5, Verse 17

FIMA

Year Book 2010-2011

FEDERATION OF ISLAMIC MEDICAL ASSOCIATIONS

الاتحاد العالمي للجمعيات الطبية الإسلامية

FIMA GLOBAL RELIEF:

THE VISION, ACHIEVEMENTS AND MORAL OBLIGATIONS

الإغاثة على صعيد العالم: الرؤية والإنجاز والالتزام الأخلاقي

Publisher:

Jordan Society For Islamic Medical Sciences

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Editorial

Dear FIMA members
Assalamu Alaykum
Bismillah al-Rahman al-Rahim

Praise be to Allah the Most Merciful, the Most Beneficent. May Allah shower His blessings and peace on His Prophet and Messenger Muhammad (PBUH).

I begin by thanking the FIMA Executive Committee for honoring me with the responsibility to be the Editor-in Chief again for this yearbook. I thank Allah (SWT) for giving me this opportunity and enabling me to accomplish this task. I pray to Allah (SWT) to accept my effort in His way and to reward all who participated in this effort.

The FIMA Executive Council concurred that the theme of this yearbook be Relief Work because such an endeavor had been a significant aspect of FIMA's accomplishments throughout the last two decades. In this yearbook there are several articles each addressing one aspect of the multiple programs and activities of FIMA in the field of relief.. The yearbook is thus more voluminous. Instead of decreasing the number of or the length of the articles , the Editorial Board decided to have this yearbook cover both 2010 and 2011

Relief encompasses many aspects but is mainly meant for helping communities in distress whether it is economic, physical or both. It is usually caused by natural disasters but it can also be man-made. Although FIMA was not established as a relief organization, it nevertheless took it upon itself to actively participate in relief work whenever it was needed and wherever it was possible considering its relatively meager financial resources.

The founders of FIMA in 1981 captured the essence of humanitarian relief when it listed it as one of FIMA's aims and objectives, "To mobilize professional and economic resources in order to provide medical care and relief to affected areas and communities." This objective was further elaborated at FIMA's eighth Council meeting held in Amman, Jordan in July 1991. It was confirmed in the following FIMA Council meeting in Malaysia, September 1992. In September 1994, in Paris, a master plan was drawn whereby all Islamic Medical Associations (IMAs) and partner relief Non-Governmental Organizations (NGOs) would undertake relief activities in coordination with an IMA located in or adjacent to the disaster- stricken area or country. Dr Aly Mishal was appointed as the coordinator between FIMA and the other collaborating relief organizations / NGOs.

The involvement of FIMA in relief is based on the conviction that relief work is rewarding in this life but more importantly is greatly rewarded by Allah (SWT). Drs Hafeez Ur Rahman and Aly Mishal expanded on this theme in the opening chapter entitled Relief: Volunteerism or Obligation. They emphasize the deep rooted tradition of charity / relief in all religions citing examples from the Jewish, Christian, and Islamic scriptures and religious writings.

Dr Jeddar chronicles the relief wok that FIMA has been involved within various areas of the World, from Moluccas islands in the Far East to Haiti in the West. He also reported that FIMA depended on coordinating its relief work with other Islamic relief organizations based in other countries especially in the countries where relief work was needed. The first major FIMA

coordinated relief activity was in Bosnia Herzegovina during the 1992-1995 period and more recently in Haiti after the earthquake of 2010.

Drs Salleh and Abdel Aziz discuss the concept of Total Disaster Management. It is meant to significantly reduce the disaster risks and to more effectively respond to disaster. They delineate its components; better understanding of disaster risks, enhancement of competence by sharing knowledge, experience and expertise, application in all phases of the disaster management cycle, and cooperation of all stakeholders.

Drs Karaman et al describe the development and activities of Doctors World Wide (DWW). It is the international relief arm of Hayat Foundation which acts as Turkey-IMA. The work of DWW is to provide medical aid at three levels: emergency relief, extended medical relief, and lastly rehabilitation, reconstruction and medical education.

One of the most successful FIMA relief projects is FIMA Save Vision (FSV). Drs Hafeez Ur Rahman, Intzar Butt, Zahid Latif et al describe its initiation, its organization, impact, and achievements over the six years of its existence. Its goal is to combat blindness, the commonest cause of which is cataracts. Surgical treatment would restore vision in most of the cases. The program was implemented in 13 countries in Africa, South and Southeast Asia so far.

In the initial phase of FSV, a series of relief teams of volunteer FIMA member ophthalmologists performed eye examinations, and cataract surgery in makeshift eye camps that were set in primitive general hospitals and other available public buildings. The teams also trained local ophthalmologists and eye care paramedical personnel. The program's success has been dependent on collaboration with local health authorities, as well as philanthropic organizations in many countries, as well as the World Health Organization (WHO). The success of this program was recognized. It won the 2009 American College of Physicians, Richard and Hilda Rosenthal award.

Drs Jaljuli, Hafeez Ur Rahman and Aly Mishal discuss the efforts by FIMA to establish eye hospitals or eye sections in general hospitals in the underdeveloped remote areas in Africa, South and Southeast Asia.

Dr Rayes, in another article, details FSV program in Sri Lanka. There, maturity onset cataract accounts for 66% of blindness. He states that if the selection criterion for cataract surgery is visual acuity of 6/60, the number of eyes needing surgery will be 314,500.The main effort in Sri Lanka is led by the Kuwait Hospital Foundation which established the Kuwait Hospital. There are several organizations that partnered with the hospital. More than 5,000 patients had undergone cataract surgery, free of charge, at this hospital. FIMA established an eye care center in the hospital.

Dr Hafeez Ur Rahman details the work of FIMA in Darfur. FIMA established an eye hospital in al-Genaina, Darfur West in 2006. Since then 5,040 cataract surgeries were performed.
Engr. Abdullahi and Dr. Ibrahim detail FSV program in Nigeria. The first eye camp was in 2007, followed by four through January 2009. In 2009, seven eye camps and in 2010 four camps were conducted. Four more camps were conducted up to the time of their submission of the manuscript in 2011. The authors describe how the camps were organized and operated and their results.
Dr M. Iqbal Khan discusses another important FIMA relief initiative that is FIMA Save Dignity (FSD). Vesicovaginal and vesicorectal fistulae are serious medical and psychological problems that cause great social harm, loss of women's dignity, and often result in family breakups and social

isolation of affected women. The most common cause of these fistulae is neglected obstructed usually unattended deliveries. This is the result of lack of proper maternity services especially in remote / rural areas of the underdeveloped countries. In a sense, these fistulae are almost completely preventable with proper maternity care, and mostly correctable by surgery. However, the surgical repair involves delicate and skilled operative technique and needs to be performed by especially trained gynecologic surgeons. These conditions are almost non-existent in many of the poor developing countries. FIMA formed teams, the first of which arrived in Darfur, Sudan in 2008. So far, four camps carried out 167 surgical repairs in Sudan. Similar camps were arranged in Afghanistan and Pakistan with 89% success rate.

Another equally important program is FIMA Save Smile (FSS) aimed at surgical repair of facial clefts. Dr Parvaiz Malik discusses this program. Cleft lip / palate is a relatively common congenital malformation with an incidence of 1/700 live births. FSS was formally adopted by FIMA executive Council on March 14,2010 in its meeting in Makka, Saudi Arabia. A team of US physicians, members of the Islamic Medical Association of North America (IMANA) performed 62 repairs in Khartoum, Sudan with excellent results during March 2010. Local plastic surgeons participated to get training in these procedures, and the surgical equipment was donated. The IMANA team returned to Sudan in March 2011 and 80 successful surgical repairs were performed. Another camp is planned to return to Khartoum this year. Meanwhile, DWW-Turkey team surgically corrected 125 cleft lip / palates in Palestine, Yemen, and Syria, in 2010-2011.

Drs Mohammad Khan, and Mohammed Tariq in another article describe the role that Pakistan IMA (PIMA) played in providing medical-humanitarian relief work in Pakistan since 2005. During this period Pakistan had been afflicted with several calamities; destructive earthquakes in 2005, massive internal displacements of people propelled by military operations of 2009-2010, and the huge floods of 2010. They describe the contribution and collaboration of several other IMAs and NGOs in their relief efforts and how all these efforts were coordinated on the ground to result in a successful outcome. They provide guidelines for PIMA, FIMA, and other relief organizations to further strengthen the impact of the relief efforts. Some of these guidelines have already been incorporated by the National Disaster Management Coordination office.

When we think of disaster medical relief, we do not usually think of medical education or regular training of physicians. But unfortunately this is important in Palestine. The grim situation of being under the harsh Israeli occupation, and especially the siege of Gaza caused serious damage to medical education. It created a significant need for outside help especially in training of the Palestinian physicians in the various medical specialties outside Palestine. This topic is discussed in an article by Dr Mishal. He describes FIMA's efforts in this regard. This was accomplished in conjunction with various institutions and civil charitable organizations. Sponsored electives were offered to Palestinian medical students mainly at the Islamic Hospital, Amman, Jordan. Residents from Palestine received specialty training mainly at medical institutions in Jordan. In addition FIMA sponsored post graduate training of few residents in Egypt, Pakistan, and Malaysia. FIMA also helped in arranging for some professionals to visit Gaza to support medical training there, but only for short periods. Telemedicine has been applied in collaboration with the Arab Medical Union of Egypt and the Jordanian Committee for Supporting the Health Sector in Gaza.

One of the worst examples of man-made disasters is the situation in Gaza / Palestine. Gazans have been under the harsh Israeli occupation from 1967 to 2005 and the later imposition of siege in 2006.The situation became significantly worse with the military assault in December 2008 and the

heavy bombardment from air, ground and sea for 22 days ending on January 19, 2009, amidst wide international condemnations. In addition to the massive casualties, 21,000 homes were demolished, 50,000 individuals were rendered homeless, 15 of Gaza's 27 hospitals and 43 of its primary health care centers were destroyed. Half a million people were left without running water and one million without electricity.

Human relief organizations around the world were appalled by these atrocities and many attempted to break the siege. Dr Musa Nordin and colleagues describe, in a very important article, such efforts.
The authors briefly report the recent history of Palestine and summarize the impact of the Israeli occupation, and the subsequent siege and the war on Gaza. They then describe the establishment of Viva Palestina (Long Live Palestine), a British-based charity registered in January 2009 and the almost simultaneous establishment in Malaysia of Viva Palestina Malaysia (VPM). VPs were similarly formed in many other countries. Their aim was to break the siege and to deliver much needed medical and humanitarian supplies to Gazans. They had launched four convoys. The authors describe specifically the fifth such convoy VP5. It comprised 380 participants from 30 countries driving 147 vehicles carrying desperately needed humanitarian supplies worth 5 million USDs. It departed from London, UK on September 18, 2010 and finally allowed to cross through Rafah, Egypt, into Gaza to arrive there on October 19, 2010. The authors describe the route they took, and how their cargo was delivered to the Government of Gaza. The first recipient was al-Shifa Hospital, the largest hospital in Gaza. The Malaysian contingent met with various local NGOs and helped to fund several local projects. Although this was not a FIMA endeavor per se, VPM had members of Malaysia IMA notably Dr Nordin , a past president of FIMA. They, in addition to 366 volunteers from 30 nations from several religious, ethnic and political backgrounds truly represent the universality and connectedness of humanity and the true essence of Relief, the theme of this issue of the yearbook.

I hope this book will be an important source of information about FIMA achievements in the field of relief work and an incentive for FIMA to continue this type of work. It is a reminder for all of us to think of the bounties that Allah (SWT) has blessed us with. We need to thank Him and be willing to share these blessings with those who are in need. I hope this Year Book will be an inducement for all of us to commit to relief work, and to generously donate money and time to support these activities.

I conclude by thanking all the authors who contributed to this issue. I especially thank the other members of the Editorial Board; Drs Aly Mishal, Abul Fadl Mohsin Ebrahim, and Musa Nordin for their valuable help and guidance. I sincerely appreciate the work done by Dr Mishal's staff for copy editing and proofreading of the manuscripts, especially Ms Elham Mohammad Swaid.

I pray that Allah (SWT) accept and bless our efforts in His service. May Allah (SWT) guide us to the right path and have mercy on us. Amin.

Wassalam
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Federation Of Islamic Medical Associations (FIMA) in Brief

- Established at the outset of the 15th Hijrah century, December 1981, in Orlando, Florida, USA, where senior leading medical professionals representing ten Islamic medical organizations, from various parts of the world, convened and laid down the foundation of the Federation.
- Subsequently FIMA was incorporated in the State of Illinois as a non-profit organization, then acquired the special consultative status with the United Nations Economic and Social Council (UN-ECOSOC).
- Since that time, FIMA membership progressively expanded to include 27 full members, 17 associate members, and more than 15 prospective and collaborating organizations from all over the world.
- Most FIMA activities and achievements are based on the endeavors of its member Islamic Medical Associations, in constructive mutual cooperation, and harmonious understanding.
- Islamic medical activities of FIMA have a holistic nature. Leadership, mutual cooperation and innovation are prerequisites for the welfare of our communities, our Ummah and humanity at large.
- These activities include, but are not limited to:

1. Cooperation in humanitarian medical relief work, where and when needed in disaster stricken countries. The FIMA Save Vision Program was initiated in early 2005. To date more than 80,000 eye surgeries, performed by volunteer ophthalmologists and teams from IMAs in several countries, in Africa, South and Southeast Asia, where visual impairments are rampant. The program included training of local medical professionals to continue and widen this activity by qualified local talents. The program also included establishment of eye hospitals in deprived communities.
   This activity qualified FIMA for a distinguished award from the American College of Physicians (ACP), designated for outstanding humanitarian achievements.
   Over the past two years, two new humanitarian activities were launched: The cleft lip/palate, and the vesico-vaginal fistula projects, both highlighted as significant medical and psychosocial problems in several needy communities.
2. Scientific, professional and ethical jurisprudence related conferences, seminars and publications.
3. Establishment of the Consortium of Islamic Medical Colleges (CIMCO), to foster cooperation in improvement of curriculum, training, research, administration, and up-bringing of model medical practitioners.
4. Establishment of the Islamic Hospitals Consortium (IHC), to pursue cooperation and coordination among medical professionals and hospital administrators in areas of experience exchange, benchmarking, improvement of health care delivery, ethical, administrative and operational activities, to meet the most advanced international standards, in the context of Islamic principles.
5. Publication of FIMA Year Books, which address biomedical, ethical, scientific and other issues that are needed for medical practitioners, educators as well as Jurists.

6. Medical students activities, including conferences, seminars, publications, camps, Umrah and Ziarah programs.
7. Collaboration to extend a helping hand to Muslim medical practitioners in underprivileged countries, to work together and organize professional medical societies.
8. Establishment of resource centers. The HIV/AIDS Resource Center has been functional in prophylactic, social and therapeutic activities in several countries for the past two decades. The Biomedical Ethics Resource Center has been functional for the past decade. Action in preparing a comprehensive Encyclopedia of Bioethics and Medical Jurisprudence is underway.

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Humanitarian Relief: Volunteerism Or Obligation?

*Hafeez Ur Rahman * and Aly A. Misha'l*

Abstract:

Humanitarian relief is a popular slogan earning enormous respect across the world. Volunteerism is an act of providing time, effort and resources for the benefit and welfare of others, as a gesture of moral and social responsibility, without any expectations of material returns or rewards.
In the broader sense, volunteerism in relief work is looked upon as a self-motivated act provided in a spirit of sacrifice towards benefiting others.
The paradigm in which we look at voluntary relief work has a paramount effect on performance, spirit, scope and continuity of relief activities. If volunteerism in relief work is looked upon as purely voluntary work, adopted by individuals or groups, subject to their willingness or mood to put forth their efforts , then this mindset subjects relief work to inevitable pitfalls, interruptions and limitations.
An alternative paradigm views humanitarian relief as a social, moral and religious obligation and this mindset unleashes a powerful altruistic drive which transforms the entire work ethics of the volunteer.
Throughout the course of human history, the spirit of volunteerism to help and benefit others has been inspired by all religious beliefs.
This article attempts to outline the various paradigms of volunteerism in humanitarian relief work with particular attention to the "rahmatan lil alamin" (mercy to mankind) outlook as espoused by Islam.

Keywords: Relief, volunteerism, community service, worship, Islam.

Introduction:

Voluntary work is invariably performed by highly self-motivated individuals, and may include physical, intellectual or financial contributions, provided to benefit others, especially at times of urgent need.
Volunteerism is a lifeblood of communities, through which organizations are established and various social, health, educational, environmental and charitable activities are conducted. Relief and volunteerism are human endeavors intimately connected to the concept of charity and altruism among all human societies.

Relief work is highly respected and condoned in all religious beliefs since the beginning of humanity.
There are voluminous evidence to document this noble endeavour. Every religion believes that relief is a sanctimonious activity and promotes it unreservedly.
The following are relief related examples in the Jewish scriptures:
"Three signs identify this people: They are merciful; they are bashful; and they perform deeds of loving-kindness" [1]

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"If, however, there is a needy person among you…do not harden your heart and shut your hand against your needy kinsman. Rather you must open your hand and lend him sufficient for whatever he needs." [2]
"Doing charity and justice is more acceptable to the Lord than sacrifice." [3]

Rabbi Hiyya advised his wife, "When a poor man comes to the door, be quick to give him food so that the same may be done to your children." She exclaimed, "You are cursing our children [with the suggestion that they may become beggars]." But Rabbi Hiyya replied, "There is a wheel which revolves in this world."[4]
"Charity is equal in importance to all other commandments combined." [5]

"If a person closes his eyes to avoid giving any charity, it is as if he committed idolatry." [6]
"And now abideth faith, hope, charity, these three; but the greatest of these is charity." [7]
In the Christian scriptures we encounter the following heritage.
"For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in..." [8]
"But no stranger had to spend the night in the street, for many a door was always open to the traveler.' [9]
"It is not to share your food with the hungry and provide the poor wonderer with shelters. When you see the naked, to clothe him, and not to turn away from your own flesh and blood." [10]
"Share with God's people who are in need. Practice hospitality.' [11]
"Do not forget to entertain a stranger, for by doing so people have entertained angels without knowing." [12]
" And above all things have fervent charity among yourselves : for charity shall cover the multitudes of sins." [13]
The Hindu scriptures contain many examples of charity and relief related heritage:
"Give charity to the poor as today you are rich and tomorrow you may be poor" [14]

These are just a few of the quotes of teachings from the pre Islamic era. We, as Muslims believe that teachings of all pervious revealed religions stem from the same divine origin as Islam.
In the Islamic paradigm, we have the exclusive advantage that all the teachings of the Creator and His Prophet SAW are authentic, fully preserved and readily available.
The concept of volunteerism, relief and charity work in Islam extends beyond the confines of social responsibility and embraces the pivotal concept of "rahmatan lil alamin" (mercy to mankind) to always strive towards "maslahah ummah" (benefits to humanity). It is deemed a highly spiritual and moral obligation of worship, for the sake of gaining Allah's pleasure and His acceptance of our deeds.
Even during the pre-prophetic life of Mohammad (PBUH), humanitarian work was manifested in several instances. When the first verse (*Ayah*) of the Qur'an was revealed to him at Hira Cave, Mohammad was deeply shaken, and when he returned to his home, his wife, Khadija (RA), witnessing his unusual attitude, addressed him with the following words:
"By the name of the Almighty, He will never let you down, for you are kind to relatives, share the burdens of those who have not , take charge of the poor, host guests and support the perseverance on the right path…". [15]
This was the first testimony from a person who was an intimate witness to his lifestyle and attitudes towards charitable work even prior to divine revelation, with a strong belief that his charitable works will shield him from all forms of evil.
When the Prophet (PBUH) migrated to Madinah, among others he explored a source of water supply for the immediate needs of his companions. He requested Usman (RA) to purchase a well and supplied water to the early community of Muslims for free. . This was probably the first act of charity undertaken by one of the companions upon the advise of Prophet Muhammad (PBUH).

He was so anxious for the well being of the Muhajirun (migrants from Mecca) and their families that very soon he established the historic *"Muakhat System"* in which the Ansars (local inhabitants of Madinah) were made brothers with the Muhajirun. The Ansars opened their houses for the Muhajiruns and shared their property, houses and business with them. They had shown such a tremendous sacrifice on the advice of the Prophet SAW that they are known as *"Ansars"* forever which means "Those who help."

The Prophet Muhammad (PBUH) desired all his companions to establish strong ties with each other. They should love each other like family members and always take care of others with the true spirit of brotherhood. He said, "Your love and kindness for each other would be displayed like one soul. If there is some trouble in one part of the body the whole body shares it by developing sleeplessness and fever." [16]

Allah (SWT) clearly emphasized the importance of charity in the Glorious Qur'an:

(أَلَمْ نَجْعَل لَّهُ عَيْنَيْنِ، وَلِسَانًا وَشَفَتَيْنِ، وَهَدَيْنَاهُ النَّجْدَيْنِ، فَلا اقْتَحَمَ الْعَقَبَةَ، وَمَا أَدْرَاكَ مَا الْعَقَبَةُ، فَكُّ رَقَبَةٍ، أَوْ إِطْعَامٌ فِي يَوْمٍ ذِي مَسْغَبَةٍ، يَتِيمًا ذَا مَقْرَبَةٍ، أَوْ مِسْكِينًا ذَا مَتْرَبَةٍ)

"Have We not made for him a pair of eyes? And a tongue, and a pair of lips? And shown him the two pathways? But he has made no haste on the path that is steep. And what will explain to thee the path that is steep? (It is freeing the bondman, or the giving of food in a day of privation. To the orphan with claims of relationship, Or to the indigent (down) in the dust."[17]

Allah (SWT) has clearly mentioned that the toughest deed is to adopt the path of charity, and later He announced the rewards for those people who adopt this toughest (steep) path.
Allah (SWT) explains righteousness for His creations in the clear and famous Qur'anic verse, which was named: *"Ayatul Birr"* , which means: The verse of righteousness.

(لَّيْسَ الْبِرَّ أَن تُوَلُّواْ وُجُوهَكُمْ قِبَلَ الْمَشْرِقِ وَالْمَغْرِبِ وَلَكِنَّ الْبِرَّ مَنْ آمَنَ بِاللَّهِ وَالْيَوْمِ الآخِرِ وَالْمَلآئِكَةِ وَالْكِتَابِ وَالنَّبِيِّينَ وَآتَى الْمَالَ عَلَى حُبِّهِ ذَوِي الْقُرْبَى وَالْيَتَامَى وَالْمَسَاكِينَ وَابْنَ السَّبِيلِ وَالسَّآئِلِينَ وَفِي الرِّقَابِ وَأَقَامَ الصَّلاةَ وَآتَى الزَّكَاةَ وَالْمُوفُونَ بِعَهْدِهِمْ إِذَا عَاهَدُواْ وَالصَّابِرِينَ فِي الْبَأْسَاء وَالضَّرَّاء وَحِينَ الْبَأْسِ أُوْلَئِكَ الَّذِينَ صَدَقُوا وَأُولَئِكَ هُمُ الْمُتَّقُونَ)

"It is not righteousness that you turn your faces towards East or West, but it is righteousness to believe in God and the Last Day, and the Angels, and the Book, and the Messengers:
To spend of your substance, out of love for Him, for your kin, for orphans, for the needy, for the wayfarer, for those who ask, and for the ransom of the slaves; to be steadfast in prayer, and practice regular charity; to fulfill the contracts which you have made; and to be firm and patient, in pain (or suffering) and adversity, and throughout all periods of panic. Such are the people of truth, the God fearing." [18]
This verse gives a clear set of guidelines for the believers. After professing faith, *"Iman"*, one is enjoined to spend one's beloved substance for the needy people of the world. This is so important that it is mentioned in this verse even before *"Salat"*. It is also obvious that this spending is over and above *"Zakat"*, as *"Zakat"* is separately mentioned after *"Salat"* in the same verse.
In the early verses of Surah al-Baqarah, Allah (SWT) revealed:

(ذَلِكَ الْكِتَابُ لاَ رَيْبَ فِيهِ هُدًى لِّلْمُتَّقِينَ، الَّذِينَ يُؤْمِنُونَ بِالْغَيْبِ وَيُقِيمُونَ الصَّلاةَ وَمِمَّا رَزَقْنَاهُمْ يُنفِقُونَ، وَالَّذِينَ يُؤْمِنُونَ بِمَا أُنزِلَ إِلَيْكَ وَمَا أُنزِلَ مِن قَبْلِكَ وَبِالآخِرَةِ هُمْ يُوقِنُونَ)

"This is the Book; in it is guidance sure without doubt, to those who fear God. Who believe in the unseen, are steadfast in prayer,
And spend out of what We have provided for them.And who believe in the Revelation sent to you, and sent before your time, and (in their hearts) have the assurance of the Hereafter."[19]
The pre-requisite for guidance from Allah is evident in the abovementioned verses. There is no guidance for those who are reluctant to spend in

the path of Allah (SWT). Those who do not care about the poor and needy will not benefit from the Qur'an. In the very next verse it is stated,

(أُولَئِكَ عَلَى هُدًى مِّن رَّبِّهِمْ وَأُولَئِكَ هُمُ الْمُفْلِحُونَ)

"They are on the (true) guidance, from their Lord, and it is these who will prosper"[20]

Allah (SWT) inspires mankind to be always mindful and responsible for the welfare of their fellow humans by describing the nobility of this vocation and offering incentives and rewards to those who performs it. He says:

(مَن ذَا الَّذِي يُقْرِضُ اللَّهَ قَرْضًا حَسَنًا فَيُضَاعِفَهُ لَهُ وَلَهُ أَجْرٌ كَرِيمٌ)

"Who is he that will loan to Allah a beautiful loan? For (Allah) will increase it manifold to his credit, and he will have (besides) a liberal reward." [21]

We are encouraged to invest in the well being of our fellowmen and He will reward us abundantly. Allah (SWT) credits this investment in the preservation and the enhancement of maslahah ummah (benefits to humanity) as a loan to Himself. Undoubtedly, He can help His own creation but in his infinite wisdom, He desires that His creation *"Ibad"* should work to help one another.

In certain circumstances, voluntary actions assume moral obligatory dimensions, defined by Islamic scholars as *"Forood al-Kifayah"*. These are acts volunteered by able individuals or groups, to address a social gap or need in the community. If this act was not duly conducted, then the whole society (or *Ummah*) is held responsible, or sinful, before Allah (SWT). [22-23]

The society (or *Ummah*) is also held responsible and guilty, if it failed to induce and support some of its members to become qualified and to perform the relief work.

The application of the concept of *Fard al-Kifayah* has significant implications on the purely voluntary versus obligatory undertakings. Whenever a serious situation inflicts societies or individuals, and a need arises for qualified experts in medical or nonmedical specialties, then it is incumbent upon volunteers from those specialties to get involved in relief as soon as possible. Otherwise they, and society at large, are held responsible for this failure and are sinful before Allah (SWT). In other words, volunteerism becomes obligatory in such circumstances.

This concept may not be applicable in instances where relief work could be addressed by governmental or nongovernmental Agencies.

The Islamic culture and moral obligation of volunteering in relief work widens this concept to include local communities, the wider Muslim community, as well as humanity at large, without distinction of race, color, religion or ethnicity. This universal concept of voluntary work by Muslims renders them as truly world citizens.

Historically, past Muslim societies have cultivated a culture of volunteerism, which uplifts and inspires the noble virtues of sincerity and altruism among people.

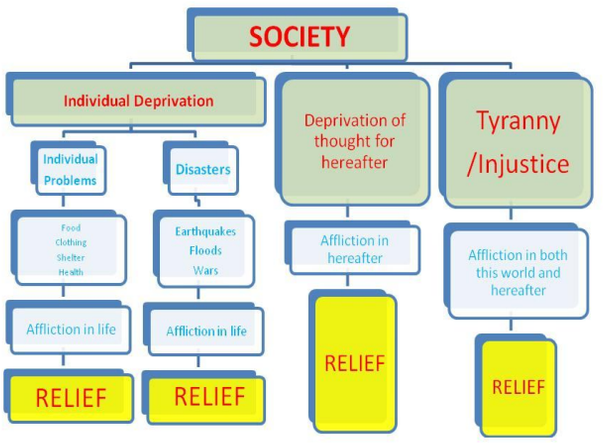
At the personal level, voluntary acts to relieve the sufferings of others invokes the feelings of calmness, peacefulness, tranquility and serenity in one's innerself and enhances one's sense of faith, confidence and self-fulfillment.

Volunteerism enhances compassion and *ihsan (goodness)* among individuals and communities. When we work to help others, we in fact translate values of compassion and sincerity within ourselves. The Prophetic Hadith (narrated by al-Baihaqi) states: "Whoever relieves a mu'min (believer) of his difficulties, Allah will relieve him of his own difficulties. Whoever covers the weakness of a mu'min, Allah will cover his own weakness. And Allah consistently helps the individual who helps his brother".[24]

The figure below illustrates the different areas where human beings may need help from others.

In all the three main areas, any service provided by human beings for their fellowmen comes under the definition of relief. Our Creator and the Prophet have enjoined us to extend our hands for relief in all these areas. We are duty bound for this

and would be awarded abundantly on the Day of Judgment.



If we work in the field of relief with the concept and belief as enjoined by our Islamic faith, this undertaking will confer upon us returns which are sublime and eternal.

We will be doing relief activities for the sake of our own relief, relief on the day of judgment and the divine promise of Jannah (paradise) in the hereafter.

This concept guides us to embrace the Holy Paradigm of Relief and distance ourselves from seeking the worldly rewards of relief activities which are meagre, uncertain and short term. Even the noblest worldly concept of service to humanity will only last till one's final breath, whereas this Holy Concept will guide us through this temporal life and extends eternally into the world hereafter.

With this holy paradigm of relief embedded in our hearts, we will be motivated to work in every relief area for the sake of attaining the pleasure of Allah. Only the pleasure of Allah has guaranteed satisfaction for this life and the life Hereafter.

Organization and Excellence in Relief work:

Many individuals respond voluntarily often in a reflex manner, without prior prior thought and planning to various urgent situations. Examples include a person rushing to save a drowning child or attend to a bleeding casualty of a road traffic accident.

The motives for such actions are often deeply entrenched in the hearts and minds of certain individuals as a manifestation of their noble ethical, religious or social principles. The volunteer expects no material returns, and may on the contrary inadvertently incur injuries or material loss.

The other category of voluntary actions are those which are undertaken following prior contemplation and careful planning. Examples of these include individuals and groups working in the areas of human rights, combating poverty and disease, increasing access to education and those highlighting environmental issues.

A group approach to relief work would considerably expand the scope of humanitarian relief, outreaching a wider target population, enhance effectiveness and productivity and also ensure sustenability and longevity of the relief activities.

Organized volunteerism has to be performed by qualified people, using up-to-date scientific tools, innovations and experiences in specific aspects of voluntary relief work.

Professionalism in conducting relief is an application of quality and excellence *(Ihsan)* in this vital function. *Ihsan* is the highest rank of good deeds.

Volunteers ought to receive appropriate training in the specific field of work they plan to get involved in.

Proper planning and organization in voluntary relief work is mandatory in order to achieve best outcomes and impact.

This includes close follow up, proper evaluation and re-evaluation to avoid or remedy pitfalls and deficiencies in performance. Regular reports meetings, seminars and conferences to discuss and analyze various aspects of achievements of endpoints, deficiencies or handicaps are cornerstones in improving performance, continuity and building a culture of excellence.

Appropriate selection of the type and line of relief work is crucial for the volunteer's productivity, performance satisfactions, continuity and the nurturing of leadership skills.

Other significant considerations for both individual and organizational relief work include constructive consultations with other volunteers, democratic decision-making and transparency.

Volunteerism and our new generation:

It is a widely held observation that our communities lack in nurturing the culture of volunteerism among our youth in schools and universities.
Our younger generations are not as informed nor overly concerned about the concept of voluntary work and helping others. This may be due to a lack of proper family upbringing, together with deficiencies of school and university curricula towards establishing and nurturing the spirit and value of volunteerism. Financial and economic factors are other possible attributable factors. Moreover, most non-governmental and social organizations lack the programs, skills and media coverage to address the youths and motivate them to engage in voluntary social and relief activities. This has created an unhealthy social ambience in our communities that envisages volunteerism as an exceptional undertaking rather than the norm or rule. This handicap in dealing with our youths should be properly addressed and remedied to create a positive and constructive culture of volunteerism.
Our societies and humanity at large are in need of voluntary organizations and institutions to complete or substitute what governments fail to accomplish.
Moreover, these institutions provides knowledge of deficiencies and needs of communities, which is instrumental in calling for reforms and remedial actions by official state planning or by non-governmental actions.

Many of these voluntary institutions work professionally within their niche relief zones and channels the community's resources in an efficient and impactful manner. Their humanitarian relief efforts help to alleviate many of the maladies and sufferings in the community which the state maybe oblivious of or lacks the political will or the capacity to deal with.

Volunteerism and employment:

Many vital aspects of social, charitable, educational and other activities cannot be effectively or efficiently performed by full time employees, whether in the public or private sector.
Employees have limited hours of actual work, and usually have limited scope of involvement and commitment towards the many needs of their communities.
This handicap of the role of the state and its employees, leaves significant gaps which needs to be addressed by various voluntary organizations.
Voluntary institutions which are wholly dedicated to humanitarian relief, fired with passion for the cause combined with flexibility and a pragmatic work culture and a relative lack of bureaucracy and corruption serves the wider community better and often at a much smaller cost.
Volunteerism and employment, however, should complement one another to share accomplishments and responsibilities at different times, scopes, places and circumstances. Moreover, the working relationships between volunteers and employees should always be harmonious and constructive.

Useful tips and advice:

- Organized volunteerism should be shouldered by professionals with proper training and skills in their field of action, with quality standards of performance.
- A volunteer should be selective in choosing the specific field he/she desires to devote and dedicate his/her efforts. Volunteers constitute a very precious resource to the community, and humanity at large, and selectivity is essential for the best outcomes.
- Voluntary work should be provided within a sense of responsibility, commitment and moral obligation. One should always try to

remain humble in this noble vocation and not make too much noise about volunteering one's time, effort, knowledge and experience.

- Humility, compassion, empathy and harmonious working relationships are indispensable qualities of volunteers. Needless to say, egocentricity and a superiority complex is contradictory to the above values.
- Communities and individuals afflicted with various tragic circumstances, especially at times of disasters, are all human beings and deserve care and compassion, regardless of color, ethnicity, religion or nationality. A Muslim volunteer is a true world citizen.
- Harmony and respect in working relationships with paid employees of governments or organizations, is mandatory for success of relief work.
- Culture of volunteerism should be nurtured and spread in communities, with special attention to the youth.
- Volunteerism needs a long or sometimes even a life-time commitment. One may increase or decrease one's involvements but one should never stop. There is no rest for a Muslim until he meets his Creator.
- Although voluntary work in many instances is optional, in certain urgent or life saving situations in which the skills of the volunteer is indispensable, voluntary work by qualified individuals becomes mandatory. Like other *Forood al-kifayah*, the volunteers and the whole society, become accountable and guilty if the relief work is not provided in due time.
- Finally, some enthusiastic individuals and groups may raise issues of propagation (*dawah*) of Islam, together with volunteerism and relief work. Sincerity, humility, compassion, professionalism and quality performance are the real parameters of humanitarian services. Actions speaks louder than words and undoubtedly, the syaksiah (personality) of the Muslim volunteer and his amal (deeds) would speak voluminously for the beauty of his deen (creed).

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FIMA GLOBAL RELIEF:
The Concept, Achievements and Challenges

Ashraf Jedaar *

Abstract:

The Federation of Islamic Medical Associations (FIMA) was incorporated in the USA, in December 1981, as a non-for-profit organization aiming at promotion of healthcare, education, research and collaborative work among Muslim medical professionals all over the world, to serve humanity, guided by Islamic principles and the glorious Islamic civilization.
Although FIMA has not been established as a relief organization, medical relief endeavors to communities stricken by calamities and disease, have been consistently on the agenda of FIMA and the Islamic medical associations (IMAs) under its umbrella.
From Maluku Islands in the Far East to Haiti in the West, FIMA relief teams, acting voluntarily, saved no effort to strive in alleviation of human suffering, regardless of creed, ethnicity, nationality or religion.
In this overview, we took the time and effort to dig into FIMA extensive archives of relief activities, in a retrospective concise manner, to present most relief activities conducted by FIMA, member IMAs, and collaborating relief NGOs, with even-handed documentation and pertinent historical backgrounds.
Leaders of various relief teams have been specified by name in this concise report, but this, in no way ignores or negates other participating team members, who generously and voluntarily provided time and effort in these altruistic, humanitarian activities, with the aim and intention to alleviate human agony, and to please Allah, our Creator, the source of all mercy, healing and wisdom.

Keywords: Medical relief, human disasters, Federation of Islamic Medical Associations (FIMA).

Introduction:

Since the inception of The Federation of Islamic Medical Associations (FIMA) in December 1981, humanitarian relief featured prominently in its charter, which stipulates:
"To mobilize professional and economic resources for the provision of quality health care, services and relief activities, wherever needed".
Although FIMA is not a relief organization, virtually every FIMA Council meeting has itemized relief as a priority agenda.
During the 1980s, all Islamic Medical Associations (IMAs), under umbrella of FIMA, conducted relief activities in their own countries and in neighboring countries that suffered from natural or man-made health disasters. All IMAs have specified significant portions of their humble finances towards relief and rehabilitation of fellow human beings. Volunteerism has always been the backbone of these altruistic endeavors by all IMAs.
In Islamic teachings, medical professionals are guided by a wealth of heritage in the Glorious Qura'n and the Sunnah of the Prophet (PBUH). The following are only few illustrative examples:

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"*And if anyone saved a human life, it would be as if he saved the life of the whole humanity*".[1]

"*Those who spend of their wealth in the path of Allah by night and by day, secretly and openly, for them are their reward with their Sustainer. There is neither fear on them nor shall they grieve*".[2]

"*The believers, men and women, are protectors/helpers of each other: they enjoin what is right and forbid what is wrong*".[3]

Not until the 1991 FIMA Council Meeting in Amman-Jordan, that relief work has entered a new stage of international collaborative undertaking between various IMAs and other like-minded relief non-governmental organizations, a perspective that imparted awesome outcomes with professional finesse, sincere human touch, in an Islamic spirit.
FIMA, with the huge manpower of over 50,000 medical professionals, equipped with deep rooted sense of volunteerism and welfare of mankind, stepped into an era of worldwide commitment and achievement that escalated year after year.
Over the past two decades, highlights of FIMA's history reveal the following milestones:

- **In July 1991:**

IMAs and relief organizations leaders and professionals, assembled in Amman-Jordan, at the time of the eighth FIMA Council Annual meeting. The concept of expansion of relief work from a local endeavor to international dimensions was adopted. FIMA relief has since, crossed the boundaries and extended professional helping hand, which went beyond just food and medicine.
The concept of relief work has been again confirmed at the 9th Council meeting in Malaysia, September 1992.

