

**ISLAMIC MEDICAL ASSOCIATION
OF
SOUTH AFRICA:
ACTIVITIES AND PROJECTS**

by

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Dedicated to

Professors Syed Salman Nadvi and Abul Fadl Mohsin Ebrahim
and
the late Ebrahim Mahomed Mahida

CONTENTS

ACKNOWLEDGEMENTS	iv
INTRODUCTION	1
CHAPTER ONE: ESTABLISHMENT OF THE IMA - HISTORICAL BACKGROUND	4
1.1 THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL	4
1.2 The MEDICAL ASSOCIATION OF SOUTH AFRICA	6
1.3 THE CHRISTIAN MEDICAL FELLOWSHIP OF SOUTH AFRICA	8
1.4 THE NEED FOR AN ISLAMIC MEDICAL ASSOCIATION	10
1.5 FORMATION OF <i>LAJNATUL ATIBBA</i>	11
1.6 TRANSFORMATION OF <i>LAJNATUL ATIBBA</i> TO THE ISLAMIC MEDICAL ASSOCIATION	15
1.7 REACTIONS TO THE FORMATION OF THE IMA	24
1.8 OFFICIAL LAUNCHING OF THE IMA	27
CHAPTER TWO: A SURVEY OF THE IMA ACTIVITIES AND PROJECTS	31
2.1 SETTING UP OF IMA BRANCHES	31
2.2 ASSISTING IN FORMULATING HOSPITAL POLICY	32
2.3 MEDICAL ETHICS	33
2.4 FEDERATION OF ISLAMIC MEDICAL ASSOCIATIONS (FIMA)	34
2.5 SETTING UP OF ITS FIRST PERMANENT OFFICE	35
2.6 ANNUAL CONVENTIONS	35
2.7 RELIEF WORK	36
2.7.1 Participation in Local Relief Work	37
2.7.2 Role in International Relief Work	38
2.8 RELIGIOUS AIDS PROGRAMME (RAP)	42
2.9 VACCINATION FOR PILGRIMS	43
2.10 COMMUNITY RADIO STATIONS	44
2.11 GENERAL	45
CHAPTER THREE: IMA CLINICS	47
3.1 MISSION STATEMENT OF THE IMA CLINICS	48
3.2 KWAZULU-NATAL CLINICS	49
3.3 SUMMARY OF THE KWAZULU NATAL CLINICS' ACTIVITIES	62
3.4 GAUTENG CLINICS	66
3.5 WESTERN CAPE CLINICS	71
3.6 IMACSA	73
3.7 OUTREACH SERVICES	73
3.7.1 Specialist Clinics	74
3.7.2 Eye Clinic	75

3.7.3	Dental Clinic	75
3.7.4	Home Care Nursing Programme	76
CHAPTER FOUR: ACADEMIC ACTIVITIES OF THE IMA		78
4.1	BOOKS	78
4.2	BOOKLETS	79
4.3	<i>JIMASA (JOURNAL OF THE IMA OF SOUTH AFRICA)</i>	85
4.4	<i>BIMA (BULLETIN OF THE IMA)</i>	86
4.5	PAMPHLETS	87
4.6	GENERAL	87
4.6.1	The Oath of the Muslim Physician	87
4.6.2	Medical Research	88
4.6.3	Students' Electives	88
4.6.4	Public Education	89
4.6.5	Promoting the Establishment of IMA in Neighbouring Countries	89
4.6.6	Participation in International Conferences	89
4.6.7	International Links	90
4.6.8	IMA Health Manifesto	90
4.6.9	Submissions on Ethical Issues	91
CHAPTER FIVE: EVALUATION OF THE IMA IN LIGHT OF THE RECONSTRUCTION AND DEVELOPMENT PROGRAMME (RDP)		93
5.1	THE RDP	93
5.2	HEALTH PRINCIPLES AND PROGRAMMES	94
5.3	THE RDP <i>VIS-A-VIS</i> IMA CLINICS	97
5.3.1	Right to optimal health	98
5.3.2	Free health care services	98
5.3.3	Preventive and promotive activities	99
5.3.4	Primary care facilities and training of health care workers	99
5.3.5	Health care personnel's experience of working in rural settings	100
5.3.6	Prevention and control of major risk factors and diseases	100
5.3.7	Promotion of general health and encouragement of healthy lifestyles	101
5.3.8	Health education on sexuality, child spacing and substance abuse	101
5.3.9	Respect for patients' rights	101
5.3.10	Oral health care	102
5.3.11	Caring for the terminally ill	102
5.3.12	Rehabilitation services	102
5.3.13	Provision of equipment for people with disabilities	102
5.3.14	Development of comprehensive women's health care services, including contraceptive services	103
5.3.15	Preventive and promotive health programmes for children	103
5.3.16	Water, electricity and communication systems	103
5.3.17	Promotion of research that aims at improving the health of people	104

CONCLUSION	110
APPENDICES	119
BIBLIOGRAPHY	133

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INTRODUCTION

In the early 1970s, a few Muslim doctors, noting with concern their problems of facing contradiction between the dictates of the *Shari'ah* (Islamic Law) and certain medical practices permitted under the laws of the country, established first a *Lajnatul Atibba*¹ (meaning the Doctors' Committee) and then later an Islamic Medical Association (IMA). They were also conscious of the disparate health services under the apartheid government of South Africa. This prompted them to embark upon the establishment of a modest Sunday Clinic at Braemar on the south coast of Natal (now known as KwaZulu Natal). This attempt was to cater for the needs of a black (African) rural community which had virtually no access to any form of health service.

The initial name of this group of health care providers was *Lajnatul Atibba*. The group's objective was to provide voluntary health service to all, irrespective of race, colour and religion.

After almost a decade of making efforts and persistence, this "Doctors' Committee" evolved into a fully fledged, well-structured professional body which was named the Islamic Medical Association of South Africa (hereafter referred to as IMA). Since its formation the organisation has grown from strength to strength and has made great strides in various fields.

Over the years the Islamic Medical Association of South Africa has developed into a

1. The correct transliteration is *Lajnat al-Aṭibbā'*.

large national body with a membership of over 1 500 Muslim doctors and other health care professionals. It has branches all over South Africa and runs clinics in three of the nine provinces.

It is also involved in numerous activities such as welfare, health care, health education and research. The IMA has also succeeded in establishing links with other overseas medical organisations and other associations and holds annual conventions. At these conventions prominent Muslim and non-Muslim personalities from medical and non-medical fields are invited as guest speakers. At these conventions, academic papers of a high standard are presented by both the local and overseas participants.

Its members have also shown a keen interest in the Reconstruction and Development Programme (RDP). They have always been committed to provide voluntary health service to all, irrespective of race, colour and religion.

It is to be noted, however, that during the initial years of its formation, the IMA was beset with innumerable problems, and had it not been for the perseverance and dedication of a small dedicated group of people, this organisation would not have come into being.

In view of the fact that there is no documented historical record of the IMA whose activities have had an impact in this country and abroad, I decided to research the IMA and its activities with the aim of evaluating its contributions to the South African communities in general and the RDP in particular.

Thus the objectives of my study will be to:

- a) analyse the reasons which led to the founding of this Association;
- b) investigate its activities and contributions and evaluate its impact in this country and beyond the geographical boundaries of South Africa;
- c) evaluate its role and contribution in post apartheid South Africa in the light of the RDP;
- d) investigate the concerns of the IMA about major contradictions between the dictates of the *Shari'ah* and accepted medical practices under the secular law.

Chapter One

ESTABLISHMENT OF THE IMA - HISTORICAL BACKGROUND

At the very outset, it is imperative to point out that certain medical organisations were already in existence in South Africa before the IMA came into being. However, the need for the establishment of the IMA in the early 1970s can only be fully appreciated if one is aware of the role and functions of the already existing medical organisations. Their roles and functions are discussed hereunder:

1.1 THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

This council is a statutory body which was established in 1928 by the Parliament Act 13 of 1928.¹ It is self-regulatory and autonomous of the government. All medical practitioners, dentists, psychologists or as interns, have to be registered with the Council in order that they may practice their professions. The primary objective of the Council is to assist in the promotion of the health of the population of the Republic. It has a variety of functions, viz. control over the medical register, to determine standards of professional training and setting and maintaining fair standards of professional practice, approval of training schools, the recognition of local and foreign medical qualifications, inspection of training and conducting certain examinations.

1. Strauss, S.A. *Legal Handbook for Nurses and Health Personnel*. Cape Town. King Edward VII Trust. 6th Ed. 1987, p. 58.

An important function of the Council is the exercise of its disciplinary powers over persons registered with it. The disciplinary duties of the Council and the professional boards are discharged in accordance with strict legal principles following upon formal complaints lodged with the Council against registered persons. In addition, the Council advises the Minister of Health on matters within its competence and also communicates to the Minister information on matters of public importance which come to the attention of Council.¹

It should be noted that pharmacists, nurses, chiropractors, homeopaths and dental technicians have their own statutory regulatory bodies and do not register with the Council. The Council should not be confused with the various professional associations which are voluntary bodies. The Council is a statutory body and the country's official "keeper of registers". Registration with the Council is a legal prerequisite for practising any of the Council's registrable health professions.²

The Council has always been "white" dominated as no "non-white" was elected on the Council's body. Hence it came to be regarded as an apartheid structure by "non whites". This feeling was further exacerbated by the Council's handling of the death of a "black" medical student, Steve Biko, who died in detention on 12 September 1977. This case had a profound effect on the medical profession. The Council and the Medical Association of South Africa have paid dearly, in terms of membership, political clout and credibility, for what was perceived as their silence and apathy then.³

1. *South African Medical and Dental Council's Brochure*. Pretoria. November 1994.

2. *ibid.*

3. "Sometimes having to say you're sorry" in *South African Medical Journal (SAMJ)*. Cape Town. Medical Association of South Africa. Vol. 85. No. 8. August 1995, p. 715.

At present the Council is an interim structure because it is being re-organised in the light of the new Health Policy of the new democratic government of the country in order to have greater emphasis on professional practice, democracy, transparency, equity, accessibility and community involvement. It is presently known as the Interim National Medical and Dental Council of South Africa.¹

1.2 THE MEDICAL ASSOCIATION OF SOUTH AFRICA

The Medical Association of South Africa (hereafter referred to as MASA) was founded in 1927.² Membership is voluntary and open to all doctors registered with the Medical Council to practise in South Africa. It is an independent and voluntary professional organisation for doctors. It serves the interests of the medical profession, represents its members and promotes health for all.

The role and function of MASA is summarised below as the main object of the Association:³

- (i) to represent the medical profession in all matters of collective and individual interest;
- (ii) to act as the principal co-ordinating and negotiating body for the medical profession;

1. *Pamphlet* issued by Interim National Medical and Dental Council of South Africa. Pretoria, n.d.

2. *Pamphlet* issued by the Medical Association of South Africa. Cape Town, n.d.

3. Memorandum of Association and Articles of the Medical Association of South Africa. Pretoria. February 1993.

- (iii) to serve the needs of members of the association to enable them to function optimally as professionals;
- (iv) to promote health through the expertise and influence of the medical profession;
- (v) to take an active part in the promotion of healthcare programmes for the benefit of the community;

MASA is the oldest medical association in the country and has by far the largest membership. It has the most advanced organisational structure and has a vast array of resources and expertise. It also enjoys recognition by the World Medical Association and is run on a full-time basis.

Unfortunately MASA has been perceived, both at home and abroad, as an essentially “white” organisation and a captive of the political status quo, especially during the apartheid years. It remained silent on race-based public policies affecting the medical profession and the community, such as the restriction of medical school admissions on the basis of race, the segregation of hospitals and other health facilities, and (government) interference with doctors’ treatment of prisoners and detainees.¹

In order to break away from its negative past image and in the spirit of national reconciliation MASA adopted a resolution of unreserved apology to persons, within and outside the medical profession, who might in the past have been hurt or offended by any

1. "Shedding the burden of the past" in *SAMJ*, op. cit. Vol. 85. No. 8. August 1995, p. 705.

acts of omission or commission on its part. This was adopted at its Annual Federal Council Meeting in Pretoria in June 1995.¹ Today MASA is a part of the new democratic process that is sweeping over the country. It has recently changed its name to the South African Medical Association from June 1998.

MASA functions within the ambit of the secular laws of the country and, therefore, it cannot cater for the needs of any special group or any particular religious or cultural requirement.

1.3 THE CHRISTIAN MEDICAL FELLOWSHIP OF SOUTH AFRICA

The Christian Medical Fellowship of South Africa (hereafter referred to as CMF) was founded in 1950 with its first committee meeting held at the University of Cape Town.²

The aims of the CMF, according to its constitution are as follows:³

- (i) to unite Christian doctors, dentists, medical students and members of the para-medical services in a Fellowship for the promotion of Christian witness, prayer and Bible study.

1. "MASA pledges unreserved apology" in *SAMJ*, op. cit. Cape Town. Vol. 85. No. 8. August 1995, p. 733.

2. *Letter* written by T. Germond with the caption "Introduction for Medical Students to the Christian Medical Fellowship of South Africa". Pretoria. October 1996.

3. *Constitution* of the Christian Medical Fellowship of South Africa. Cape Town. 1965.

- (ii) to inspire its members to win others for Jesus Christ and to increase among members of the medical profession, faith in Him and acceptance of His ethical teaching.
- (iii) to propagate and defend the fundamental truths of Christianity as set forth in paragraph A.3 of this constitution.
- (iv)
 - (a) to foster interest in mission work
 - (b) to assist in the recruitment of Christian medical men and women for the mission field.
 - (c) to assist actively those already engaged in medical mission work.
 - (d) to encourage members to consider entering neglected or underserved areas, medical or geographical, where Christian witness is needed.
- (v) to establish and promote international contact with organisations with similar aims.