- **September 1994:**

Under auspices of the eleventh FIMA Council Meeting in Paris-France, a comprehensive meeting of Islamic relief organizations was held, to coordinate relief activities and face challenges. The meeting was attended by the Deputy Health Minister of Bosnia which was still under fire.
A master plan was drawn, whereby all IMAs and cooperating relief non-governmental organizations (NGOs), would undertake relief activities in coordination with an IMA located in, or adjacent to the country considered a disaster-stricken area (regionalization).
Dr. Aly Mishal, from Jordan, was appointed as coordinator between FIMA and the other collaborating relief NGOs.
In this meeting, FIMA was looked upon as a huge medical manpower provider, which should complement the efforts of other relief NGOs that own significant financial and material resources:

- **July 1999:**

At a special relief session, during the 16th FIMA Council meeting in Beirut-Lebanon, IMAs relief representatives and leaders from other relief NGOs, discussed lessons, achievements, challenges and shortcomings of relief work during the past years. Dr. Hafeez Ur Rahman, from Pakistan, was appointed as FIMA Relief Coordinator, with the following terms of reference:

1. To coordinate relief activities of different IMAs.
2. To invite like-minded relief NGOs to participate in different relief activities organized by FIMA.
3. To seek cooperation with international relief organizations.
4. To prepare a relief database of FIMA, as well as international volunteering medical professionals.

- **June 2001:**

Following the 18th FIMA Council meeting in Sarajevo, Bosnia, a relief workshop was conducted, under the theme: Medical Dilemmas in

Developing Countries, chaired by Dr. Hafeez Ur Rahman. Deliberations and experiences were presented, significantly in the land that was subjected to one of the worst man-made atrocities of recent human memory.

- **July 2002:**

A pre-congress symposium titled "Healing Across Borders" was conducted by Mercy Malaysia (MM) in collaboration with FIMA, chaired by MM President Dr. Jamilah Mahmoud, with participation of Islamic Relief-UK president, Dr. Hani al-Banna, prior to the 19th Council meeting, and the FIMA international scientific convention, in Kuala Lumpur- Malaysia.

- **April 2003:**

During the 20th FIMA Council meeting in Johannesburg-South Africa, the whole Scientific Convention was titled "Relief and Rehabilitation: Challenges and Opportunities". Leaders of major Islamic NGOs participated in this meeting, with significant input:

- Dr. Jamilah Mahmoud- Mercy Malaysia.
- Dr. Hani al-Banna-Islamic Relief-UK.
- Dr. Imtiaz Soliman: Waqful Waqifin- South Africa.
- Dr. Sadaf Alam: Doctors Worldwide-UK.
-Dr. Ashraf Jedaar was appointed as FIMA Relief Coordinator.

- **June 2005:**

FIMA Exec. Committee appointed Prof. Hafeez Ur Rahman as coordinator of the major relief project: FIMA SAVE VISION.

Subsequently, he formed the FIMA International Ophthalmology Committee, for further planning, widening and execution of the project.
FIMA SAVE VISION program has, since then, attained local and international recognition and admiration.

- **July 2006:**

During the 17th FIMA Council meeting in Yogyakarta-Indonesia, the site of a recent destructive earthquake, Dr. Jedaar, FIMA Relief coordinator proposed the program of Training of Relief Workers.

- **July 2008:**

At the 25th FIMA Council meeting held in Marrakech, Morocco, a resolution was approved: Training of Trainers in Disaster Preparedness.

- **August 2009:**

During the 26th FIMA Council meeting in Khartoum-Sudan, a workshop titled "Disaster Preparedness Workshop" was conducted.

- **September 2010:**

Following the 27th FIMA Council meeting in Beirut-Lebanon, a scientific convention was held under title: Care For People With Special Needs.

- **From 1988 until present:**

FIMA has been an active member of the Islamic International Council for Dawa and Relief (IICDR) and its Relief Committee since 1988. This Council combines more than 80 Islamic relief organizations in its membership, and has provided significant widespread relief achievements wherever needed.

FIMA Relief Model:

The FIMA Relief Coordinator, supported by all affiliated members, constantly monitors the environment for any disaster, natural or man-made. He would then commission a Rapid Needs Assessment (RNA) by local collaborators closest to the disaster. With the support of his Relief Committee, the coordinator appoints a local relief

coordinator (LRC) to coordinate the FIMA response to the disaster. After formulating a holistic multi-disciplinary response, he communicates the plan to the broader FIMA membership and associated collaborators. Continuous communications remains critical in coordinating the response effectively and efficiently. After the completion of the response, a critical evaluation/audit is completed to acknowledge all collaborators and remain accountable to its membership. Further consultation with its network determines FIMA's involvement in the long-term reconstruction and rehabilitation phase of a disaster. Critical to this process is a sincere acknowledgement of the contributions of its collaborative partners to remain accountable and transparent in all its affairs.

Overview of Relief Activities Over The Past 2 Decades:

Digging into FIMA archives, we will chronologically present various landmarks of FIMA relief ventures. It is not intended to be an exhaustive expose, since many local and regional relief activities have been continuously undertaken by various IMAs. But we hope this overview would render a perspective of this awesome undertaking, with its achievements, pitfalls, challenges and hopes.

Some major relief projects will not be addressed in this overview, such as FIMA Save Vision, Save Smile, Save Dignity, relief of Pakistan's earthquakes and floods, and others. They will be presented separately, by leaders who pioneered them.

Bosnia and Herzegovina 1992-1995:

A prolonged human tragedy, where relief encountered many obstacles, but with significant achievements.

The 4 year unjust Serbian aggression started in April 1992. By the second half of 1994, Sarajevo became under siege, with continuous bombardment by Serb forces from surrounding mountains.[4]

From 1992-1995, the Bosnian people suffered tremendously from severe shortages of medicines, consumables and medical instruments, let aside food. Practically, all purchasing came down to a halt! The only trickling supplies came from relief NGOs.

Since April 6,1992, the Bosnian people suffered extensive war casualties. Those who survived were saved mainly by humanitarian aid, starting with United Nations High Commissioner for Refugees (UNHCOR), then extended to other NGOs, including Islamic relief organizations.

Targets for the Serb aggression included purposeful and intended hospital destruction. The number of hospitals has dwindled down from 29,000, pre-war, to 13,000, post war.

Many surviving medical professionals were forced to flee Bosnia. The remaining ones received no salaries for almost 3 years! Their numbers were 15,000 in Bosnia, and 6,000 in Sarajevo alone.

FIMA, through its European member, ARABMED, was anxious to provide medical relief, in the face of many formidable obstacles: geographic, safety, financial and other logistics.

Dr. Wasim Tadfi, from ARABMED, left Zaghrib-Croatia, with 3 other doctors, went inside Bosnia, visited medical centers in Sarajevo in 1993, and carried 15,000 Deutsche Mark (DM) which were distributed to Bosnian medical professionals. The team made 3 trips. At that early stage, a total of 95,000 DM were used for:

- Payments to medical professionals who have been serving their communities without salaries.
- Payments to the medical director of Bihac Hospital, under siege, for his staff.
- Medical supplies and consumables, especially to Bihac Hospital.
- Purchase of 2 ambulances.

Contributions came from FIMA members, with significant ARABMED input. At that time the

project of "Bosnian Doctor Sponsorship" became very pertinent.

The agonies of Bosnia

FIMA and its member organizations, decided to channel their donations, cash or material, through ARABMED-Europe, with their easier proximity and access.

In September 1994, FIMA held an Annual Meeting in Paris, hosted by Ibn Sina Medical Association in France. A special relief conference was held with participation of representatives of Bosnia-Merhameh charity society, ARABMED, other IMAs and other Muslim relief NGOs.

The conference was chaired by Dr. Aly Mishal of Jordan. The Bosnia plight was the main theme. Needs, obstacles and means of relief supplies were extensively addressed. The main outcomes at that stage included:

- ARABMED reported channeling USD 158,000 to Bosnia, in the form of payments to medical professionals, supplies and consumables, in 1993-1994.
- All FIMA members were re-instructed to channel their Bosnian support through ARABMED, and to organize sending medical volunteers through the same route.
- Adoption of the "Bosnian Doctor Salaries". The Bosnian delegation informed the audience that as little as 100 DM will support a Bosnian medical professional to stay steadfast in his/her country and take care of suffering people.
- Establishment of a project to manufacture and supply medicines and consumables to Bosnian medical centers, to create jobs, and build infrastructure.
- Establishment a factory to produce artificial limbs, that were sorely needed in Bosnia.

Late Alija Izetbegovic /leader during the Bosnian liberation war

In March 1994, Dr. Ozejr Skaka, from Merhama Society-Bosnia, and later on, a founder of Bosnia IMA, visited Jordan for several weeks, where around 100,000 USD were collected by Jordan IMA, Islamic Hospital and concerned collaborators, to support relief efforts in Bosnia.
Following the Paris FIMA Convention, relief activities escalated and became more productive. Thirty six physicians were sponsored in Sarajevo alone.
From December 1995 to April 1996, the medical staff at Bihac Hospital received DM 35,000 in salaries from ARABMED and IMA-Malaysia, with medical supplies.
Parallel to this effort, the IMA of Egypt, working through the Cairo-based Arab Medical Union (AMU), and the Relief Committee of the Egyptian Medical Association, chaired by Dr. Abdul Qadir Hijazi, a previous FIMA president, provided medicines, consumables, tents, food supplies, clothes and salaries to Bosnian doctors in excess of 2.2 million DM.

IMA-Malaysia and Mercy Malaysia deployed medical teams, medical supplies and consumables prior and after the cessation of hostilities.
IMA South Africa (IMASA) collaborated with Waqful Waqifin Foundation in provision of relief materials. This Foundation was able to send an equipped mobile hospital, which was stationed in the besieged city of Mostar. It, unfortunately, was bombarded by Serbs. Two of its caravans were destroyed, but the rest were functional.

Relief after the War:

Following the Dayton Peace Accord on November 30,2002, more than 919,000 Bosnian refugees and internally displaced persons (IDPs) returned homes[5,6]. Seventy four percent of whom returned to the Federation of Bosnia and Herzegovina. While the rest returned to Serb Republic. Nearly half a million people were still outside Bosnia and Herzegovina.
Relief work, since then, took new and different avenues.

From another FIMA perspective, the new Bosnia IMA was established and joined FIMA as a full member.

Kosovo Relief 1999:

Kosovo is located in the core of Balkan. With a population of 2 millions, the original inhabitants were of Albanian descent. The region fell under Serb domination in the 12th century. In 1389, the Ottomans defeated the Serbs and dominated the country.[6] Kosovo people embraced Islam.
After the Balkan war in 1912-1913, Serbs found their chance to control Kosovo again. Following the London Conference in 1913, the territories inhabited by the Albanian people were subdivided into two parts. One was Albania, and the other was Kosovo, which was dominated by the Serbs.[7]
Since then, the Serbs applied a policy of ethnic cleansing and land appropriation, in a policy to establish Greator Serbia. Many Kosovans were forced to migrate to Albania, Turkey and other parts of the world.[7]

The Kosovan refugee crisis started in early 1999, when kosovans waged campaigns demanding their human and national rights, and the Serb authorities reacted with extreme and harsh measures.

Kosovo in the core of Balkan

Many Kosovans were forced to flee their homes in successive waves. Tens of thousands, shocked, desperate and exhausted, arrived at Northern Albania, the poorest districts of Albania, deprived of health facilities, with poor hygienic conditions. Moreover, this snow-covered mountainous area had poor road systems, and difficult access.
Although the Albanian government's response was too little, too late, the local people received the deprived, impoverished immigrants generously, within the limitations of their original poverty.
As the human suffering escalated, the Albanian government declared a state of emergency and called for international help.

The first FIMA member organization to respond was ARABMED of Europe. FIMA requested its member IMAs to channel their help through ARABMED, as much as possible.

- ARABMED: Deployed medical teams, medical supplies and consumables to refugee camps. One team was led by ARABMED president, Dr. Hassan Najjar, functioned in refugee camps in Tirana and Kukes areas, with support to local Albanian medical professionals to enable them to better serve refugees.
- In early May 1999, the first Malaysian medical team arrived to Albania, in collaboration between IMA-Malaysia (IMAM) and Mercy Malaysia. They provided medical care and supplies to refugees in camps.
- IMA-North America (IMANA), through its Red Crescent Committee, chaired by Dr. Shahid Siddiqui, provided medical care, established mobile medical teams, and purchased a new, well equipped ambulance. The team was able to care for 250-350 patients daily.

IMANA also established a central pharmacy, and a rotating physician system, for better coverage.

- Pakistan IMA (PIMA) started by a media campaign in Pakistan to collect donations, under a slogan of "Kosovo Relief Mission", and then dispatched 4 successive medical teams, that functioned in a successive complementary manner. The first team arrived to Albania through Italy and Turkey, in May 1999, with participation of experienced medical professionals, including university professors.

This first mission was led by Prof. Mohammad Tariq, in cooperation with The Islamic Circle of North America (ICNA-USA), provided medical care to refugee camps, and supplied 50,000 USD worth of medical supplies. Doctors spent 2 weeks, but one PIMA volunteer, Dr. Initiaz Ali, spent 5 weeks to guarantee continuity until the second team arrived on June 7th, 1999, that reached Albania through Turkey, led by Dr. Amir Aziz.

- IMA-Saudi Arabia (IMAKSA), in collaboration with Saudi relief NGOs, dispatched teams, established 10 equipped medical clinics and established a 50 bed hospital in Albania.
- Hayat Foundation-Turkey, on nearly continuous basis, provided 15 doctors and

provided medical supplies to refugee camps in Albania.
- IMA-South Africa (IMASA), in collaboration with the Waqful Waqifeen Foundation, provided medical supplies and consumables.
- Bosnia IMA (BIMA) provided medical care for Kosovan refugees who managed to arrive to Bosnia.
- Several other IMAs from various countries, sent their relief donations through ARABMED or other IMAs that managed dispatching teams.

Constructive cooperation took place among these FIMA-member IMAs, as well as with other Islamic relief NGOs, especially:

- Islamic Circle of North America (ICNA).
- Canadian Muslim Women.
- Saudi Arabian Haramain Relief.
- Islamic Relief-UK.
- Mercy Malaysia.
- Waqful Waqifeen- South Africa.
- Arab Medical Union-Egypt and Egyptian Medical Association Relief Committees-Egypt.

On July 2nd 1999, FIMA Council meeting was held in Beirut-Lebanon. The Kosovo and Chechnya human plights were top on the agenda of the relief session in which the Council discussed the relief situation reports from professionals who came back from Kosovo. FIMA Council re-affirmed its stance regarding organization and widening of relief work in these 2 areas.

At a later stage, when NATO interfered and stopped the Serbian aggression, refugees started going back home, to find burned houses, demolished schools and mosques. A new stage of relief work emerged and FIMA volunteers started to go to Kosovo, especially to Prizron area. Practitioners from PIMA, in cooperation with ICNA, established a clinic, mobile health teams, and purchased 2 well equipped ambulances, from which, thousands of people benefited.
Prof. Hafeez Ur Rahman, led this third PIMA medical team to Kosovo through Italy, after attending the FIMA Council Meeting in Beirut-Lebanon. They were joined by 2 Pakistani doctors who stayed from the second mission.
Prof. Hafeez Ur Rahman, FIMA coordinator of medical relief, had the opportunity to contact local Kosovan physicians. Upon explanation to them of FIMA structure, aims and objectives and scopes of functions, they managed to form the Kosovo IMA, led by Dr. Ghulam Mustafa of Prizron. The team found a treasure of 17,000 Qur'an copies, in Albanian language, stored in Albania. They distributed all of them to concerned people and mosques.
The team contacted 13 Muslim relief NGOs and served in their clinics.

Chechnya Relief 1999:

Chechen people have resisted Russian military aggression since the beginning of the 18th century. After over a century of struggle, Tsarist Russia managed to occupy the whole region of North Caucasus. This event heralded the first wave of immigration to several countries, especially Turkey, Syria and Jordan.[8]

In 1917, when Tsarist Russia collapsed to the Bolshvic regime, the North Caucasus declared independence, under the North Caucasus Federation in 1918[8], which was recognized by Germany, Turkey, Austria, Bulgaria and Bolshevik Russia under Lenin.

The Soviet Union, however, invaded the region in 1922, facing population resistance. During Stalin rule, nearly the whole Chechen nation was forcefully exiled to barren wastelands of Siberia, and to deserts of Kazakhstan. Over a third of Chechen people perished from 1944-1957, when survivors were finally allowed back home.[8]

In November 1990, the Chechen National Conference declared independence of Chechnya and Ingushita, as did several other former Sovict republics. In October 1991, the people of Chechnya-Ingushita elected their first president.[9]

The independent Chechen-Ingushetia Republic has never signed the Russian Federation treaty, and has never been part of this Federation.

Russia invaded the new republic in 1996, which resulted in destruction, suffering and immigration to neighboring republics, and a situation evolved needing humanitarian relief.

The 1st FIMA medical mission to Chechnya, in December 1999, was led by Dr. Tanveer Zubairi, then president of Pakistan IMA, accompanied by Dr. Hafeez Ur Rahman, FIMA relief coordinator, and two other physicians in collaboration with IMANA, ICNA and Islamic Relief-UK.

Approximately USD 100,000 were raised by PIMA for this mission.

The team arrived at Tiblisi-Georgia, carrying life saving medical supplies, to be delivered to physicians working among injured and sick Chechen refugees.

Hayat Foundation of Turkey (FIMA-member) extended a helping hand by providing travel arrangements from Istanbul to Tiblisi.

Unfortunately, the team was denied visas at Tiblisi airport. They had to go back to Istanbul, where they delivered the medical supplies with Hayat Foundation, to be sent to Chechen refugee camps in Georgia, through Turkish NGOs.

IMANA Red Crescent Committee delegated a team of medical professionals to extend needed care to Chechen refugees in neighboring republics.

Hayat Foundation of Turkey, in collaboration with IMAs of Pakistan and Malaysia, managed to deliver medical supplies to Chechen refugees, and to care for refugees in Turkey, especially children.

PIMA conducted a second relief mission, this time through Azerbaijan, the closest safe area to Chechnya, on May 3-10,2000.

With major transport hardships the team established two clinics in refugee camps. They traveled by road from Baku to a village inside Chechnya, 470 kilometers away, to discuss needs, which were:

- Clothing and blankets for the impending bitter winter.
- Food, especially canned.
- Vehicles, ambulances.
- Orphan sponsorships.
- Specialists in trauma, orthopedic and general surgery.

Unfortunately, various hurdles of many types, minimized meaningful delivery of relief resources to inside Chechnya, or even to refugee camps.

Chechnya humanitarian relief work remains a sore area in view of major difficulties of accessibility.

Afghan Relief 2001:

Following the September 11,2001 incident, a major USA-led western onslaught was waged against Afghanistan during October 2001, which resulted in over 12,000 deaths, more than 32,000 individuals with serious injuries and more than one million displaced Afghanis.

Acute, wide scale influx of crouds of impoverished Afghani refugees poured into Pakistan, most of whom were locked in border areas between the two countries. More victims wandered around with increasing numbers of casualties and sick, hungry civilians inside and outside Afghanistan, a situation that deteriorated into a major humanitarian disaster.

Since the early days of the crisis, FIMA, pioneered by the IMA of Pakistan (PIMA), organized a medical humanitarian campaign. Constructive collaboration was established among various IMAs and other Islamic relief NGOs, with relief teams dispatchment, monetary and material donations. Prof. Hafeez Ur Rahman, FIMA Relief Coordinator, led a Needs Assessment delegation to the troubled border areas.

PIMA received medical teams at Pakistan airports, housed them and distributed them to hospitals, clinics and mobile units functional at the Pakistan-Afghan border, in refugee camps, or even in Afghani cities, Kabul, Kandahar, Jalalabad, Spin Boldak and others, where medical care, surgical procedures, and medical supplies were provided.

PIMA relief base compound at Chaman (one km from the border), included well organized teams of (25-30) doctors/paramedics, a large warehouse for medical supplies and 3 ambulances. A new basic hospital capable of performing emergency surgeries was established.

In Spin Boldak, another border town, Drs Tanveer Zubairi, Ata Ur Rehman, Arshad Waheed and Sakib Ansari spearheaded an early assessment task, with participants from Doctors World Wide (DWW), Mercy Malaysia and other NGOs, and established plans for relief work.

PIMA, supported by FIMA-member IMAs and other Islamic relief NGOs, established and operated many medical centers, mobile clinics, in addition to the hospitals in Quetta, Peshawar and other cities.

In Chaman, at the Pakistan side of borders, PIMA established a central facility capable of hosting tens of medical professionals, to facilitate organized distribution of teams, with communication and transport facilities.

PIMA and other FIMA collaborating NGOs at the Pakistan-Afghan borders

At least 29 relief organizations and IMAs, (especially from Malaysia, Indonesia and South Africa), collaborated with PIMA, to make this combined relief undertaking one of the most extensive, productive, organized, recognized and respected by neighboring governments, as well as international organizations.

Free Eye Camp at Chaman

At any one time, more than 50 volunteering medical professionals and 70 supporting personnel were functional in hospitals, health center and mobile clinics.

IMAs and relief NGOs from outside Pakistan dispatched 57 medical-surgical missions comprising of more than 350 doctors/nurses/paramedics, volunteering to work in these medical facilities.

A cataract surgery program was undertaken in collaboration with The World Health organization-Eastern Mediterranean Region (WHO-EMRO). Five PIMA ophthalmologists participated.

This humanitarian crisis continued for a long time following the September 11 incident, with continuous needs for relief that took different forms.

Iraq Relief
2003:

Following Iraqi invasion of Kuwait in 1990, and the Western armed response that expelled Iraqi military from Kuwait in 1991, a siege was imposed on Iraq. Since then, a complex prolonged humanitarian crisis gradually developed.

Initially, crowds of refugees left Kuwait by land, through Iraq and settled in Jordan side of the Iraqi-Jordan border. They left behind their entire livelihood. From various nationalities, many of them without money or identity documents, were in dire need for relief work.

The Islamic Hospital-Jordan (FIMA member) and other relief NGOs in Jordan, shouldered the brunt of relief efforts which included provision of food and medical care, for several months until refugees and their governments, together with international efforts, gradually resolved this humanitarian problem.

In 2003, after 12 years of siege on Iraq, the US and allied forces bombarded Iraqi cities, and subsequently invaded the country and demolished its regime. A major humanitarian crisis emerged inside Iraq which necessitated relief assistance to a people suddenly deprived of their health care system as well as their means of day to day living.[10]

Several FIMA member IMAs, and Islamic relief NGOs, hastily organized relief missions to Iraqi cities, in collaboration and logistics facilitation by IMA- Jordan and the Islamic Hospital in Jordan.

This was one of the relief endeavors in which volunteering Muslim relief workers were shot at, killed or injured in the course of their duties.

Dr. Jamilah Mahmoud, team leader and Mercy Malaysia (MM) president, arrived in Baghdad by land through Jordan, accompanied by medical professionals from (MM) and IMA-Malaysia (IMAM).

As Dr. Jeffery Abu-Hassan, IMAM secretary, described the incident, the relief team was subjected to a tragic event on April 12,2003, being caught in crossfire while they were exiting from a Baghdad children hospital, using a Red Crescent emblazoned car, amidst chaos and panic. The local translator, and the pharmacist were killed. Dr. Jamilah and Dr. Baba were injured, received first aid in Baghdad, transferred to Jordan Islamic Hospital where their condition was stabilized, then

left back to Malaysia. Dr. Baba suffered permanent sequelae of spine injury.
At later stages of the Iraqi conflict, medical relief took different forms. A new IMA-Iraq was established, joined FIMA , and subsequently participated with FIMA in relief work.

FIMA Medical Mission
for the BAM Earthquake in Iran 2003

On December 26th, 2003, a catastrophic earthquake brought unbelievable destruction and misery for the inhabitants of Bam city in Iran. It was just before dawn at the time of Salat-ul-Fajr (Fajr prayers).That earthquake killed more than 40,000 people in a period of few moments. Similar numbers were badly injured and many more were shelterless in a very cold weather. They were stunned, with the loss of their kith and kins as they were helplessly watching the rubble of their sweet homes, underneath many of their relatives were buried, dead or alive. The hospital of the city along with few clinics was showing the picture or ruins.[11]

The epicenter of Bam earthquake

Arg Fort, a two thousand years old historical heritage of this city, was leveled with the ground.
Many countries sent their first aid missions to the affected area. The visible and active mission were from Saudi Arabia, Afghanistan, Pakistan, Jordan and India. Many Western countries also sent relief items and manpower to Bam.


Arg Fort before and after the earthquake

FIMA Relief immediately planned to help the suffering brothers and sisters of Iran. The first delegation of three doctors led by Dr. Hafeez Ur Rahman, FIMA secretary, flew to Tehran on 31st December and then traveled by road to reach Bam. They carried three tons of medicine and hospital consumables and handed them over to the Red Crescent Society of Iran. They also joined hands with the doctors of Pakistan Army and facilitated them in procurement of medicines.

Emergency medicines were purchased in Kirman City which is about 200 km from Bam. and delivered to the Pakistan Army Mission.

FIMA-PIMA team visiting the Jordanian Relief mission in Bam

They also distributed blankets to the needy people. These blankets were also purchased from Kirman City

In addition to its professional duties, the delegation met with officials of city government and Red Crescent Society and conveyed the deep condolences on behalf of PIMA/FIMA members. The delegation also visited the emergency hospital organized by the Jordanian Army and Red Crescent Society of Saudi Arabia.

This mission left Iran on 7th of January 2004, while a second mission led by Dr. Surbuland Zubair, comprising of five members, a joint collaboration of Islamic International Medical College (IIMC) and PIMA, arrived in Iran on 4th of January. They carried equipment, medicine and tents for emergency hospitals which were again handed over to the local authorities on their desire. Both missions were warmly welcomed by the Iranian government and were generously facilitated by the Iranian Embassy in Pakistan.

Iran Air and Pakistan International Airlines provided free carriage of consignments.

ICNA Relief of USA and al-Khidmat Foundation of Pakistan financially supported these missions.

Darfur-Sudan: 2004
Relief Missions as Eye Opener for Sudan Health Dilemmas

Darfur is a Sudanese province, located in the west, neighboring Libya and Chad. Its area is more than that of France, and the population are 6 million, all Muslims[12].

There are several medium-size cities, with universities, and medical schools.

Outside the main cities, Darfur society is tribal, with occasional, long standing, conflicts related to water and grazing. Nearly all the tribal people are traditionally armed as part of their nomadic life and culture.

Tribes are either from ancient African origins (e.g. The Zaghawa tribes in Darfur and Chad) or of Arab origin that emigrated to Sudan since the early Islamic era, and were assimilated by extensive intermarriages and prolonged combined lifestyle for centuries.

Early in 2004, a tribal conflict took place in western Darfur, over local water and grazing issues[12]. The Sudanese Government, as usual, intervened to mediate the conflict, and was initially successful, but, unexpectedly, a group of men, broke their subordination to their Zaghawa tribal chief, and declared disobedience to the Sudanese government, claiming Darfur independence. They started armed attacks on villages, and police outposts. Other tribes counteracted, and tribal skirmishes erupted.

Amidst all this, the innocent villagers sought refuge for their lives by immigrating to safe places, mainly near the main cities in Darfur, where the Sudanese government provided food and security. Some of the villagers near the borders with Chad, went to that country.

As of September, 2004, when FIMA sent the first relief mission, there were about 300 thousand refugees, most of them were under the Sudanese

government's care near the main cities of al-Fashir, Niala and al-Jinaina.

First FIMA Medical Relief Missions:

Led by then FIMA president, Dr. Aly Misha'l, in collaboration with the Sudan-Islamic Medical Association (SIMA) and the Sudan Health Ministry, four specialists from The Islamic Hospital in Jordan, and workers from SIMA went by plane from Khartoum to al-Fashir city, capital of Northern Darfur. The trip took 2 hours.
Immediately the group delivered medical supplies to the main hospital, which was clearly in need for all kinds of supplies. The group started medical work, together with their Darfur counterparts. They visited the main refugee camp at Abu-Shoke, 20 km. from Al-Fashir, where 42 thousand refugees reside in homes made of hay and wood, fed and protected by the government, and cared for medically by Sudanese, and Red Cross personnel.

First FIMA relief team to Darfur-Abu Shoke IDPs Camp, October 2004

Medical workers from Arab Medical Union (AMU)-Egypt were the first to come for relief, followed by Saudi Red Crescent, then FIMA, Islamic Hospital-Jordan and Hayat-DWW-Turkey.

The main medical problems encountered were: Malaria, gastroenteritis, hepatitis and children malnutrition. During the whole stay, the team learned about only 6 injured people who stated they were attacked in the desert by armed men who could be outlaws or opponents of the government. It took them two days to be brought to the government hospital in al-Fashir.
FIMA team visited the refugee camp and was again informed that the main health problems were malaria, gastroenteritis and children malnutrition.
The Red Cross hospital was empty during the time of the visit. 70 thousand refugees were assisted to leave the camp back to their villages, with government support and protection.
The team also visited the medical school at al-Fashir University. They informed the team that their doctors conduct health services to the refugees whenever they obtain medical supplies. They welcomed Arab and Muslim medical teams to come and conduct mutual medical work to needy refugees and villagers.
The team received warm welcome by Darfur government, health authorities, intellectuals and the local community at large.
The needs for more medical teams and supplies were very clear and profound.
A second FIMA team, again came from Jordan Islamic Hospital in December, 2004, with participation of 5 specialists, mainly surgeons.
Most surgeries, FIMA team dealt with, were elective or long standing. Very few violence-related casualties were encountered and dealt with by Sudanese surgeons.
Other teams from IMA S. Africa and other IMAs arrived successively.

The most requested supplies were:
Antibiotics, antimalarials, I.V. fluids (with infusion sets, canulas and syringes), baby food, oral electrolytes and vitamins. Water purification systems, and insecticides were also needed.
Medical personnel mostly needed were:
Ophthalmologists, pediatricians, internists, surgeons and anesthesiologists.

This preliminary relief mission served as a valuable eye-opener for the relief needs in Sudan, and was very instrumental in the initiation of FIMA relief activities in collaboration with the Sudan IMA, and of the large-scale FIMA Save Vision initiative in Sudan and Sub-Saharan Africa in general.

Aceh Tsunami 2004:

At dawn of December 26,2004, a massive earthquake, measuring 9.3 on Richter scale, at a sea depth of 30 km, struck Indonesia off the coast of Sumatra. The resulting huge tsunami waves, reaching heights of 30 m, caused massive destruction of life and property in Aceh district in northern Sumatra, and other neighboring areas, and many surrounding countries, such as Thailand, Bangladesh, Sri Lanka, India, Maldives and Port Elizabeth in South Africa, 8,000 kms on the far western coast of Indian Ocean[13].

In Aceh, 550 villages were destroyed, more than 230,000 killed, many thousands were missing, or injured, quarter of a million displaced, and 50,000 children left orphaned. The casualties included 2000 medical professionals, about half of the health manpower in the district[13].

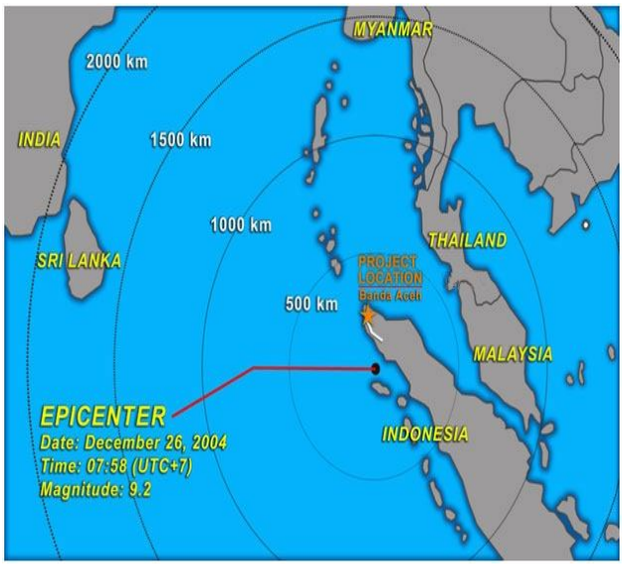
FIMA relief response started immediately. Dr. Jamal Mohammad, from IMA-Indonesia, acted as local relief coordinator, in collaboration with other FIMA-Indonesia member NGOs, Fokki and MUKISI.

Thirty eight medical missions from eight IMAs, were dispatched from FIMA, with emergency relief supplies. They established equipped clinics operated by medical teams. There was a cash donation of over 260,000 USD.

Most teams had to land in Jakarta, then to Medan in Northern Sumatra, and by local flights to Banda-Aceh.

With no airport workers or employees, teams had to hand carry their own luggage and medical supplies. They also had to prepare their own food.

In addition to clinics, field hospitals were quickly erected.



Mosque in the mid of total destruction

Significant relief efforts were provided by many FIMA-member IMAs:

- IMA-Malaysia and the sister relief NGO: Mercy Malaysia, in cooperation with the Indonesian Red Crescent, provided urgent care, very early after the tragedy. The Indonesian Army provided full cooperation in carrying teams and relief supplies by military planes to disaster areas.

IMAM and MM adopted a 3 stage relief plan that extended for more than one year.
The first team was led by IMAM president, Dr. Musa Nordin and members of IMAM Executive Committee.
From the first days of the disaster, 5 Malaysian medical teams were dispatched, the last of which was on January 18,2005. The teams included physicians from various specialties, nurses, engineers, experts in underground waters and others. Initially, in addition to medical care and food provision, the teams helped in provision of water, sanitation and electricity.
The other relief stages included rehabilitation, construction, training and psychological care for post-traumatic problems.

- PIMA:

1st team arrived in Aceh on January 19,2005, consisting of five doctors and carrying urgent medical supplies. They immediately purchased an ambulance from Jakarta, to be transferred to Aceh.
An initial donation of USD 7000 was handed over to IMA-Indonesia to help in their leading relief efforts in Aceh.
They collaborated with IMA-Indonesia to rehabilitate and operate a local hospital in Banda-Aceh.
The second PIMA team arrived on January 25, rented a local helicopter, for one month, to facilitate transportation of relief supplies from Jakarta to Banda-Aceh.
Two other teams subsequently followed.
The teams cooperated with the relief mission of the Pakistani Army, that established a field hospital.
This hospital was later commissioned to PIMA, and remained functional for several months.

- IMA-South Africa in collaboration with the Waqful Waqifin:

Dispatched the first medical team on January 28,2005: three doctors experienced in emergency medicine, together with an experienced psychiatric team to deal with post-traumatic stress disorders (PTSD). Other medical teams followed over the next several months.

- IMANA:

The first team arrived on January 18,2005 led by IMANA president, Dr. Parvaiz Malik, a plastic surgeon, who performed special surgeries in the remaining functional hospitals. Medical, surgical care and medical relief materials were provided in Aceh health centers.

Plans were made, in cooperation with IMA-Indonesia, for continuation of teams and donations, including psychiatry specialties to manage PTSD. Four consecutive IMANA teams participated.

- Hayat Foundation and DWW-Turkey:

Dispatched medical teams and medical supplies.

- ARABMED-Europe, and IMA-Jordan and other IMAs:

Sent donations to IMA-Indonesia, and pledged continuation of support.

- IMA-Egypt:

In collaboration with Relief Committee of Egyptian Medical Association, led by a previous FIMA president, Dr. Abdul Qader Hijazi, and the Arab Medical Union (AMU), sent teams and donations. The first team was led by AMU president, Dr. Abdul Munim Abul Fotouh.

FIMA participated in an Aceh-relief conference held in Amman-Jordan on January 30-31,2005 by the Islamic International Council for Dawa and Relief (IICDR), with participation of 24 Islamic relief NGOs. Over 2 days, the conference discussed the ramifications of the disaster.

Thirty million USD were reported as donations sent so far in the form of cash, food, medicines

and other relief materials. These donations have been channeled through relief routes different from those of FIMA. Additional 40 million USD were pledged.
The participants decided to form a combined local relief committee with participation of FIMA, to be functional on the ground in Indonesia.
Later on, Dr. Aly Misha'l, FIMA president, visited Aceh, met with FIMA and IMA-Indonesia teams, listened to recommendations and needs, then left to Jakarta, where he worked to assemble local representatives of IICDR combined relief organizations to form the local relief committee, with Prof. Jurnalis Uddin and Dr. Jamal Mohammod to represent FIMA.
One special and sensitive issue was tackled that is the fate of the orphans of Aceh. It was reported that several foreign NGOs, Christian, Hindus and Buddist were active in extraditing orphans, without proper permissions or documentation. The Indonesian government subsequently, established measures to stop this illegal and unethical act.
FIMA established 2 orphanages with 200 children each, and maintained them for one year.

FIMA teams also provided training in trauma counseling for local health workers and educators.
Many lessons were learnt from the experiences of this major natural disaster, that surpassed any other in recent history by its sheer force and sudden destruction. These lessons formed themes of seminars and assays in subsequent months.

Yogyakarta- Indonesia Earthquake 2006:

An earthquake measuring 6.9 on Richter scale struck the Bantul district of Yogyakarta province in central Java, on May 27,2006.