The CMF is a full member of the International Christian Medical and Dental Association. It is a non-denominational, non-racial Christian medical fellowship. It welcomes all registered members of the medical profession who are in sympathy with its aims and who subscribe to the membership declaration which states, "I declare my faith in God the Father and in God the Son, the Lord Jesus Christ, Who is my Saviour. I desire to be ruled by God the Holy Spirit"¹. Thus one has to be a Christian believing in the Trinity in order to join the CMF. Hence the CMF is a Christian religious medical association with emphasis on Christian missionary work.

1. See appendix A of this dissertation.

1.4 THE NEED FOR AN ISLAMIC MEDICAL ASSOCIATION

The need to form an Islamic Medical Association was felt in the early 1970s. Muslim health care professionals in general were faced with certain ethical dilemmas in their practices and some of them came to the realisation that they, as Muslims, should apply Islamic teachings in their practices. This meant that they had to educate themselves on such matters as family planning, birth control, sterilisation, abortion, alcohol containing drugs, pig derived medicines (insulin, heparin, gelatin capsules), reconstructive surgery (how much to replace? What parts to replace? How much to reconstruct?), organ transplantation, etc.¹

At this juncture, it ought to be mentioned that the needs of the Muslim health care professionals could not be adequately catered for by the existing medical organisations like the SAMDC which is only a statutory governing body for all medical practitioners, nor by MASA which has a secularistic outlook, and certainly not by the CMF which is Christain based with a missionary outlook. It became imperative and clear, therefore, that Muslims should and can have their own medical association so as to cater for the specific needs of Muslim physicians and to promote a better understanding of Islam and of medicine within the framework of Islam. Such an association could also promote research and publications in the field of Islamic Medical History, Prophetic Medicine, Islamic Medical Ethics and Medicine in general. It could even set up its own clinics in the disadvantaged rural black areas where little or no health services existed.²

1. Amod, F. Formation of the Islamic Medical Association of South Africa - The Early Years. Durban. Islamic Medical Association of South Africa. 1996, p. 23.

2. *ibid*, p. 27.

1.5 FORMATION OF *LAJNATUL ATIBBA*

Discussion on the necessity of forming an association for Muslim doctors gained momentum only after the late Mr Mahmood Moosa and Ebrahim Jadwat of the Muslim Youth Movement (hereafter referred to as MYM) returned to Durban after having attended a convention of the Muslim Students Association (MSA) of North America in Lafayette, Indiana in 1973.¹ At that convention they had come into contact with members of the Islamic Medical Association of North America and were convinced that it was possible to establish a similar association in South Africa. Upon their return, in September 1973, they called up a meeting of a group of doctors, dentists and medical students and urged them to seriously think about establishing a separate association for Muslim doctors.²

At that meeting, it was agreed to establish such a body which would cater for the needs of Muslim doctors. The core committee that was elected to bring the association into fruition comprised of Drs GM Hoosen, YH Mahomedy, FA Randeree, MAK Omar, GHS Tootla (a dentist) and MH Khatree (a 5th year medical student). From then on, regular meetings were held at Dr Tootla's rooms in order to discuss the constitution, to look into the feasibility of establishing a clinic which would cater for primary health care, and other activities of this association. During the course of the meetings the name Islamic Medical and Dental Association of South Africa (IMDASA) was thought to be a suitable one for their association.

1. Interviews with Dr GM Hoosen and Mr E Jadwat - August 1995.

2. Interviews with Mr E Jadwat, Drs GM Hoosen, YH Mahomedy, MAK Omar and MH Khatree - August 1995.

On 18 March 1974 the core committee met at Dr YH Mahomed's home where the draft constitution of IMDASA was finalised. This constitution later formed the basis of the first IMA constitution in March 1981. The core committee then decided to invite the Muslim doctors and dentists from KwaZulu Natal and Transvaal (now known as Gauteng) to a meeting to officially launch the IMDASA.

The involvement of the late Dr MI Essack of Kismet Clinic was significant as he made available to the core committee a list of names and addresses of Muslim doctors and dentists in the then Natal and Transvaal. Notices were sent inviting them to a meeting on 7 July 1974 at the Orient Islamic School, Durban, to form the IMDASA.¹ When news of this meeting reached the public, there was an uproar among non-Muslim and some Muslim doctors. Articles were printed in and letters written to the local newspapers opposing the formation of such an organisation.

The two main concerns of the antagonists were firstly, that a precedent was being set in establishing an "ethnic" association and secondly, that such a move would divide the Indian community in the political sense. There was tremendous pressure placed on the core committee, urging them not to form IMDASA. This led to one member of the core committee opting out. They were also threatened to be black listed if they persisted in forming such an association. Counter arguments were that there already existed "ethnic" medical organisations like the Christian Medical Fellowship and the Red Cross. Moreover, Islam transcended racial distinctions and adherents of Islam are found in all racial groups and not only amongst Indians. The fears of the antagonists were baseless

1. Interviews with Drs GM Hoosen, YH Mahomed and FA Randeree - August 1995.

and had to be ignored. The noble intentions of the association were clear in that it was to serve all the people irrespective of race, colour and religion. Nonetheless, the fear of being ostracised was acknowledged.

Professor Syed Salman Nadvi, Head of the Department of Islamic Studies, University of Durban-Westville, suggested to the core committee that if an “Arabic” name was to be selected for the association, it would deflect the opposition against the formation of IMDASA. Thus on Wednesday, 3 July 1974, the core committee met with Advocate *hafiz* Abu Bakr Mahomed and other members of the MYM in order to decide on an appropriate Arabic name. The name *Lajnatul Atibba* (“The Doctors’ Committee”) was finally adopted.¹

It was on Sunday afternoon, 7 July 1974, that for the first time ever a public meeting for Muslim doctors and dentists was held at the Orient Islamic School in Durban. The aim was to officially launch the *Lajnatul Atibba*.² Due to the uproar that was created, only about 30 persons attended that meeting.³ Refreshments for the participants was willingly provided free of charge by “Hansa’s Take Away” - a part of show of support by the Muslim public to the health professionals in their endeavour to form such an association.⁴ It was unfortunate, however, that the majority of doctors, who were opposed to the idea from the beginning, attended that meeting and came with the specific purpose of preventing the establishment of that association. The meeting was chaired by Dr GM

1. Interviews with Drs GM Hoosen, YH Mahomed, FA Randeree, MAK Omar and Mr E. Jadwat - August 1995.

2. *Lajnatul Atibba Brochure*, June 1996.

3. Interview with Drs GM Hoosen, YH Mahomed and MAK Omar - August 1995.

4. Interview with Mr M Hansa - October 1995.

Hoosen and the main speaker was Advocate *hāfiẓ* Abu Bakr Mahomed, the then president of the MYM.

It was during that meeting that for the first time in public, certain Muslim doctors with political motives voiced their opposition against the formation of such an association. Their objectives were varied. For example, some felt that it would be an opposition to the Medical Association of South Africa (MASA); others felt that it was an "ethnic" medical council; some specialists were worried that they would not get any referrals; others were afraid that it would antagonise their non-Muslim friends and colleagues; and some who were politically aligned to the Natal Indian Congress and the Transvaal Indian Congress felt that it would divide the Indian community. On the whole there was no support from the majority of those who attended that meeting for the formation of a national Islamic medical body. It was suggested in passing though that there would be no objection if *Lajnatul Atibba* was established as a sub-committee of the MYM.¹ The irony of that whole exercise was that although Muslim doctors constituted 70% of the so called "non-white" doctors in the country at that time, they could not succeed in forming an Islamically aligned association at that meeting.

Dr GM Hoosen was elected as chairman of *Lajnatul Atibba* with Dr MAK Omar as secretary and Dr YH Mahomed as treasurer. The executive was later expanded to include Dr FA Randeree and MH Khatree (then a final year medical student). Until then the core committee had attempted to facilitate the formation of an association but, thereafter, it evolved into a forum for Muslim doctors albeit under the auspices of the

1. *Lajnatul Atibba Brochure*. June 1996.

MYM. Although the initial members were disappointed that more Muslim doctors had not joined them and that an Islamic Medical Association could not be formed, their spirits were never dampened.

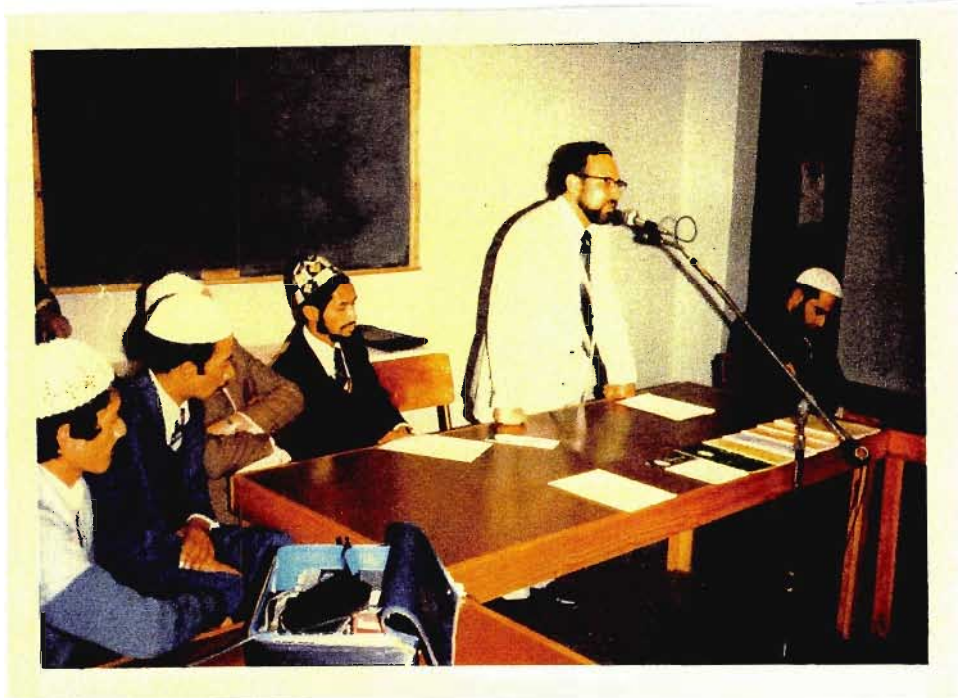
The first meeting of the executive of *Lajnatul Atibba* took place on Tuesday, 9 July 1974, at the residence of the late Dr MI Essack at La Mercy, Durban. At that meeting a decision was taken to initiate the pilot project of a clinic.¹ The MYM suggested that As Salaam at Braemar on the south coast of Natal was an appropriate venue as that rural area did not have any form of health services. This area was remote and the nearest town, Umzinto was 20km away. The nearest hospital in Scottburgh was about 40km away. It must be remembered that back in 1974, transport to the rural areas were woefully inadequate. The establishment of this clinic will be discussed in the chapter which deals with the activities of the IMA.

1.6 TRANSFORMATION OF LAJNATUL ATIBBA TO THE ISLAMIC MEDICAL ASSOCIATION

The transformation of *Lajnatul Atibba* to the Islamic Medical Association (IMA) of South Africa was prompted by Dr M Khan of Port Shepstone after his return from Buffalo in 1977 where he had attended the Annual Convention of the IMA of North America. Initially some members of *Lajnatul Atibba* had doubts about the establishment of an IMA in South Africa in the light of the problems that they had encountered in the past. Dr GM Hoosen, upon the advice of Dr M Khan, attended the next convention of the IMA of

1. Interviews with Drs GM Hoosen and YH Mahomed, August 1995.

North America which was held in Detroit, USA, in September 1978. Both of them had personally met Dr Ahmed El Kadi, a founding member of the IMA of North America, and thought that they should invite him to South Africa so as to assist them in transforming *Lajnatul Atibba* to the IMA. Dr El Kadi accepted the invitation and arrived in September 1979.¹ Dr El Kadi was taken on a tour of the country by Drs GM Hoosen and M Khan in order to promote the concept of the IMA among health care workers in the then Transvaal, Natal and the Cape. The *Lajnatul Atibba* produced a motivation for the formation of the IMA which was distributed on the tour.²



Dr El Kadi addressing Muslim health care professionals

In the Transvaal, Dr Ismail Nanabhai acted as the host of Dr El Kadi. In Cape Town he was taken care of by Mr Saleh Mohamed and Mr Ebrahim Bardien and in Port Elizabeth by Dr M Rafiq Khan. In Natal, the executive committee of *Lajnatul Atibba* hosted Dr El Kadi.³

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1. *Brochure of the 10th Annual Convention of the IMA*. June 1990, p. 10.
 2. See appendix B of this dissertation.
 3. Interview with Dr GM Hoosen - October 1995.