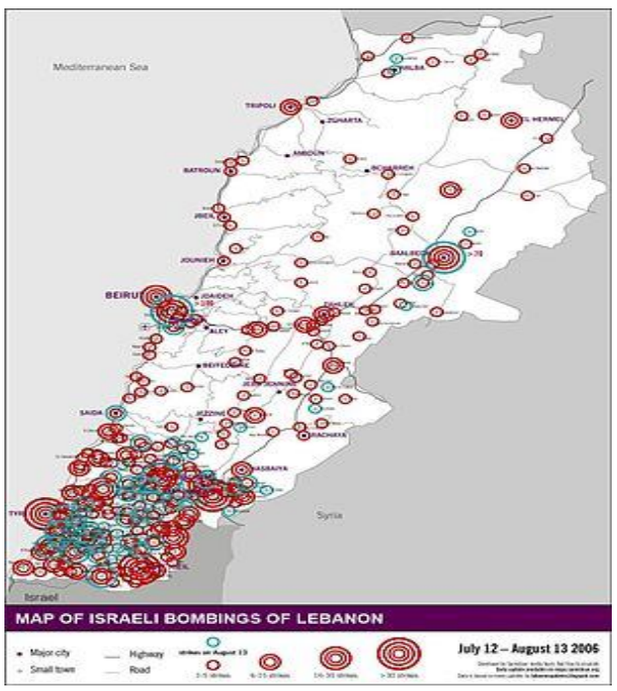
The official death toll was 5,782. There were 36,000 injured individuals, approximately 350,000 homes destroyed and 1.5 million displaced persons. All hospitals were filled with casualties. There was large scale destruction of schools, hospitals, roads and essential services.

IMA-Indonesia (IMANI) and other Indonesian FIMA members (FOKKI and MUKISI) shouldered the brunt of relief work. Dr. Jamal Mohammad, Dr. Wahyu Sulistiadi and Dr. Eka Ginanjar led relief responses. A relief camp was established in Yogyakarta and IMANI doctors from various specialties provided medical-surgical care. Dr. Dadang (orthopedic surgeon) with his team, came from Bandung. Other specialists came from Jakarta.
Approximately 200 professionals volunteered, emergency relief supplies and water purification systems were distributed.
FIMA responded by sending cash donations of about 93,000 USD.
By local hands, the ramifications of the earthquake became under control.
FIMA Council meeting was held in Yogyakarta in June,2006, as previously scheduled. Planners had in mind to witness the quake ramifications, on the ground.

Lebanon Under Fire 2006:

From July 12- August 14,2006, Lebanon, especially South Lebanon, suffered tremendously from Israeli massive air, sea and ground offensive, with the excuse of punishing the terrorism of Lebanon resistance forces[14-15].
The grim outcome was 1,200 dead, the vast majority of whom were civilians, women and children, tens of thousands injured with all types of weaponry including internationally banned weapons, more than one million displaced from their homes.
Moreover, there was extensive infrastructure damage involving homes, schools, hospitals, worship places, roads, bridges and public buildings.
The brunt of FIMA relief was shouldered by the IMA of Lebanon (IMALB). Drs. Fuad Rifai and Imad al-Hout functioned as local relief coordinators, who immediately started initial needs assessment, communication and reporting network with FIMA, IMAs, and NGOs, and

supervising local and international FIMA relief undertakings.



Lebanon South: Heavy brutal Israeli bombardment, resulting in a large wave of civilian casualties and mass immigration

IMALB struggled to provide various kinds of relief to the displaced persons, who left the southern regions and poured to other, relatively, safer areas especially in and around Beirut. A wide relief committee was hastily assembled that combined several Lebanese associations and charitable NGOs.
Refugees needs were timely provided, including food, water, clothing, health care in and out of hospitals. Lodging of displaced families took place in homes, schools, mosques and public buildings.

IMALB regularly updated FIMA on the status of the internally displaced persons (IDPs) relief. Dr. al-Hout made a tour in neighboring countries, including Jordan, where he addressed gatherings, associations and NGOs about the situation, its ramifications and obligations. Relief donations were raised from IMA-Jordan and other NGOs.

Dr. Fuad Rifai, IMALB president, circulated the immediate relief needs:

- Additional ambulances.
- Medical supplies and consumables, for both acute and chronic care, in view of consumption of necessary medications from local markets.
- Food materials, including infants and children nutrition.
- Blankets, clothes and cleaning materials.
- Shelters.

Fortunately, the local Lebanese health manpower was enough to deal with all health needs of IDPs, and no outside manpower help was needed.

FIMA, member IMAs and collaborating relief NGOs response was timely and effective.

Seven ambulances, plane loads of supplies, food materials, medications and consumables came through Jordan, Syria and by sea.

The following IMAs/NGOs had remarkable input:

- Pakistan: PIMA and al-Khidmat Foundation.
- South Africa: IMASA and Gift of Givers Foundation (Waqful Waqifeen).
- USA: IMANA.
- Egypt: IMA, AMU and Medical Association.
- Turkey: Hayat-DWW.
- Malaysia: IMAM-Mercy Malaysia.
- Sudan: SIMA-Sudanese NGOs.
- Jordan: IMA, Islamic Hospital.
- Indonesia: IIMA, MER-C Indonesia.
- UK: Islamic Relief.
- Saudi Arabia: IMAKSA-World Assembly of Muslim Youth (WAMY).
- Islamic International Council for Dawa and Relief: 80 Arab-Muslim relief NGOs.

Finally, when cease-fire was imposed on August 14th, there was a great deal of misery, pain and destruction, that needed, prolonged and dedicated relief efforts for years to follow, taking in consideration, hostilities are continuous .

Bangladesh Floods:
Cyclone CIDER
2007:

On November 15,2007, Cyclone CIDER, a category five tropical cyclone, struck Bangladesh mainland, causing extensive flooding and destruction[16].

As per Red Crescent, 10,000 people lost their lives, and more than three million lost their homes and livestock. Crops were destroyed and trees were uprooted.

The most affected districts were Morolgonj and Sharankhola. A massive disaster situation emerged with urgent humanitarian needs for food items, drinking water, shelters, medical teams and supplies.

The local FIMA member, Bangladesh National Doctors Forum (BNDF) and SAWAB organization, started relief work, in collaboration with Muslim Aid-UK, and notified FIMA relief coordinator for urgent relief needs.

Prof. Kamrul Ahsan, BNDF chairman, e-mailed information relief reports to FIMA coordinator and to member organizations.

Donations came from Hayat-Turkey, IMASA, IMAKSA, PIMA and IMA-Jordan.

On December 15-18,2007, Prof. Mohammad Iqbal Khan (PIMA Relief) with the director-international affairs-al-Khidmat Foundation, came to the Cyclone-hit area, witnessed the grave situation with near complete lack of health care facilities.

PIMA donated 2 ambulances to Bangladesh IMA/SAWAB, to serve coastal districts of Borguna and Patuakhalr, and to transport poor patients to hospitals.

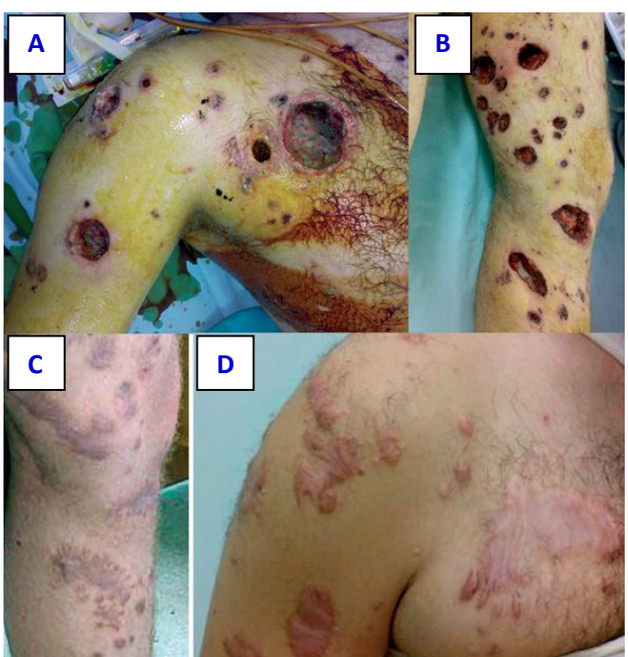
Prof. Iqbal Khan, PIMA relief team in Bangladesh

Prof. Iqbal Khan-PIMA relief team in Bangladesh

Gaza Crisis:
2008:

The world witnessed one of its worst humanitarian crisis on December 27, 2008, when Israeli war machine bombarded the helpless population of Gaza, Palestine. Israel mounted unrelenting air, land and sea attacks, killing over 1,400 people, many of whom were women and children. More than 10,000 were injured, some of them seriously. Hundreds of thousands lost homes and became IDPs [17].

They destroyed soft targets including homes, schools, mosques, hospitals, energy supplies, communication channels and other social structures. Israel brazenly ignored the global condemnation of this invasion and continued its merciless terror attacks violating all humanitarian and human right principles and statutes, including the use of white phosphorous and depleted uranium bombs, destroying the fuel supply to emergency services including hospitals, preventing ambulance services from evacuating the injured to safety and essential care and treatment, attacking hospitals and its staff, sealing the borders and preventing all humanitarian aid from reaching its intended recipients.



White Phosphorus burn [19]
Many lesions, with severe underlying destruction and necrosis (A,B). After 16 months of follow up(C,D).

FIMA responded immediately, mobilized its disaster response to aid the innocent and helpless victims. The FIMA response is summarized below.

- Doctors WorldWide-Hayat Foundation-Turkey, supplied 2 trucks (43 tons) of emergency relief aid procured in Cairo and transported to the Rafah border (worth USD 230,000), when border crossing first opened. During the second week, DWW purchased 12 ambulances in Cairo worth USD 400,000 for use in Gaza. A plane load of medical equipment and other supplies was delivered to Shifa Hospital in Gaza City. A second team of 10 surgeons and support staff was dispatched to Gaza to work in Khan Younis for the next 2 weeks. DWW committed itself to medical education and establishing specialized care facilities including a burn unit.

- Mercy Malaysia-IMA Malaysia, sent a USD 100,000 worth of medical equipment, consumables and drugs (5 trucks, 50 tons) and delivered to the Ministry of Health (MOH) Gaza upon border opening. Another USD 100,000 consignment procured in Cairo was delivered later. A second team under the leadership of Dr. Mohamed Ikram was delegated to work in Gaza.

- MER-C Indonesia-sent a medical team along with medical supplies since the start of conflict.

- IMA-Sudan and other local relief agencies delivered 4 plane loads, approximately 100 tons worth USD 500,000 of food, medical and emergency supplies. They sent a team of 11 doctors and surgeons to the region.

- IMANA sent 2 medical teams (22/01/2009) and (25/01/2009) with medical equipment, medications and consumables. They indentified the following critical needs, and deficiencies:

  - Medical equipment, monitors, surgical instruments outdated or deficient.
  - Rehabilitation hospital with training of local expertise.
  - Trauma counseling of the traumatized population especially vulnerable children.
  - Continuing education of local medical professionals lacking in basic skills and

disaster management due to isolation and prolonged siege.

- IMA-Jordan, in collaboration with the Jordan Medical Association, sent 3 teams of over 40 doctors, many of whom were surgeons. During their stay they donated medical equipment and supplies to the local health authorities.

- IMA-Pakistan (PIMA) sent two surgeons along with the IMANA delegation as well as three others, under leadership of Prof. Iqbal Khan.

- When borders opened to medical professionals. Arab Medical Union (AMU), including IMA-Egypt, sent 21 doctors and 40 more the following day.

- Arab Medical Union delivered 200 units of blood and 1,000 more units the following day.

The following funds were transferred to local relief and charity NGOs in Gaza:

- Pertubuhan Jamaah Islah Malaysia (JIM), through IMA-Malaysia, USD 42,400.
- FIMA/IMA South Africa/other contributions, USD 100,000.
- IMA Pakistan, USD 17,500.
- IMA Jordan: USD 100,000.

FIMA has committed itself to the reconstruction and rehabilitation of the health system in Gaza and is currently engaged in the following services:

- Dispatching specialized medical-surgical teams to provide care to those deprived of care in view of the local deficiencies and prolonged siege.

- Medical education and training at all levels including undergraduate and postgraduate teaching as well as in-service training of health personnel isolated by the sanctions imposed by Israeli authorities.

- Supporting a maternity hospital with financial assistance, medical equipment, personnel and training.

- Assisting the health authorities in rehabilitating primary health structures and clinics and extending its services to the entire population.

- Provision of needed medicines, consumables and medical equipments to medical institutions. In 2010, FIMA paid for X-Ray and ultrasound equipments, surgical, lab. and other medical equipments in excess of 350,000 USD. These purchases were donated mainly by IMANA, IMASA, and IMA-Jordan.

There were significant contributions from IMA-Egypt in collaboration with Arab Medial Union and the Egyptian Medical Association.

IMA-Sudan and IMA-Malaysia/Mercy Malaysia provided significant aid in the post war period.

IMA-Malaysia was instrumental in organizing VIVA PALESTINA initiative, which is addressed elsewhere in this publication.

FIMA humanitarian-medical relief activities has been ongoing, by various IMAs and collaborating NGOs, ever since the December 2008 aggression.

Dr. Omar al-Ayyat, FIMA Ex Co member With Health Minister in Gaza

West Sumatra-Indonesia Earthquake 2009:

On September 30 and October 1st, 2009, two earthquakes, measuring 7.9 and 6.0 on Richter scale, struck Padang and Pariaman districts in West Sumatra, causing 1,200 deaths, 4000 injured and more than 250,000 displaced from destroyed homes[18]. Major infrastructure, homes, schools, hospitals and mosques were destroyed. Roads, communication system, electricity and water supplied were affected. Upon receiving disaster details from Prof. Jurnalis Uddin, from IMA-Indonesia, FIMA relief coordinator circulated an appeal to FIMA members. Funds were collected mainly from YARSI University-Jakarta, IMANA and IMA-Jordan, to reconstruct a school and mosque in the village of Lambeh, district of Pariaman, at a cost of approximately 100,000 USD.

On June 7,2010, Dr. Aly Mishal, FIMA executive director, and Prof. Jurnalis Uddin, YARIS University President, attended the ground breaking ceremony of the project, with participation of the villagers, local and regional representatives.

Ground breaking ceremony- Lambeh-West Sumatra, June 2010 Prof. Jurnalis Uddin (YARSI) and Dr. Aly Mishal/FIMA Executive Director

On September 18,2011, the completed project was inaugurated by FIMA president, Dr. Parvaiz Malik, Dr. Aly Mishal and Prof. Jurnalis Uddin, amidst warm welcome of the villagers of Lambeh, and the district.

Dr. Parvaiz Malik-FIMA President: Prof. Jurnalis Uddin-YARSI president and Dr. Aly Mishal: Inauguration of Lambeh village school and masjid

Lambeh village-West Sumatra: Villagers celebrate inauguration of masjid and school, Sept.2011

Haiti Earthquake 2010:

Dr. Parvaiz Malik, FIMA president, provided the following report on February 20,2010:

A devastating earthquake of 7.0 magnitude on the Richter scale, hit the island of Haiti on January 12, 2010, just before 5:00 PM. The capital city of Port-au-Prince was the closest to the epicenter and sustained most of the damage. About a quarter million men, women and children have died, and over 200,000 people are reported to have been injured. Out of the population of 10 million, 1-3 million have been internally displaced[20-21].

Haiti is already a country beset with extreme poverty, unemployment and disease, and this earthquake has further exacerbated these problems. Some of the statistics are staggering: The average age in men is 53 years and in women is 56 years. One out of eight dies before they reach the age of 5. Medical facilities are scarce. There are only 2,000 doctors in the country for a population of 10 million. The majority of the population has never seen a doctor in their lifetime. They also have the highest rate of HIV/AIDS in the Western hemisphere, second only to African sub-Sahara. The per capita income is equal to USD 450, compared to USD 43,740 in the United States.

Dr. Parvaiz Malik/FIMA President with IMANA relief team, Haiti, 2010

IMANA, one of the largest member associations of FIMA was among the first organizations to respond. Dr. Ismail Mehr, the chairman of IMANA Relief, moved quickly, collaborating with Todd Shea, executive director of Current Disaster Response Source (CDRS)-Pakistan who has been providing logistics and much needed continuity in functions of IMANA and other teams in Haiti.

Dr. Parvaiz Malik in OR-Haiti, 2010

Todd facilitated the connection with AIMER Haiti, a local community based organization. Bogeux Children Park in Tibbare was converted into a mini hospital and an urgent care outpatient clinic. On day 5 post-earthquake, IMANA had a team on the ground in a functioning facility. So far, several teams of IMANA doctors from all specialties have actively participated. A number of non-Muslim physicians from all creeds and beliefs have also joined the IMANA teams, giving a diverse flavor to the effectiveness of the relief work. Deployment of IMANA medical teams continued through the month of March. Team members also assisted several other medical camps as needed. FIMA secretary Dr Tanveer Zubairi was in Los Angeles, California (USA) and visited the headquarters of UCP and Wheels of Humanity in North Hollywood. He had a formal meeting with its office bearers and its president. Their future rehabilitation services to Haiti were discussed.

I had the honor of representing FIMA in Haiti. I left for Haiti on February 3rd with my son Dr. Imran Malik who had previously worked with me in Pakistan during the major earthquake of 2005. Within an hour of my arrival in the camp, I operated on a 9 year old Haitian boy for a large umbilical hernia. We joined the IMANA team and performed multiple tasks at the site, where the outpatient clinic served about 300 to 350 patients a day for mostly primary care. Many of these patients walked several miles to see our doctors, some of them for the first time. Many ailments were earthquake related, from infected necrotic wounds to PTSDs. The lack of food, medications and medical support has exacerbated their pre-existing medical problems. Gastro-intestinal, and pulmonary infections exist in huge numbers. We debrided a large number of infected wounds caused by crush injuries. We spent the latter part of the days, and sometimes nights, volunteering in the General Hospital of Port-au-Prince. This largest hospital of Haiti had only 87 beds prior to the earthquake. Now, the building is severely damaged and currently functions in the tents installed in the adjacent streets.

While I was there, I had a strategic meeting with the board members of AIMER Haiti, at Jean-Henry and Chantal Ceant's residence, a key figure couple in Haiti, and discussed the long term plans of health care provision by IMANA physicians and probably international teams from FIMA member countries. Various aspects of a medical clinic in underserved area of Haiti and possibility of a mobile clinic was discussed. I had the opportunity to meet the USA Cable News Network (CNN) team in Port-au-Prince and briefed Dr. Sanjay Gupta its Senior medical reporter and its anchorman Anderson Cooper. Our team members also assisted actor Sean Penn in his facility to plan and deliver medical care.

As the nation of Haiti enters the rehabilitation stage of this major disaster, it needs medical care in the next months and years to come. After losing the infrastructure, the recovery is definitely far away. The people of Haiti need our help. We must join hands with IMANA and other NGO's to fulfill this goal.

Historical Events-2011:

In countries of North Africa, the Middle East and the Horn of Africa, the year 2011 heralded major historical events. From Tunisa (December 24th,2010) to Egypt (January 25th,2011), to Libya (February 17th ,2011), to Yemen (January 15th,

2011), to Syria (January 29th ,2011), popular movements seeking freedom and justice, have culminated in far-reaching horizons.

In all these countries, there were human casualties and suffering that needed humanitarian relief work from all concerned.

In Somalia, nature imposed another type of human agony: Drought, famine, death, disease and widespread displacement.

In all these countries, detailed relief accounts await authentic document by relief workers who led these activities, especially in Yemen and Syria are not ready for this publication. Only main outlines will be presented here from FIMA perspectives:

Egypt:

For about 18 days following the 25th of January, more than 850 deaths and 6000 injuries were documented in the major freedom popular movement.

When telephones and e-mails became functional in Egypt, FIMA contacted our colleagues in the IMA of Egypt and the Arab Medical Union, remembering their significant past record in collaborating with FIMA in many humanitarian-medical relief activities in disasters in many regions of the world.

FIMA, specifically, inquired about medical-humanitarian needs in the events that practically changed history in the region.

Our Egyptian colleagues assured us their medical professionals had pioneering roles in providing medical-surgical care on the streets and in hospitals. The list of volunteers has been extensive and was never exhausted.

They provided medical consumables, and large amounts of plates and screws to the hospitals that took care of an extensive number of bone fractures.

Initially, they had no deficiency of any medical, surgical or other relief needs, and they only asked for our Duas.

Two weeks from eruption of this major event, our Egyptian colleagues informed us of their needs for help, to continue their extensive medical relief work, and to assist in supporting families of those killed.
FIMA responded with pledges of financial support. Donations were immediately wired from IMA-Jordan and IMANA.

Libya:

Since eruption of the popular movement on February 17th, a humanitarian crisis of multidimensional dimensions started to unfold.

- Major exodus of foreign nationals rushed out to various Libyan borders with neighboring countries, especially those with Egypt and Tunisia, where crouds of people, mainly from Sudan, Somalia, Bangladesh and other countries, including women and children, waited for weeks to be granted access to these countries. Their humanitarian needs were acute especially those injured or sick.

FIMA dispatched a situation assessment mission to the Libya-Tunisia borders, with participation of Dr. Labib Syed from IMANA, and Abdullah Taha Orhan from Hayat-DWW-Turkey.
A detailed report was issued on March 8, which portrayed the relief situation. The conclusion was that the border situation was acute and transient, since most displaced people were taken care of by their governments. Moreover the United Nations and other international agencies were active with only skeleton crews for special cases.

There was no need for FIMA to send relief teams to that region.

On the eastern side, the Libya-Egypt borders, in addition to the fleeing refugees, mostly Egyptian workers going back home, there was an urgent medical crisis in cities of the eastern Libyan region, including Benghazi. Foreign physicians, nurses and other medical professionals, on which Libyan hospitals depend, have left the country during the initial days of the crisis. A detailed report assessing the situation was sent to FIMA by Dr. Amr Arfeen-The Arab Medical Union(AMU-Egypt) on March 6, with plans of relief collaboration in Libya.

Arab Medical Union (AMU)-Relief at Egypt-Libya Borders,2011

AMU (and IMA-Egypt) provided the following:

- 85 Egyptian doctors, from various specialties, led by Prof. Ahmed Abdul Aziz, and 300 nurses went to Libyan hospitals in eastern Libya.
- Provision of urgent medical supplies.
- Establishment of a field hospital at the border area.
- Engineers and technicians were sent for technical assistance.

Organization of relief collaboration Dr. Aly Mishal, FIMA Executive Director meets AMU and Egypt IMA leaders in Cairo, May 2011

Dr. Aly Mishal with Dr. Abdel Munim Abul Fotouh-AMU Chairman- Cairo, May 2011

IMA-Saudi Arabia and WAMY deployed 3 medical teams to the eastern Libyan province. Dr. Salih Al Ansari, IMAKSA president, pioneered these activities.

Hayat Foundation and DWW-Turkey provided donations of essential medical supplies worth of USD 300,000. A medical team visited wounded Libyans under treatment in Turkish government hospital in Izmir.

Later, in November 2011, the president of IMA-Jordan visited Benghazi in a medical mission to conduct cardiovascular surgeries, made contacts with Libyan physicians to establish an IMA in Libya.

Somalia:

Somalia and some neighboring countries in the Horns of Africa have faced one of the worse humanitarian disasters ever experience in their recent history[22]. Close to 3 million Somalis became in urgent need of humanitarian aid in view of severe droughts, famine, starvation and mass death. Another half a million of IDPs went to refugee camps in border areas with Ethiopia, Kenya and Djibouti. Mass fatalities, especially among starved children, was appalling. There were urgent needs from everything: food, water, shelter, clothes, medical care and sanitation. UN and other international relief NGOs, provided relief work mainly at borders of Ethopia and Kenya, and ignored Somalia inland, in view of security concerns. Muslim relief NGOs, including FIMA, were concerned with IDPs large gatherings inside Somalia, especially in Mogadishu area, in collaboration with:

- Somali Young Doctors Association (SOYDA)- a FIMA member.
- Arab Medical Union (AMU):
  A field hospital was established in Mogadishu.
- Hayat Foundation-DWW-Turkey:
  Several medical teams were dispatched. A Mogadishu hospital was established.
- Islamic Relief (IR), with long-standing activities in Somalia with offices, and other logistics.
- Muslim Aid.

Somali famine tragedy

FIMA appointed Dr. Ismail Mehr, IMANA relief chairman, to coordinate FIMA relief efforts in Somalia. He flew to Somalia in August 11,2011 for assessment.

Over the following 12-18 months, the following collaborations were approved to function, mainly at Banadir Hospital-Mogadishu.

- FIMA to supply financial contributions, medical supplies on rotation basis of 2-4 weeks for each IMA.
  The first team arrived from IMA-Pakistan on September 12: Two pediatricians, one ophthalmologist and 2 physicians.
  Teams from IMA-Jordan, Hayat/DWW, IMANA and to follow.
- SOYDA to harmonize local movements, logistics and activities among IDPs, and to supplement FIMA, IMANA, DWW teams.
- IR agreed to coordinate and fund the following:
  - Nairobi, Kenya office to function as base for receiving and hosting teams in Nourobi overnight.
  - Coordinate flights from Nairobi to Mogadishu. On return, teams will be hosted until departures.
  - In Mogadishu: Logistics of reception, hosting, transport, security, food and help in procuring medical supplies.

This collaborative relief plan was implemented until October 6, when a very disturbing event erupted suddenly with a lethal explosion in Mogadishu conducted by Shabab movement. At the time of this event, the second FIMA team from Jordan was in Dubai airport in route to Mogadishu, composed of 7 medical professionals, mainly pediatricians, with medical supplies and cash donations. When Mogadishu was shocked with the explosions, they were strongly advised to go back home, as nobody was ready to receive them in Mogadishu. They were in tears when they took the same plane back to Jordan.

Subsequently, medical relief activities continued by AMU, in their completed Mogadishu hospital, and DWW at Banadir hospital. DWW new hospital will be ready around mid February 2012, InshaAllah.

Somalia will need diligent relief efforts from all concerned for a long time to come.
In this context, FIMA, WHO-EMRO, Ministry of Health-Somali land, University of Hargeisa, and Manual Charity Hospital in Hargeisa, organized a MOU to establish a Diploma and Master Program in Ophthalmology.

Prof. Hafeez Ur Rahman-FIMA Save Vision Chairman, will supervise the project, whereby FIMA will provide the trainers and curriculum.

FIMA/PIMA team in Mogadishu, Sept-Oct. 2011

SOYDA Relief Mobile Team

FIMA, IMANA, PIMA, SOYDA Medical teams in Mugadishu

Dr. Omar al-Ayyat, FIMA Ex Co member, with Arab Medical Union relief team to Mogadishu, August 2011

In view of widespread malnutrition especially among children, DWW established the Shifa Nutrition and Health Center for IDPs in Mogadishu area.

This was a significant achievement, urgently needed under these prevailing conditions.

DWW Shifa Nutrition and Health Center
Mogadishu- Somalia

Dr. Ismail Mehr, IMANA relief coordinator, in IDPs camp-
Mogadishu-Somalia, August 2011

The Somali people agony continues to rage amidst miseries
of draught, famine and cruel internal hostiliites

Syria 2011
Turmoil and agony:

Since January 29th, 2011, Syria has entered into an unprecedented phase in its recent history. Widespread public demonstrations and unrest, with extreme harsh measures, resulted in major suffering and casualties. Tens of thousands of civilians, women and children, with casualties, flocked to the neighboring countries of Turkey, Lebanon and Jordan.

FIMA, through member IMAs in Turkey, Lebanon and Jordan, in collaboration with relief NGOs, provided medical humanitarian relief in refugee gatherings and for casualties admitted to hospitals.

No relief work could be extended inside Syria, in view of prevailing circumstances and closures. The absence of a Syrian IMA was another handicap in provision of FIMA relief work inside Syria.

FIMA, Muslim NGOs and Relief Work:
Addressing Horizons, Pitfalls and Deficiencies:

We have reviewed several relief activities conducted by FIMA and collaborating Muslim NGOs, over the past two decades, in an effort to study and learn from the many obstacles, difficulties and shortcomings of Islamic relief activities conducted in several crises-stricken countries.

From Bosnia and Kosovo in Europe, to Afghanistan, and the Maluku islands in Southeast Asia, to several African countries, to Palestine, Lebanon and Iraq in the Middle East, there were, and still are, valuable lessons to be learned. Some of these experiences were never recorded properly to allow useful analysis, but others were fairly well documented in Islamic relief literature.

The experiences of the past years of relief work, however, functioned as eye-openers for all of us, on many shortcomings, and dire needs to further

develop, improve and correct our planning and procedures. Some areas that need serious rethinking include, but are not limited, to the following issues:

- Lack of mutual planning and harmonization among IMAs, Islamic and other relief NGOs in aspects of manpower, materials, priorities and distribution.
- FIMA had adopted a (regionalization) scheme of relief activities, whereby all efforts are to be directed through an IMA or cooperating Islamic NGO, in a country adjacent to the disaster-stricken area. This arrangement has, unfortunately, been frequently underutilized.
- Absence of relief database for relief manpower that can be actively mobilized when needed.
- Lack of organized communications and mutual planning among IMAs, NGOs and international relief organizations. FIMA is not a relief entity, but it is an important provider of medical relief manpower, and could establish successful working relationships with concerned relief organizations that could provide the material aspects.

We will document here the main conclusions under the title (The Required Muslim International Humanitarian Role) as presented by Dr. Hani El Banna president of Islamic Relief-UK, a major NGO with significant collaboration with FIMA relief activities, at the UK House of Commons on February 4th 2003. This was one of the first organized accounts of ways, means and objectives of relief work conducted by Muslims.
After listing the moral and religious Islamic foundations of human relief work, the presentation established the following main principles and requirements, to impact the effectiveness and successes of this vital endeavor as follows:

(A) The Official and Governmental Role:

- There is an ongoing global crises of accusations of organized international Islamic terrorism. This resulted in intimidations, and sometimes closures, of Muslim relief NGOs, and attacks on Muslims in general. Muslim governments in this regards, should build trust in their citizens and NGOs, encourage, cooperate and support them to fulfill their charitable and humanitarian tasks.
- Education, the media, and facilitation of legal procedures, should be utilized to encourage volunteering activities and dedication in humanitarian work towards crises-stricken communities and countries. Companies and institutions should be encouraged, and granted legal and moral incentives to donate for relief work.
- Partnerships and collaborative activities between NGOs, governmental and official authorities to organize and execute relief work.
- The Quasi-Governmental organizations: Should use their governmental facilities and connections to support and facilitate the above mentioned issues. Proper dialogue should be always open and functional with institutions, such as Red Crescent societies, and organizations established by governments to establish areas of collaboration and understanding with Muslim NGOs.
- The media, in particular, should be directed to highlight humanitarian Islamic relief activities to the public and encourage their support.

(B) The Role of NGOs:

- Should gain increased public confidence and support, by transparency, credibility, clarity of work, involvement of local people in decision making, public discussion of plans and budgets, publications of facts and financial statements, building bridges of confidence with donors and motivation of big donors…. etc.
- Should fulfill the aspirations of the individuals through charity: The NGOs should work diligently to create the feeling

and confidence in the donating citizen that this humanitarian work is fulfilling to his/her wishes to help the needy and disabled. All concerned should realize that this is a clean, pure, unconditional humanitarian Islamic relief work directed to those who need it, regardless of their ethnicity and faith.

This was an eloquent presentation of the Islamic foundations of relief work by the president of Islamic Relief, and of means and ways to make them function.

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TOTAL DISASTER RISK MANAGEMENT:
The Way Forward

Mohamed Ikram M. Salleh(1) and Azhar Abdul Aziz(2)

Abstract:

Total Disaster Risk Management (TDRM) centers around two crucial principles, namely, "involvement of all organizations and individuals" and "implementation during all phases of disaster". It is an approach aimed at significantly reducing disaster risks and effectively responding to any disaster. The extent of the damage that stems from numerous hazards and its management are overwhelming for any particular relief agency, necessitating a holistic approach that covers all relevant stakeholders and to initiate collaborations at all levels of the society.

Key words: Disasters, risk managment, relief.

Introduction:

Disasters do happen. Disasters, whether natural or man-made, are noted to be on the rise. They cause tragic loss of lives and considerable damage to homes, public facilities, livelihoods, and the environment.

The Asian region has been at a significantly higher risk of disasters.

On record, the Asian region has accounted for 75 percent of all human life losses, 88 percent of all affected populations, and 54 percent of all economic damages in recent decades[1]. As population grows rapidly, more and more people become at risk, especially in the developing countries where the growth is fastest and poverty is most prevalent.

As Muslims, we are often asked and obliged to respond to such disasters, thus the need to equip and prepare ourselves for the worst.

Understanding disasters, their characteristics and impact on the affected population will determine the type and nature of response. The health practitioner is commonly needed during the emergency phase of the typical disaster cycle, to save lives or reduce morbidity.

Relief responses during the recovery phase will facilitate recuperation physically and psychologically and at the same time prevent further harm to the affected population.

Disaster preparedness can greatly mitigate the impact of disaster. Governmental and community based activities targeted towards capacity building has been found to effectively reduce mortality as well as the economic impact on the affected community and hasten its recovery following a disaster[2].

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Definition of Disaster:

Disaster, according to WHO, is defined as a "a serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental losses, which exceed the ability of the affected community or society to cope using its own resources"[3].
Whereas the American College of Emergency Physicians states that a disaster has occurred "when the destructive effects of natural or man-made forces overwhelm the ability of a given area or community to meet the demand for health care"[4].
In simple terms, it is when there is "so much to do, by the so few, with so little resources"[4].
A disaster is a result of the combination of hazards, conditions of vulnerability and insufficient capacity or measures to reduce the potential negative consequences of risk.
This can be expressed in a simple equation:

Disaster Risk = Hazard x Vulnerability / Capacity:

Vulnerability is a set of conditions and processes resulting from physical, social, economical and environmental factors, which increase the susceptibility of a community to the impact of hazards. Capacities are positive factors that increase the ability of people and the society they live in, to cope effectively with hazards, that increase their resilience, or that otherwise reduce their susceptibility.
We may not be able to prevent hazards but if we can reduce vulnerability or increase the capacity of a given community, then we can reduce the probability of harmful consequences when a disaster strikes.
As disasters happen more often and disaster risk increases in the world, the human society and its development are put to greater risk. Repeated disaster occurrence further worsens poverty, setbacks the economy, and impedes development. This is why reducing disaster risks are so important a concern and issue to sustainable human development.

Total Disaster Risk Management (TDRM):

It is an approach towards reducing disaster risks more significantly and responding to any disaster more effectively. The TDRM approach is a holistic viewpoint and course of action that allows us to appreciate and address the underlying causes of disaster risks. In recognizing disaster risk reduction and response as a prerequisite of sustainable development, TDRM helps ensure that development efforts do not increase disaster risks, but instead, they preserve socio-economic investments and gains.
As such, TDRM encourages us to have the following approach in understanding and dealing with disasters:

1. **We must deepen our understanding of disaster risks.**

The triggering factors and conditions in the community that brought about this hazard are some of the answers that we seek. Economic, social and religious factors are important determinants and will have an impact during a disaster. Can we influence these factors then?

2. **We must enhance our competence in dealing with disaster risks, with shared knowledge, experience and expertise.**

Identifying, analyzing, and assessing disaster risks are the activities that we need to prioritize, followed by communicating and educating the public at risk. Prevention, mitigation and preparedness activities will improve our capability to respond better for the incoming disaster.

3. **We must consolidate our capacities and actions through stronger cooperation.**

Knowing our own limitations in managing disaster risks and getting help from others in building each

other's capacities through partnerships and cooperation, will definitely improve our profile.

4. TDRM applies disaster risk management in all the phases of the disaster management cycle.

We can improve our efforts to reduce disaster risks of their adverse impacts if we apply disaster risk management throughout the disaster management cycle. The approach mainstreams disaster risk management into development activities and links them in all the phases of the disaster management cycle, as shown in Figure I.

Figure I:

The phases of the disaster management cycle

With reducing disaster risks as an aim, it becomes imperative for us to ensure that our disaster response and our rehabilitation and reconstruction efforts do not put back the affected communities into the same vulnerable situation as they were before.

This calls for a better understanding of how disaster risks are shaped (hazard mapping and risk analysis) and how to translate this knowledge into action to reduce the vulnerability of communities (disaster risk reduction).

We must give importance to measures and interventions that could effectively reduce disaster risks in whichever phase of the disaster management cycle.

We should also constantly enhance our capacity not only in disaster preparedness and response (e.g. emergency drills, search and rescue, and relief distribution), but also in disaster mitigation, prevention, rehabilitation and reconstruction that should reduce disaster risks as well (e.g. reforestation, construction of flood control basins, tide wall and erosion control dams, hazard and risk mapping, and land use planning).

5. TDRM encourages the multidimensional involvement and cooperation of all stakeholders, including the government, the private sector, and the local community

Since tackling disaster risks could be an overwhelming problem for one group or organization, a multidimensional, that means multilevel, multiagency, and multidisciplinary approach should be the norm. It is a continuous process where all stakeholders should take an active part. It should also be both a bottom-up approach, that empowers local communities to understand and deal with their own disaster risks, and a top-down approach that encourages governments to establish a national policy for disaster risk reduction and response.

To give an idea of an effective disaster risk reduction and response, here are some features:

- Presence of Early Warning System that works effectively.
- The public is aware of risks and knows how to respond properly.
- People's resilience is founded on faith, knowledge, and past experiences.
- Preparedness and response plans are tested and improved periodically.
- A relief activity promptly answers needs of victims without creating dependency.
- Recovery from a disaster is attained beyond the previous state of vulnerability of the community.
- Reconstruction and rehabilitation activities do not rebuild risks.

In January 2005, 168 Governments from all over the world adopted a 10-year plan to make the world safer from natural hazards at the World Conference on Disaster Reduction, held in Kobe, Hyogo, Japan[5]. The Conference provided a unique opportunity to promote a strategic and systematic approach to reducing vulnerabilities and risks to hazards. It underscored the need for, and identified ways of, building the resilience of nations and communities to disasters.
To achieve the expected outcome and strategic goals, the Conference has adopted five priorities of action[6]:

1. Ensure that disaster risk reduction is a national and a local priority with a strong
institutional basis for implementation.
2. Identify, assess and monitor disaster risks and enhance early warning.
3. Use knowledge, innovation and education to build a culture of safety and resilience at all levels.
4. Reduce the underlying risk factors.
5. Strengthen disaster preparedness for effective response at all levels.

In summary, the benefits from TDRM approach are as shown below:

1. **Cost-effective development investments.**

Successful disaster risk management ensures value for money and the preservation of development gains.

2. Best use of limited resources.

Good resource management is achieved through cooperation, coordination and efficient sharing of reliable information.

3. Effective application of local knowledge and experience.

The active involvement, cooperation, and coordination among all stakeholders, including the local community, allows for the proper use and better appreciation of local knowledge, experience and expertise.