The MYM played a vital role in co-ordinating a series of public meetings throughout the country so that the health care workers could be exposed to the thoughts of Dr El Kadi on the need for the formation of an IMA. Meetings were held in the Vaal Triangle, Cape Town, Port Elizabeth, Durban, Pietermaritzburg, Ladysmith and Newcastle. In his address, Dr Ahmed El Kadi drew parallels between the situation in South Africa and the Muslim minority in North America and he shared his experiences of how they had formed an IMA and also shed light on the activities of the IMA of North America. In his talk, he also explained that Islam is for all mankind, therefore, the IMA is open to all who wish to be guided by its moral and ethical criteria and hence it cannot be claimed by anyone to be an ethnic body but rather a universal medical community which aimed at providing health service to all of mankind irrespective of race, colour and religion. Many doctors were inspired by his commitment to Islam and service to humanity. He played a pivotal role in bringing about the formation of the IMA in South Africa.¹

Although not all Muslim doctors were convinced that it was necessary for them to form an IMA, the overall consensus among the Muslim healthcare providers was that there was definitely a need for them to have their own IMA. Wherever the meetings were held, core members were identified and eight branches in all were formed. The seeds for a national Muslim medical association were thus sown. Thereafter, *Lajnatul Atibba* was finally transformed and came to be known as the IMA of South Africa from September 1979. The new name was ratified at the first IMA Convention in March 1981. The Durban branch of the IMA became the co-ordinating centre for the activities of the IMA during the early stage in the history of the IMA.²

1. *Brochure 10th Annual Convention of the IMA*. June 1990, p. 10.

2. *ibid*, p. 10.

The first meeting of the IMA Durban Branch was held on Tuesday, 30th October 1979, at the Orient Boardroom with Dr GM Hoosen in the chair. The members discussed the future role of the IMA and the following are some of the points that emerged:¹

1. The scope envisaged for the IMA was much wider than that of Lajnatul Atibba and hence that name was no longer relevant.
2. The aims and objectives of the IMA needed to be clearly defined in order to eliminate conflicts and adverse reactions. An aims and objectives sub-committee was therefore elected comprising of Drs D Mall, AG Adam, GM Hoosen, the late MI Essack and the late AN Essa.
3. Research and papers on Islamic Medical history, Prophetic Medicine and *Qur'ānic* Medicine should be presented from time to time. Dr DS Mall undertook to organise the format for that and to arrange the relevant programmes.
4. The clinic that was opened by the MYM in Malagazi, KwaZulu Natal, and the one opened by the Islamic Dawah Movement (IDM) in Umhlanga - Marianhill, KwaZulu Natal, were to be brought under the umbrella of the IMA. Dr MY Motala of Shifa Hospital, Durban, took a keen interest in that task and was responsible for refurbishing and running of the Malagazi clinic together with Dr A Khan, also of Shifa Hospital.
5. A host of possible future activities of the IMA were listed and it was agreed that these activities could only be implemented if a central office could be set up. Some of these activities pertained to locum services, advisory facilities for foreign

1. *Minutes of the 1st IMA Durban Branch Meeting. 30th October, 1979.*

graduates, professional exchange of graduates, under-graduates scholarship facilities and advice, etc

6. The following persons were elected as the executive: Chairman-Dr GM Hoosen; Secretary - Dr E Seedat; Treasurer - Dr YA Chenia, Clinics Representative - Dr MY Motala.

It is interesting to note that much progress was made by the time they met for the second meeting on 13 November 1979. The following are some of the points that emerged:¹

1. A draft of the aims and objectives was read out and the committee was to meet again to finalise the format.
2. The treasurer made a strong plea for funds and suggested a membership fee. The house decided that a minimum of R 25.00 should be levied for doctors.
3. There was a strong feeling that a regular bulletin should be circulated. Drs AG Adam and the late AN Essa volunteered to assist in this. This initiated the regular publishing of *BIMA (Bulletin of the IMA)* and the first bulletin was compiled and published by Dr GM Hoosen about two months later in January 1980. This publication was enhanced in the early stages by Professor Syed Salman Nadvi's input. The first two issues of BIMA were actually printed in Cape Town free of charge by Mr Saleh Mohamed.
4. As for the membership drive, it was agreed that this should be on a personal basis with every member undertaking to introduce a new member to the association.

1. *Minutes of the 2nd IMA Durban Branch Meeting*, dated 13 November, 1979.

Once the aims and objectives brochure was ready it would supplement the individual's effort.

5. Dr SA Thokan's suggestion that all new Muslim medical students to be introduced to the IMA on admission to the medical school was accepted.
6. The Chairman was given the task to work on the constitution as a national project.

By the third meeting on 27th November 1979, the aims and objectives of the IMA were circulated to all the branches and the sub-committee awaited comments. By the sixth meeting on 12th February 1980, the membership drive had spread into Transkei and moves were set in motion to establish links with Zimbabwe. Dr A Harneker agreed to head the medical ethics sub-committee.¹ On 23rd February 1980, the first get-together was held for the new medical students in Durban.

By the seventh meeting on 29th April 1980, the second issue of BIMA was published as well as "An Introduction to the IMA". Also by that time the IMA got involved with two other clinics viz. at Malagazi and Umlaas-Marianhill. In April 1980, a bank account was opened with Standard Bank, Grey Street, Durban, and there was a credit balance of R 448.00 in the account.²

At the eighth meeting on 8th July 1980, the aims and objectives of the IMA were accepted by all members and adopted. These are listed below:³

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1. *Minutes of the 6th IMA Durban Branch Meeting*. 12 February, 1980.
 2. *Minutes of the 7th IMA Durban Branch Meeting*. 29 April, 1980.
 3. *Minutes of the 8th IMA Durban Branch Meeting*. 8 July, 1980.

1. To promote a better understanding and appreciation of Islam and of medicine within the framework of Islam.
2. To constantly remind and educate the Muslim health care professionals of the Islamic values, morality, etiquette and ethics and to apply these in the health care sector.
3. To promote professional and non-professional contact among Muslim health care professionals at all levels through activities such as meetings, dinners, seminars, guest speakers and conventions.
4. To seek affiliation to medical institutions through professional co-operation.
5. To co-operate with other organisations on matters of mutual interest.
6. To orientate health care education with Islamic values and outlook in the application to patient care.
7. To promote research and publications in the field of Islamic Medical History, Prophetic Medicine, Islamic Medical Ethics and Medicine in general from the Islamic viewpoint.
8. To be a “mercy unto mankind” in the true example of our Prophet (s.a.w.s) by providing necessary assistance within our scope and capability and wherever needed in the form of clinics, relief work and rehabilitation.
9. To co-ordinate the relevant group and individual activities of Muslim health care professionals.
10. To have a central information bureau as a service to the members regarding employment opportunities, exchange programmes, scholarship and graduate and under-graduate training opportunities.

11. To establish libraries for the use of the members and others who may wish to use them.

At that meeting, the members decided as a policy to take a stand on all public issues where injustice had been perpetrated; also on such issues that fell within the domain of Islamic Medical Ethics and on other general issues that concerned them as Muslims. Therefore, they formed an "Action Committee" which had the primary task of informing the general body of the IMA on any matter or issue which needed a public response. The following volunteered to serve on that committee: Drs AH Khatree (co-ordinator) I. Goga, D Peer and Prof A Moosa. The members decided to take a stand on the Biko case and the new committee was requested to draft a resolution and present it for approval at the following meeting and to decide on ways of publicising it. It was also resolved at that meeting to hold an annual general meeting and a convention, either in that year or early in the following year (1981).

By the ninth meeting on 14th October 1980, it was decided to publish a statement policy on the Biko case in the following issue of *BIMA*. Preparations for the publication on *Family Planning and Abortion* were going well and another booklet entitled *Muhammad (SAW) - The Family Man* was also under print. It was agreed that Durban was the only plausible venue for the first annual convention but the date had still to be decided. Dr R Gardie of White River represented the IMA at the annual convention of the IMA of North America in 1980. He was the first to represent the IMA of South Africa at an international convention and thus the existence of the IMA in South Africa came to be recognised internationally. Regarding the war in Afghanistan, it was agreed in principle

that all possible assistance should be given to the *Mujāhidūn*. It was also felt that any health personnel who were to visit Pakistan should be urged to visit the refugee camps and offer moral support and professional help. Prof AS Mitha suggested that if possible a group of doctors should consider volunteering to offer their services at the Afghanistan refugee camps.¹

At the tenth meeting on 9th December 1980, it was decided that Durban would be the venue to officially inaugurate the IMA and the date was set for 14-15 March 1981. The Chairman announced that an IMA was established in Mauritius independently of South Africa and that Dr SA Thokan was present at its inaugural meeting.²

In December 1980 the first booklet of the IMA was published entitled *Family Planning and Abortion - The Islamic Viewpoint* by *Qadī* MI Quasemi. It was published jointly with the MSA, thus another milestone was achieved by the IMA.

At the eleventh meeting on 10th February 1981, the Natal Medical School was confirmed as the venue for the first IMA convention and a tentative programme was tabled. The house suggested that a session should be held with the '*ulamā*' (religious scholars) regarding medical ethical issues. Dr MH Khatree was given the task of convening the first IMA convention.³

The IMA was represented at the First International Islamic Medicine Conference in

1. *Minutes of the 9th IMA Durban Branch Meeting*. 14 October, 1980.

2. *Minutes of the 10th IMA Durban Branch Meeting*. 9 December, 1980.

3. *Minutes of the 11th IMA Durban Branch Meeting*. 10 February, 1981.

Kuwait from 12 - 16 January 1981. This was the second time that the IMA of South Africa was represented at an international conference. The IMA delegation comprised of Prof A Moosa, Drs M Khan and GM Hoosen who presented a paper entitled "Islamic work through medical service in South Africa". At that conference, the IMA of South Africa planted the seed for the formation of the Federation of Islamic Medical Association (FIMA) which came into existence eleven months later. Upon returning to South Africa, a report on the conference was presented by Prof A Moosa to the IMA members. Work then began in great earnest for the preparation of the first historic IMA convention in South Africa from 14 - 15 March 1981.¹

1.7 REACTIONS TO THE FORMATION OF THE IMA

When the dates and venue for the inaugural convention were announced and the reality of the existence of the IMA became known, there was a tremendous uproar and opposition from a wide sector of the medical and non-medical fraternity, mainly non-Muslims but including some Muslims as well. A powerful backlash was unleashed against the IMA in the newspapers. A Mr L Hariram launched an organisation called the "Non-Muslim Brotherhood" which intended to actively campaign against the IMA by printing handbills and taking paid advertising space in newspapers listing the names of the IMA members calling for them to be boycotted. This was reported in the *Leader*, a Durban-based Indian weekly newspaper, on 13 March 1981, a day before the first convention was scheduled to be held.² Some Muslims and non-Muslims felt that the

1. *Formation of the Islamic Medical Association of South Africa - The Early Years*, op. cit., p. 29.

2. "Muslim medicos sectional-claim" in the *Leader*. Durban. 13 March, 1981.

apartheid government had already created racial division in the country, therefore the existence of the IMA would create further divisions. This argument was rather shortsighted as it meant that all the religious and cultural organisations that existed throughout the country were also guilty of creating divisions, so why was the IMA singled out only?

After the first IMA convention which was held from 14 - 15 March 1981, a vicious campaign against the IMA was launched by some non-Muslims in the *Letters to the Editor Column* in the Durban-based Indian newspapers and the *Sunday Times Extra* which lasted right up to the last week of May 1981. Anti-IMA and anti-Muslim sentiments were expressed in the letters thus creating anti-Muslim hysteria eg. Karen Paul's letter in the *Graphic* (ceased publication in October 1987), a Durban-based Indian weekly newspaper, dated 24 April 1981 which stated among other things that "the 1949 riots were caused by them" (ie. Muslims) "Why don't all these Muslims run to Pakistan, etc."¹ From most of the letters, prejudice against Islam and Muslims were expressed. The IMA was accused of being ethnic and sectionalist by the non-Muslim writers. Even a columnist of the *Graphic* had a satirical dig at the IMA and the Muslim doctors in its issue of 27 March 1981.² The Medical Graduates Association (MGA) of Natal University condemned the formation of the IMA in the *Sunday Times Extra* dated 22nd March 1981 and described the move "as an attempt to cause and accentuate divisions within the broad ranks of the oppressed in South Africa".³ In response the IMA members attended the

1. Paul K. "For Muslims only" in the *Graphic*. Durban. 24 April, 1981.

2. "Some Unani Inanity" in the *Graphic*. Durban. 27 March, 1981.

3. Chetty, R. "Graduates attack Muslim Medical Group" in the *Sunday Times Extra*. Johannesburg. 22 March, 1981.

following MGA annual meeting to clarify the IMA position. The MGA was questioned about the recent press statements and it became very clear that the MGA was totally ignorant of the aims and objectives of the IMA.

Reacting to the accusations of being sectional, Dr GM Hoosen explained once again in one of the local newspapers the reasons for the IMA and its aims and objectives.¹ A press release in this regard was first published in the *Natal Mercury* dated 16 March 1981, the morning after the convention.² It was heartening to note that the Muslim community was united in its support for the IMA and many Muslims responded against the various accusations eg. Zaheer Ebrahim in the *Leader* dated 15th May 1981 stated "It is ironical that whenever Muslims organise themselves for the task of fulfilling their Islamic obligations they are in almost every instance faced with a backlash instigated by certain petty-minded groups who oppose any attempts at manifesting the Islamic personality."³ The truth of that statement was borne out when the doctors had tried to form the IMA in 1974 and later when they established a clinic at As Salaam.

However, it must be noted that not all the letters from non-Muslims were negative. Some of them were also positive, eg. the writer RP Singh from Durban whose letters appeared in the *Leader*⁴ and in the *Sunday Times Extra*⁵. That of Ishwarlal Desai appeared in the

1. Hoosen, G.M. "Islamic Body is not sectional" in the *Graphic*. Durban. 3 April, 1981.

2. Hoosen, G.M. "Body to satisfy needs of Muslims" in the *Natal Mercury*. Durban. 16 March, 1981.

3. Ebrahim, Z. "Muslim challenge to other faiths" in the *Leader*. Durban. 15 May, 1981.

4. Singh, R.P. " Apartheid mentality of Muslim critics" in the *Leader*. Durban. 10 April, 1981; and Singh, R.P. "Religious ties should not be emphasised" in the *Leader*. Durban. 24 April, 1981.