4. **Good governance.**

Effective policies and planning, and sustained socio-economic development make good governance and successful local leadership.

Finally, as Muslims, we need to remember that disasters are but a trial from Allah, and that we need to deal with them as best as we can. The Qur'an says: "Who hath created life and death that He may try you, which of you is best in conduct; and He is the Mighty and Forgiving"[7].

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A GROWING EXAMPLE FOR GLOBAL RELIEF EFFORT:
Doctors Worldwide (Dww)

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Abstract:

In this article we introduce Doctors WorldWide (DWW) as an international medical and humanitarian relief organization. A short history of the organization is given. The "mission and vision" of DWW, as well as its "principles and ethical values" to which we adhere to through our relief activities are stated.

We have three platforms to provide medical aid: 1. Emergency relief, 2. Extended medical relief and 3.Rehabilitation, reconstruction and medical education.

In the article we share examples of DWW's activities in each platform.

DWW projects and activities implemented over the past 6 years are enumerated. A summary of what we have done throughout the history of DWW is given

Key words: medical relief, humanitarian relief, disasters.

Introduction:

Hayat Foundation for Health and Social Services, acting as Turkey-Islamic Medical Association (IMA) was established in 1988 in Istanbul. Hayat has been a full member of the Federation of Islamic Medical Associations (FIMA) since 1996 and has been closely cooperating and collaborating with FIMA in several activities. Since Hayat Foundation is allowed by law to implement projects only inside the country; Doctors WorldWide (DWW) – Turkey branch (DWW-TR) was established to be the international relief arm of Hayat Foundation. Accordingly, cooperation between FIMA and DWW-TR has been going on through relief activities in many fields.

DWW was established in 2000 in Manchester, UK[1,2]. It was founded through initiatives of few doctors and health professionals from Turkey, UK and USA. DWW-Turkey was founded in 2004 in Istanbul, Turkey to provide medical relief and aid to those who are in need without any access or means to basic medical care.

DWW has a scope of providing medical relief to all world citizens in need, regardless of their race, religion, ethnicity or nationality. Up to this time DWW has undertaken many projects in more than 30 countries in 4 continents, providing medical and humanitarian relief to the needy.

DWW has put signature under the conduct of BOND[3] (British Overseas NGO's for Development).

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Moreover, DWW is a member of International Red Cross and Red Crescent movement and Non-governmental organizations (NGOs) Disaster Relief Agreement.DWW is a charity registered in the UK and Turkey.

History of DWW:

DWW, has undertaken many projects in cooperation with TİKA[4] (Turkish International Cooperation and Development Agency), OIC[5](Organization of the Islamic Conference), UN (United Nations) and many local and international NGO's. In addition, DWW has participated in education and field exercises organized by UN-OCHA[6] (United Nations Office for the Coordination of Humanitarian Affairs)and UN-DAC[7] (United Nations Disaster Assessment and Coordination) and is accredited by them. DWW also cooperates with the above mentioned institutions during field operations. DWW-Turkey's activities are encouraged by theTurkish Government and Presidency. [8]

Mission and Vision:

DWW aims to provide relief work among people, who are victims of poverty, famine, disease, natural and man-made disasters, wars and civil wars, irrespective of their race, religion, ethnicity, nationality, ideology or politics.
DWW fulfills its aims by the means of projects that are effective in implementation, well-planned in advance, equity-based, addressing the heart of the problem, and most importantly are sustainable.

Principles:

- *Primum non nocere* , first do no harm.
- Confidentiality.
- Informed consent.
- Respect for human dignity and medical neutrality.
- Implementing legitimate and scientific methods.
- Not acting without competence.

Ethical Values:

- Sanctity of the human-being
- Morality
- Volunteering
- Modesty
- Selflessness
- Honesty and credibility
- Independence
- Transparency

Basic Activity Platforms:

DWW works on these three platforms to provide medical aid[1,2]:

1. Emergency relief: Short-term urgent relief in case of disasters, whether man-made or natural
2. Extended medical relief: After addressing urgent health care issues, focuses on prevention of epidemics and outbreaks of infection due to poor hygiene and sub-optimal living conditions.
3. Rehabilitation, reconstruction and medical education: Long-term medical relief in cooperation with local health professionals. Major emphasis is placed on assistance with the rehabilitation of societies no longer at war in re-establishing their health-care system. DWW is committed to providing medical education and training to local health care workers whenever possible.

DWW has been working diligently to meet these needs. It has undertaken, and is still undertaking a number of major projects throughout the world.

Relief Activities:

<u>Emergency Relief Activities:</u>

- Darfur-Sudan Humanitarian Crisis – April 2005

Provided medical relief services in al-Geneina. Hospital/West Darfur.
Donations collected from Turkey.
New eye unit established.

- Muzaffarabad Earthquake- Northern Pakistan – October 2005-2006.

DWW sent relief teams within the first 48 hours and gave medical services for 8 months in the field

Set up of field clinics
First permanent health center established in Komikot village
First children hospital built in New Balakot City.

- Aceh and Jogjakarta Earthquakes-Indonesia – June 2006 – December 2004.

DWW provided medical aid and volunteer doctors

- Gaza Attacks Since 2006

In city of Khan Younis a new trauma center worth $600,000 was established in cooperation with another Turkish NGO- the Light House Association (2006)
Physicians from Gaza were brought to Istanbul, Turkey for training on trauma and resuscitation (2006).
Medical coordination team sent to Rafah border, DWW provided urgently needed medicines and 12 ambulances, of which 2 were equipped with intensive care facilities in cooperation with other Turkish NGOs(2008)[9].
Three specialist physicians arrived from Gaza to Istanbul for advanced surgical training in general surgery, urology and plastic surgery for three months by experienced professors in training hospitals who are members of DWW-Turkey.

- Lebanon war – 2006

In 2006 war in Lebanon, need assessment was made and DWW sent two and a half containers of medicine and medical supplies worth $750,000

- Swat-Pakistan internally displaced persons (IDPs) Crisis – June 2010

Mobile clinics and ambulances were sent to treat the victims; DWW provided basic health care in Mardan refugee camp for four months

<u>Rehabilitation, reconstruction and medical education:</u>

Doctors Worldwide is putting a lot of effort and time to establish projects in this regard. The major projects that have been undertaken so far and still going on are:

- Capacity Building Projects in Democratic Republic of Congo Since 2005.[10]

Maternity clinics and hospitals, HIV/AIDS prevention programs, and Poverty reduction programs

- "Violets of Hope" Project – Since 2005

Treatment of genital fistulae patients in Niger. These fistulae are mostly the result of obstetric trauma resulting from poor obstetric care
Eighty six women have been operated upon so far in Niger
A new hospital will be built only for fistula patients in Niger in the near future

- "Smiling Children" Project – Since 2007

Surgical treatment of cleft lip/palate
Surgical treatment of children with hypospadias.
So far in Palestine (West Bank and Gaza), Yemen and Syria: More than 1500 elective patient examinations and approximately 400 operations have been performed

- Africa "Eye Light" Project – Since 2005

Treatment of preventable lack of sight and other visual diseases
In Sudan, Niger and Kenya so far approximately 1000 cataract patients were operated upon

- Circumcision Campaigns for needy children – Since 2005

Approximately 150,000 circumcisions were performed so far in Democratic Republic of Congo, Macedonia, Greece, Turkey and Georgia

- Qurbani Campaigns – Since 2005

31,491 share of Qurbani distributed in some African countries such as Democratic republic of Congo, Kenya, Ghana and Niger in the last six years.

DWW Qurbani 1428 H in Congo

Other projects undertaken in 2011:

- Kenya: "Health for All" Project:

Two volunteer urology teams, in turn, worked in Sayyida Fatimah Hospital in Mombassa/Kenya. They trained local doctors for endoscopic prostate surgery.
A pediatric surgeon worked for 10 days in Sayyida Fatimah Hospital and performed 70 surgeries.
Ophthalmology team went to Sayyida Fatimah Hospital. Forty three operations and 200 elective examinations were performed.
DWW plan to send four ophthalmology teams each year
DWW donated an operative ophthalmologic microscope to Sayyida Fatimah hospital and educated the local staff to use the new medical device.

Prof. M. Ihsan Karaman:
DWW Urology team-Kenya-2011

- Yemen:

A five-doctor DWW team travelled to Yemen for need assessment and performed some complicated surgeries. DWW plans to organize 4 surgical camps, train local doctors and implement hospital modernization projects.

- Pakistan[11]

A Federation of Islamic Medical Associations (FIMA) Mobile Clinic providing obstetric-gynecologic care was arranged to serve flood disaster victims in collaboration with Pakistan Islamic Medical Association (PIMA) and other Islamic Medical Associations (IMAs).

Necessary medicines worth $700,000 was collected in Turkey and sent to flood affected area in three installments.
Two Basic Health Units were renovated in Nowshera and Sind.
A big regional 100-bed capacity hospital will be built in Jampurarea in collaboration with the foreign ministry of Turkey and TIKA.

- Libya:

Emergency Relief: A need assessment was undertaken in the field together with the Arab Medical Union (AMU), FIMA and Islamic Medical Association of North America (IMANA).

- Kyrgyzstan:

A five-doctor DWW team visited three cities of Kyrgyzstan for a need-assessment for future collaboration. They gave scientific lectures to local doctors in five specialties and performed some operations

- Georgia:

1350 children were circumcised in rural areas of Tbilisi and Batum by DWW volunteers on two occasions.

- Somalia tragedy:

The following relief account may seem somewhat lengthy, but it is coming deep from our hearts which are heavy with the scenes we faced in Somalia.

- In August 2011, a DWW delegation paid a 24-hour visit to Mogadishu/Somalia with Prime Minister Tayyip Erdogan. During this visit, we personally witnessed the crisis in the Horn of Africa. Due to the shortage of time and strict security measures applied to the Prime Minister's delegation, we could not meet up with SOYDA representative Dr. Abdiqani Sheikh Omar, although we had previously agreed to meet. However, right after my return, our delegation of three people who went to Mogadishu representing DWW had contacts with Dr. Abdiqani about the details of the FIMA/IMANA/Islamic Relief joint relief efforts.
- DWW, as an integral part of the FIMA family, will partake with all our available

means in the joint FIMA/IMANA/Islamic Relief aid activity that have started at the Mogadishu Banadir Hospital. Right now, we are experiencing a boom in volunteer doctors in Turkey who are eager to go and serve in Somalia.

- We have developed new projects and action plans to answer the needs of the Horn of Africa, firstly on July 2011. Among these, we are agreed to provide volunteer support to Benadir Hospital/Mogadishu in November 2011.

Since FIMA handed over its 'Volunteer Support' project to DWW Turkey, we have been providing physicians to Benadir Hospital. In this period, from the 31th of October, 2011 we had sent 3 volunteer teams which consisted of 18 physicians (**Family Medicine, General Surgery, Pneumology, Pediatric Surgery, Ob/Gyn., Internal Medicine, Urology, ENT and Pediatrics**), three pharmacists, five nurses and one intensive care nurse. And within these services our volunteers performed approximately 3,000 patient examinations and 65 surgeries. And more than 10,000 boxes of medicine have been distributed.

There is no state authority in Somalia. Accordingly, there are also some difficulties that we occasionally faced being caught in the middle of clans and different groups in Mogadishu. Because of this risk, we have taken our own safety and security measures as Doctors Worldwide. However, we believe that giving humanitarian and medical aid for suffering people in Somalia is an indispensable duty for us as a part of whole Islamic Ummah, and humanity at large.

Meanwhile, our 60 bed capacity 'Shifa Hospital' is still under construction. On 29th of November construction workers from Turkey have been sent to the field and hopefully DWW-Shifa Hospital will start to give services in February 2012, InshaAllah.

After Shifa's opening we are planning to provide regular teams of volunteer physicians, pharmacists and dentists every month to support 13 Somalian physicians who will work in Shifa Hospital as our employees.

DWW Pediatrician caring for a malnurtished child

They have already been provided an intensive training programme for 7 weeks in a University Hospital in Istanbul.

Nevertheless while we have focused on giving health services, we did not forget our brothers and sisters in Somalia, and we distributed 5,050 shares of Qurbanis during the Eid ul Adha.

As DWW-Turkey, we did realize 558,000 US$ of our project costs and we are seeking for more funds to increase our implementation capacity. Right now we are preparing Project Proposals and soon we would like to share our proposal to FIMA fraternity for future cooperation and support.

Last but not least, we would like to share a piece of good news that honoured us, and will significantly facilitate our aid activities in Somalia. Our Turkish friend Dr. Kani Torun, the Ex-CEO of the DWW-UK and member of the executive board of DWW-UK and founders' committee of the DWW-Turkey at present, has been assigned as the first Ambassador of the Republic of Turkey to Somalia.

We at the DWW are all proud and greatly empowered by the fact that a medical doctor has been assigned as ambassador to a country for the first time in the history of Turkey. Our brother Dr. Torun, who takes office in Mogadishu in mid November, will also be serving as a moral representative for the FIMA.

DWW-Shifa Hospital-Mogadishu- Somalia

- Van – Turkey:

On the 23th of October 2011, Van; one of the eastern cities of Turkey, was hit by an earthquake with the magnitude of 7,2. Just after the earthquake occured, lightly equipped Doctors Worldwide Search and Rescue (DWW-SAR) team met in DWW Turkey Office with 31 team members and did the preparations to depart to the field as soon as possible, and 12 hours after the earthquake occured, DWW-SAR team reached to the disaster field. Our team consisting of 4 physicians and 27 professional and light SAR volunteers did an intense work in first 72 hours and supported the heavy SAR teams who were working in the rubbles of Erciş District.

After 80 hours, with the cooperation of SAR teams from all over Turkey, the critical hours have passed and our SAR team came back to Istanbul.

After the need assessments we have done in Van, we have decided to give health services in 5 villages on the seashore of Van Lake, which were 80% collapsed after the earthquake. Between the dates 28th October 2011 and 17 November 2011, our volunteers gave medical and psychological services with the volunteering of specialist doctors in Güveçli, Dağönü, Yeşilsu, Özyurt and Halkalı villages of Van.

During this time we have also distributed food parcels in Yeşilsu and Dağönü villages and school items, winter jackets, boots for children in Dağönü village, with the cooperation of 'Mercy Malaysia' which sent a team of four volunteers to do need assessment to Van earthquake area.

While we were giving services in villages, second earthquake with the 5.6 magnitude occured in Van. And in 48 hours we have managed to establish a 92 sq.m field hospital in Gevas Hospital area.

It was used as the main hospital and specialists in emergency medicine, pediatrics, gynecology and patient registration have been transferred to that tent hospital. For 40 days that field hospital gave health services to more than 20,000 persons in Gevas district.


Dww Turkey volunteers giving health service in tents


Doctors Worldwide Turkey / Van Gevas Field Hospital

Now, as DWW with the cooperation of Van Health Directorate, we are implementing 'Mobile Clinic Project' which provided health services to the villagers in 5 villages for 5 months.

In this Project we will also provide regular psychological support and treatment, disaster awareness and public health trainings to the disaster victims in these 5 villages. The Project will end in June 2012.

Conclusions:

The following is a summary of the worldwide relief activities provided by DWW over the past 6 years:

- 2 million patient examinations.
- 150,000 circumcisions.
- 1,000 cataract operations.
- 2,000 refractive error examinations.
- 86 vesico-vaginal fistula operations.
- 400 cleft palate and hypospadias operations.
- Qurbani meat distribution to one million Africans.
- Implemented projects over 30 countries in 4 continents.

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SAVE VISION INITIATIVE: FIMA Campaign To Combat Blindness

*Hafeez Ur Rahman *, Intzar H.Butt, Zahid Latif, Saeed Anwar, Usman Raza, and Ayesha S. Abdullah*

Abstract:

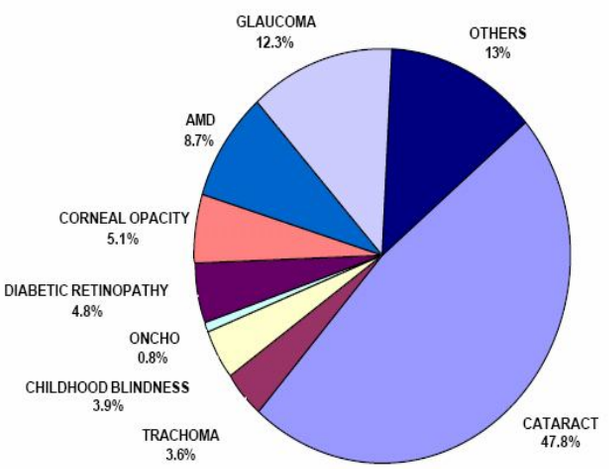
In early 2005, the Federation of Islamic Medical Associations (FIMA) launched a program to combat visual impairments in developing countries of Africa, South and Southeast Asia. This ongoing program was given the name: FIMA SAVE VISION.
To date, more than 80,000 eye surgeries have been performed, mainly for cataract, in addition to several training programs for ophthalmologists and paramedics, eye hospitals established or properly equipped, and memoranda of understanding and collaboration were executed with local, regional and international organizations, concerned with preservation of vision.
In this article, achievements and difficulties of this ongoing program, over the past 7 years, will be presented.

Key words: Visual impairment, Cataract, Healthcare, FIMA Save Vision.

Introduction:

The Federation of Islamic Medical Associations (FIMA) started the SAVE VISION initiative in January 2005, with eye camps in Darfur-Sudan.
The program has been a sustained activity aiming at combating visual impairments, especially cataract-related, in disadvantaged countries and communities of Africa, South and Southeast Asia, with weak eye care infrastructure and limited, absent or poorly distributed qualified eye care professional manpower.
Nearly 50% of causes of blindness is due to cataract[1].
The rest of causes are: Glaucoma, diabetic retinopathy, childhood blindness, trachoma, onchocerciasis, …etc.
Blindness is most prevalent in developing countries, where around 90% of the world's blind people live.

Around three-quarters of the world's blind children live in developing countries in Africa and Asia[2].



Global Causes of Blindness[1]

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In 2004, according to the World Health Organization (WHO), approximately 314 million people worldwide have low vision, and out of those, 44 million people are blind. Eighty percent of blindness is avoidable, i.e. treatable and/or preventable[1].

In 2010, WHO released latest global estimates of visual impairments. Number of people with visual impairment, worldwide, is 285 million. Of those, 39 million are blind[3].
The improvement in numbers has been attributed largely to decline of infectious causes.
The top three causes of visual impairment in 2004 were: Uncorrected refractive errors, cataract and glaucoma.
The top three cause of blindness in 2010, were: Cataract, glaucoma, and age-related macular degeneration.
For every 24 hours, 86,400 individuals are added to the blindness pool, 50,000 of them are due to cataract, out of whom only 30,000 are operated upon, and around 20,000 are added to the backlog of cataract[3-5].
Cataract blindness can be treated successfully with surgery. Cataract surgery is considered one of the most cost-effective forms of health interventions[2].
In some developing countries, the rate of cataract surgery is less than 250 operations per million people per year, as compared to a rate of 8,000 in some developed countries.
One million people are operated upon every year, but 1.5 million are added every year[3-5].
WHO estimates that without major intervention, the number of blind people will escalate to 75 million in 2020[2], and the economic burden of blindness will rise from USD 42 billion per annum in 2000 to 111 billion by the year 2020[2].
In the Eastern Mediterranean region, WHO statistics reveal widespread prevalence of visual impairments, with at least 6 million people with various degrees of visual impairment.
Seven countries in the region have extensive needs for combating various etiologies of blindness, namely: Somalia, Sudan, Djibouti, Yemen, Iraq, Palestine and Afghanistan[6].

In Sudan, as an example, there were 160 ophthalmologists by 2003, of whom 110 were in the capital area, Khartoum. Only 50 were scarcely dispersed in the remaining provinces of Sudan. In the province of West Darfur, there was not a single eye doctor, or eye-care facility until late 2005[7,8].
In this paper, we will present the FIMA Save Vision Program launched in January 2005, starting in Darfur-Sudan, following a pilot visit by a medical relief team from Jordan, led by then FIMA president Dr. Aly Misha'l, in October 2004.
FIMA leadership has adopted this relief program as an ongoing activity, wherever needed to alleviate human suffering. A steering committee was appointed with headquarters in Pakistan, where experienced and dedicated ophthalmologists have established a record of excellence in combating visual impairment in South Asia.
Cataract, as a leading cause of blindness around the globe, holds true for Sudan as well. It is estimated that cataract represents approximately 60% out of all etiologies of blindness there. The backlog of cataract cases in the country is estimated to be around 350,000[7,8].
Cataract surgical rate (CSR) in Sudan was only 830, and Sudanese health authorities aim to achieve a CSR of 2500 by the year 2010. This target, though not that high, might be quite difficult to achieve, given the various constraints Sudan is facing.

Program objectives:

1- Reach out to people suffering from visual impairment in needy, deprived communities, especially in remote areas in Africa and Asia. The main target is alleviation of cataract, the main cause of treatable blindness.
2- Training and capacity building of local eye doctors, nurses and other paramedics, in an effort to maintain and widen the SAVE VISION Program by qualified local expertise.
3- Establishment of permanent, fairly well-equipped and sustainable eye hospitals, or eye

units in existing local hospitals, to help in the continuity and effectiveness of the program.

Program methodology:

The action model for achievement of program objectives has evolved over the years, in respect to local factors, FIMA capabilities of volunteering professionals/finances, and scopes of collaboration with NGOs and governments. The following are salient methodology basis:

1- Deployment of specialists in eye care and surgery, with their qualified teams, to needy countries and communities, especially in remote, deprived, and marginalized areas, to treat visual impairments, especially the most prevalent cause of blindness, namely: cataract.

The Program has deliberately attempted to balance the prevalent, long standing bias towards main cities, where eye-care human resources (HR) are largely concentrated.

2- Eye surgical equipments, instruments, special eye lenses (IOL), medications and other consumables to be made available for proper medical and surgical care.

In the first 2 years, the teams had to carry along their equipments by plane.

3- Collaboration with local, regional and international organizations that aim at alleviation of visual impairments in needy areas. Cooperation is underway with WHO-EMRO, Arab Medical Union, other NGOs, as well as official health authorities in target countries.

4- Development of eye training centers, workshops and training manuals to local eye doctors, nurses and paramedics, in target countries.

5- Cooperation with concerned NGOs and local health authorities to raise funds to establish and equip eye hospitals in needy countries.

6- Help in raising proper awareness towards the problem of visual impairment.

Program Results:

By August 2011, FIMA Save Vision activities have been successfully extended to 14 countries in Africa and Asia.

The project statistics reveal the following data:

- Eye-care camps conducted: 376.
- Total patients examined: 793,299.
- Total cataract surgeries with IOL: 81,556.
- Total volunteering eye surgeons: 547, from 13 countries: Pakistan, Jordan, Sudan, Saudi Arabia, Indonesia, Egypt, Turkey, Malaysia, Nigeria, Sri Lanka, Bangladesh, Ireland, and Morocco.
- Tables I and II reveal numbers of patients examined, and operated upon in African and Asian counties, respectively:

Table I: FSV DATA – AFRICA:
January 2005-August 2011

Country	Patients examined	Patients operated-cataract	Number of eye volunteering surgeon
Sudan: Darfur, Gadarif, Kassala, Dongla and Halfa, Khartoum, Omdorman, Al-Duain, Kosti, Al-Jadeed, White Nile, Malakal, Kurdofan, Behri.	267,080	30,474 Operations not related to Cataract have also been done (number not included)	156

Country	Patients examined	Patients operated-cataract	Number of eye volunteering surgeon
Chad	3000	250	2
Somalia	4000	500	4
Mali (collaboration with WAMY)*	9500	770	4
(collaboration with KF and Nigerian NGOs):** Katsina, Lagos, Hadeja, Madughuri, Kazauri, Gasau, Daura, Dutse, Kaduna, Minna, Kontgora, Kano, Funtua, Lafia.	99,200	9333	95
Senegal	8000	678	9
Niger	10,600	1,034	6
Burkina Faso (Collaboration with IIRO)***	4500	370	4
Cameron	4500	500	4
Morocco	4500	548	6
Zimbabwe (in collaboration with IMA-Zimbabwe)	2000	150	4

*World Assembly for Muslim Youth, Saudi Arabia.
**Kingdom Foundtion, Saudi Arabia, later known as Al-Waleed Bin Talal Foundation.
*** In cooperation with Serendib Foundtion- Sri Lanka.
**** Islamic International Relief Organization, Saudi Arabia.

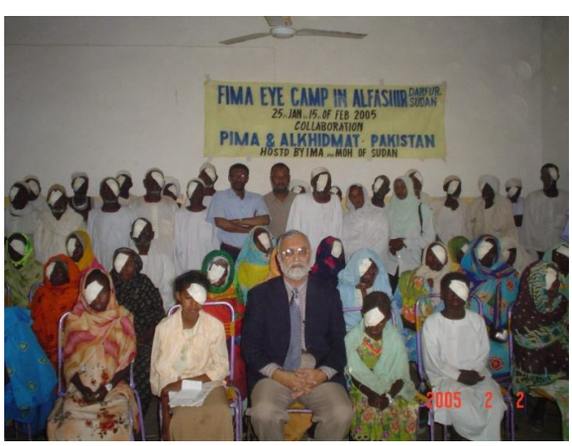
TOTALS:

- Patient examined: 416,880.
- Patients operated-cataract: 44,607.
- Number of eye volunteering surgeon: 294, and unspecified number of Turkish and Sudanese eye doctors.

Table II: FSV DATA-ASIA
January 2005-May 2011

Country	Patients examined		Patients operated	
	Camps	Hospitals	Camps	Hospitals
Sri Lanka	8,000	75,000	750	7,478
Indonesia	10,000	-	1000	-
Pakistan (Including Afghan Refugee Camps) and Pak. Jails	270,419	10,000	26,681	1040
Totals in Asia	373,419		36,949	

FSV Camps: Sudan, Chad, Mali and Nigeria



On far right: Dr. Intzar Butt-FSV Team Leader

Children Family blindness- Katsina, Nigeria

FSV in Malakal- Sudan, 2008

Prevention of Blindness Trust (POB) - FIMA Save Vision in Pakistan:

Prevention of Blindness Trust (POB) was established by the Pakistan Islamic Medical Association (PIMA) in 2005, and officially registered in 2007, with main objectives parallel to those of FIMA Save Vision.
Leaders of this project have been the main activists and pioneers of FIMA Save Vision Program. The thrust of POB has been mainly in Pakistan, including camps of Afghan refugees and Internally Displaced Persons (IDPs) of earthquakes, floods and hostilities. POB consist of nine-member board of trustees, having vast experiences and enthusiasm in medical relief, nationally and internationally. It's current chairman is Dr. Intzar Hussein Butt, senior ophthalmologist in The Services Institute of Medical Sciences (SIMS)-Lahore, and leader of many FIMA Save Vision camps, and training activities in Asia and Africa. More than 200 highly qualified ophthalmologists from different distinguished professional and training institutions of Pakistan are committed to voluntary relief work, within the folds of POB and FIMA Save Vision activities for the achievement of excellence in eye care, education and research for the welfare of humanity, regardless of ethnicity, faith, nationality or color.

Since its inception, POB has provided care for about 3 million outpatients, and performed more than 25 thousand, eye surgeries, mainly cataract with IOL implantations. POB has arranged for more than 270 free eye camps in 40 districts of Pakistan, and has deployed experienced ophthalmologists and paramedics, under umbrella of FIMA Save Vision, to 12 African and Asian countries with deficient eye care facilities and eye care manpower.

During Pakistan earthquakes in 2005 and 2008, internally IDPs in 2009, and the Monsoon 2010 floods, POB took the lead in provision of eye care, and thousands of eye surgeries, as well as participation in general relief activities.

The following are projects implemented or planned by POB in Pakistan:

- 2010: A special eye care project for timely identification and diagnosis of visual impairments in childhood.
- Eye care for prison inmates. 8000 individuals examined, 45 eye surgeries performed, and eye glasses distributed.
- A blind rehabilitation project has been initiated to help building the talents of blind individuals, including computer training workshops. Hundred free white canes were distributed.

- Training workshops/seminars for eye-care professional: More than 15 in and outside Pakistan, and more than 300 eye care professionals trained.
- Community eye care centers in different areas of Pakistan have been initiated.
- Eye awareness programs have been conducted in several areas of Pakistan. This public educational activity has been expanded by establishing a POB websites (www.pobtrust.org) which is being updated regularly.
- A future plan: Establishment of a tertiary eye care institute in Lahore-Pakistan.

Other Program Outcomes:

- Establishment of Eye-Care Centers: This activity has been addressed by two manuscripts in this issue of Year Book.
- Training-capacity Building: In almost all eye camps, FIMA teams adopted programs of practical training of local ophthalmologists, nurses and other paramedical professionals, to improve sustainability of eye care by qualified local hands. Training has been also conducted in Pakistani and Jordanian ophthalmology centers.

FIMA SAVE VISION- Specialized training courses:

- Advanced capacity building for eye surgeons from several countries in special training centers in Pakistan.
- Oculoplastic Workshop, in Khartoum-Sudan, August 2006. In collaboration with Ministry of Health (MOH)-Sudan. Conducted by Prof. Imran Sahaf, Head of Department of Ophthalmology-Lahore General Hospital- Postgraduate Medical Institute.

The workshop included presentations, interactive sessions, hands-on training for 52 Sudanese eye surgeons.

- Training workshops in Gusan and Katsina-Nigeria, June 14-15,2008, conducted separately by senior Pakistani ophthalmologists, one for 12 local eye-doctors and the second for 40 nurses-paramedics.

- Training workshop in Lagos-Nigeria, June 22-24 2008, conducted separately for 13 Nigerian eye doctors, and for 35 Nigerian paramedics.

- Training workshop in Maiduguri-Nigeria, January 4-9,2009: for 25 local eye doctors. The program included a special session on "small Incision Cataract Surgery-SICS". A parallel training session was also conducted for 10 ophthalmic nurses and OR technicians. Trainers were senior ophthalmologists and OT from Pakistan.

- Keratoplasty surgery (Corneal transplantation), in Khartoum-Sudan, January-February 2009. 25 corneas were imported from Sri Lanka, through a MOU. Trainers were Senior ophthalmologists from Pakistan.

Eye surgeons trainees from Palestine, Sudan and Jordan in Pakistan, 2006

FSV Training-Local eye professionals

Prof. Imran A. Sahaf-Pakistan
Oculoplastic workshop- Sudan, August 2006

Oculoplastic workshop- Khartuom-Sudan,
August 2006

Collaborations and Memoranda of Understanding (MOUs):

The Save Vision Program could not have fully achieved its outcomes without significant collaborations with several local, regional and international concerned NGOs and governments:

- Sudan: MOH and Sudanese Islamic Medical Association (SIMA).
- Nigeria: Governmental and NGOs.
- Al Basar International Foundation-Saudi Arabia. (MOU) has been executed on December 16,2009. One area of collaboration was the FIMA Manual for Paramedics, which was reproduced and adopted by Al-Basar Foundation in their centers all over the world.
- World Health Organization (WHO-EMRO): collaboration has been operational in several EMRO countries. A formal 4 Year collaborative agreement has been executed, as partners for VISION 2020, in December 2009.

MOU: FIMA and WHO, December 2009
Prof. Hafeez Ur Rahman and Prof. Hussein A. Al-Gezairy-Regional Director, WHO-EMRO

- Ophthalmology Diploma and Masters Program in Hargeisa-Somalia: MOU with WHO and Manhal Institution in Hargeisa, has been executed in July 2011. A joint venture, whereby FIMA will provide trainers as well as the postgraduate Manual.
- Saudi Arabian "Kingdom Foundation", later known as Al-Waleed Bin Talal Foundation. MOU has been executed for the period from May 2008 to June 2009, whereby the Foundation granted the FIMA Save Vision Program financial support for several eye camps.
- Arab Medical Union (AMU), stationed in Cairo-Egypt, that represents all Arab Medical Associations. FIMA-AMU

collaboration in this program, as well as other relief endeavors, has been harmonious and long standing.

- FIMA International Ophthalmic Committee: formed in 2006, to foster proper and wide implementation of Save Vision aims and objectives.

FIMA International Ophthalmic Committee: Meeting- Kasala-Sudan,2006

- The World Assembly of Muslim Youth (WAMY)-Saudi Arabia: collaboration in holding of eye camps the African countries: Chad, Senegal, Nijer and Mali.

- An agreement with " Sri Lanka Eye Donation Society"-August 2007, to provide live corneas for transplantation. This society has good setup for procurement and donation, with surplus corneas.

- Islamic International Relief Organization (IIRO)-Saudi Arabia: collaboration in eye camp in Burkina Faso, June 15,2009.

Conventions:

FIMA Save Vision representatives have participated in the following conventions:

- The London International Conference on Development of Better Health Services in Darfur-Sudan, March 12-13,2010 organized by: British Friends of Sudan (BFOSS), in collaboration with Ahfad University for Women, Development Action Now (DAN)-Sudan, and the London Middle East Institute-School of oriental and African Studies-University of London.

- Seminar-Workshop held in Cairo-Egypt, November 23-26,2008, in collaboration with WHO-EMRO, and International Agency for Prevention of Blindness (IAPB), under Vision-2020.

- Symposium (VISION 2020 in Africa-The Next 10 Years), held in Bahrain, March 27-28,2009, in collaboration with WHO-EMRO, International Agency for Prevention of Blindness (IAPB), and the Middle East African Council of Ophthalmology (MEACO).

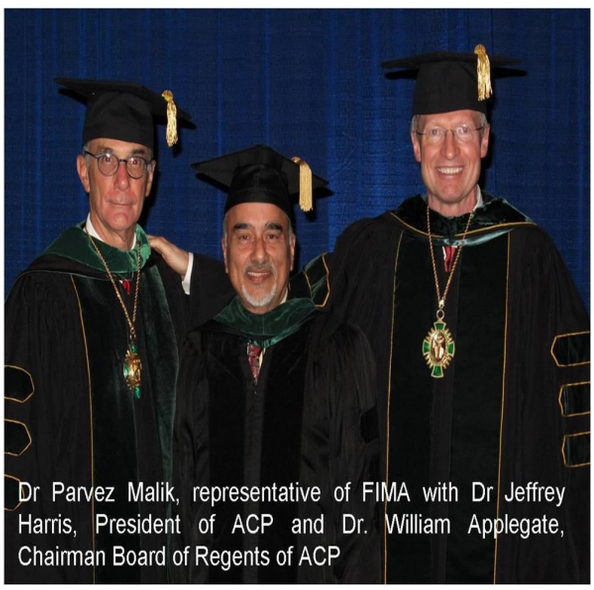
Awards:

FIMA Save Vision Program won the American College of Physicians (ACP) Award of 2009, named (Richard and Hilda Rosenthal Award). In a formal letter, from ACP Chair-Awards Committee, Dr. Barbara J. Jurner, to FIMA Save Vision Chairman, the following significant paragraphs are worth documenting:

" Dear Dr. Hafeez Ur Rahman, As Chair of the Awards Committee of the American College of Physicians, I am pleased to inform you that, based on the recommendations of my Committee, the Board of Regents has voted to elect FIMA Save Vision as our 2009 recipient of the Richard and Hilda Award #2 …"

" The competition for this award was extremely stiff but FIMA Save Vision's contributions were the most outstanding".

Dr. Parvaiz Malik, FIMA president, received the Award in ACP-Ceremony on April 23th, 2009[9].



Dr Parvez Malik, representative of FIMA with Dr Jeffrey Harris, President of ACP and Dr. William Applegate, Chairman Board of Regents of ACP

Concluding remarks:

Since its inception in January 2005, FIMA Save Vision experience represents a case example of international move forward in public health, particularly community eye health. The effort has been largely silent, humble and without media elaboration.

Over time, the program culminated in creating tremendous impact in improving equity, access and coverage in needy, marginalized communities in Africa and Asia.

The approach has been to mobilize and coordinate voluntary resources, foster local, regional and international collaborations, and create local ownerships and sustainability by local qualified medical manpower that insure continuities and effectiveness of the program.
Qualified ophthalmologists went outside their countries to participate in Save Vision activities in other needy communities.

There were significant pitfalls and deficiencies in implementation of the program which is still expected to evolve and correct some of its methodical shortcomings to go forward.

The future horizons are loaded with grim global statistics which indicate that one human being, somewhere in the world, goes blinds every five seconds. Hence, more dedicated efforts are needed in the years ahead.

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FIMA EYE HOSPITALS IN DEPRIVED COMMUNITIES

Adnan A. Jaljuli, Hafeez Ur Rahman and Aly Misha'l*

Abstract:

The Federation of Islamic Medical Associations (FIMA) launched the Save Vision Initiative in early 2005 aiming at improving eye care and reducing visual impairments in underprivileged communities, especially in Africa, South and Southeast Asia.

The initiative includes sending volunteer eye-care teams to conduct wide-scale screening and surgical campaigns, and training of local ophthalmologists and other healthcare personnel to continue this activity by qualified local professionals.

This article outlines achievements, hopes and challenges of another aspect of this initiative namely: establishment of eye hospitals, or eye sections in existing general hospitals in deprived, underprivileged, remote areas in Africa, South and Southeastern Asia.

Keywords: Blindness, visual impairment, developing countries, FIMA Save Vision.

Introduction:

Visual impairment is widely prevalent in third world developing countries, especially in Africa and Asia. According to estimates published by the World Health Organization (WHO) , more than 44 million people worldwide are blind, with major preponderance in the underprivileged regions of sub-Saharan Africa, south and southeast Asia[1] .

Many other people suffer from visual impairment not reaching the stage of blindness. In many of these regions, there is marked deficiency of both qualified ophthalmic surgeons, as well as eye hospitals.
The World Health Organization in the Eastern Mediterranean Region (WHO-EMRO) issued troubling estimates of visual impairment in the region, with more than 6 million blind individuals in addition to 16-17 million people with other types of visual impairments [2], most of which are correctable or preventable.

Seven countries in this region have been considered to be markedly deficient in eye care, namely: Sudan, Somalia, Djibouti, Yemen, Palestine, Iraq and Afghanistan[2]. The backlog of cataract, a major cause of preventable blindness, in Sudan, as an example, has been reported to exceed 500,000 individuals, with many provinces completely deprived of eye-care facilities and ophthalmic teams.