5. Singh, R.P. "Muslims 'always aim for the top'" in *Sunday Times Extra*. Johannesburg. 12 April, 1981.

Graphic on 22nd May.¹ An excellent letter written by Mrs Vasie Pillay also appeared in the *Leader* on 24th April.² The sentiments expressed by these writers were that Muslims were not sectionalists as they had established many institutions like R.K. Khan Hospital, M.L. Sultan Technikon, A.M. Moola Charitable Trust and Joosub Charitable Trust, etc., from which many non-Muslims had benefitted.

1.8 OFFICIAL LAUNCHING OF THE IMA

The first IMA convention was held from 14-15 March 1981 at the Natal Medical School. It was a historical occasion and another milestone in the history of Muslims of South Africa. More than 150 Muslim doctors and paramedical personnel from all over South Africa and neighbouring states participated in it.



First IMA Convention, Durban

1. Desai, I. "Surprised at Sadiq Ali's Ignorance" in the *Graphic*. Durban. 22 May, 1981.
2. Pillay, V. "Therapy for anti Muslim writers" in the *Leader*. Durban. 24 April, 1981.

Many attended it simply out of curiosity and by the end of the convention the membership more than doubled. The opposition to the IMA before the convention was a great blessing in disguise. It gave the IMA nationwide publicity which it would never have had otherwise received and it also piqued the curiosity of many Muslim health care workers from throughout the country. The convention was held over two days and scientific papers on general practice, psychiatry, cardiology, paediatrics, gynaecology and surgery were presented by the IMA doctors themselves. The two important items in the programme were a symposium on the role of the Muslim doctor in South Africa which was held on Saturday after 'ishā' ṣalāh (night prayer) and a symposium on Sunday before zuhr ṣalāh (noon prayer) on Islamic Medical Ethics. A separate session was held to discuss the relevance of the IMA because some people were not too clear about this due to the adverse publicity. Dr M Khan suggested holding this session and it proved to be useful because it cleared the air and most of these people became members of the IMA at the end of the convention.¹

Attorneys Mr SE Lockhat and Mr ASOF Sayed helped in the drafting of the first constitution of the IMA which was finally adopted at the convention. The Muslim medical students also played a very active role in the running of the convention. The first National Executive was elected during the convention and comprised of Dr GM Hoosen as President, Prof A Moosa as Vice-President, Drs MH Khatree as Secretary, MAK Omar as Minute Secretary and FA Randeree as Treasurer. Their task was to promote the

1. *Formation of the Islamic Medical Association of South Africa - The Early Years*, op. cit., p. 37.

concept of the IMA and initiate its aims and objectives throughout the country and the world.¹

At the end of the convention, the President of the IMA issued a press statement in which the reasons for the formation of the IMA were spelt out. The aim of this statement was to prevent any adverse reaction or misinformation. The following statement appeared in the *Natal Mercury*:²

“An IMA was formed to satisfy the needs of Muslim doctors and para-medical personnel which could not be catered for by other existing organisations in South Africa. One of the main aims was to promote a better understanding and appreciation of Islam and of medicine within the framework of Islam. The organisation will constantly remind and educate the Muslim health care professionals of the Islamic values, etiquette and ethics. It would also promote research and publications in the field of Islamic Medical History, Prophetic Medicine, Islamic Medical Ethics and Medicine in general from an Islamic viewpoint. Clinics, relief work and rehabilitation would also be provided”.

After the convention, membership forms were sent to 700 Muslim doctors whose names appeared in the South African Medical Registrar with the hope of enlisting them as IMA members. The annual membership fee was set at R 25.00.

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1. *Formation of the Islamic Medical Association of South Africa - The Early Years*, op. cit., p. 37.
 2. Hoosen, G.M. "Body to satisfy needs of Muslims" in the *Natal Mercury*. Durban. 16 March, 1981.

In view of the mass hysteria against the IMA that was created in the local press, the IMA requested to be given the *jumu'ah* (Friday Prayer) platform in all the *masājid* (mosques) in Durban in order to explain to the Muslim public the reasons for the establishment of the IMA.

At that stage the IMA did not have an office and thus all administrative work was carried out from the homes of the executive members. The secretary kept a manual register of membership. Most of the IMA expenses were paid for by the National Executive, but expenses incurred for printing, stationery and official postage were paid for from membership fees.¹

1. Interview with Dr MH Khatree - August 1995.

Chapter Two

A SURVEY OF THE IMA ACTIVITIES AND PROJECTS

The IMA of South Africa soon gained recognition both in South Africa and abroad. It had become a well-structured, fully fledged, independent organisation. Its members were committed to follow the *sunnah* (example) of the Prophet (s.a.w.s) and exemplified this by providing voluntary service, wherever and whenever needed. From the second convention onwards, which was held from 29 - 31 May 1982 at the Natal Medical School, the IMA grew from strength to strength and over the years its membership grew and its activities were clearly defined.

All the activities of the IMA are discussed in this chapter with the exception of the Clinics and its academic activities. These two require a separate discussion because of the very nature of their activities.

2.1 SETTING UP OF IMA BRANCHES

After the first convention, members of the National Executive made attempts to form branches throughout the country. In such places where there were no branches they built strong contacts with people who could organise IMA meetings and lectures and motivate for membership. Members were urged to participate in Islamic activities and to increase their Islamic knowledge.

In August 1981, five months after the official launch of the IMA, the membership was 242 with 8 functional branches in Durban, Cape Town, Lenasia, Pretoria, West Rand, Rustenburg, Ladysmith and Newcastle.¹ Moreover in less than a year after its inauguration (March 1981) the IMA had made great strides and had grown considerably. Its membership by February 1982 (11 months after its establishment) reached 324.²

2.2 ASSISTING IN FORMULATING HOSPITAL POLICY

The Durban-based King Edward VIII Hospital Administration sought the assistance of the IMA in defining hospital policy with regard to matters such as disposal of human parts and foetus from Muslim patients, the procedure to follow for Muslim deaths in the hospital, medico-legal post mortems on deceased Muslims, etc.³ The involvement of the IMA in this regard was vital as these issues are important to Muslims because they involve Islamic rituals and rulings.

The IMA negotiated a site for the construction of a *jamā'āt khānā* (a place for holding the congregational prayers) at the King Edward VIII Hospital which would serve the needs of the then 120 Muslim doctors, 40 paramedics and 80 medical students. A committee was thus appointed to survey and implement that project.⁴ Thus in the very year in which it was launched, the IMA gained recognition by the general medical fraternity.

1. *Secretary's Report* presented at the First Council Meeting dated 15 August 1981.

2. *Minutes of the Second Council Meeting* dated 6 February 1982.