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Over the past 7 years, FIMA embarked on the Save Vision Initiative, in collaboration with other concerned local and regional, governmental and non-governmental organizations. This major activity entailed sending volunteer ophthalmology teams, equipped with instruments, consumables and medications, to undertake strategic tasks: setting up camps for screening, selection of candidates for eye care, performing surgeries, training of local physicians and other paramedical personnel and establishing of local eye hospitals, eye sections in existing general hospitals, and provision of equipments, instruments and consumables to eye hospitals in deprived communities.

This article outlines this latter aspect of promoting eye care, namely establishing or supporting eye-care facilities in concerned needy countries.

The Initial Phase:

The story of this FIMA relief project started following a series of relief teams of volunteer physicians that came to Darfur-Sudan since October 2004. During their general medical relief activities in various regions of that troubled province, team members discovered widespread visual impairments, especially those related to cataract, in Darfur in general, and the Western province, particularly in its capital Al-Genaina. This impression was shared with a team of eye surgeons deployed by the Arab Medical Union (AMU)-Egypt to that province.

This province, with a population of two million and more than 500,000 internally displaced persons (IDPs), was completely deprived of any eye care facility, or any ophthalmologist, neither in public nor in the private sectors. The province is in close proximity to the Republic of Chad, with long and porous borders, tribal inter-relationships and frequent border crossings. The neighboring districts of Chad are likewise, completely deprived of any eye-care facility.

Early in 2005, FIMA started delegating eye medical teams to provide screening activities and perform surgical care in make-shift eye camps, that were set up in primitive general hospitals, or in other available public buildings.

Since cataract was found to be the most prevalent cause of visual impairment, and the most correctable, most eye camps and campaigns were designed and directed towards alleviating this problem.

All participating ophthalmologists were volunteers from several Islamic Medical Associations (IMAs), pioneered by Pakistan IMA, and included ophthalmologists from Jordan, Malaysia, Saudi Arabia and Egypt. Close collaboration was established with the Arab Medical Union (AMU), stationed in Cairo, Egypt, with significant medical relief activities in Sudan and other African countries.

The central roles of the Sudanese Islamic Medical Association (SIMA) which is a FIMA member, and the Sudanese health authorities, were vital, especially in consideration of local logistics and health manpower.

Special equipments, instruments, consumables, medications and the special intra-ocular eye lenses were provided by FIMA, and carried along by eye medical teams to places of action. WHO-EMRO had a constructive and harmonious working relationship with those engaging in this activity.
Following a series of eye camps conducted in the city of al-Fashir, Northern Darfur, led by Professor Hafeez Ur Rahman, from Pakistan, then the General Secretary of FIMA, the attention was directed towards the deprived district: Western Darfur and its capital al-Genaina.
In April 2005, the first FIMA eye camp was conducted in al-Genaina. Thousands of patients poured into the city from neighboring areas, and from places as far as Chad. More than 30,000 individuals were screened, and approximately 100

cataract surgeries, with intra-ocular lens (IOL) placement, were conducted.

In view of the high prevalence of eye impairments in the province, and the needs for continuous and stable plans to provide professional eye care to reduce the backlog of visual impairment in that deprived and remote area, members of FIMA team sought to discuss ways and means to establish a permanent eye-care facility there.

Dr. Adnan Jaljuli, a senior ophthalmologist and ex-health minister in Jordan, who was a member of this FIMA team, was instrumental in planning the project with the local Sudanese health authorities. The idea was welcomed and received with enthusiasm. A field visit was undertaken to a small 250 square meters (sq.m.) abandoned building in al-Genaina, which was previously utilized as a nursing home.

A preliminary understanding was reached, to transform this humble building into an eye hospital, sponsored by FIMA. Subsequently, Dr. Jaljuli further discussed this project in Khartoum, with the Federal Health Minister and with WHO-EMRO representative in Khartoum. The project was again received with enthusiasm and promise of cooperation.
Upon his return to Jordan, Dr. Jaljuli wasted no time in requesting an experienced professional architectural firm to prepare the drawings for the hospital .

Taking in consideration that such eye care facilities will be needed in other deprived communities in other countries s, two types of design were made:

First: Design of simple, small, local, economic eye hospitals for deprived remote areas.
The simple design included one operating theater that accommodates more than one operating table, laboratory, separate five- bed post- operative rooms; one for males and the other for females and one outpatient clinic, in addition to necessary basics and logistics of administration, laundry, kitchen, electro mechanics and waiting areas. These can be accommodated into 350 sq.m.space

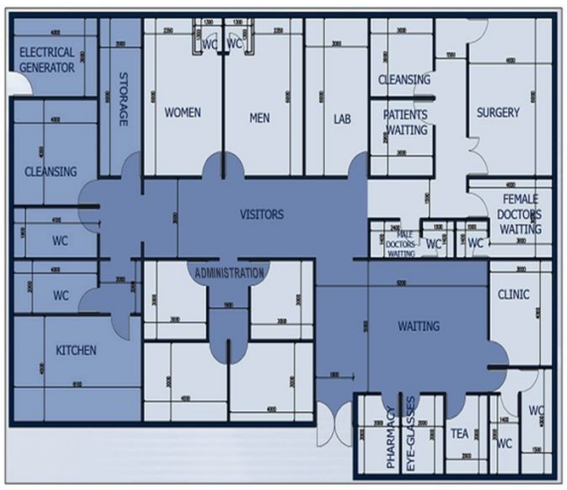

Figure (1): Local Eye Hospital Design

Second: Design of simple, small ophthalmology units in existing local general hospitals in deprived remote areas. This design allows significant savings of space and finances, in view of combined ancillary portions of laundry, kitchen, waiting, electro mechanics…etc. The whole eye section could be established in 200-250 sq.m. area.
In June 2005, in an annual meeting held in Sana'a, Yemen, FIMA Council approved all segments of FIMA Save Vision Project, including establishment of eye hospitals in underprivileged areas.

A collaborative understanding was successfully established between FIMA, IMA-Sudan, the Sudanese health authorities, and WHO-EMRO, to accomplish this first eye-care project in al-Genaina, whereby:

- The Sudanese health authorities was to provide the building, remodel it based on the professional design from Jordan, provide non-medical furniture, and appoint nurses and paramedical personnel.

FIMA was to delegate volunteer eye surgeons and teams from time to time to augment the drive for reduction of this extensive backlog of visually impaired people. FIMA was to provide training of local Sudanese professionals, and to provides ophthalmology equipment; instruments, and consumables including the special eye lenses, as well as medications. Surgical equipments were lifted by FIMA to this hospital in early 2006 at a cost of over USD 100,000.

- WHO-EMRO would support the Sudanese health authorities in providing incentive remuneration, for one year, of one Sudanese eye specialist to be deployed from Khartoum on full-time basis at al-Genaina Hospital.

Al-Genaina eye hospital early phases

WHO-EMRO would also help FIMA in provision of some consumables and medications:

The selected Sudanese eye surgeon was sent to Pakistan for further specialized training in ophthalmology, sponsored by IMA of Pakistan (FIMA member).

The hospital was officially opened on February 27, 2006, and has been fully functional since then, as a symbol of successful and harmonious collaboration, in good faith, between the above bodies.

In 2008, a small building extension was added to the hospital, which now includes:

- The operating section:
  - One room for major operations.
  - One room for minor operations.
  - Sterilization room.
  - Nurses' room.
  - Supplies' room.

- Doctor's office.
- In-patient six-beds male room, another six-beds female room, one isolation room, and nurses' room.
- The new extension includes:
  - Two examination rooms.
  - One vision examination room.
  - Medical records room.

This hospital was well equipped with various instruments and consumables to function as an independent eye care facility.

In the latest operational report, the following achievements were accomplished by the FIMA Eye Hospital at al-Genaina:

- Cataract surgeries from 2006-2009: 4000
- Cataract surgeries in 2010: 420
- Cataract surgeries in the first 6 months of 2011: 620

- Several eye camps have been conducted in the hospital, and 800 surgeries performed
- Total Surgeries: 5,840
- Number of out-patients treated in hospital clinics: approximately50,000

Patients seeking eye care in the hospital come from West Darfur and from regions extending all the way to tribes of the neighboring Republic of Chad.

Inauguration of al Genaina Eye Hospital, Feb 2006
Federal Health Minister-Sudan with Profs. Mamoun Homaida, Adnan Jaljuli and Hafeez Ur Rahman

FIMA Eye Center in Kuwait Hospital-Peshawar- Pakistan:

This general hospital was established by the Red Crescent Society of Kuwait, more than thirty years ago, for medical care of Afghan refugees, on free or minimal charge basis. Subsequently, Peshawar Medical College (PMC) opened the hospital for the general public.

In January 2008, FIMA developed the eye department at this hospital, provided eye surgery consumables and IOLs, and started free cataract surgeries for needy Afghan refugees and local population. To date, more than 1000 cataract surgeries have been performed. The hospital is currently one of the training hospitals of PMC.

Eye Hospital at al-Qadarif- Sudan:

Al-Gadarif is a far eastern Sudanese province. Needs assessment conducted by the IMA of Sudan and Sudanese health authorities revealed tremendous need for an eye hospital, similar in magnitude to that of West Darfur.

Preliminary preparations, including architectural drawings were prepared. The project is waiting collaborative efforts to be executed.

Eye Health Care in Putlam, Sri Lanka:

Prof. Hafeez Ur Rahman, coordinator of FIMA Save Vision Program, was invited to visit Sri Lanka in 2008, by the Sarandeeb Foundation. Putlam is a city with 50,000 people, with nearby refugee camps, at that time, of about 100,000 people, mostly Muslims.

Sarandeeb Foundation runs a small hospital of 50 beds, established by Zakat House in Kuwait in a suburb of Putlam.

In April 2008, FIMA conducted an eye camp in this Kuwait Hospital and performed 750 eye surgeries. FIMA offered to establish an eye department in the hospital. An agreement was established, and the department became well-equipped and functional in May 2008. An eye surgeon from Colombo, the capital city, started visiting the hospital once a week to perform eye surgeries.
Other NGOs conducted free eye camps in the new eye department. As of July 2011, 7478 cataract surgeries were conducted, in collaboration with other NGOs.

Eye Hospitals in Palestine:

As stated earlier, WHO-EMRO statistics classified Palestine as one of 7 most needy countries for eye care in the Eastern Mediterranean region, with extensive deficiencies in dealing with visual impairments.

FIMA conducted surveillance activities in various regions of the West Bank and Gaza territories of Palestine, to assess the situation of eye care facilities, in cooperation with other local and regional nongovernmental organizations (NGO)s.

Based on these assessments, and in view of major barriers imposed by Israeli occupation and siege that prevented deployment of eye camps inside Palestine, FIMA formulated plans to improve training of Palestinian ophthalmologists, provide eye equipment and consumables, and to establish eye hospitals or eye sections in existing general hospitals.

This is a concise outcome conducted thus far:
Almost all FIMA relief activities within the Save Vision Program in Palestine have been conducted through the FIMA member organization in Jordan, The Jordan Society for Islamic Medial Sciences. Significant contributions were made by IMA-Egypt and the collaborating Arab Medical Union (AMU) of Egypt.

- Zakat Hospital in Toulkarm in the West Bank:

Toulkarm is a province in Northern West Bank of Palestine with a population of around 170,000 as of 2004[3] with no eye hospitals.
FIMA collaborated to establish an eye section and to provide eye equipments and instruments at a cost of approximately 120 thousands USD, which were all delivered.
FIMA sponsored training of an ophthalmic surgeon in Pakistan, and training of an operating room nurse in Jordan.

- Zakat Hospital in Jenin in the West Bank:

Jenin is a province in Northern West Bank with a population of approximately 300,000 as of 2004[3]. It has no eye hospitals.
In cooperation with Zakat Committee in Jenin, an eye unit was established in the existing general hospital, and FIMA assisted in channeling 300,000 USD donated by the charitable Arab Fund in Kuwait. FIMA sponsored training of a Palestinian physician from Jenin in Jordan.

- Gaza Strip:

There were approximately1.4 million Gazans, as of 2004[3]. The eye care facilities are extremely poor. There is a very limited number of qualified eye surgeons.
FIMA sponsored, or assisted, in the following eye care facilities in the Gaza strip.

- FIMA provided ophthalmological equipment and surgical instruments to al-Nasr Hospital, a part of al-Shifa complex in Gaza, at a cost of USD 90,000.
- Eye section at the general hospital established by the Society of Community Service: FIMA donated surgical equipment and instruments at a cost of USD 150,000.
- The same society subsequently established a separate Eye hospital in a rented building in May 2009. FIMA donated equipment for an operating room with a recovery room at a cost of USD 120,000.

During the period from May 2009 to December 2010, this hospital conducted various eye surgeries that exceeded 28,000 at minimal or no charge.

FIMA, represented by the IMA-Jordan, have cooperated with The Jordan Committee to Support the Health Sector in Gaza, and OIC (Organization of Islamic Conference) by sending a senior eye surgeon who conducted posterior chamber eye surgeries in early 2011.

- Early this year, the same society obtained a piece of land to construct a teaching and training eye hospital composed of 6 flights with:

- 5 outpatient clinics with specialty equipped eye examination rooms.
- 2 main operating rooms, one minor surgery operating room and one Lasik room.

- Eye bank.
- One floor for male wards and another for female and pediatric wards.
- Library and lecture theater.
- Administration department.

FIMA has provided the architectural plans and drawings donated by a prominent center in Jordan. FIMA will extend help by providing equipment and training curriculum. FIMA sponsored training of one ophthalmologist and one nurse from Gaza, both have since returned to Gaza to establish the first eye bank.
Another physician from Gaza was sponsored for ophthalmology residency training in Jordan.

Challenges and Hopes:

Words cannot describe the extreme feelings of happiness and gratitude on the faces of individuals who regained their eye sight after years of blindness or severely impaired vision, with similar feelings of satisfaction and sense of humanitarian accomplishment by the treating volunteering eye doctors. These sincere feelings should not conceal the many pitfalls and challenges that accompanied these successful achievements.

Lessons learned over the past few years point to the following salient challenges:

- Establishment and equipping eye hospitals in remote, deprived areas of developing countries with poor resources, is a very costly endeavor. Building of sound collaborations with concerned governments, with local, regional and international organizations is an essential element in initiating and continuing this humanitarian effort.

FIMA was only partially successful in this direction. A comprehensive and active outreach program should be pursued to reach international, as well as local concerned supporters.

- Volunteering eye surgeons' participation in FIMA eye camps and FIMA sponsored eye hospitals for treatment and training, is not enough! These activities should receive more dedication and continuity. Experienced ophthalmology practitioners, educators and researchers, need financial sponsorship to spend longer periods, including providing sabbaticals for university professors.
- Training of local eye doctors, nurses, technicians and other paramedical personnel should receive attention in the same countries where the services are conducted. Trainers as well as training facilities are instrumental in maintaining, widening and improving eye care by experienced local talents.
- Equipment and instruments supplied to local eye hospitals need proper maintenance and updating. FIMA teams frequently encountered major deficiencies in this regard.
- Follow-up of patients who receive surgical care need to be conducted so as to assess outcomes.
- Finally, research of causes of local or endemic eye health problems, efficacy of therapeutic modalities and other related issues deserve proper attention and planning.

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FIMA GIVES VISION TO POOR SRI LANKANS

*M. L. M. Rayes**

Abstract:

Sri Lanka, a developing nation in South Asia, has significant prevalence of visual impairments, deficiency of eye care facilities and qualified eye surgeons, especially outside major cities. The situation worsened over the past three decades of internal conflict between Tamil rebels and the government. To a large population segment, the governmental eye care services are not available, and the private sector services are not affordable. Charitable and humanitarian non-governmental organizations came forward to ease the burdens of visual impairments.
This article presents the role of the Federation of Islamic Medical Associations (FIMA), and other relief NGOs, in alleviating visual impairments, with reference to the central role of the Kuwait Hospital Foundation in Sri Lanka.

Key words: Visual impairment, Cataract, Sri Lanka.

Introduction:

Impaired vision and blindness are one of the major public health problems facing many developing countries. Although the diseases that affect the eyes are generally common and widespread in all nations, it is the developing countries and poor nations, where, due to poor resources and inadequate infrastructures in delivering health care services, the disease burden remains very heavy.
In 2010, World Health Organization (WHO) released new global estimates of visual impairment using the most up-to-date studies. WHO estimates that the number of people with visual impairment (presenting vision) is 285 million (65% of whom are aged over 50 years). Of these, 246 million have low vision (63% over 50) and 39 million are estimated to be blind (82% over 50)[1,2].
These estimates were based on 50 national and sub-national studies from 38 countries, published and unpublished, conducted since 2004, and on previous studies that were still representative. The majority of the 50 surveys were rapid assessments for the population 50 years and older.
Regional estimates were calculated with a model taking into account, among other factors, the country's economic development status, after having verified the fit between data on visual impairment and development indicators.

The distribution of blind and visually impaired persons of all ages in the six WHO Regions is shown in Table I.

The top three causes of visual impairment (VI) are uncorrected refractive errors, cataract and glaucoma. The top three causes of blindness in the 2010 estimate are cataract, glaucoma and age-related macular degeneration[1].

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The distribution of VI by age group is 7% in the 0-14 years age group, 28% in the 15-49 years age group, and 65% in the 50 years and older age group.

Sri Lanka, being a developing South East Asian nation, has its own share of this disease burden. While the public sector eye care services are extremely limited and far from meeting the demands of the public, the cost of care in the private sector is prohibitive to many affected patients. It is indeed the humanitarian sector that frequently comes forward to help poor patients and ease the disease burden of the society in Sri Lanka and other developing countries.

Status of Eye Health Care in Sri Lanka:

Sri Lanka is a beautiful small island at the southern tip of South Asia. It has a population of 19.2 million. (50.2% female and 49.8% male). It has a higher literacy rate and life expectancy rate when compared to other neighbouring South Asian countries. Life expectancy at birth is 71 years for male and 74 years for females[3].
The Kandy Eye Study, is a population based survey conducted in the Kandy district of Sri Lanka's central province[4]. In this study of 1721 eligible subjects, 1375 participated (79.9%). Their average age was 57 years. All subjects underwent evaluation at presentation with best corrected log MAR visual acuity, and slit lamp examination. Primary outcome measures were visual impairment (corrected visual acuity less than 6/18 in the better eye) and blindness (corrected visual acuity less than 3/60 in the better eye), based on WHO criteria. The rates of blindness, visual impairment and low vision were 1.1%, 5.9% and 4.8% respectively.

The study revealed that the prevalence of blindness is considerably greater than previously believed. It also showed that cataract and age related macular degeneration are the leading causes of visual impairment
Cataract caused 79% of visual impairment, and age related macular degeneration caused 15%[4].
Total number of blind population in Sri Lanka is 81,000. Maturity onset cataract accounts for 66% of the blind population. Number of people blind due to cataract is 54,000. (Impaired vision not included in this calculation).Total of cataract blind eyes with visual acuity (VA) below 3/60 is 125,800. If criteria for selection for cataract surgery is brought up to 6/60, the number of eyes needing surgery would be 125,800*2.5= 314,500[3].

Human Resources and Infrastructure in Delivering Eye Care in Sri Lanka:

Inspite of higher health indices and literacy rates, skilled human resources to deliver eye care services do not exist in many parts of the peripheries of Sri Lanka. Furthermore, lack of infrastructure development and the destruction of already existing poor infrastructure due to three decades of war between Tamil Tigers and the government of Sri Lanka destroyed whatever was available.
This left a large segment of the Sri Lankans totally isolated from centers in big cities where eye services were available either at the private sector at a very high cost or in the government sector where the long waiting list is too long and many will not survive to reach the top of the list.
It has been identified by the Sri Lanka Eye Foundation that the lack of accessibility and affordability to eye care services are the main causes of preventable blindness in Sri Lanka.

Humanitarian Sector:

While the private sector eye care was unthinkable to most Sri Lankans and the public

sector was struggling at the breaking point to cope with the demand of the public, there was one sector that came forward to ease the burden of blindness in the society through charitable means.

This humanitarian sector linked all generous hearts to provide sight in the eyes of poor blinds and came forward to help through Kuwait Hospital Foundation, a Not –for- profit entity that runs 50 beds hospital in a remote area of North central province of Sri Lanka, Puttalam.

The Kuwait Hospital Foundation, while providing general medical care to poor Sri Lankans, became more focused on eye care, and until August,2011, has so far completed 5718 cataract surgeries to all segments of poor Sri Lankans irrespective of their ethnicity, language, religion or culture.

The other services at the Kuwait Hospital include; emergency relief in national calamities, affordable healthcare services, mobile medical services, OPD Services, In-ward treatment-medical and surgical, surgical theatre facilities, labor wards and maternity care, home nursing, well baby clinics, well mother clinics, blood donation campaigns, health check- up education and training, nurses training program locally and abroad and conducting health awareness programs in rural areas.

The Kuwait Hospital Foundation's services are accessed by those who "have" by providing affordable private medical care and those who "have not" are looked after by the Corporate Social Responsibility (CSR) system using Zakat/ Sadaqa.
Further, the Kuwait Hospital collaborates and works with the government and many national and international non-governmental organizations (NGOs), charity organizations, and philanthropists.
Table II shows NGOs that collaborate with the Kuwait Hospital in various relief projects.

Cataract Projects:

Since the inception of this hospital many free charitable projects including, cataract projects were conducted in collaborations with local and international NGOs.
More than 5000 patients have undergone cataract surgery free of charge at Kuwait Hospital.
Table III shows implemented cataract projects and collaborating NGOs[5].

Involvement of FIMA:

FIMA has come forward and spread its wings in service to reach as far as the north central province of Sri Lanka where it has a permanent FIMA Vision Care Centre that provides human services to desperate poor Sri Lankans to restore their most invaluable gift of Allah, the eyesight.
In August 2007, Professor Hafeez Ur Rahman, Director of FIMA Save Vision Project, visited Sri Lanka to initiate collaboration for combating visual impairment, with concerned Sri Lankan organizations.

A fruitful meeting was held with the administration of Kuwait Hospital, in which FIMA agreed to provide ophthalmology technical support and establishment of **FIMA Eye Care Center** at the hospital, which was later implemented in May 2008, and became the hub of eye surgeries and care for other relief NGOs.

The first FIMA eye camp was conducted at the Kuwait Hospital in April 2008. Over 750 eye surgeries, mainly for cataract, were conducted by volunteer FIMA ophthalmic teams.

In this visit, Prof. Hafeez Ur Rahman achieved another breakthrough by a collaboration understanding, with the Sri Lanka Eye Donation Society, to provide FIMA with corneas for transplantation, in FIMA various ophthalmology projects, and other relief activities, especially in Africa.

First FIMA eye camp- Sri Lanka, April 2008

Cataract post-op follow ups
Sri Lanka Kuwait Hospital-FIMA collaboration

Two Sinhalese patients coming out of vision test at the FIMA Eye Care Center.

Some of Eye equipments supplied by FIMA to Kuwait Hospital, Puttalam

Indeed since the establishment of this eye care center, a generous relief gesture by FIMA, a large number of patients from all ethnic backgrounds have benefited.

Many local ophthalmologists were hired by the charitable organizations to provide services to poor blinds who live in remote peripheries of Sri Lanka.

FIMA's contribution in establishing this invaluable center has indeed been praised by thousands who were benefited and got their vision back, who otherwise would have died without having any opportunity to once again see this wonderful world that Almighty Allah created with beauty, and would have continued to live as outcasts and a burden for themselves, their families, the society and the country.

May Allah bless in abundance in both worlds all those who contributed towards this worthy project.

Table I:
Distribution of blind and visually impaired of all ages in the six WHO Regions.

WHO Regions	Visual impairment (millions)	Blind (millions)
African Region (AFR)	26.3	5.9
Americans Region (AMR)	26.6	3.2
East Mediterranean Region (EMR)	23.5	4.9
European Region (EUR)	28.2	2
South East Asia Region (SEAR)	90.5	12
Western Pacific Region (WPR)	90.2	10.6

Table II:
Partner organizations that work with the Kuwait Hospital:

- Sri Lanka Jama'at-e-Islami
- Zakat House Kuwait
- Red Crescent Kuwait
- Serendib Foundation for Relief and Development
- Al- Basar International, Saudi Arabia
- Federation of Islamic Medical Associations (FIMA) and Pakistan Islamic Medical Association (PIMA).
- Association of Muslim Youth of Sailan (or Ceylon)
- Base Hospital Puttalam
- Women Organization for Development Equality, Peace and Temperance
- Islamic Relief Committee
- Humanitarian Social Service Foundation
- Consortium of Humanitarian Agencies
- Help Age Sri Lanka
- Muslim Hands
- Muslim Aid - UK

Table III:
Various health and welfare projects and NGOs involvements in collaboration with Kuwait Hospital[5].

No	Type of Service	Sponsor	No. of Beneficiaries
01	Blindness control program-1 (cataract surgery)	1.Kuwait Red Crescent 2.Al Basar Foundation-KSA	899
02	Blindness control program-2 (cataract surgery	1.Kuwait Red Crescent 2.Al Basar Foundation-KSA	1,095
03	Blindness control program-3 (cataract surgery)	1.Zakat House Kuwait 2.Al Basar Foundation-KSA 4.Serendib Foundation for Relief and Development	1,057

No	Type of Service	Sponsor	No. of Beneficiaries
04	Blindness control program-4 (cataract surgery)	1.Sharjah Charity International 2.International Islamic Relief Organization –KSA 3.Federation of Islamic Medical Associations (FIMA) and Pakistan Islamic Medical Association (PIMA) 4.Serendib Foundation for Relief and Development	769
05	Blindness control program-5 (Refraction)	1.Serendib Foundation for Relief and Development	233
06	Blindness control program-6 (cataract surgery)	1.World Call Islamic Society – Libya	25
07	Blindness control program-7 (cataract surgery)	1. Al Basar Foundation-KSA	983
08	Blindness control program-8 (cataract surgery)	1.Muslim Aid	66
09	Mobile Medical Clinics - 1	1.Consortium of Humanitarian Agencies (INGO)	10,003
10	Mobile Medical Clinics - 2	1. Kuwait Hospital	2,094
11	Mobile Medical Clinics - 3	1.World Islamic Call Society – Libya	1122
12	Diabetic Control Clinic	1.Consortium of Humanitarian Agencies (INGO)	1,046
13	Dental Clinic for Students-1	1. Kuwait Hospital	217
14	Dental Clinic for Students-2	1.Islamic Relief Committee	128
15	Dental Clinic for Students-3	1.World Islamic Call Society - Libya	1612
16	Well Mother Clinic - 1	1.Islamic Relief Committee	13
17	Well Mother Clinic - 2	1. Kuwait Hospital	57
18	Well Baby Clinic	1.Kuwait Hospital 2.Women Organization for Development	342
19	Blood Donation to National Blood Bank	1. Kuwait Hospital	212 Donors
20	Nurses Training-1 (Abroad)	1.Islamic Circle of North America 2.Human Care Foundation	11
21	Nurses Training-2 (Abroad)	1.Sharjah Charity International 2.Serendib Foundation for Relief and Development	06
22	Nurses Training-3 (Local)	1. Kuwait Hospital	16

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COLLABORATIVE MODEL FOR EYE CARE:
FIMA Project in al-Genaina, Darfur West, Sudan

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Abstract

The Federation of Islamic Medical Associations (FIMA) launched its Save Vision project in Darfur, Sudan in January 2005. First, Fima organized eye camps in remote and deprived areas and provided free eye care services to the community including thousands of surgeries leading to restoration of vision of blind people. Later, in 2006 FIMA established an eye hospital in al-Genaina, Darfur, West Sudan, which till that time was totally deprived of any eye care facility and thousands of treatable blind patients were desperately waiting for any care provider.

This hospital is a viable example of collaboration of different governmental and non-governmental, national and international organizations. Ministry of Health (MOH), Sudan, World Health Organization-Eastern Mediterranean Region (WHO-EMRO), Sudanese Islamic Medical Association (SIMA) and FIMA joined hands and established an eye care facility for the first time in this heavily populated area. This article deals with the significant performance of this hospital in the last five years. It addresses how a well directed joint effort can change status of an area from totally deprived of a facility to an area matching with other developed parts of the country in this respect in a short span of five years.

Key words: Cataract, treatable blindness, Public health.

Introduction:

The Federation of Islamic Medical Associations (FIMA), as the name indicates, is a federation of more than 40 Islamic medical associations across the globe. FIMA Save Vision is an ongoing project of FIMA. Its activities started in January 2005 with an Eye camp at al-Fashir in Darfur, Sudan, and spread throughout disadvantaged countries and communities of Africa, South Asia and South East Asia. The American College of Physicians (ACP) has recognized the originality of the services approach and the humanitarian and economic effectiveness of the FIMA Save Vision initiative by awarding it with the ACP Hilda and Rosenthal Award 2009.[1]

By the end of 2010, FIMA activities have extended to 13 countries. Until then, 649 visits of eye surgeons from around the world, had organized 376 eye camps in these countries. At these camps they examined around 675,000 patients, and performed more than 67,000 eye surgeries with the common focus on cataract surgeries.[2]

The initiative has significantly contributed to upgrading of Cataract Surgical Rate (CSR), that is the number of surgeries/million population/year, in these countries through sustained camp activities and subsequent establishment of eye hospitals in a few of them.

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To date, three eye hospitals have been established, one each in Africa, South Asia and South East Asia.
This paper focuses on the Sudanese experience at al-Genaina, Darfur, West, Sudan as a case example for the model and its unique approach.

West Darfur is one of the three parts of Darfur province of Sudan. al-Genaina is the capital and major city. The western porous borders of this province is with the Republic of Chad. This area has been under social conflict for centuries, and has been in a state of civil war since 2004. This situation deprived the area from all sorts of developmental activities. Health is the most neglected area, and eye care facilities were totally non-existent till the year 2006.
All types of chronic eye diseases were prevalent, among which cataract was dominating. Huge backlog of bilateral blinds due to cataract were waiting in this area.
Sudan as a whole is deficient in eye surgeons but this area was totally deprived of any eye surgeon.
The population of Sudan according to population statistics of 2003 is approximately 37 million, with an annual growth rate of 2.6%.[3]
Darfur West has a population of around two million. Out of these 30,000 are estimated to be blind, with an estimated minimum of 18,000 cases of cataract.
Cataract, as a leading cause of blindness around the globe, holds true for Sudan as well. It is estimated that cataract represents 60% out of all cases of blindness there. Irrespective of its type, cataract is present in all regions of Sudan. The Backlog of cataract cases in the country is estimated to be around 350,000.[4]

Cataract surgical rate (CSR) in Sudan was 830 in 2004.[4] Sudan aims to achieve a CSR of 2500 by the year 2010.[4] The target, though not that high, might be quite difficult to achieve given the problems and constraints the Sudanese Eye Care System is having. The core problems and constraints of the Sudanese eye care system may be summarized as follows:

- Weak infrastructure, particularly in the area of eye care.
- Few qualified and skilled human resources (HR) for eye care.
- Mal-distribution of the available HR.

Sudan, in 2003, had only 160 ophthalmologists - of whom 110 were deployed in the capital territory Khartoum- and only 50 were scarcely dispersed in the remaining parts of Sudan. The West Darfur province was conspicuous by the absence of a single ophthalmologist even as late as 2005.[3]
In this backdrop, the Save Vision activities of FIMA were started in Sudan in the early months of 2005.

Aim:

- To develop a sustainable support system for prevention of blindness, focusing on cataract-related blindness, in this resources-constrained Sudanese province.

Strategic Objectives:

- Improving the CSR, and thus reduce the cataract backlog in the country
- Creating and/or strengthening the eye care infrastructure in the country
- Capacity building of the eye care HR in the country

Methodology:

The action model for the achievement of these strategic objectives initially started as a collaborative activity in the form of private to private partnership at the international level, i.e., social worker individuals/organizations/welfare groups in the host country (Sudan) on one hand, and FIMA on the other hand.
Neglected and marginalized locations of the country were preferred over central locations for the intervention, in deliberate attempt at balancing the existing care bias towards major cities where the country's Eye Care HR is largely concentrated.

Genaina, in the province of Darfur West, was among one of the areas selected for the intervention. It is not only a marginalized and hard to reach area of Sudan, but in fact it is the hardest to reach due to the fact of being a conflict zone. It has a population of around 2.0 millions. Of this, total blind population is estimated to be 30,000, with 18,000 cases of cataract.

Volunteer ophthalmologists and paramedics from different countries were mobilized by FIMA for regular screening camps and cataract surgeries in the area, starting from January 2005 till present, Data was shared with the country's MOH.

The camp activity was availed for side by side capacity building activities of various cadre local Eye Care HR; and establishing credibility based partnerships with MOH and WHO for sustaining the activity. Al-Genaina FIMA Eye Hospital is a practical example of the partnership that was established in 2006.

Results and Discussion:

1. *Camp Activities*

During the period of five years, six screening and cataract surgery camps have been held in al-Genaina, Darfur West, with the voluntary support of 33 eye surgeons from five countries, contributing a total of 226 days and 2260 man-hours. During this period, 32,200 patients were screened and 3,163 cataract surgeries were performed. (Table 1).

The camp cost under the FIMA Save Vision initiative was found to be very economical, i.e. 50 USD/patient for cataract surgery, inclusive of medicines/supplies and travel costs of the surgeons and teams from abroad.

2. *FIMA Eye Hospital, al-Genaina: A Case example of Multi-partnership*

As indicated already, FIMA al-Genaina Hospital was established in early 2006 as a calculated move to strengthen and sustain the prevention of blindness activities that were started in the area through eye camps. The hospital is a good model of transition from private- private partnership to private - public partnership at national and international levels, involving local private social structures, national public health agency (MOH Sudan), international private (FIMA) and public organizations (WHO).

MOH and WHO exhibited interest to enter into this partnership due to the credibility that was demonstrated by FIMA volunteers through continuously undertaking the massive activity in a quality manner with holistic approach towards long term sustainability of the initiative through training of local health professionals and establishment of eye care center in the host country.

The local Sudanese health authorities provided the hospital physical structure, which was remodeled according to a professional building plan. Non-medical furniture and HR, including nurses and other paramedical personnel, were provided by MOH.

FIMA provided volunteering ophthalmologists, eye equipments, consumables and medical supplies, as well as staff development and training activities.

Eye camp, February 2005, prior to Inauguration of Eye Hospital at al Genaina

OR in action, Eye Camp at al Genaina Eye Hospital, January 2007

FIMA trained a Sudanese newly graduated ophthalmologist delegated by MOH in two separate training events on Oculoplasty and Keratoplasty at Khartoum-Sudan, while imparted a comprehensive three weeks training in Pakistan.

Paramedics were given on-job training by the visiting eye surgeons. WHO contributed salaries of the Sudanese full-time ophthalmologist for the first year, and also contributed some consumables. During the period of five years (2006 to 2011) the Hospital has extended care to 50,000 people, on out-patient basis, and performed cataract surgeries on 5,040 patients, some of them came all the way from neighboring Chad (Table 2).

3. *Impact on CSR*

Al-Genaina-Darfur West had virtually zero CSR prior to the launch of FIMA initiative in 2005, while that of Sudan on the whole was 714 as of 2004. [3]

Darfur West with zero CSR in 2005, has been able to achieve a mean CSR (2006 – June 2011) of 820 per million/year.

This was the output with a single ophthalmologist stationed there. Recently another ophthalmologist has joined the hospital which is expected to increase CSR to more than 1500/million/year. (Tables 3 and 4).[4]

Dr. Siddiq, the first Sudanese ophthalmologist at al-Genaina Hospital with Dr. Mubin Abu Ilbi from Jordan-volunteer ophthalmologist

Prof. Hafeez Ur Rahman, Dr. Intzar Butt with other professionals from Pakistan and Sudan.
Al-Genaina Eye Hospital, 2006

Conclusions

The experience narrated above is a good case example of incremental move forward in public health, particularly community eye health, in face of stringent resources and local calamities. It was a silent humble start that culminated in creating tremendous impact over time.

The targets were improving equity, access and coverage. The approach was to mobilize and coordinate the voluntary resources. Planning and implementation was based on a vision for creating local ownership and sustainability.
Partnerships base broadened as a natural outcome of credibility that was demonstrated than claimed.

Table 1: Camp activities in al-Genaina (Darfur West)

Date of the Camp	No. of Participating Eye Surgeons	Duration in days (10 working hours/day)	Outpatient cases	Cataract Surgeries
March 2005	8	6	8000	1011
August 2005	9	6	4000	352
January 2007	5	6	5100	500
May 2008	4	6	5000	500
March 2010	3	5	5000	375
Oct 2010	4	5	5100	425
Total	***33***	***226 days; 10 hours/day=2260 man hours***	***32200***	***3163***

Source: FIMA Camp Records

Table 2: Performance of FIMA al-Genaina Hospital (Darfur West)

Period	Outpatient Cases	Cataract Surgeries
2006	7000	900
2007	11000	1050
2008	13000	1200
2009	10200	850
2010	4700	420
2011	4100	620
Total	***50,000***	***5040***

Source: FIMA al-Genina Hospital Records

Table 3: Cataract Surgery Rate (CSR)* of Sudan (Overall)

Year	CSR of Sudan (Overall)
2003	650
2004	830
2005	1200
2006	1570
2007	1710

*Number of cataract surgeries per 1 million population per year

- Source: Sudanese National Coordinator's Report at WHO EMRO Conference on Prevention of Blindness, Cairo, Egypt 2008

Table 4: CSR of Darfur West, Sudan

Year	CSR of Darfur West
2003	0
2004	0
2005	0
2006	Average of 5 years (camp + hospital surgeries) = 820 surgeries per 1 million population per year
2007	
2008	
2009	
2010	
2011	

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FIMA SAVE VISION IN NIGERIA
An Insider's Account and Views

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Abstract:

Nigeria is an example of a populous African nation, with prevalent and escalating visual impairments, and significantly inadequate health professionals in eye care, which is more manifest in rural areas. Avoidable blindness has been alarmingly on the increase.
Concerned Nigerian individuals and groups, realizing the achievements of the Save Vision Program adopted by the Federation of Islamic Medical Associations (FIMA), were successful in establishing a collaborative, harmonious working relationship, whereby the concerned Nigerian groups insure the needed local surveys, logistics in reception and hosting of medical teams from FIMA, bringing with them volunteering experts in ophthalmology, medications, consumables and instruments to conduct mass, free eye camps in needy regions of Nigeria.
This paper presents this successful collaboration with significant fruitful outcomes on the long road to turn the tide in combating visual impairments in Nigeria.

Keywords: Visual impairments, cataract, Nigeria, FIMA Save Vision.

Introduction:

Nigeria is the most populous country in Africa with an estimate of 150 million (2008)[1] and a gross domestic product (GDP) of $342 b, and per capita of $2,249 (2009). Nigeria is the 6th largest producer of oil and a largely agrarian rural population. However, despite its vast natural and human resources, the health index of the country is among the worst in the world. The UN Human Development Index (HDI) has placed Nigeria on the 145th of 172 nations of the world[2].
Nigeria is generally faced with the problem of inadequate health care delivery. Available statistics on ophthalmic care have indicated that in people over 40 years of age cataract accounts for about 43% of around one million cases of blindness[3]. This means that over 400,000 people could regain their sight through good eye care management. There are about 230 ophthalmic doctors and 1200 ophthalmic nurses and paramedics in Nigeria[4], which is grossly inadequate to provide basic eye care support services, moreover, they are less available in rural areas where a higher number of patients need eye health services[3]. Even if the services are available, most people cannot afford the charges[5]. As a result, the figure of avoidable blindness through cataract is on the increase at an alarming proportion with an expected 0.6 million cataract patients in 2020[3].

With this prevalence rate, the available eye care facilities and eye care professionals, the chances of helping people with cataract and enlightening those within the risk group are very low.

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Some Nigerians concerned with the gloomy situation, made contacts and initiated collaboration with FIMA to intervene in Nigeria. In the execution of its mandate and attainment of its core objectives, FIMA commenced its activities in Nigeria in 2007 in collaboration with some concerned groups.

As of February 2011, FIMA had conducted and/or facilitated the conduct of over 18 Free Eye Camps in which over 12,000 cataract surgeries and related ophthalmic services were offered. The immediate impact of these activities was not only the regaining of sight by over 8,542 patients, but also an improved quality of life for them and their families[6].

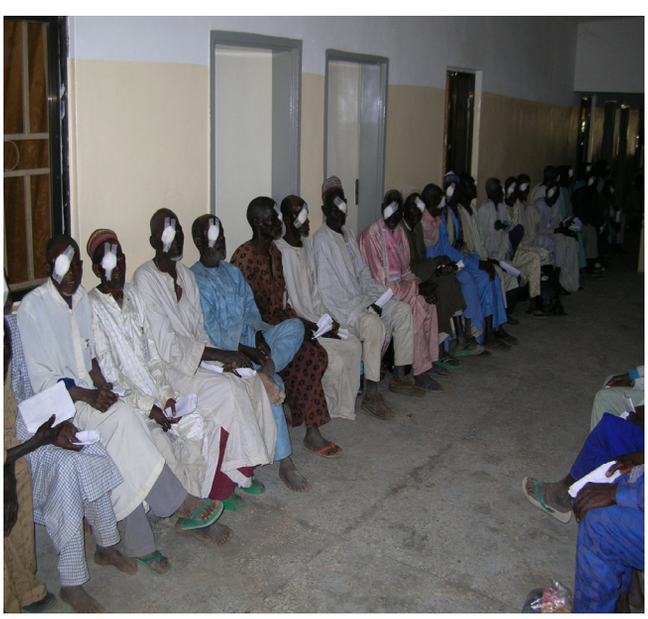
Almost all of the participating surgeons where volunteers sent by FIMA from different countries with the main contribution from Pakistan and Jordan (In few camps some doctors were also sent by other organizations such as The International Islamic Relief Organization and Arab Medical Union).

In addition, FIMA, in collaboration with its partners in Nigeria, had facilitated the provision of state of the art ophthalmic equipment, facilitated training and imparting skills to Nigerian ophthalmic surgeons and nurses as well as providing drugs, medicaments and eye glasses.

Outline of FIMA Activities in Nigeria (2007 to 2011):

FIMA started the first eye camp in 2007 at Katsina, sponsored by Ecological Consultants (8th to 12th June 2007). Total of 468 cataract surgeries were successfully conducted. Five surgeons and one technician from Pakistan and one surgeon from Saudi Arabia participated and were supported by two local surgeons and 18 nurses and paramedics.

Second camp in 2008 was in 2 centres: at Epe in Lagos state south west of Nigeria and in Katsina, Katsina state in northern Nigeria. The camps were co-sponsored by WAYEF, a non-government organisation, and Ecological Consultants between 18st to 22nd June at Epe and 23rd to 27th June at Katsina respectively. A total of 660 patients (394 male, 266 female) benefited. At this camp 9 doctors and one technician from FIMA (Pakistan, and Jordan), One doctor from Saudi Arabia participated. Over 25 Nigerian doctors also participated.
Additional two camps were done towards the end of 2008 and early 2009 at Hadejia, sponsored by AVM Hamza Abdullahi, and at Maiduguri sponsored by FIMA in collaboration with Borno State Government, between 30th Dec 2008 and 3rd Jan 2009, with the total number of surgeries 1,024.



FIMA Save Vision-Katsina, 2010

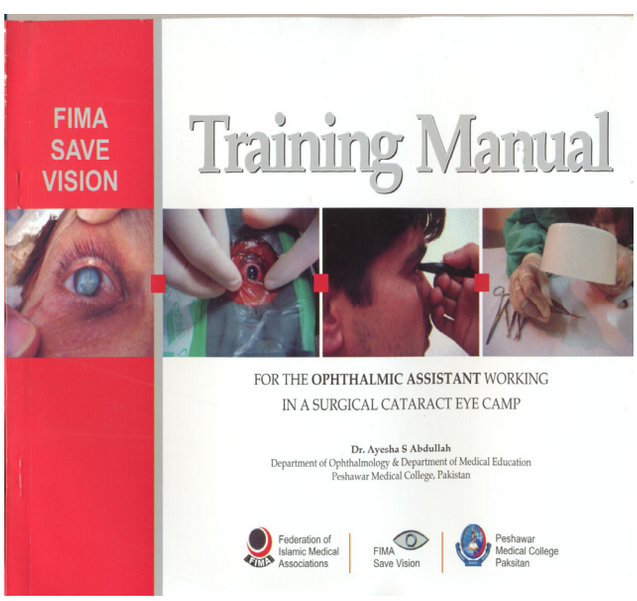
FIMA Eye Camps- Katsina-Nigeria

In most camps, programed training of Nigerian doctors, nurses and paramedics were conducted, in an effort to promote these vital activiites by qualified local professionals.

Prof. Hafeez Ur Rahman Training workshop- Nigerian eye surgeons

In 2009 a total of 7 free eye camps were conducted. Two camps held simultaneously: at Katsina sponsored by Ecological Consultants, and at Gusau sponsored by General Aliyu Gusau from 15th to 20th June. Kazaure camp sponsored by AVM Hamza Abdullahi took place on 20th June to 24th June simultaneously with Maiduguri sponsored by Hon. Mohammed Ali Ndume. The next two camps were also done simultaneously between 24th Dec to 28th at Dutse sponsored by AVM Hamza Abdullahi ,and at Daura sponsored by Maryam Education Trust Fund.

Between 29th Dec 2009 and 2nd Jan 2010 another Free Eye Camp sponsored by i-Care, a non-governmental organisation, was conducted in Kaduna. A total of 3,376 cataract patients benefited during these camps.



In July 2010, four camps were conducted in Nigeria. Two camps held simultaneously from 12th to 16th July 2010 in Niger State; the one at Minna was sponsored by the former military president, General Ibrahim Babangida and the

one in Kontagora was sponsored by Alh Sani Duba. The two other camps were conducted simultaneously from 17th to 21st July 2010. The Katsina camp was sponsored by Ecological Consultants, while that of Maiduguri was sponsored by Hon Ali Ndume. A total of 11 doctors and 2 technicians from FIMA (Pakistan, Jordan and Palestine) and 2 doctors from Saudi Arabia participated (6 Nigerian doctors also participated). In all, 2,461 patients benefited from successful cataract surgeries.

Dr. Intzar Butt: Training workshop-Ophthalmic nurses-Nigeria, 2009

FSV team in Kadona-Nigeria, December 2009 with wife of Kadona governor, director of i-care NGO

In February 2011. two camps were conducted, one in Kaduna between 22nd February and 27th February sponsored by i-Care, and the second in Kano between 28th February and 5th March sponsored by FIMA in collaboration with Aminu Kano Teaching Hospital Kano . Total of 1,079 patients benefited at the two camps.

Later in July, two eye camps were conducted by FSV in Katsina, where 470 patients were operated upon, and in Lafia-Nassarawa State, where 261 patients were operated on. Three ophthalmologists from Pakistan and one from Jordan participated.

Table I shows summary of Free Eye Camps conducted in Nigeria under FIMA (2007 – 2011) with breakdown of beneficiaries and names of sponsors

Organization of the camps:

In all the camps the following were adopted as the general procedure;

1. Pre-camp visit
   A team comprising of doctors from FIMA, FIMA National Patron, FIMA International Coordinator and FIMA National Coordinator, visit the location hosting the camp, to check on available facilities and meet with stakeholders. Advises are given where needed to make the camp a success. This activity usually takes place a month prior to the date of the camp.
2. Screening of patients
   Local staffs arrange to meet the patients in their locality to select those to benefit from the camp. Hand cards are given to the selected patients with the date they will report for surgery. Those that need medications and glasses are also treated during the screening.
3. Admission of patients
   Selected patients report to the hospital were the camp will hold. Here, basic tests of blood sugar, BP and serology were done as the second screening.
4. Surgery
   Patients that meet the requirements and qualify for surgery then go for intraocular lens calculation (Biometry) before being

prepared for surgery. Patients are given local anaesthesia of the eye and sent for surgery which in most cases was extracapsular cataract extraction with intraocular lens implantation (ECCE + IOL). After the surgery, patients were admitted for the night.

5. Post operation
   1st Postoperative Day (POD 1)
   Patients are usually seen after the pad has been removed and the eye cleaned with a sterile swab. The surgeons will examine all patients to ascertain the results of the surgeries.
   Patients are usually discharged home on that day, after they are given instructions on how to take care of their eyes and proper use of medication which is given for free.
   Patients were also informed of follow-up at designated eye clinics within their localities.
6. Follow-ups
   Follow up visits are done at 1 week, 3 weeks and 6 weeks after surgery.
   As most of secondary institutions (general hospitals) where the camps were done are not research oriented, no proper documentation of the results including postoperative complications. Also there are lot of loss to follow up.
7. Success Rate

As mentioned earlier, no data to ascertain this but on the average it can be estimated between 75 and 85 percent success rate.

General Remarks:

The commencement of activities of FIMA in Nigeria has brought a lot of relief to the teaming patients who would have remained blind for uncertain periods. This has in turn improved the socio-economic well-being of many families.

After the initial camp in Nigeria in 2007, many sponsors indicated interest and sponsored camps. However, as FIMA largely rely on arrangements and logistics by sponsors, problems are usually encountered at the commencement of camps, especially in screening of patients and selection of proper surgical candidates.

FIMA has shown consistent interest in the camps in Nigeria and as a mark of its appreciation and recognition; FIMA has awarded Plaques of Honour to four individual sponsors of Eye Camps in Nigeria. FIMA has equally recognized the efforts and commitment of some individuals and has given them honorary appointments such as The National Patron of FIMA activities in Nigeria (Engr Maimaje Ibrahim Abdullahi), The International Coordinator of FIMA Activities in Nigeria (Mr Yusuf Umar Chedi) and National Coordinator of FIMA Activities in Nigeria (Dr Imam Wada Bello). Also through FIMA, some of the sponsors have purchased the following equipments for the success of the eye camps in Nigeria.

1. Ten operating microscopes.
2. Two keratometers.
3. Two A-Scan ultrasound devices.
4. Slit Lamp.
5. Hot air oven.

Suggested future improvements include proper documentation of follow up visits, change in type of surgeries offered toward sutureless techniques (small incision cataract surgery or phaco emulsification) which increase intra-operative safety and decrease post-operative suture related complications and need for glasses[7]. And finally, more concentration is needed on capacity building through increased training of Nigerian ophthalmic practitioners which will make the country self-dependant in managing cataract patients.

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Table I: Summary of FIMA Free Eye Camps in Nigeria (2007-July,2011) with sponsors, locations and numbers of beneficiaries:

SR/NO	Year	Duration	Sponsor	Location	Patients operated
1	2007	8-12, June	Ecological Consultants	Katsina	468
2	2008	18-22 June	Ecological/WAYEF	Lagos (South West Zone)	331
3	2008	23-27,June	Ecological/WAYEF	Katsina (North West Zone)	329
4	2008/2009	30 Dec-3 Jan	FIMA/BORNO STATE	Hadejia	518
5	2008/2009	30 Dec-3 Jan	Ndume	Maiduguri	506
6	2009	15-20 June	Ecological Consultants	Katsina	484
7	2009	15-20 June	General Alyui Gusau	Gusau	515
8	2009	24-28 June	AVM	Kazaure	513
9	2009	24-28 June	Ndume	Maiduguri	526
10	2009	24-28 June	METIF and IIRO	Daura	345
11	2009	24-28 June	AVM	Dutse	467
12	2009/2010	29 Dec-2 June	I-Care	Kaduna	576
13	2010	11-15 July	IBB	Minna	465
14	2010	11-15 July	SDF	Kontagora	370
15	2010	17-21 July	Ecological	Katsina	520
16	2010	17-21 July	Moh Ndume	Maiduguri	530
17	2011	22-27 Feb	I-Care	Kaduna	687
18	2011	28 Feb-5 March	FIMA/AKTH	Kano	392
19	2011	27-31 July	FIMA/Ecological	Katsina	470
20	2011	27-31 July	FIMA Ecological	Lafia	261
					9273

FIMA SAVE DIGNITY PROJECT:
A Passion To Eradicate All Fistulae

*Mohammad Iqbal Khan**

Abstract:

Vesico-vaginal fistula remains a major public health issue in the developing world. More than 2 million women worldwide are living with the problem of fistula, mostly in Africa and Asia, with an addition of 50,000 to 100,000 new cases every year. Over 80% of cases result from neglected obstructed labour, and the condition may follow 1–2 per 1000 deliveries. The Federation of Islamic Medical Associations (FIMA) launched a fistula eradication programme with the name of FIMA Save Dignity Project (FSD), by the decision of the general council and executive council meeting held in Makkah in 2009.
Vasico-vaginal and Recto-vaginal Fistulae eradication move was commenced from the very remote area of Sudan and expanded to other countries. The fistula surgery is an extensive and expensive surgical undertaking and FSD project has taken up this programme with passion of its completion and prevention.

Keywords: Fistula, Vesico-vaginal, Recto vaginal, FIMA, Save Dignity, Obstructed labor, Cesarean section, surgical repair.

Introduction:

The term fistula in medical sciences means an abnormal communication between two epithelial surfaces. The urinary and rectal fistula results from the injury, disease or congenital disorder that connects an abscess, cavity or hollow organ to the body surface or to another hollow organ (between vagina and urinary bladder i.e. Vasico vaginal fistula- VVF, and between rectum and vagina i.e. rectovaginal fistula- RVF)[1].

Vesico-vaginal fistula is a health condition caused by the interplay of numerous physical, social, cultural, and political factors along with economic situation of women and their societies. This interplay determines the status of women, their health, nutrition, fertility, behaviour, and susceptibility to develop a fistula.
Surgical techniques to correct various types of fistulae are usually cumbersome and require extensive skills.[2-5]
The disease is more prevalent in sub-Saharan Africa. Nearly 30, 000 new cases are added up each year in sub-Saharan Africa, including Sudan, Ethiopia, Chad, Ghana, and Nigeria[6-12]. In Sudan there is a central fistula centre in Khartoum where five to six cases are repaired each year adding up in the backlog which can never end up without external help to cope with the existing situations.

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Gravity of the situation:

African countries are awaiting surgery for these complex ailments resulting in severe socio-economical stress to the communities. These communities are unable to cope with the situations because of the lack of facilities, trained doctors in this field, nursing staff, rehabilitation staff and lack of maternity services especially in rural areas. Female genital mutilation is found to be nearly 100% even at present times and this augments the disease burden. Only in these deprived areas of Sudan, it is estimated that 20,000 women are awaiting surgery. Young women of 15 and 30 years, having this health dilemma, as a result of birth trauma mainly in rural populations, suffer for the rest of their lives due to unattended deliveries in the villages and due to adverse local traditions. This injury results in persistence leakage of urine causing severe socio-economical and health issues. They are persistently wet and socially discarded. Ninety nine percent of these women are already divorced. Lack of resources and primary health care in the region do not allow them to get access to the cure of this curable disease. Persistent political turmoil and civil war do not allow international agencies to intervene, and the hope of becoming dry in life has become a dream.

In a relief meeting, this health problem was outlined by several concerned health professionals, and by representatives of the Sudanese Islamic Medical Association (SIMA).

FIMA took the initiative and launched a project with the name of FIMA Save Dignity, aiming to mobilize international assistance to overcome the situation. The first team arrived in Khartoum and Darfur in October 2008. The team, comprising of a surgeon and a leading specialist in this field, submitted its recommendations after studying the disease pattern, burden, existing facilities and future plans. FIMA Save Dignity signed two Memoranda of Understanding (MOUs): with a local Non-Governmental Organization (NGO) named Twasu, and with the Sudanese Islamic Medical Association (SIMA) for the domestic assistance and local arrangements. SIMA, as local partner, shouldered the responsibility for arranging camps and provision of logistics, while Twasu, a local women body, selected, transported patients and provided assistance for rehabilitation of patients after surgeries.

The First FIMA SDP Team with local authorities at al-Fashir- Darfur Airport

Objectives of the Project:

- Surgical cure of the Vesico vaginal and Recto vaginal fistulae
- Rehabilitation of the suffering women
- Taking these women back to their societies and families.
- Developing preventive strategy to reduce the backlog build-up.
- Training the local doctors, nurses and paramedics to develop their capacity to handle the situation on their own (long term)
- Conduct periodic surgical camps with the help of philanthropists and relief bodies to reduce the disease load and ultimately eradication of the disease.
- Conduct training workshops for doctors and nurses as well as social workers aiming to

cure, rehabilitation and prevention of the disease.

Project Implementation:

- FIMA Safe Dignity (FIMA SD) project conducted four camps in Sudan, two by Pakistani specialists, and two in collaboration with the Egyptian Medical Syndicate and Arab Medical Union, carried out 167 operations of Vasico vaginal (VVF) and Recto vaginal fistulae (RVF).

Arab Medical Union doctor at al Genaina- Darfur-Sudan

Extending its services to other countries, FIMA SD project proceeded with more achievements. A four-day VVF camp was conducted by Pakistani doctors in Jalalabad, Afghanistan, 23 successful surgeries of VVF and RVF were performed. Moreover FIMA SD project carried out 29 VVF and RVF surgeries in Rawalpindi, Pakistan. Overall success rate was 89%, even in complex procedures like VVF and RVF when carried out consecutively.

FIMA Surgical team in action (VVF), Darfur-Sudan

The camps were programmed and implemented through a series of systematic measures including: Staff arrangements, Patient selection, forming volunteering professional teams, travelling to the area, conducting surgeries, follow ups and camp completion reports.

Patients and families waiting area. FIMA VVF camp, Darfur-Sudan

Five years old girl with congenital recto and vesico- vaginal fistula

VVF Post Operative follow up

In 2010, at the conclusion of the second camp, FIMA SD project signed a joint MOU with Prof. Abbo's Fistula centre in Khartoum for future cooperation aiming to eradication of VVF from Sudan.

Future Planning:

FIMA SD project is planning to conduct series of camps and training workshops during 2011 and 2012 to achieve the above mentioned objectives. At the same time, FIMA SD Project will submit a comprehensive report to the Governments and international health organizations for combating this problem. The report will elaborate both curative and preventive aspects of the disease with suggestions to take sound measures for elimination of this problem on short term and long term basis.

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FIMA SaveSmile

Parvaiz Malik *

Abstract:

Several African countries, including Sudan, have marked incidence of various types of orofacial birth defects, with significant lack of qualified surgeons and healthcare teams, to minimize the overall management burden. While these congenital anomalies are not life threatening, they have significant implications on nutritional, speech, psychosocial and low self-esteem aspects of human development.

Within relief activities of the Federation of Islamic Medical Associations (FIMA), this correctable problem was discussed. It was decided to pioneer a project of programmed surgical correction by volunteering qualified surgical teams in needy developing countries, especially in Africa, with special attention to train local surgeons in an effort to widen this activity by local hands.

This presentation outlines the initial steps implemented, primarily in Sudan.

Key words: Cleft lip/palate, Orofacial defects, FIMA relief, SaveSmile.

Background:

Cleft lip/palate is one of the world's most common congenital malformations and happens in one out of 500-700 children born across the globe [1,2]. Its onset is very early in pregnancy and is a result of failure of mesenchymal migration to unite one or both of the maxillary prominences with the medial nasal prominences, resulting in a unilateral or bilateral cleft of the lip, respectively[2,3]. It occurs more commonly in males and is caused by genetic and environmental factors[2-4]. It can be associated with other anomalies[4].

A recent consortium of scientists supported by National Institute of Health, identified two human genes that, when inherited in a slightly altered form, may play a role in cleft lip/palate[5]. These two genes are called MAFB and ABCA4. Cleft lip/palate can be unilateral or bilateral, complete or incomplete.

Objective:

The main objective of this article is to introduce a new project launched by the Federation of Islamic Medical Associations (FIMA), called FIMA SaveSmile. The project will implement the task of coordinating cleft lip/palate surgeries performed by IMA's surgeons, identifying the locations for the camps, facilitate communications with the host country through local IMA's and record the data of its activities.

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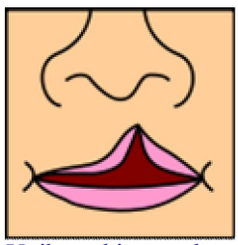
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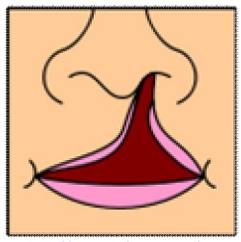
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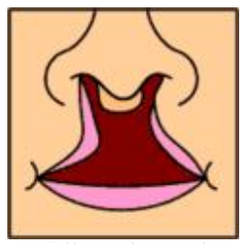
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Methods:

Historical background of creation of FIMA SaveSmile Project is explained and the performed activities to date are highlighted.

Results:

After an overwhelming success of FIMA Save Vision, an award winning project[6], the current Federation of Islamic Medical Associations (FIMA) leadership has been exploring other avenues for medical relief work in various specialties on the global level. During a discussion in the FIMA Executive Committee 2008 meeting in Jeddah, proper planning to deal with these correctable birth defects was discussed. Professor Mamoun Humaida, President of the Sudanese Islamic Medical Association, outlined the prevalence of this problem in Sudan, especially the remote and rural areas, together with lack of qualified surgeons to minimize the backlog of uncorrected cases, at proper timing. Dr. Parvaiz Malik, a plastic surgeon from the Islamic Medical Association of North America (IMANA) responded by a proposal to organize the first free camp to correct cleft lip and palate in Sudan. The new relief project was approved and adopted by FIMA, with the hope to expand it to other needy countries. The incidence of cleft lip is significant in Sudan[2,7] and there is an extreme shortage of surgeons performing the repair. Being prevalent in the lower socio-economic population, most parents are not able to afford these operations.
A large number of cleft lip and palate surgeries are performed by surgeons from many Islamic Medical Associations (FIMA members) across the globe every day, however a need was felt to formalize such activity under the umbrella of FIMA. Medical relief efforts by Muslim doctors should be recognized collectively rather than individual accomplishments. The idea of FIMA SaveSmile and FIMA SaveDignity was conceptualized. These projects were formally adopted by FIMA EXCO in the March 14, 2010 meeting in Makkah.

A team of two plastic surgeons from USA, Dr. Parvaiz Malik and Dr. Khalique Zahir, anesthesiologist Dr. Ismail Mehr and Dr. Labib Syed, of Islamic Medical Association of North America (IMANA) travelled to Sudan in March 2010 to launch the FIMA SaveSmile project. First, the team travelled to al Fashir, Darfur to assist the FIMA SaveDignity team for the vesico-vaginal fistula repair operations. Then a four days Cleft Lip/Palate Camp was held at the University of Medical Sciences & Technology, Khartoum, Sudan in collaboration with Sudanese Islamic Medical Association (SIMA).

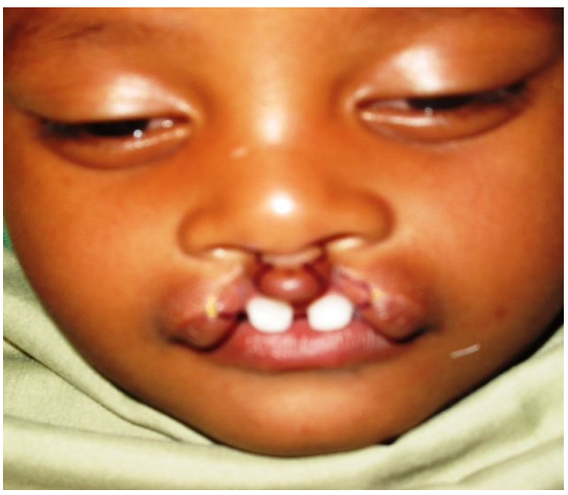
Over two hundred patients with primary and secondary cleft lip and palate patients were screened. The team performed 62 operations with excellent immediate results without any complications. Imam Sheikh Noor and Imam Mohamed Magid, a past and current presidents of Islamic Society of North America, both of Sudanese descent, joined the team in Khartoum for moral support and help with the communication with local community.
The camp was a great success. The local maxillofacial and plastic surgeons assisted and obtained training to perform these surgeries on

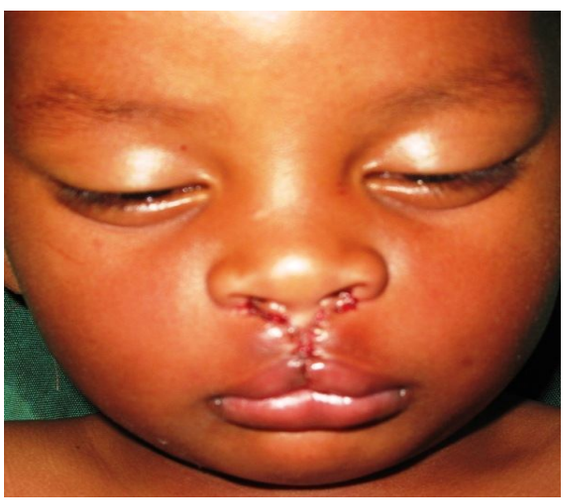
day to day basis. At the end of the camp, the equipment and supplies were donated to the dental school so that the trained surgeons can continue to repair cleft lips/palates.

A second team of plastic surgeons, anesthiologists, pediatricians, and volunteering medical students, returned to Sudan in March 2011. Over 150 patients were evaluated and eighty successful surgeries were performed to repair cleft lip and palate.

Dr. Parvaiz Malik, FIMA President with other relief workers Sudan- March 2010

Dr. Parvaiz Malik-FIMA President with FIMA-IMANA surgical team- FIMA SaveSmile-Sudan, March 2010



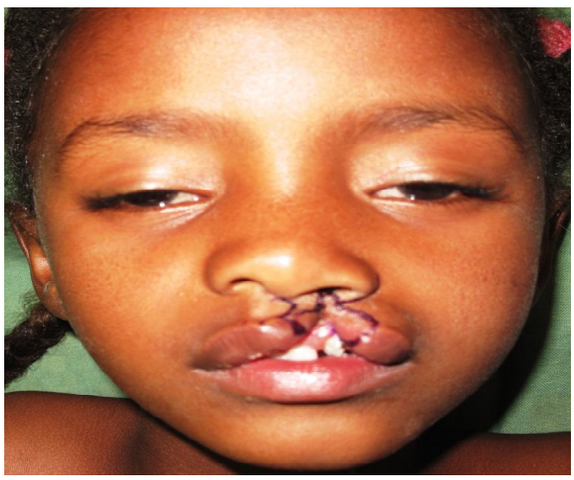


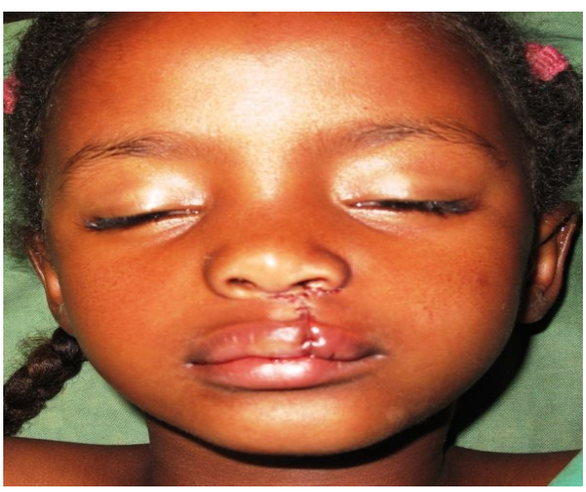
Complete bilateral cleft lip corrected, Sudan-March 2010

All local arrangements and logistics were again managed by Sudanese Islamic Medical Association. Next camp has been scheduled for 2012.

Paralled relief teams were formed by The Doctors World Wide (DWW), affiliate of Hayat Foundation of Turkey, a FIMA member. They operated on 125 cleft lip/palate surgeries in Palestine, Yemen and Syria in the past year.

A total number to 267 cleft lip/palate surgeries have been performed by FIMA SaveSmile teams since its inception in 2010.





Unilateral Cleft lip corrected

Conclusions:

The Federation of Islamic Medical Associations (FIMA) has adopted a new project, FIMA SaveSmile.

Teams of Muslim physicians and allied health professionals will be encouraged and supported to provide surgical care to children and adults across the globe born with cleft lip/palate anomaly, under the umbrella of FIMA.

During the past year, 267 surgeries have been performed in four countries by teams from two FIMA member countries, USA and Turkey. An additional effort was pursued to train local surgical teams, to widen and continue this activity by local qualified hands.

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FIMA SUPPORTS SPECIALTY TRAINING OF PALESTINIAN PHYSICIANS

Aly A. Mishal *

Abstract :

Medical education and specialty training of Palestinian physicians has been chronically suffering from major handicaps and deficiencies. The grim circumstances under harsh Israeli occupation, repressive measures, aggression, mass punishments and siege, together with poor economic standards, have culminated significantly into low standards of both medical care and medical education.
Until 2 decades ago, there were no Palestinian medical schools, and when finally the Palestinians managed to establish their first medical school, they were faced with various obstacles and deficiencies. This situation has created a major necessity for outside help, especially in training of Palestinian physicians in various medical specialties outside Palestine, with continuous efforts to improve standards of training inside Palestine.
Efforts adopted by the Federation of Islamic Medical Associations (FIMA) and collaborating NGOs will be outlined in this article.

Keywords: Medical training, Israeli occupation, Gaza siege, FIMA medical relief.

Introduction:

The Palestinians plight story is one of national and human catastrophe due to the illegitimate, immoral and unjust occupation by Zionist Israel. Palestinians have been living under foreign occupation for decades enduring the restrictions implemented by the occupying power.
This was compounded by the military invasion, further restricting access to essential items vital for "normal existence".

The people of Palestine have become destitutes in their homeland, and the current situation has been described as a crisis of human dignity[1-2]. Prior to the Israeli occupation of Palestine in 1948, usurping 78% of her land, the people of Palestine enjoyed the highest standards of living among people of the Middle East.
Although they had no medical schools, their youths went abroad to obtain medical education and training.
The Nakba (catastrophe) continued with further confiscation of Palestinian land for Jewish settlements, and its 1967occupation of what was left of Palestine, namely the West Bank and Gaza Strip. Between the years 1948-1967, these 2 territories, under Jordan and Egyptian administration, respectively, enjoyed acceptable standards of medical care. Medical students joined medical schools in Arab, Islamic, western and eastern countries.

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Support for this renaissance of medical education came from individual families, and scholarships awarded by various governments and non-governmental agencies that sympathized with the plight of the Palestinians, under the longest military occupation in modern history, oppression, ethnic cleansing, racial discrimination and various types of human rights violations imposed by one the most cruel occupations in human history [2-6].

Since 1967, health services in the occupied Palestinian territory continued to decline with shortages of staff, hospital beds, medications, essential and specialized services. The current services have been unable to provide adequately for the health needs of the people especially in tertiary care and Palestinian patients continued to be referred to tertiary health institutions in Jordan and Egypt[6-8] . The pool of trained and specialist physicians have continued to dwindle due to death, retirement or forced migration, with poor substitution.

The first medical school was established by a charitable Palestinian NGO in occupied Al-Quds (Jerusalem) in 1994. The second was also established in the city of Nablus in the West bank, in 1999. Both institutions suffered from various handicaps and deficiencies that have prevailed until now.

In the Gaza strip, the situation was much worse. Under Israeli occupation, perennial military blockade and incursions, medical care deteriorated to extremely low standards.

Local medical education lagged behind. Two medical schools were established by local NGOs. The first was a branch of the medical school in Al-Quds, established in 1999, while the second was established only in 2006. Both schools have been suffering from lack of educators, poor building structures, meager equipments, very poor finances, and the military siege has barred all forms of external influx of educational materials, and qualified educators.

The World Health Organization (WHO-EMRO) health statistics describes the following parameters for 2009 [9]:

Numbers per 10,000 population:

- Physicians: 17.4
- Dentists: 4.6
- Pharmacists: 7.6
- Nurses and Midwives: 16.1
- Hospital beds: 12.9
- Primary health care centers: 1.8

In the same year (2009), there were 52 hospitals in the West Bank and 24 in Gaza [9]. All of these health facilities suffered major deficiencies in all parameters of health care provision.

Israeli's long occupation has been rampant with violence, atrocities, and human rights violations causing significant casualties which often did not receive appropriate timely medical-surgical care.[1,4-8]

This situation resulted in alarming numbers of fatalities and morbidities. Many individuals lost limbs, eyes or other organs, and became handicapped, which could have been prevented if there was immediate and appropriate medical and surgical attention.

Throughout the Israeli occupation, many community leaders in Palestine, medical institutions and non-governmental organizations have raised their voices and appealed for external help to bridge the serious gaps in Palestine's health care and services.

FIMA, represented by Islamic medical organizations and collaborating NGOs, especially in Jordan and Egypt, received persistent requests and projects, calling for help and support in both areas of specialized patient care, and training for various medical specializations.

A series of contacts, seminars and conferences were held over the past 2 decades, that included medical professionals and educators from inside

and outside Palestine, to draw a picture of various health-related needs.
Various schemes have been adopted and implemented in areas of patient care. This article will concentrate on medical training of Palestinian graduates inside and outside occupied Palestine.

All medical specialties were in real need in both the West Bank and Gaza Strip. The following specialties, however, were deemed more urgent in the milieu of war, aggression and oppressive harsh measures of Israeli occupation:

- Neurosurgery.
- Cardiovascular and Chest surgery.
- Orthopedic surgery.
- General surgery.
- Ophthalmic surgery.
- Plastic and reconstruction surgeries.
- Anesthesia and Intensive Care.
- Physical therapy and rehabilitation.
- Pediatric psychology and psychiatry.
- Nursing, especially in operating theaters and intensive care units.

FIMA, realizing the heavy implications and requirements of this major effort, have worked diligently to enlist support, collaboration and commitment of concerned NGOs, institutions and individuals.

Over the past 2 decades, productive and harmonious collaboration was conducted with the following partners , that rendered this major project a significant success, Alhamdu Lillah.

- The Jordan Committee for Support of the Health Sector in Gaza-Representing the four health associations in Jordan.
- The Jordan Committee for medical care of Palestinians in Jordanian hospitals- The Jordan Medical Associations.
- Arab Medical Union- Egypt.
- The Islamic Hospital in Jordan.
- World Health Organization (WHO-EMRO).
- Qatar Red Crescent Society.
- Islamic Medical Society of North America (IMANA).
- Jordan Society for Islamic Medical Sciences- Jordan Medical Association.
- Partners International Medical Aid -PIMA.

Experience of the last 2 decades

In the face of various adversities, the process of training of Palestinian physicians has continued to proceed over the past 2 decades. Initially, numbers of trainees were limited. Many of them received their undergraduate medical training in institutions with less than the desired standards. As the process of training continued, graduates of local Palestinian medical schools formed most of the trainees in this FIMA-supported project. These young graduates represented the top class of students entering medical colleges. Inspite of major deficiencies in Palestinian medical colleges, these prominent students maintained high standards of performance that accompanied them during their postgraduate training.

We will present here the following types of medical education and training provided by FIMA and collaborators:

(1) Medical students from Palestinian medical colleges:

This took the form of elective training, which was conducted mainly at the Islamic Hospital in Jordan, a recognized center of medical education and training. More than 150 medical students have been accepted so far. For many of them, at certain periods of their undergraduate years, there was unsafe and interrupted access to their medical schools, in view of the harsh security measures of the Israeli occupation. To most of them, there was lack of educational facilities, equipments and trainers, together with serious lack of medical references and periodicals in all Palestinian

medical colleges. Medical references were provided to libraries in Palestinian medical colleges, carried by the trainees at the conclusion of their training.

(2) Short-term training for specific needed medical or surgical procedures, to improve the performance of physicians. Around 40 physicians, in addition to 30 nurses and other paramedical personnel received sponsorships for training in Jordan, mainly at the Islamic Hospital in Amman.

(3) Residency training:

This is mainly conducted at the Islamic Hospital in Jordan. Selection criteria were adopted, along the same lines for Jordanian candidates. Candidates from the West Bank received training tuition waivers, and partial sponsorship as monthly stipends throughout their training, which extends from 4-5 years, after which they sit for Boards examinations.

Candidates from Gaza also received training tuition waivers, and full financial sponsorships.

Table I shows the number of trainees from West Bank and their respective specialties. These data were obtained from the Islamic Hospital as from 1999.
Prior to that, we could not receive authenticated statistics for the period (1988-1998), during which it is estimated that more than 15 Palestinians have successfully graduated and obtained the Jordan Boards in several specialties.

Training of physicians from Gaza has been conducted at several training centers in Jordan, including the Islamic Hospital, Medical colleges at the University of Jordan and at the Jordan University of Sciences and Technology and other training centers.

This training program has been steered by the Jordan Committee for Support of Health Sector in Gaza, in collaboration with FIMA.

(4) Training inside Palestine:

Various obstacles, related to Israeli occupation restrictions and siege, imposed severe limitations for medical educators and trainers to access Palestinian medical institutions. Some professionals managed to enter Gaza to support medical training, but for only very short periods, with limited inputs.

The issue of telemedicine was discussed in seminars, and in teleconferences conducted with health leaders in Gaza, where the needs are extensive for the improvement of medical education.
Telemedicine has been applied in collaboration with the Arab Medical Union (AMU) and Jordan Committee for Supporting the Health Sector in Gaza. Thus far, the input of this program has been limited and awaits further improvement.

(5) Training in other countries:

FIMA sponsored training of one Palestinian ophthalmologist in Pakistan, in collaboration with the Islamic Medical Association of Pakistan. Another surgeon from Gaza has been sponsored for training in thoracic surgery in Egypt.

A program of specialty training in Malaysia is currently under execution, in collaboration with the Islamic Medical Association of Malaysia, and other NGOs. Malaysia is one of very few countries that grant entry visas to Palestinians. Funding of this project came from the Islamic Medical Association of North America (IMANA), a FIMA member.

Major obstacles to medical training:

1.The siege imposed on Gaza curtails the free movement of trainees, trainers, educational materials and participation in conventions.
2. Some trainees have unsatisfactory basic medical standards. This applies to graduates of some east

European and African countries. This handicap was minimized recently with the increasing numbers of graduates of local Palestinian medical colleges.

3. Lack of stable financial support to the trainees and training process.

4. Some neighboring countries impose restrictions on travel and stay for Palestinian trainees.

5. Some trainees fail to return to serve their local communities, after graduation, in view of the poor economic situation in their homeland.

The way forward:

Palestine is a tragic story of a breakdown in health care services and infrastructure and a decline in medical education and training consequent upon an illegitimate military occupation, with documented records of curtailing any form of progress and development.
FIMA, other humanitarian NGOs and individuals have to face major hurdles in their efforts to improve health care, health education and training in Palestine.

Notwithstanding, sincere and diligent efforts of all concerned to rehabilitate and rectify the current shortcomings should consider the following recommendations:

- The new Palestinian medical schools should be supported by encouraging Palestinian and non-Palestinian medical scholars, researchers and educators to provide plans and efforts to develop and promote standards of performance of medical education, research and training.

- Training of a new generation of Palestinian medical graduates in centers outside Palestine to guarantee building a backbone of local trainers and educators in Palestinian medical schools.

- Training of paramedical, nursing, health technicians and other health care professionals, to complement the workings of the physicians.

- Pursue campaigns of ensuring various types of support to Palestinian medical schools and training, inside and outside Palestine.

- Collaborate with other human rights organizations and activists in a global humanitarian effort to address this "greatest moral crisis of our modern times" which has impacted heavily on the people's standards of living, health care services and training of health care professionals.

- Encourage and facilitate external elective training of medical students from Palestinian medical colleges.

Table I: West Bank Trainees Since 1999

Specialty	Number of Trainees
Pediatrics	18
Internal Medicine	13
General Surgery	4
Obstetrics-Gynecology	5
Diagnostic Radiology	4
Anesthesia	4
Ophthalmology	2
Emergency Medicine	1
Orthopedic surgery	1
Total trainees	52

Table II: Trainees from Gaza, since 2008:

Specialty	Number of Trainees
Pediatrics	1
Internal Medicine	3
General Surgery	1
Ophthalmology	1
Cardiovascular Surgery	1
Urology	2
Orthopedic Surgery	2
Diagnostic Radiology	4
Anesthesia and Intensive Care	4
Oncology	1
Emergency	5
Laboratory Medicine	1
Ear, Nose and Throat	1
Specialized Dentistry	3
Specialized Nursing	9
Total	39

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RELIEF AND DISASTER PREPAREDNESS:
PIMA Experience from Recent Calamities in Pakistan

Mohammad Iqbal Khan and Mohammad Tariq*

Abstract:

Between 2005 and 2010, Pakistan has been afflicted by several unprecedented calamities, natural and man-made, that caused massive tragic consequences. From the 2005 destructive earthquakes, to the massive internal displacement of people, propelled by military operations of 2009-2010, to the huge floods of 2010, Pakistani people and infrastructure have suffered extensive destruction and human agonies of major magnitude, leaving unforgettable harm and suffering with long lasting devastating impact for many years to come.

Pakistan Islamic Medical Association (PIMA), a founding member of the Federation of Islamic Medical Associations (FIMA), has to its credit a record of achievements in medical-humanitarian relief work as a result of its sterling role in three Pakistani calamities. Over the past three decades, PIMA has also made significant contributions in the alleviation of calamities in other parts of the world.

In this article, we will present roles played by PIMA in the provision of relief work in recent disasters in Pakistan. The issue of application of recognized standards of Disaster Management and Preparedness will be addressed in the context of PIMA experiences of relief work provided on the ground.

Key words: Earthquakes, floods, relief, disaster management.

Introduction:

Pakistan experienced unprecedented disasters over the past several years. Pakistan Islamic Medical Association (PIMA), since its inception, has been committed to promote health awareness among communities, provision of medical care to victims of poverty, disease, natural disasters and war, with active contributions in national and international calamities. PIMA has become one of the leading global medical relief organizations.

In rendering valuable relief activities during and post various disasters, whether natural or man-made, PIMA has diligently functioned within the broadly recognized Disaster Management and Preparedness parameters.

Over the past three decades, PIMA has established volunteering networks, motivated professional manpower, and established medical and welfare centers, hospitals, free medical camps, and training activities.

Health awareness programs and health education workshops were conducted to educate the public regarding personal and community hygiene and other health issues related to internally displaced persons (IDPs) camps.

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PIMA augmented the facilities already existing in and around disaster-stricken areas, by enrolling qualified professionals, providing life saving medications and consumables, especially in the district headquarter hospitals and rural health centers.

PIMA provided clean water to IDPs camps. Campaigns for prevention of epidemic-communicable diseases in refugee camps have also been conducted.

Disaster management cells at the central level were established, and expanded to provisional and local levels, to meet urgent needs of any possible disaster, with training and preparedness drills for disaster management teams.

In regards to collaborations with other Non-Governmental Organizations (NGOs), PIMA has successful collaboration and harmonious relief working relationships with the Federation of Islamic Medical Associations (FIMA), the international umbrella of Islamic medical associations (IMAs) in many regions of the world, together with many relief NGOs and governmental authorities in disaster-stricken countries.

PIMA's vast experiences in disaster management, mainly focused on health and medical needs of affected communities, has been built from regular campaigns during the first Afghan war, to Kashmir conflict, the second Afghan war, the 2005 earthquake, IDPs of Malakand and Swat, to the major 2010 floods, and PIMA relief involvement in other regional and international disasters.

In this presentation, an attempt is made to present PIMA/FIMA experiences, achievements and challenges in relief activities during and post three main calamities that afflicted Pakistan from 2005 to 2010.

Devastating Earthquake - Pakistan 2005:

The 2005 Kashmir Earthquake (also known as the South Asian Earthquake or the Great Pakistan Earthquake)[1,2], was a major earthquake, with epicenter at Azad Kashmir, about 19 km (11.8 miles) northeast of the capital city of Muzaffarabad. The earthquake occurred at 08:50:38 Pakistan Standard Time (03:50:37 UTC) on 8th October 2005. It registered a debatable 7.6 or 7.7 on the Richter scale, making it a major earthquake similar in intensity to the 1906 San Francisco earthquake, 1935 Quetta earthquake and 2001 Gujrat earthquake. A total of 147 aftershocks were registered in the first day after the initial quake. Twenty-eight of these aftershocks occurred with high magnitudes, of which one had a magnitude of 6.2. On October 19, a series of strong aftershocks, one with a magnitude of 5.8, occurred at about 65 km (40.5 miles) north-northwest of Muzaffarabad. There have been daily aftershocks. As of October 27, there have been more than 978 aftershocks with a magnitude of 4.0 and higher.

That earthquake created serious human, social, economical, ecological, environmental and international impacts.

As of 8 November 2005, the Pakistani government's official death toll was established at 73,276, with additional nearly 1,400 people died in occupied Kashmir and fourteen people in Afghanistan. Nearly 160 thousand people were badly injured during that calamity. These official death toll and numbers of injured are merely rough estimates. Other data suggest the death toll to be between100 and 200 thousand, again that being only a rough estimation.

As Saturday was a normal school day in the region, most students were at schools when the earthquake struck. Many were buried under collapsed school buildings. It was estimated that nearly 25 thousand children died and nearly 3,400 children were disabled. Many people were trapped in their homes and, because it was the month of Ramadan, most people were taking a nap after their pre-dawn meal and did not have time to escape during the earthquake. Reports indicated that entire towns and villages were completely wiped out in Northern Pakistan, with other surrounding areas also suffering severe damage.

Most of the affected people lived in mountainous regions with access being impeded by landslides that blocked roads, leaving an estimated 3.9 million people homeless. The United Nations (UN) reported 4 million people were directly affected, prior to the commencement of winter snowfall in the Himalayan region. It is estimated that damages incurred were well over USD 5 billion (300 billion Pak Rupees). Five crossing points were opened on the Line of Control (LOC) between Indian occupied Kashmir and Azad-Jamu-Kashmir (AJK) to facilitate the flow of humanitarian and medical aid to the affected region, and international aid teams from around the world came to the region to assist in relief.

Widespread severe damage was reported in Balakot (almost completely wiped out), Garhi Habibullah, Rawalakot, Bagh and Muzaffarabad (near the epicenter) where 30,000 were thought to have died. The quake triggered landslides, burying roads in many areas of North-West Frontier Province (NWFP) and Azad Kashmir.

- Hundreds of thousands of buildings collapsed or sustained severe damages.
- One of the two residential towers (Margalla Towers in F-10 sector, Islamabad), believed to contain up to sixty apartments each, collapsed in the earthquake in Islamabad. Pakistani government officials at the site stated the number of people affected by the collapse was in the hundreds, most of whom were feared dead. Over fifty-two people were rescued from the collapsed residential "Margalla Towers".
- All approaching roads to Muzaffarabad and surrounding towns were blocked due to major landslides.
- The Karakoram highway was blocked at several points, hindering relief efforts.
- Damage to buildings and several casualties have been reported in surrounding provinces of Punjab and NWFP.

Rescue and relief operations:

The sad part of the story is that none was prepared to reduce the impact of disaster created by this calamity. National and international relief agencies did not realize the actual magnitude and nature of disaster for more than 24 hours. In most of the regions there was no power, food or water; there was also the danger of disease spreading. Distributing relief supplies to the victims was especially urgent as the victims faced the risk of exposure to cold weather due to the region's high altitude and the approaching winter. Food, medicine supplies, tents and blankets were identified by relief workers as essential items. On October 10 2005, the United Nations warned that the earthquake left 2.9 million people homeless and they were in need of shelter. On October 13 2005, snow started to fall on Kashmir mountains. Many regions were facing an increasing threat of being cut off from help as snow forced closure of even more roads in the mountainous region.

Heavy snowfall in the region, around the epicenter which started shortly after the earthquake struck, hampered relief efforts.

Also relief efforts in many remote villages were hampered, as roads were buried in rubble and many affected areas remained inaccessible. Heavy equipment was needed to clear the roads and to rescue survivors buried under the earthquake wreckage, as many rescuers were picking the rubble with pickaxes and their bare hands, looking for survivors.

Rescue efforts were also affected by the numerous aftershocks that continued to rattle the region and put rescue workers in danger as they searched through the wreckage for survivors.

On Monday, October 10 2005, survivors were still being found and rescued from the wreckage, including a 2-year-old girl in Islamabad. Then on Wednesday, a Russian rescue team rescued a 5-year-old girl in Muzaffarabad who had been trapped for nearly 100 hours.

PIMA teams were providing relief at the right spots. They set up several field hospitals, medical centers and sent relief teams to far flung areas of

AJK and NWFP. Several thousand injured were provided emergency and long term medical relief.

PIMA rescued Naqsha Bibi, a 30-year old woman, on the 63rd day of the earthquake from Kashmiri refugee camp near Muzaffarabad, a miraculous event in the history of rescue operations. She managed to survive for that period without food and shelter. By the grace of Almighty she survived in a good state of health.

Naqsha Bibi (63 days under rubble)visited by Profs M. Tariq, Faroque Khan and Aly Mishal

PIMA/FIMA Response:

The tremendous mobilization of national and international relief efforts was historic and exemplary. In the history of Pakistan, such motivation and contributions were unparalleled in rescue and relief works during natural disasters. From the very first day of the disaster, PIMA positively coordinated relief efforts, utilizing its medical and administrative manpower and local resources.

PIMA's relief activities in the earthquake area, coordinated by Prof. Mohammad Tariq, then FIMA general secretary, and his colleagues, were unmatched and unprecedented. That was acknowledged by WHO and other relief NGOs. PIMA's relief intervention resulted in providing more than 200 hospital beds continuously for the first two years after the quake.

FIMA-PIMA leadership-In Kashmir Earthquake Area-2006

FIMA-PIMA leadership-In Kashmir Earthquake Area-2006

From day one, with all his relief commitments, Prof. Tariq alerted FIMA president and FIMA Relief Coordinator of the situation.

Immediately, all FIMA network of IMAs and collaborating relief NGOs were made aware of the catastrophe and its urgent needs. All were called upon to mobilize urgent efforts to participate.

Prof. M. Iqbal Khan in IDPs camp

Several IMAs formed joint relief activities and missions with their community-based relief organizations:

- Pakistan: PIMA, Jamaat Islami and al-Khidmat Foundation.
- Malaysia, the Islamic Medical Association of Malaysia (IMAM) and sister relief organization: Mercy Malaysia.
- South Africa: The Islamic Medical Association of South Africa (IMASA) and Waqful Waqifin (Gift of the Givers Foundation).
- Egypt: IMA-Egypt, Arab Medical Union and Egyptian Medical Association.
- USA: The Islamic Medical Association of North America (IMANA), the Islamic Circle of North America (ICNA) and the Association of Pakistani Physicians of North America (APPNA).

Prof. M. Tariq leading relief teams

- Turkey- Hayat Foundation-Doctors World Wide (DWW-Turkey).
- Sudan: The Sudan Islamic Medical Association (SIMA), and Sudanese relief organizations.
- Saudi Arabia: The Islamic Medical Association of the Kingdom of Saudi Arabia (IMAKSA), the World Assembly of Muslim Youth (WAMY), and other relief NGOs.
- Jordan: IMA-Jordan and Islamic Hospital.
- FIMA, as a member of the Islamic International Council for Dawa and Relief (IICDR), participated in a special relief meeting convened in Cairo-Egypt on November 17,2005 to assess each NGO

contributions since the early days of the disaster. Dr. Aly Mishal, a previous FIMA president, attended the meeting, and appraised the NGOs of the roles provided by PIMA/FIMA.

The meeting organized a local combined relief committee in Pakistan, from representatives of IICDR organizations, to be chaired by Prof. M. Tariq on behalf of FIMA.

IICDR relief organizations spent more than 100 million dollars, for this disaster, in the form of material, teams, and construction, mostly through channels other than FIMA.

- Other NGOs from outside Pakistan:
  - IMA Indonesia and MER-C Indonesia.
  - Mercy Singapore.
  - Bangladesh BNDF (FIMA member).
  - Muslim Foundation- Denmark.
  - UK-IMA-Dr. Tanveer Siddique and 10 orthopedic surgeons.
  - IMAs of Bosnia and Kenya medical teams.
  - Australia: Dr. Khatree and 4 medical colleagues.

Prof. Muhammed Tariq, Prof Hafeez ur Rehman and myself functioned as coordinators and initiated an immediate assessment of needs and damage. 4 hospitals were commissioned to manage the injuries (Gilani hospital in Abottobad, 3 field hospitals in Muzafferabad, Bagh and Balakot). Mobile missions were sent to more remote areas. The following interventions were included in the PIMA/FIMA response:

- 20 medical missions from 15 IMA's and more than 30 relief organizations and NGO's
- Emergency supplies included tents, blankets, clothing, medicines, medical equipment and surgical supplies ($4,000,000)
- Cash contributions ($600,000) from various IMAs.
- Local response overwhelming! al-Khidmat Foundation/PIMA providing 45 truck-loads of supplies and equipment daily.
- DWW/Turkey sent relief teams within the first 48 hours and gave medical service for 8 months in the field
  - Set up of field clinics
  - First permanent health center established in Komikot village
  - First Children hospital built in New Balakot City.
- Mobile Clean Drinking Water, delivered to 500 families/day
- Multiple Mobile Basic Health Units, treated 4,800 patients
- Excavation Project, cleared ~ 20 miles of roadway
- $10,000 was transferred to al-Khidmat Foundation to establish a Women and Children's health center in Layyah, Punjab
- Collaboration: Al-Khidmat, PIMA, Pakistan Kidney Institute (Dr. Saeed Akther)
- Dr. Abdul Qadir Hijazi, a previous-FIMA president, and then current chairman of Egypt Medical Association-Relief Committee, delivered 200,000 USD, to help in reconstruction of a hospital in Muzafferabed.

This was a rare humanitarian relief situation in which Islamic relief organizations provided more than 75% of the total relief effort. Table I and II show an overview of manpower and services of this endeavor:

There were over 1000 surgeries performed under general anesthesia in Muzaffarabad hospital, with 175,000 out-patients examined and 4,500 hospital admissions. A total of 14 operative tables were working at one time.

Discover Islam, an NGO from Bahrain, offered to build and bear the expenses of a rehabilitation hospital in Islamabad.

The response of the Pakistani people was so tremendous that it was unimaginable, given the scale of their personal losses. So much relief

goods have been donated by our own people, although enough trucks were not readily available.

Al-Khidmat Foundation sent 45 trucks of relief goods daily to disaster areas. There has been no major outbreak of communicable illness. There were 3 cases of advanced tetanus and all of them died. Our hospital in Islamabad, being a major one, had taken 1800 extra admissions. Surgeons worked around the clock. After surgeries we often wondered where to discharge patients.

At times we got so busy that we could not send regular reports. We needed sincere prayers in that unique Ramadan and we bowed to His Will and Hikmat.

Closing remarks:

To append a "conclusion" to the tragedy in Pakistan/Kashmir is inappropriate while people were still suffering and fellow health workers still struggling to rehabilitate the millions left homeless and traumatized. Let us, therefore, use this space to praise Allah (SWT) and invoke His peace and blessings on His noble Prophet Muhammad (PBUH), his family and companions, and through whose example we have been honored with such selfless men and women, young and old, who braved the most trying conditions to bring comfort to their fellow human beings. May Allah bless them abundantly for their efforts, no less than those who offered support in whatever form.
To our own brothers and sisters in FIMA, the IMAs and those relief organizations who joined them in their efforts, we say a hearty *shukran jazilan(abundant thanks)* ! And if anyone needs to be singled out for his efforts thus far, it is our coordinator in Pakistan and PIMA, Mohammad Tariq. He added value to his life-task as care-giver and carried the flag of FIMA and PIMA with distinction. May he find fulfillment and contentment in that and all his future efforts.

Internally displaced People in Pakistan 2009-2010:

As a result of military action in Swat and Malakand division at the north of Pakistan, nearly all of the population of the area (about 3.5 millions) were displaced to Peshawar and nearby areas of Khaybar Pakhtoon Khawa (KPK) of Pakistan, rendering disruption of the local functionaries and civic services. Huge medical-humanitarian crises ensued, thereby necssitating the provision of emergency assistances.

PIMA set up field hospitals, maternity and child care centers, more than two dozen clinics functioning around the clock in the different refugee camps. PIMA provided indiscriminate services to all refugees till the last internally displaced person returned home. PIMA, not only intervened in the camps, but also established seven clinics in Swat and Malakand and strove to provide services to those who had lost their every belonging and were in the process of rehabilitation. As the single largest NGO in medical relief, PIMA played a pivotal role in relieving the sufferings of the victims with the brotherly help of FIMA and other international partners.

PIMA teams in action: SWAT IDPs

Flood Disaster in Pakistan 2010:

Extra ordinary heavy Monsoon rains and floods in the rivers of Pakistan created unprecedented flooding in Pakistan reminiscent of the flood storms of Noah (PBUH). History has not experienced such floods causing the displacement of over 20 million people, a disaster bigger than the Tsunami in 2004, Pakistan Earthquake in 2005 and Haiti Earthquake in 2010 altogether. Among the affected, nearly 50% were children and one million pregnant women.

In excess of 3.5 million acres, out of 5.23 million acres of agricultural lands, came under water[3-5], which is more than the land mass of Bangladesh, Cuba and England put together. Over a million houses were destroyed. In the north of Pakistan, Khybar Pakhtoon Khawa (KPK), over 4 million people were displaced, 2,834 villages went under water and 179,585 houses were destroyed[2].

In Punjab, 1,787 villages in 8 districts went under water. More than 8.2 million people were affected. About 80.73 billion Pak Rubees worth of crops were destroyed, including cotton, sugar cane and rice. There was total disruption of road and rail tracts in these districts rendering great difficulties for relief workers. In Sind, 368,4247 people were displaced and 2,534 villages went under water, causing destruction of 462,251 houses.

In Baluchistan, 672,171 people were displaced and 2,584 villages went under water, causing destruction of 75,261 houses. The civic and communication facilities, including rail and roads, went under water.
Medical and health facilities in these areas were either completely destroyed, or badly damaged, paralysing the functionaries.

PIMA took the initiative from the very beginning of the flood warning, and because of its extensive network all over the country, remained the only single largest medical relief organization that provided services reaching to every corner of the affected region.

PIMA relief teams in flood-stricken areas-2010

Flood Relief:

PIMA has remained committed to the welfare of flood affected population. PIMA started medical relief operations from the very first day through its members throughout the country. At central and provincial levels, PIMA flood relief cells were immediately established, which further extended to every locality, to provide immediate and effective relief to the affected population, mainly focusing on community health and medical issues. Where possible, humanitarian assistance in all fields was also provided, including food materials, shelters, water filtration plants, restoration of civic services and augmentation of the work of other public sector and NGOs.
PIMA established medical relief centers in all flood affected areas. The summary of relief activities is as follows:

There were over 2,837 medical centers, 3,128 doctors, 5,855 paramedics and 7,671 volunteers for treatment and services to more than of 502,320 patients in affected regions.

Good cooperation with the Pakistani army, especially using army helicopters to reach flooded communities, was instrumental in the effectiveness of relief efforts.

PIMA enjoyed the international collaborations in this campaign. Volunteer physicians along with paramedics from 17 countries joined hands with PIMA to provide effective medical relief in the flood affected regions of Pakistan.
Through free eye camps in flood affected regions, thousands of eye surgeries were performed by the Prevention of Blindness project (POB) of PIMA.
PIMA distributed thousands of Eid gifts to children and women in the affected regions.
Cash amounts in excess of 2.5 million Rupees were distributed to flood victims through collaboration with Sharja Charity International.
Several thousand families were provided food and household materials during the acute phase of disaster in collaboration with other organizations and public sector facilities.

PIMA health teams in flood areas

Taking in consideration the acute requirements of the region, and to meet the community requirements, thousands of specially prepared hygiene kits were distributed through collaboration with Malaysian Relief Agency (MRA) and other NGOs.
Several hundred medical kits were distributed with health educational pamphlets in the affected areas of Sind Province.

Most modern water filtration plants were installed in Sind and KPK, in collaboration with Mercy Singapore.

Health Awareness Programs and health education workshops were conducted to educate people regarding personal and community hygiene issues and health issues related to camps.

Medical kits-from MRA-Malaysia

Water purification and distribution

PIMA also augmented the facilities already existing in the areas by making them functional, if they were not, and by providing lifesaving drugs to these health facilities, like District Headquarter hospitals, Tehsil Headquarter Hospitals and Rural health centers. Donated injectable antibiotics were dispensed to these centers along with water dispensers and equipments for very basic needs. PIMA also provided clean water in the camps and carried out several campaigns for prevention of communicable diseases.

PIMA established regular DISASTER MANAGEMENT cell at central level, and extended it at provisional and local levels, to meet the urgent needs of any future disaster. This cell prepared written Standards of Operation (SOPS) and guidelines to manage a disaster of any scale, both nationally and internationally, and also provided opportunity for training and preparedness drills for disaster management teams.

Al-Khidmat Foundation-Pakistan, with a distinguished record of relief achievements, played leading roles during this disaster. More than 470 medical camps and 630 physicians, treated 2,75 million people, and 24,000 relief volunteers saved around 97,000 human lives.
Drs. Tanveer Zubairi, FIMA general secretary and Hafeez Ur Rahman, chairman-FIMA SAVE VISION Program, were assigned the tasks of organization and integration of international flood relief efforts.

Through this collaboration, FIMA member IMAs and sister relief NGOs from various parts of the world, waged campaigns to support relief efforts, and were instrumental in conducting a major, productive Islamic international cooperation with impressive outcomes.

Field prayers- Faith and Action

Cash donations in hundreds of thousands of USDs were transferred to PIMA relief accounts, or to al-Khidmat Foundation from various IMAs, especially IMANA, IMASA, IMA-Jordan, IMA-Egypt, AMU-Egypt, Hayat, DWW-Turkey and IMANI-Indonesia.
Many IMAs/NGOs dispatched medical teams to work under PIMA leadership.

The following is just a short overview of some flood relief cooperative activities. In no way does it cover all the extensive undertakings, some of which were still underway, when this report was written:

- IMANA pledged USD 125,000 in support for management and operations of the al-Khidmat Maternity Hospital in Quetta, Pakistan.
- IMASA collaborated with al-Khidmat by donating $75,000 toward the al-Khidmat school package distributed among 3,000 students.
- PIMA Mobile Mother and Child Clinic was established as a collaboration between PIMA, DWW and IMA Indonesia, IMA-Jordan and Muslim Aid (UK)

Mobile Mother and Child Clinic: A Unique project: Collaboration of FIMA/PIMA/DWW-Turkey

- DWW/Hayat Foundation donated mobile clinics and ambulances to treat the victims as well as:
  - providing basic health care in Mardan refugee camp for 4 months
  - collected medicine worth of $700,000 in Turkey and sent to flood-affected areas in three installments
  - 2 Basic health units were renovated in Nowshera and Sind
  - A big regional hospital of 100-bed capacity planned in Jampur area in collaboration with Foreign Ministry of Turkey and Turkey Foundation (TIKA).
    - 6,550 Patients were examined and a further 2,680 tests performed.


Dr. Tanveer Zubairi-FIMA Secretary with team of Mobile Mother and Child Clinic

- IMANA made the following contributions in the FIMA relief efforts:
  - Immediate response was to transfer USD20,000 to al-Khidmat Foundation and USD10,000 to PIMA.
  - Al-Khidmat, utilized funds under IMANA banner to expand relief activities in Charsadda District of Khybar Pakthunkwa
    - Food distribution and establishment of camps, serving 55,000 IDP's.
    - Mobile clean drinking water, delivered to 500 families/day.
    - Multiple mobile basic health units, treated 4,800 patients

- Excavation project, cleared ~ 20 miles of roadways.
- USD10,000 was transferred to al-Khidmat Foundation to establish a Women and Children's health center in Layyah, Punjab
- Collaboration: al-Khidmat, PIMA, and Pakistan Kidney Institute (Dr. Saeed Akther)
- PIMA similarly completed the following projects in collaboration with IMANA:

  - Purchased medical supplies and equipment for field hospitals.
  - Established 5 IDP camps in conjunction with PKI accommodating 14,000.
  - Established 2 diarrhea centers in Sukkur in collaboration with WHO and (Pakistan Kidney Institute) PKI.

- Dera Gazi Foundation (DF):

- Operating 7 basic health units (BHU), six of them in Rajunpur and one in Dera Ghazi Khan. The BHUs served approximately 90,000 patients. Each BHU was fully staffed with a doctor and local pharmacy tech and ancillary staff.
- Dera Ghazi Khan BHUs remained operational, seeing 100-150 patients per day. In Dera Ghazi Khan there are 2 vocational training centers for women.

- The last current project: The installation of water pumps. A total of 1,000 water pumps installed throughout villages in the affected areas. Each water pump has the PKI/IMANA logo on it.

Lessons and Concerns:

With all PIMA/FIMA major relief involvements and achievements, there were several deficiencies and handicaps during these recent relief undertakings, that need proper efforts and preparedness: The following are some of the main concerns:

- Lack of proper information about disasters-related issues, local conditions and local culture, among some international relief NGOs.
- Lack of education, training of relief providers and perpetual drills.
- Lack of coordinated activities among various relief NGOs.
- Resources from Pakistani nationals from all over the world, although generous, were used in a scattered manner without much coordination and cooperation.

Horizons ahead:

Prediction of disasters and reduction of their impact by proper preparedness are the mainstay of disaster management[6-9]. PIMA, with a holistic and multidisciplinary relief approach, has been always struggling to be functional in line with the main guidelines and standards of disaster management. The way forward, however, awaits more quality actions to increase efficiency and effectiveness of disaster emergency response and preparedness at community, national and international levels.

The following recognized guidelines represent horizons to strive for by PIMA, FIMA and other relief organizations:

- Sound and well coordinated warning system is required for all sorts of calamities.
- Disaster prediction and preparedness mechanism at national, provincial and city levels needs to be introduced.
- Regular training workshops on disaster management for medical and other workers.
- Prepare a list of volunteers ready to leave their normal work place in minimum possible period to extend services to minimize the effect of disaster.
- Training of these volunteers and periodic exercises to deal with emergency situations in a scientific way.
- Medical relief and rehabilitation must be part of continuing Medical education (CME)

programs for all categories of health professionals.
- Set up a disaster response centers and teams at national, provincial and district levels.
- Coordination between all relief organizations (including NGOs and governmental organizations) through coordination centers.
- Senior professionals, specially doctors, must be ready to respond immediately in disaster situations.
- Extend helping hands, financial and material resources to other nations and countries when deemed necessary.
- Some resources must be in reserve for unforeseen situations and disasters. Every medical institution and health care unit must allocate reasonable percentage of human and material resources for this purpose.
- Every doctor must be educated that humanitarian / relief work is the most rewarding and noble work one can provide.
- Disaster management system must be included in the curricula of various university programs especially in every medical and nursing schools.
- Continuous upgrading of disaster management tools are required through continuous research and innovations.
- Regular drills are required to be conducted at all levels. Special efforts are required for training and regular exercises for medical relief workers.
- Relief and rescue departments must develop coordination plans at all levels and with all sorts of relief bodies including NGOs and public sector organizations.
- All relief activities must be channeled effectively to reduce the pilferage and loss of valuable resources.

Some of these recommendations have already been incorporated by National Disaster Management Coordination Office. Still more needs to be included and many more needs to be developed in the future.

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Table I: Personnel deployed:

Specialties	National	International	Total
Ortho/plastic surgeons	212	26	238
General surgeons	206	41	247

Specialties	National	International	Total
Physicians	194	13	207
Gynecologists	37	13	50
Anesthesiologists	88	14	102
Psychologists/psychiatrists	21	9	30
Medical officers	655	100	755
Female Medical officers	88	15	103
Paramedics	519	22	541
Pharmacists	178	18	196
OT technicians	115	3	118
Lab technicians	28	2	30
X-Ray technicians	48	0	48
Electricians	27	0	27
Administration staff	54	0	54
Volunteers	3121	35	3156
Grand total	**5591**	**311**	**5902**

Table II: Services provided:

Facilities/Services	Total		
Hospital beds	395		
Occupancy	95%		
OPD patients	65898	Admissions	6114
Mobile teams	52141	Admissions	437
Surgeries in hospitals	5625		
Minor procedures	34427		
Normal procedures	106		
Surgical deliveries (Cesarean sections)	23		
X-rays	5913		
Ambulances	7		

VIVA PALESTINA 5: A GLOBAL LIFELINE TO GAZA

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Abstract:

The Viva Palestina 5 (VP5), Life Line to Gaza convoy departed from London on 18 September 2011 and travelled 3,000 miles through France, Italy, Greece and Turkey before arriving in Syria. At the Syrian port of Latakia, two other convoys from Morocco and Algeria, and another from Doha-Qatar joined VP5. After 16 days of negotiations with Egyptian authorities, VP5 was allowed travel to El-Arish on 19 October 2011, enroute to Rafah and Gaza.

VP5 consisted of 380 volunteers from 30 countries, driving 147 vehicles carrying humanitarian aid worth in excess of USD 5 million. This time round, all the vehicles mainly laden with medical and educational aid, successfully passed the Rafah Crossing into Gaza.

The daytime arrival of the convoy was historical and very significant because it enabled wide media coverage and inspired the Gazans upon seeing a group of people break the siege and witness the long train of vehicles with aid arriving to support them. It delivered a powerful message that the world has not forgotten them and global efforts were underway to overturn the cruel siege on Gaza.

VP5 represented a major breakthrough because of its wider international representation, better global collaboration, bigger aid handout and paramount morale boosting for the Gazans. Repeatedly, the Gaza people echoed, "Please tell the world what is happening."

The Malaysian contingent, namely from Viva Palestina Malaysia (VPM) and Aqsa Syarif (AS: A Malaysian charitable and humanitarian NGO to mainstream the struggle to free Al-Aqsa and Palestine), reviewed the progress of some of the earlier Malaysian funded projects in Gaza initiated by Aqsa Syarif, and adopted more new projects for funding. VPM, Aqsa Syarif and their partners in Malaysia are presently raising funds to make these projects viable and sustainable. And we are fully supportive of the next convoy to Gaza, which was recently named Freedom Flotilla – Stay Human, and which is due to set sail to Gaza in the middle of 2011.

Key words: Viva Palestina, Life Line, Gaza, Malaysia.

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Brief History of Palestine and the Invasion of Gaza:

Historic Palestine is located in the Middle East, in a region bordering Lebanon, Syria, Jordan, Egypt and the Mediterranean Sea. It was part of the Ottoman caliphate until 1918 when it was occupied by Britain until 1948. The Balfour Declaration of 1917 was the antecedent to the unilateral establishment of the state of Israel in 1948. By 1949, the Nakba (catastrophe) had resulted in the expulsion of two thirds of the indigenous Palestinians and the Israeli occupation of 78 per cent of the land[1].

Gaza is a narrow coastal strip along the Mediterranean Sea, in the south of Palestine. It is about 41 km long and between 6-12 km wide, with a total area of 360 square km. The population is about 1,535,120 people (mid 2010 figures) making Gaza one of the most densely populated areas in the world.

The West Bank and Gaza Strip have been under an illegal Israeli military rule since they were occupied in the 1967 war. Although Israel withdrew from Gaza in 2005 it has since tightened its grip on the population, exercising absolute control of who and what goes in and out of the Strip by land, sea and air.

From 27 December 2008 to 19 January 2009, Israel bombarded the Gaza Strip. The 22 days of invasion and onslaught left 1,417 dead, of whom 926 were civilians including 116 women and 313 children[2]. Among the 5,380 injured were 1,872 children and 800 women. An estimated 21,000 homes were destroyed and approximately 50,000 displaced from their homes. 15 of Gaza's 27 hospitals and 43 of its 110 primary health care centers and large numbers of places of worship (mosques), and educational institutions (including schools) were targeted or destroyed.Over 30 hectares of green houses, nearly all of its 10,000 family farms and 800 water wells were damaged resulting in ½ million without running water, 1 million without electricity and resulting in acute food shortages[3].

Summary of the Impact of the Blockade and Military Operations on Gaza:

Gazans have been living under Israeli occupation for decades enduring the restrictions implemented by the occupying power. This was compounded by the military invasion, further restricting access to essential items vital for "normal existence". The people of Gaza have become destitutes in their homeland, more so the women and children. The current situation has been described as a crisis of human dignity[4].
Even prior to Operation Cast Lead, the code name for the Israeli war on Gaza 2008-2009, the Gaza economy was already in dire straits. The blockade restricted or denied entry to a range of items, fuel and diesel necessary for factories, businesses and agricultural activities to function. The net result was a stalled economy, with many businesses, factories and farms either closed or operating at reduced capacity.

In 2007, 79% of households lived below the official poverty line (USD 4 per capita/day) and some 70% below the deep poverty line (USD 3 per capita/day). These were expected to increase by the end of 2008 – even before the Israeli military operations. The agricultural sector had traditionally absorbed unemployed workers from other sectors. It could no longer fulfill this role due to the lack of fertilizers, pesticides, machinery, spare parts and access to foreign markets imposed by the siege.

Fishing that provided direct employment to some 3,000 people was also affected. Many boats and some fishermen were directly hit. Fishing activities had already been affected when Israel reduced the fishing limit from six to only three nautical miles.

Food security is the capacity of each individual to have access to adequate food at all times. By December 2008, food insecurity was on the rise. The military operations caused food insecurity to affect up to 75 per cent of the population[5]. The destruction of land and greenhouses had an impact on the availability of fresh food in the Gaza Strip.

There is an increased prevalence of stunting among 6 -16 year old children (7.2%). The levels of anemia are alarming, 66% among 9-12 months old infants and 35% among pregnant women[6].

Food prices continued to be very high and some items were prohibitively expensive (e.g. poultry, eggs and meat) and unaffordable[7].

The destruction or damage of their homes forced many people to flee and find shelter with relatives or agencies providing assistance, such as United Nations Relief and Work Agency (UNRWA). At the height of the military operations UNRWA was providing shelter to 50,896 displaced persons in 50 shelters. This number was estimated to be a fraction of those who had become homeless, most of whom found temporary shelter with relatives. This created extreme hardship for people who had to share already deteriorated and limited housing, sanitary and water facilities. People were still living in tents some six months after the end of the military operations.

This is further aggravated by the substantial destruction of the Gaza construction industry. Nineteen cement producing plants, representing 85% of the production capacity, were destroyed. Imports of concrete and other building materials into Gaza were banned. The homeless Gazans were thus prevented by Israel from rebuilding their homes.

By December 2008, 80% of Gaza's water wells were only partially functioning affecting their access to clean water. Of the water supplied in Gaza 80 per cent did not meet the World Health Organization (WHO) standards for drinking water predisposing to major health risks

The disposal of untreated waste water daily into the sea leads to significant environmental damage and health risks for human beings and marine life. Hazardous material from munitions or its debris would remain in the soil and water of the Gaza Strip for indefinite periods of time and could enter the food chain and be hazardous to life.

Medical facilities and personnel were targeted during the invasion. Seventeen health personnel were killed and 26 were injured, 29 ambulances were damaged or destroyed by bombs or crushed by armored vehicles. Forty eight percent of Gaza's 122 health facilities were shelled either directly or indirectly.

Of the 5,380 injured people reported by the Ministry, 40% were admitted to the main hospitals. Due to the policy of discharging patients as soon as feasible to free up beds and staff, there were concerns that some injuries (e.g. burns and acute surgical conditions) might have led to complications as follow-up care may have been inadequate. Some injuries would result in permanent disability.

Twenty per cent of Palestinian children in Gaza suffer from post-traumatic stress disorders (PTSD) the symptoms of which will appear over the days, months, years, or decades to come. The three weeks of intense bombardment and military ground action added new serious psychological trauma, especially noticeable in children.

The military operations destroyed or damaged at least 280 schools and kindergartens. According to the Ministry of Education, 164 pupils and 12 teachers were killed during the military operations. Another 454 pupils and 5 teachers were injured. At UNRWA schools, 86 children and three teachers were killed, and 402 children and 14 teachers were injured[8].

The education system was affected in several ways by the restrictions imposed by the blockade. The lack of construction materials had halted all new construction. Repairs to the educational infrastructure also had to be postponed. Around 88 per cent of UNRWA schools and 82 per cent of Government schools operated on a shift system to cope with the demand. The lack of educational material and equipment hampered the ability to maintain teaching standards.

The ban on the movement of people through the crossings affected not only university students planning to study or already undertaking studies abroad, but also the possibilities for academics and scholars to travel abroad on academic exchanges.

The siege on the Gaza enclave had aggravated poverty which particularly affected women, who must find food and other essentials for their families. These responsibilities sometimes compelled them to conceal their own sufferings, so their concerns remained unaddressed. A UNFPA (United Nations Population Fund) study, conducted immediately after the December-January military operations, reported a 40% increase in miscarriages admitted to maternity wards, a 50 per cent increase in neonatal deaths, a rise in obstetric complications and anecdotal evidence of deaths or health complications because pregnant women were unable to reach hospitals to deliver their babies[9].

Thirty percent of children screened at UNRWA schools had mental health problems, while some 10 per cent of children had lost relatives or friends or lost their homes and possessions. WHO estimated that some 30,000 children would need continued psychological support and warned of the potential for many to grow up with aggressive attitudes and hatred[10].

Many who were injured during the Israeli military operations sustained permanent disabilities owing to the severity of their injuries and/or the lack of adequate and timely medical attention and rehabilitation. About 30 per cent of patients were expected to have long-term disabilities[11].

In summary, the UN Goldstone report of 2009 found that the Israeli attacks on Gaza in 2008–2009 were "to a large degree aimed at destroying or incapacitating civilian property and the means of subsistence of the civilian population" and found the IDF guilty of "repeated failure to distinguish between combatants and civilians". It also found that Israel "imposed a blockade amounting to collective punishment and carried out a systematic policy of progressive isolation and deprivation of the Gaza Strip".

The Goldstone Report adds that "the destruction of food supply installations, water sanitation systems, concrete factories and residential houses was the result of a deliberate and systematic policy which has made the daily process of living, and dignified living, more difficult for the civilian population[11].

Beginnings of the Viva Palestina network:

Viva Palestina (*Long live Palestine)* is a British-based registered charity. Viva Palestina came into being in January 2009 by a group including British Member of Parliament George Galloway in response to the Dec 2008 Israeli invasion of Gaza. Its objectives are the provision from the UK of food, medicine, essential goods and services needed by the civilian population of the occupied Palestinian Territories and highlighting the causes and results of wars with a view to achieving peace[12].

About the same time in Kuala Lumpur, a group of Malaysians who had been involved in the Palestinian cause got together and decided that a national united platform for Palestine is urgently needed. On 5 January 2009, a coalition of 50 Non Governmental organizations (NGOs), cutting across race and religion, was born. It was then

known as COMPLETE, Coalition of Malaysian NGOs against the Persecution of Palestinians.

In October 2009, George Galloway on a lecture tour of Malaysia, suggested a change of COMPLETE's name to Viva Palestina Malaysia (VPM), considering our shared objectives and aspirations with VP thus presenting a united front of civil societies worldwide to the Israeli-Palestinian issue[13].

The Medical Corps of VP5 with George Galloway

VP has similarly formed in many other countries including Saudi Arabia, Canada, the Gulf States, Italy, Turkey, USA and partners in New Zealand (Kia Ora Gaza) and Australia (Al-Quds Community Centre).

Brief history of previous VP convoys:

Since her inception, VP has successfully launched five convoys to Gaza so far.

VP1 – About 110 vehicles filled with humanitarian aid travelled 5,000 miles across Belgium, France, Spain, Morocco, Algeria, Tunisia, Libya and Egypt and entered Gaza via the Rafah crossing on 9 March 2009. This was accompanied by 180 extra trucks donated by Libya.

VP2 – 200 US activists flew into Egypt from USA and entered Gaza on 17 July 2009. Much of their aid, including 33 sedan cars, were refused entry.

VP3 – Volunteers from several countries travelled via France, Belgium, Luxembourg, Germany, Austria, Italy, Greece, Turkey, Syria, Jordan, back through Syria again, and finally Egypt before entering Gaza via Rafah. The intended date of entry was 27 December 2009, the one-year anniversary of the 2008 Gaza invasion, but actual entry took place on 7 January 2010. VPM donated three fully equipped ambulances for this convoy and raised USD 33,000 for emergency aid to the convoy.

VP4 – VP collaborated with the Turkish IHH charity (Humanitarian Relief Foundation) and joined the Gaza flotilla led by the flagship Mavi Marmara. The Free Gaza Movement, which had experience of previously sending six sea convoys to Gaza also joined the Freedom Flotilla. The Mavi Marmara was illegally raided by the Israelis whose commandos killed nine innocent volunteers. Malaysian volunteers included partners of VPM from Aqsa Syarif, Haluan (a Malaysian NGO comprising of graduates from institutions of higher learning) and Perdana Global Peace (founded by Tun Dr. Mahathir Mohamad, it envisages "a serious, active and sustained struggle against war and for peace").

Preparations for VP5:

Galloway announces the next land and sea convoys to break the siege of Gaza[14-15]. We received this email mid June 2010 and there was very little doubt that Viva Palestina Malaysia (VPM) was going to be a part of this momentous event. The wheels started turning slowly but surely, gaining momentum, energy and loads of enthusiasm. We needed to raise a lot of money, as each vehicle filled with aid cost RM55,000 (USD

17,700). We started off by sending email notices out and in no time the Federation of Islamic Medical Associations (FIMA) and the Islamic Medical Association of Malaysia (IMAM is an active affiliate of VPM) rose to the occasion with RM55,000 for the purchase of one vehicle. Then came news that threw everyone into near fits. A local pharmaceutical company very generously donated RM110,000 (USD 35,400) to fully fund another two vehicles.

And good news was a constant companion as TV3, a Malaysian national TV station, came on board, pledging full support. Friday 27th August marked the start of our convoy. VPM vehicles were symbolically flagged off at TV3's headquarters and our two lady drivers; Azra Banu and Siti Azura were interviewed on our mission, objectives, hopes and aspirations, 'live' on the prime time program, Malaysia HariIni (Malaysia Today)[16].

Azra and Azura, 2 lady volunteers from VPM

Following that, VPM was at the National Mosque with the total support of the mosque committee. Donation boxes were placed all around and we were generously allocated space to sell our paraphernalia. VPM t-shirts were snapped up like hot cakes as Malaysian generosity showed its hand once more.

Men of Aqsa Syarif besides the 6 vans from Malaysia

The media was out in full force clamoring over Tun Dr Mahathir's symbolic contribution and the official check presentation from FIMA and the pharmaceutical company. The total collected surpassed all our expectations; just under RM13,000.

The following Friday we were at the Wilayah Mosque and once again the collection stupefied us; just under RM13,000.

Fund raising at the National Mosque with Dr. Mahathir, Prof. Musa Nordin and VPM activists

Shah Alampasartani (agricultural fest) was next on our list. VPM members and volunteers labored over two Sundays, tirelessly selling anything we could get our hands on; clothes, shoes, handbags, cookies, cupcakes, knick knacks. Everyone chipped in; no task was too big or small and no one too young or old. Tired feet, parched throats, hoarse voices but smiling hearts; all in the blessed month of Ramadan. Again collection exceeded expectations, RM15,000.

And Malaysians kept giving. The association of wives and female staff of Telekom Malaysia contributed RM5, 000 and anonymous donors banked direct into VPM's account.Then came the stunner, Aqsa Sharif, an NGO that is a part of VPM, came on board with the purchase of three vehicles. This brought to total six vehicles from Malaysia.

The Malaysian contingent consisted of twelve volunteers. Ten left for London on Wednesday, 15th September 2010 to begin the month long road trip. Two more would meet the convoy in Damascus on 5th October 2010.

VPM thanked everyone who had made possible the first phase of this VP5 mission. The known donors, the anonymous ones, the volunteers who were relentless in turning up at every event, the media for the much appreciated publicity and anyone and everyone who has had a hand in this most noble cause.

The second phase of VP5 was the actual breaking of the siege. VPM reminded everyone to not lose sight of the bigger picture; 1.5 million Gazans have been under a total lockdown for over 3 years by Israel. Nothing gets in and nothing gets out. Gaza remains in ruins and is cruelly denied all means to rebuild itself. VPM hopes that this convoy would break the siege for good and the blockade of Gaza is forever lifted. But be rest assured that if it is not, civil societies around the world will be relentless in their effort to force Israel to end the siege of Gaza.

It is going to be a long and hard month for our volunteers as they drive the aid laden vehicles from London through France, Italy, Greece, Turkey, Syria, Egypt and God willing into Gaza. We asked all Malaysians to pray for the safe, speedy and successful delivery of this aid to the besieged people of Gaza and the safe return of all our volunteers.

The Road Trip from London to Latakia:

VPM 5 Road map (London to Gaza)

As the Malaysian team of two women and eight men departed Kuala Lumpur for London, families and friends gathered at the airport for a somber yet boisterous send off. On arrival in London, we made our way direct to a warehouse in Luton, where all the vehicles were kept and started decking our six vehicles in Malaysian banners and flags from top to bottom. The entire warehouse was kindly donated for the use of VPUK by a couple of young men, who had quit their daytime jobs to completely be at the disposal of the convoy, getting vehicles ready for the trip. We met

volunteers from Ireland, New Zealand, Australia, Canada, US, Britain and more. Everyone was in an upbeat mood, strangers remained strangers for as long as it took them to pass each other and the camaraderie was unmistakable. Everyone was there for the same cause, same purpose and same mission.

A briefing by VPUK talked about the general code of conduct, what to expect and they warned us of difficulties of negotiations with the Egyptian government, but were hopeful of entering Gaza.
The convoy vehicles were split into two with one leaving from the heart of London for the official flag off, while the second quietly made its way to the M20 highway. We were in the second group, leaving the warehouse in Luton at 9am.

The convoy departed London on the morning of 18th September and our first stop was Paris where we were hosted by Resistance Palestine. Arriving there at 1.20am after a long day, we were warmly greeted, supper and all, and our accommodation for the night was Stade la Briquetterie, a sports hall. From then on it was a whirlwind of city after city; Paris, Lyon, Turin, Milan, Alexandrapouli, Istanbul, Ankara, Kayseri, Adana before finally descending upon Latakia.

The crossing to Greece saw us taking a ferry, a welcome change. The lull of the huge ferry ensured a good night's sleep and we awoke fresh and ready for another day. At almost every city, our vehicles would make our way to the town center to create and garner as much attention as possible. Accommodation was a mix of sports halls, camping grounds, motel and the back of our vehicles.

For the first timers the reception we received was overwhelming, but the seasoned ones kept telling us that we hadn't seen anything yet till Turkey. And how true those words were. As soon as we touched Turkish soil, it was like coming home after a long trip away. At the border itself, the Turkish people welcomed us with cries, chants, hugs, smiles and food. Bags of fruits were tossed into our vehicles as we crossed. Women, men, children, they were all there, waiting for us for hours on end. We made our way to Istanbul and at every stop we made, we were greeted warmly. Piled with kebabs, drinks and loads of goodies, it was an amazing sight. Just outside Istanbul, an even more amazing sight awaited us. Hundreds of people waited, with banners, flags welcomed us. A woman, came up to one of our Malaysian ladies, hugged and greeted her, handed her a flower and strapped a bracelet around her wrist. Another came up and hugged herheroes and just cried away. The Turkish people were expressing their personal loss. We were completing their mission and honoring their fallen heroes on board the Mavi Marmara. They embraced us with their bleeding hearts.

Visiting the grave of a martyr on board the Mavi Marmara

We met survivors from the Mavi Marmara one of whom was Abdulla Taha Can. A second year student of civil engineering, he was shot seven times; in his shoulder, arm and thighs. Two bullets remain in him. We met family members of the martyred; widows, siblings, parents, grandparents and we visited the graves of the fallen. One fallen son was Furkan Dogan, a young man of 19, Kayseri's homeboy. His town had erected a cultural center in his name and it was clear that Kayseri's fallen son will not be forgotten. The

visit to the cemeteries in Istanbul, Ankara, Kayseri and Adana were clearly emotional for many. These martyred men were strangers, yet forever lived in our hearts. We knew them not, yet they were dear to us. They are our sons, brothers, fathers who sacrificed the ultimate for the very cause we were here for. Prayers were offered each time but there was no sadness, only quiet dignity to the whole affair, a solemn respect.

Soil from the graves of two of the martyrs was collected to be taken to Gaza, one of whom was Cetin Topacuoglu. His widow, a highly dignified and brave woman asked that we do all that we can to enter Gaza "in the name of my husband, the martyrs and all the others who have died." Kevin Ovenden, the convoy director replied, "I promise you with dignity that we will do all we can to fulfill this mission."

Bidding Turkey farewell was bitter sweet for we knew we were inching closer to Gaza, but we were leaving beautiful Turkey and her people behind.

The drive to Syria was long and hard. We left Adana, Turkey right after an early breakfast and arrived in Latakia, Syria at 3.30am, some 23 hours later. As we crossed into Syria a huge reception greeted us, replete with pomp and pageantry. There was a huge canopy, a band played along, speeches by representatives of the government, food, drinks, people. It was festive and once again we were embraced whole heartedly.

Our accommodation in Latakia was an army camp. It was indeed a blessing that we arrived in the cover of darkness that masked the physical conditions of the place.

The full extent of the dilapidated camp hit us the next morning but after a briefing by the organizer where we were told to brace ourselves for an extended stay, we got down to cleaning the place and in no time at all turned it more than decent. Unknown to us then it would serve to be a home away from home for the next seventeen days.

Latakia – Home away from Home:

The objectives of the convoy were two pronged; to create awareness of the situation in Gaza and to deliver desperately needed aid to its besieged people. The trucks were loaded with pre approved aid and were mostly medical and educational in nature. Some of the vehicles were packed with aid from London itself but most of the aid was purchased and loaded in Syria. We packed all sorts of medication, school bags, books, stationary, computers and lots of paper.**(see Appendix I)** We even had two incubators which were donated by a woman who had travelled by train all the way from Barcelona to meet us in Lyon to personally hand them over.

VP5 was led by Kevin Ovenden. A man clearly with a mission, his interest in the Palestinian issue began in 1982, when he was 25. Throughout the trip he showed remarkable composure. Even when walking hurriedly, there was a quiet calm to him. A man with a heart of gold, he especially shone when interacting with the Palestinian community. No matter how tired, he always had a smile, word, gesture and a handshake.

The leadership had some difficult negotiations with the Egyptian authorities and many times could not reveal what is going on behind the scenes. This led to some frustration among a handful of the convoy members who were impatient and thirsty for information. The road trip from London to Latakia itself was often shrouded in secrecy and we would be told of our next destination at the last possible minute.

In the beginning there were grumbles and complains at the lack of information but as time passed we got used to the style and started taking things in stride. They must have had good reasons for keeping things close to their chest and must have learned some painful lessons from past convoys. It was largely on a need to know basis only.

A total of 380 volunteers in 147 vehicles from 30 countries made up the convoy. They came from all walks of life and a variety of religious, social, and economic background. It was a remarkable feeling to be in the midst of them all. Back in Malaysia we are so used to the Palestinian issue being seen as a Muslim one, with very little support from our non Muslim friends. But here so many have taken thousands of steps towards relieving some of the extreme hardships of an entire oppressed people.

The Irish were a lot you could not miss. Throughout the trip they made their presence felt. Big men with even bigger hearts, they told us the Irish had been champions of the Palestinians since the 70s. John Hurson, the man in charge of the vehicle maintenance has been on every single convoy. Tony Upton spent an entire day outside his church in Belfast over six services and raised 1,400 pounds for a vehicle. Together with a friend Fra Hughes, they travelled on the bare minimum of expenses, and friends and family back home worked extra to wire the necessary funds for petrol, toll and others. Tony was especially moved by the video of Muhammad Dura, the child who as he was being shielded by his father was cold bloodedly killed by Israeli soldiers. Then there was Little John as he was known. A bricklayer by profession, he had never met a Muslim before this trip and of course found us quite human and different from what is widely portrayed. When asked for reactions from his family he said, "My mum's very proud of me." Loud, strong and totally dependable, the Irish added so much fervor to this trip. They would hoist their flag up alongside the Palestinian's everywhere we went. And when the crowd chanted Allahu Akbar would chorus right along. In the words of one of them "where you find oppression you'll find the Irish."

The British were out in full force. There was Russ Ball; a tattoo clad, bandana wearing, tough and intimidating man with the gentlest of hearts and a twinkle in his eye. It was not long into the convoy when everyone realized that Russ was the man. An experienced driver, he was put in charge of the entire road trip and performed splendidly. Unfortunately Russ had to leave just days before we left Latakia for al Arish as his father passed away.

The Irish Convoy members

The Birmingham boys comprising British Pakistanis raised S.Pound 55, 000 and came so prepared that they had radio communication between all their vehicles. Pippa Bartolotti was a puzzle at the beginning of the trip. She was always immaculately groomed, not a hair out of place that we wondered what was a person like her doing on a trip like this. But Pippa proved us all wrong by her resilience and willingness to go the extra mile. In Lattakia she was one of the few who donned rubber gloves and got down to cleaning the toilets.

There were many other remarkable people; Roger and Hone, the Fowler team of father and son from New Zealand, Pat, another New Zealander a simple electrician with a strong sense of justice, who took his first flight ever when he flew from Auckland to London to be a part of the convoy. The Italians were another strong team. The Americans, Canadians, Australians, French and of course Arabs, contributed the bulk of the vehicles and volunteers.

It was a good representation of the growing support this cause is getting around the world. We were comrades coming together for a cause so

dear to our hearts and standing in solidarity with the people of Palestine.

On the 3rd of October 2010, the Malaysian team was complete with the arrival of Dato' Adnan Mohd Tahir, VPM's Chairman, Dato' Dr. Musa Mohd Nordin, head of VPM's Medical Committee and two crew members from TV3, a major Malaysian television station. Latakia was to be home to all 380 convoy members for the next seventeen days.

After two weeks of constant moving with very little time for anything else in between, the pause in Latakia was very much appreciated. It was here that convoy members found time to unwind, chat, mingle and got to know each other better. We were given glimpses into each others' lives, families, beliefs, culture and lifestyle. It was truly an enriching experience and we could see lifelong friendships being forged.

There were many stirring moments in Latakia. Every prayer was performed in congregation, ably and beautifully led by our Arab brothers. Chants of Allahu Akbar constantly filled the air. Chores and so much more were unselfishly shared and one morning, right after Fajr prayers, when the rain decided to pay us a visit, everyone was outstanding in their response in quickly getting the aid to drier grounds.

Congregational prayers in Latakia- Syria

The planting of five olive trees in the camp grounds was a gesture full of promise and hope for a better future for the Palestinians. The number five symbolized the fifth attempt at breaking the siege and the five continents represented on this convoy. An olive tree signifies posterity, longevity, hardiness, strength, peace and victory, all that the Palestinians are. May Allah grant the trees we planted longevity and health and the people of Gaza strength, resilience and victory InshaAllah.

The people of Latakia were gracious hosts and our needs were well taken care of. We were given breakfast, lunch and dinner throughout our stay. Convoy members were easily spotted when they went about town and often given discounts and many times were not charged for services rendered. Many of us experienced firsthand their hospitality when we were invited into their homes. These dispossessed and displaced people had so much to give.

One incident probably captured the essence of this journey. The camp we lived in is situated next to a Palestinian refugee camp. Every night the local Palestinian community would visit and would ask us all sorts of questions; where were we from, what do we do, how old are we… There was a great deal of open affection and they would hug, kiss or shake hands with us.

They wanted attention and were not abashed about it. After a while a number of the convoy members started getting weary of this nightly routine of having to spend hours entertaining these visitors.

One night, just as I was scheming my exit, a young girl I had spoken to earlier approached me and asked, "Are you happy?" I was puzzled by the question and she asked again, "Are you happy you are going to Gaza?"
I answered, "Insha Allah, if we get to Gaza, I will be very happy", to which she replied "that's my dream. You are making my dream come true." Simple words that brought everything back into

focus. This was not about us or how far we had travelled or how tired we were or how we felt.
It was and will always be about them and the fact that all of us were living their dreams.

The anticipation of the go ahead from the Egyptian government was a roller coaster ride and there was a number of false starts. After about two weeks of waiting restlessness began stirring in some of the members who had pressing issues back home. However the majority were prepared to wait it out with some willing to risk their jobs back home, trusting Allah as the provider. We did our utmost best to keep each others' morale and spirits up.

Good news finally descended, like the blessed rain on a parched day and on the 20th of October we departed Latakia for al Arish in Egypt. All our vehicles were loaded onto a ship with thirty of our volunteers, and the rest of us flew into al Arish in two flights. We bade farewell to Latakia and its beautiful people and asked Allah to take us safely and speedily into Gaza.

Breaking the Siege of Gaza:

We left Latakia with much pomp and pageantry with police escort all the way from the camp to the airport. The Syrians lined the streets in farewell. The flight was all about precision, not a passenger less or more. And as it turned out, a Bahraini brother was left without a seat and there was great disappointment all around, although the dear brother remained calm and accepting of his fate. Then the Bahraini sisters sprang into action and squeezed themselves four to three seats. A headcount found a seat available and our brother was able to join us. Such was the spirit that everyone on board kept this secret.

We landed in al Arish, Egypt and made our way to the humble hotel where we fell exhausted in the wee hours. The next morning soon after breakfast we were taken by buses to the port where our vehicles awaited. It was a strange bond between us and our vehicles, we actually missed them. We wasted no time in getting into our vehicles and soon were on our way to the Rafah crossing. Egyptian police accompanied us all the way and the people poured into the streets in greeting. The drive was heavily laden with expectations and anticipation of a mission so close to accomplishment. Convoy members sat on the window sills of their vehicles, with flags and banners coloring the air. Chants, shouts and tooting, very little could calm the excitement.

Then we saw it, the Rafah gate, and knowing Gaza laid just beyond it was surreal. Two hours were all the drive took and then we were in Gaza. No words could capture the outpouring of emotions. Tears of joy mingled with tears of sadness. The two you-tube referenced pictures the jubilation upon breaking the siege as captured by the Malaysian National News Network and Al-Jazeera[17-18].The Gazans welcomed us like no one else had. We were in Gaza, in Palestine. The blessed land, so beyond the reach of its own people was going to be home for us for the next 4 days, this mish mash of people from all over the world, coming together with the same passion.

After the official reception at the border, our 147 vehicle strong convoy made its way to Gaza city. Women, men and hordes of children waved all the way through, calling out "Welcome to Gaza!" Convoy members were happily distributing sweets when the drive slowed to a pace that allowed it and the children gleefully accepted them. And even in the shade of the night Gaza did not bother to conceal herself. We were greeted by her cries of welcome as much as her cries for help.

The convoy members were put up in various hotels and the Malaysian team stayed at the Beach Hotel, aptly called as each morning we were greeted by the sounds of the waves lapping up the shore and the sight of the Mediterranean Sea stretched before us. Soon after our arrival, we were taken around Gaza, to look at the ruins. Bombed out and completely flattened buildings

were testament. It spoke volumes of those responsible without the utterance of a single word. Lives completely shattered and then denied the dignity of rebuilding.

The Prime Minister of Gaza, Ismail Haniyeh led Friday prayers and in his sermon thanked the convoy for successfully breaking the siege and smashing Israel's control. He then hosted all 380 of us to lunch by the beach. A most gentle and tranquil man, he commanded attention without asking for it and when asked to sign paraphernalia like caps and scarves, he very kindly took time out to do just that. At an official function on Friday evening, the soil from the graves of the Turkish martyrs was solemnly handed over to him.

The vehicles we brought together, with the aid they carried, were successfully handed over to the government of Gaza to be distributed among its people. The al-Shifa Hospital was the first of the recipients. 147 vehicles packed in as much aid as possible but nowhere near Gaza's needs. We can only pray that it relieved a little of their misery, if only fleetingly.

Security was extremely tight throughout our stay. We could not go anywhere without being escorted. The day we left we totally understood this concern on the part of the government of Gaza. As we were driven out of Gaza to the Rafah crossing, lining the Mediterranean sea, well within our sight, were at least eight Israeli gunboats. From the air too we were under surveillance. Welcome to Gaza, the open air prison.

Leaving Gaza was not easy. The journey that took us forty days away from home ended all too soon. We were happy for a mission fulfilled but know that the greater mission remains. Gaza unraveled itself before our eyes and its pain still speaks to us from thousands of miles away. The people of Gaza kept thanking us but in essence it is we who should thank them. These courageous people teach us every day, every hour, every moment what it is like to be brave, strong and resilient. They live against all odds and we are humbled by their unbroken spirit that soars even with clipped wings.

Brave people of Gaza, may Allah grant you more strength, bravery and fortitude. May your spirit remain unbroken and irrepressible. May you stand united, firm and defiant against your oppressors. Brave people of Gaza, we salute you and we await the day when victory greets you Insha Allah.

Funding of Gaza Projects:

During the three days in Gaza, the Malaysian contingent met various NGOs in Gaza undertaking various projects to uplift their communities. Many of the projects visited helped to provid jobs for the women and men of Gaza. Poultry and cattle farms were providing meat which were otherwise very expensive. The dairy farms were producing milk and this was churned into cheese for local consumption.

Green houses were sprouting once again and we saw at least 4 of these whilst there paying monthly incomes of USD 200 per month to the menfolk. The women were into embroidery, sewing garments, making cakes and selling them in shops and managing nurseries for the working mothers. Monies were dispensed to many of these projects to increase their capacity and enhance employment opportunities for more men and women.

VPM identified the following projects which merit further funding :

1. SOFT LOANS FOR MICRO PROJECTS WITH "SERAJ AL OMMAL SOCIETY"

   Seraj Al Ommal Society will assess each proposed project in Gaza on its need and feasibility. Interest free loan up to a maximum of US$2,500 with easy repayment terms will be given to each qualified applicant. We intend to start with 20 projects to talling US$50,000. The fund

is expected to grow and benefit more entrepreneurs over time.

2. EMPLOYMENT FOR WOMEN THROUGH "FAMILY AND SOCIETY DEVELOPMENT ASSOCIATION"
   Family and Society Development Association has a small factory making cakes and pastries, sewing embroideries and traditional clothes. It provides employment to 30 widows and women whose husbands are martyred or imprisoned. It is under financed and lacks expertise. We intend to assist technically and financially to make the business viable and provide employment to more women in the Jabalia Camp area. Funds required would be US$80,000.

3. SMALL INTEGRATED AGRICULTURAL ANIMAL HUSBANDRY PROJECT WITH "QURTOBAH CHARITABLE SOCIETY"
   The Israeli Siege on Gaza has created extreme shortages and high prices of vegetables and meats in Gaza. Gaza has ample fertile and vacant lands available for cultivation and establishment of animal farms which would also provide employment to Palestinians. There is a ready local market for the products, and the size of the project would be dependent on the funds available. We hope to provide US$140,000 for this project.

4. "THE ROOTS OF PALESTINIAN HERITAGE" WITH "OUR CHARITY HERITAGE SOCIETY"

   This project aims to produce and market products of Palestinian cultural heritage, like crafts and souvenirs, thus preserving and protecting Palestinian identity. At the same time, it provides employment to women and disabled persons to alleviate their economic sufferings. We plan to allocate US$30,000 for this project.

5. TRAINING OF DOCTORS FROM THE MEDICAL FACULTY OF ISLAMIC UNIVERSITY OF GAZA.
   This project aims to provide post-graduate training in various medical and surgical specialties in Malaysia for medical doctors in Gaza. Close liaison is undertaken with the Federation of Islamic Medical Associations (FIMA) to provide funding for this project.

Aqsa Syarif listed the following projects in Gaza as requiring urgent attention and which they would immediately source funding:

1. Aid to the very poor in the district of Jabalia for 1 year (500 families) – USD 800,000
2. Water well drilling in Jabalia district – USD 150,000
3. Food plant center in the district of KhanYunis offering employment opportunities – USD 400,000
4. Dairy farm project in Jabalia and beitlahia (ongoing project) – USD 65,000
5. Loaf Bread factory in Jabalia and Beithahya – USD 80,000
6. Fish farm and Cattle farm – USD 100,000

Conclusions:

The Gaza invasion is yet one more tragic story in a long, sad tragedy that has befallen a people whose story has been denied and distorted. Nelson Mandela (born 18 July 1918) the president of South Africa from 1994-1998, sums it well when he said,*"it is the worst moral crisis of our times"*[19]. Thus making it a humanitarian crisis; a colossal failure of our collective humanity. Abraham Joshua Heschel (1907-1972) one of the leading Jewish theologians and philosophers of the 20th century adds *"few are guilty but all are*

responsible". He called on all concerned citizens to take on board the role of Biblical prophets who passionately advocated for the rights of the oppressed[20].

For the period 18 Sept – 25 Oct 2010, fourteen of us from Malaysia were blessed to be in the company of 366 volunteers from 30 nations on the Viva Palestina's 5th Land Convoy 'A Global Lifeline to Gaza'. It was simply extraordinary the love and passion which these ordinary convoy guys exhibited for Palestine. Driving 147 big trucks laden with USD 5 million worth of medical and educational aid for Gaza, the volunteers from several religious, national, ethnic and political backgrounds truly represented the universality and the camaraderie of humanity.

The long haul from London to Gaza represented another humanitarian piece in the complex jig saw puzzle to end the siege on Gaza, to mainstream the rights of the Palestinians to equity, justice and self determination and the ultimate prospect of peace in the Middle East[21]. VP5 and all similar efforts that preceded it has mainstreamed the international character of efforts to end the longest military occupation in modern history, people driven out of their homes never allowed to return and dispossessed of all their property. It is the collective and sustained disgust at such irrational violence towards an entire people that has seen the dismantling of the apartheid regime in South Africa and the end of genocide in Rwanda.

Yet again, civil society must take charge, where super-powers have failed the Palestinian people. The medical and humanitarian relief of VP5 'A Global Lifeline to Gaza' is one of many international efforts to end the siege of Gaza; and transform the tragic course of history in Palestine.

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Appendix I

EDUCATIONAL AID:

School bags	Color Pencils	A4 paper
Notepads	Pencil Boxes	Mathematical instructions (sets of compasses and protractors)
Pens	Story and Sciences Books	Computers
Pencils	Paints	Calculators
Erasers	Stickers	Printers

MEDICAL AID:

Incubators
Infant ventilators
CPR Mannequins (Adult, Child and Neonate)
Digital Cameras;
Sphygmomanometer;
Hydraulic Bed;
Portable suction machine;
Otoscope;
Ophthalmoscope;
Tuning Fork;
Nasal speculum;
Vaginal speculum;
Syringe pump;
Laryngoscope;
Infusion pump;
Neurological hammer;
Wheel chairs;
Examination table
Commode;
First aid kits;
ECG machine;
Doppler ultrasound ;
Cardiac Monitor;
Self administered analgesic pump;
Glucometers;
Defibrillator;
Emergency trolley;
Dressing trolley;
Traction system;
Ambu bag (adult, pediatric and infant);
Medication trolley;
Dressing set;
Minor surgical set;
Suture set;
Snellen chart;
Hydraulic lift;
Stethoscope;
Platform crutches;
Pulse oximeter;
Air mattress;
Nebulizer machine
Spirometer;
Neck collars
Medicines - syrup, tablets and injectable forms
Resuscitation tubings, artificial airways,
Surgical appliances, e.g. surgical scissors, surgical operating instruments, disposable surgical sets for different surgical procedures and biopsy sets.
Medical appliances, mainly disposable feeding tubes, urinary catheters with bags, cannulas for intravenous lines and chest tube sets.
Specialized infant milk formulas.
Machines to do rapid tests, especially in ICU setting.
Disposable dressing sets for operations, wound debriding and special adhesive dressings.
Bandages, limb support and girdles.
Motorized scooter for ambulation.
Disposable masks, gloves and protective operation wear

INSTRUCTIONS AUTHORS

Authors should submit a statement indicating that their opinions do not reflect the opinions or policies of the institutions with which they are affiliated if required by those institutions.

Authors are also expected to submit a statement informing the editor of any commercial association that might pose a conflict of interest.

Manuscript Preparation

1. Print the manuscript on one side only of white bond paper, 22 by 28 cm (8.5 by 11 inches) in size, with 2.5-cm (1-inch) margins at top, bottom and sides. It should be double-spaced throughout.

2. Begin each of the following sections on a separate page: title page, abstract and key words, the text, acknowledgements, references, individual tables and legends of figures (if any). Number the pages consecutively beginning with the title page.

3. The title page should contain:
(a) the title of the article.
(b) names of all authors (first name, middle initial, and then last name).
(c) highest degrees of each of the author(s).
(d) name(s) and address(s) of the institution(s) with which the authors are affiliated.
(e) name, address, phone number, fax number, and e-mail address of the author who assumes all responsibility for correspondence with the editors.

4. The abstract should be limited to 200 words and double-spaced, with the required margins and headed by the title of the article and name(s) of author(s). Below the abstract, list three to five key words or short phrases for indexing purposes. Whenever possible, use the terms from the Medical Subjects list of *Index Medicus*.

5. The manuscript text should be divided into appropriate headings.

Quoting Qur'anic verses and Ahadith is encouraged. The quotation should be on a separate line in the text. It should be given a reference number in the text and listed in the reference section. See examples in the Reference Section.

6. Use standard abbreviations only. Abbreviations should not be used in the title and should be avoided as much as possible in the abstracts. In the text, abbreviations should be kept to a practical minimum. The full term for which a given abbreviation stands should precede its first use in the text, unless it is a standard unit of measurement. Consult Scientific Style and Format by the Council of Science Editors

(www.councilscienceeditors.org) or the American Medical Association's Manual of Style.

9. References should be numbered consecutively as they appear in the text. Use the format of the Uniform Requirements for Manuscripts Submitted to Biomedical Journal (www.icmje.org). Journal titles should conform to abbreviations used in Cumulated *Index Medicus*.

a. Standard journal article: List all authors if three or fewer. If more than three, list the first three authors followed by et al.
Example: Halpern SD, Ubel PA, Caplan AL. Solid-organ transplantation in HIV-infected patients. N Engl J Med. 2002 Jul 25;347(4):284-7.

b. Organization as author:
Example: Diabetes Prevention Program Research Group. Hypertension, insulin, and proinsulin in participants with impaired glucose tolerance. Hypertension. 2002;40(5):679-86.

c. No author given:
Example: 21st century heart solution may have a sting in the tail. BMJ. 2002;325(7357):184.

d. Personal author(s) of books and monographs:
Example: Murray PR, Rosenthal KS, Kobayashi GS, Pfaller MA. Medical microbiology. 4th ed. St. Louis: Mosby; 2002.

e. Editor(s), compiler(s) as author:
Example: Gilstrap LC 3rd, Cunningham FG, VanDorsten JP, editors. Operative obstetrics. 2nd ed. New York: McGraw-Hill; 2002.

f. Author(s) and editor(s):
Example: Breedlove GK, Schorfheide AM. Adolescent pregnancy. 2nd ed. Wieczorek RR, editor. White Plains (NY): March of Dimes Education Services; 2001.

g. Chapter in a book:
Example: Meltzer PS, Kallioniemi A, Trent JM. Chromosome alterations in human solid tumors. In: Vogelstein B, Kinzler KW, editors. The genetic basis of human cancer. New York: McGraw-Hill; 2002. p. 93-113.

h. Conference proceedings:
Example: Harnden P, Joffe JK, Jones WG, editors. Germ cell tumours V. Proceedings of the 5th Germ Cell Tumour Conference; 2001 Sep 13-15; Leeds, UK. New York: Springer; 2002.

i. Newspaper article:
Example: Tynan T. Medical improvements lower homicide rate: study sees drop in assault rate. The Washington Post. 2002 Aug 12;Sect. A:2 (col. 4).

j. Audiovisual material:
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m. Qur'anic Verse:
Example: The Glorious Qur'an Chapter 40, Verse 68.

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o. Hadith from database:
Example: Sahih Al-Bukhari, Book 79, Kitaab al-Tibb, Chapter 1, Hadith 5354. [on-line] Available from: http://www.muhaddith.org.

10. Print each table on a separate sheet. Number the tables consecutively and use Arabic numerals. Each table must be cited in sequence at an appropriate point in the text. Each table has to have a caption. These should be brief yet indicate closely the purpose or content of the table. Each column should be precisely defined by headings. Abbreviations and special designations should be explained in a footnote to the table.

11. The term figure includes all types of illustrations such as graphs, diagrams, photographs, flow charts, and line drawings. Figures must be cited consecutively in the text with Arabic numerals. Figures should be 12.5 cm by 17.5 cm (5 inches by 7 inches). Consistency in size is strongly preferred. Any special instructions regarding sizing should be clearly noted. Freehand lettering on the figure is not acceptable. All lettering must be in proportion to the drawing, graph, or photograph. Figure legends should not appear on the figure. Multiple figures on a page cannot be accepted.

All figures must be submitted in triplicate. Illustrations should be professionally drawn. Photographs must be sharp and glossy. Do not send negatives or original artwork. Each figure or photograph should have a label on its back indicating author's name, figure

number and its top (indicated by an arrow).

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14. Author(s) is/are responsible for all the statements made in his/their work including changes made by the copy editor.

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Individual tables (if any) should be in a file called tables.doc, and legends of figures (if any) should be in one file called legends.doc.

Figures are encouraged in electronic format with a printed proof on glossy or high-quality photographic printer paper.

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