3. *Minutes of IMA Executive Committee Meeting* dated 15 June 1981.

4. *Minutes of the Seventh Executive Committee Meeting* dated 27 November 1981.

2.3 MEDICAL ETHICS

In August 1981, the IMA embarked on a project to formulate the "Oath of a Muslim Physician". It was felt that all members of the IMA should uphold it. Later on, certain wordings in that Oath were amended in order to make it applicable for all Muslim health care professionals and not just for doctors only. The reasons for this firstly, was that the Hippocratic Oath made the person swear by gods which is unacceptable to Muslims because of their belief in the Absolute Oneness of Almighty God. Secondly, in view of the fact that both the IMA of North America and the First International Islamic Medical Conference held in Kuwait in January 1981, had prepared their own "Oath of a Muslim Physician", the IMA thought it appropriate also to have their own Oath.

In 1979, as part of broadening its activities, the *Lajnatul Atibba*, with the assistance of the MSA students at the medical school in KwaZulu Natal had compiled a questionnaire on ethical issues related to medicine and sought to obtain answers from Muslim jurists (*fuqahā'*), at home and abroad.

By September 1981 a more comprehensive medical questionnaire was drawn up by the Ethics sub-committee headed by Miss Suraiya Vawda with seventeen sub-sections, viz. euthanasia, organ transplant, milk bank, genetic counselling, abortion, infertility, control of menstruation, animal experimentation, alcohol, drugs derived from animal sources, post mortem, effects of jinns, jadoo (black magic,) *ta'wīdh* (talismans) and prosthetic surgery. One of the chief features of this questionnaire was the introductory explanation to each question giving a medical background to the question under consideration. This was

circulated locally and internationally to Muslim individuals, Muslim jurists and Islamic organisations for clarification and guidance on these problematic issues.¹

2.4 FEDERATION OF ISLAMIC MEDICAL ASSOCIATIONS (FIMA)

The IMA also played a pivotal role in bringing about the formation of the Federation of Islamic Medical Associations (FIMA). In December 1981 FIMA was formed with the primary objective to unite and service the interest of Muslim Medical Organisations throughout the world. Initially, IMAs from 10 countries became members of this international body. Its founder members are South Africa, U.S.A., Canada, Nigeria, U.K., Ireland, Pakistan, India, Sudan, Jordan and Indonesia. A contingent of about 38 people representing the IMA of South Africa attended its inauguration which was held in conjunction with the 14th Annual Convention of the IMA of North America in Florida from 27 - 31 December 1981.² At the inaugural meeting, the South African delegation presented 3 papers viz., "Toilet Habits and Peri-Anal Abscesses", "Solvent Abuse in Children" and "Circumcision and Carcinoma of the Cervix".³

The then President of the IMA of South Africa, Dr GM Hoosen, was elected the first vice president of FIMA. It ought to be noted here that at that time the IMA of South Africa was in existence for only one year and to have one of its members occupy such

1. *Brochure of the 10th Annual Convention of the IMA*, June 1990, p. 27.

2. Interview with Dr GM Hoosen, September 1995.

3. Interview with Dr AA Hoosen, September 1995.

an important post proved the confidence that the international Muslim medical fraternity placed in the IMA of South Africa.

2.5 SETTING UP OF ITS FIRST PERMANENT OFFICE

In January 1982, the IMA secured its first office at Darus Salaam, Queen Street, Durban. The rental was R 65.00 per month. The office and rental were shared with the As Salaam committee¹ which was responsible for the running of the Educational Institute at Braemar.

2.6 ANNUAL CONVENTIONS

The IMA holds annual conventions. These conventions serve as a forum for its members to meet and socialise with each other. During the duration of these conventions, they are encouraged to project and implement Islamic values in their practices. These conventions are not exclusively for IMA members only but other interested members of the public are also welcomed to attend them and even to present papers. Medical students are also encouraged to attend and are involved in the various administrative functions during the duration of the conventions. Every year, since its official inauguration in March 1981, the IMA has been holding a convention and thus far 18 such conventions have been successfully held. The venue for such conventions is rotated around the country in the different provinces. Each convention has a particular theme. Scientific papers on Medicine in general as well as papers on relevant Islamic topics are presented. Prominent

1. *Minutes of the Second Council Meeting* dated 6 February 1982.

national and international Islamic scholars are invited to be guest speakers. Motivational talks on Islam and the Islamic way of life are also given by different invited guest speakers. The convention papers are published in the journal of the IMA (JIMASA). Special arrangements are made for the performance of the five daily prayers during the duration of the convention.

Over the years the conventions have become more family orientated and thus parallel sessions are held for students and family members and special activities are organised for the children of the delegates. The conventions are usually held during long weekends with food and accommodation provided for participants and their families.

The programme of the convention entails a session on medical update which is purely medical and an annual general meeting for members only where the executive is elected. Islamic topics and values, and issues which are pertinent to Islamic Medicine are also incorporated in the programme.

Special convention bags are produced each year which are given to all registered participants. Details of the conventions thus far held are briefly outlined in appendix C.

2.7 RELIEF WORK¹

Over the years, the IMA has been involved in relief work, both locally and internationally. The role of the IMA in relief work is summarised below:

1. *Brochure of the 10th Annual Convention of the IMA*, June 1990, p. 15; and *Brochure of the 13th Annual Convention of the IMA*, July 1993, p. 19.

2.7.1 Participation in Local Relief Work

KwaZulu-Natal

The floods of 1987 in the province of Natal caused immense damage to properties and lives and left many homeless. The IMA together with the Islamic Relief Agency (ISRA) played a very active role in giving aid to the various flood disaster areas. Food, blankets and clothing were collected and handed to the affected families. Milk powder to the value of R20 000 was distributed.

Gazankulu

Many refugees fled from the fighting between Renamo and Frelimo forces in Mozambique during the latter half of 1985 and were located in camps in Gazankulu. Together with IDM, SANZAF (South African National Zakah Fund) and MYM the needs of the refugees were identified. In addition to the collecting of food, blankets and other requirement, the IMA contributed R 10 000.

Unrest Areas

The IMA together with the ISRA has been providing relief in the form of medical assistance to victims of unrest in many parts of the country. During September 1985, political unrest led to rioting in Inanda, KZN, where more than 1 600 families were displaced. These people were housed temporarily at the community hall in Phoenix,

Durban, where they received voluntary medical assistance from the IMA. In 1986, the IMA Western Cape initiated a medical relief programme for the victims of violence due to the unrest at Crossroads. Recent work has been in KwaZulu Natal, especially the South Coast and Malagazi areas.

Street People

The IMA has provided medical and relief service for the so-called “street people” of Durban since 1989. In 1990, the IMA Durban Branch also ran a mobile clinic for six months on a once-a-month basis in Central Durban, providing medical assistance to the inner city homeless community. The Western Cape Branch was also involved in assisting the “street children” in Cape Town during the years, from 1991 to 1994.

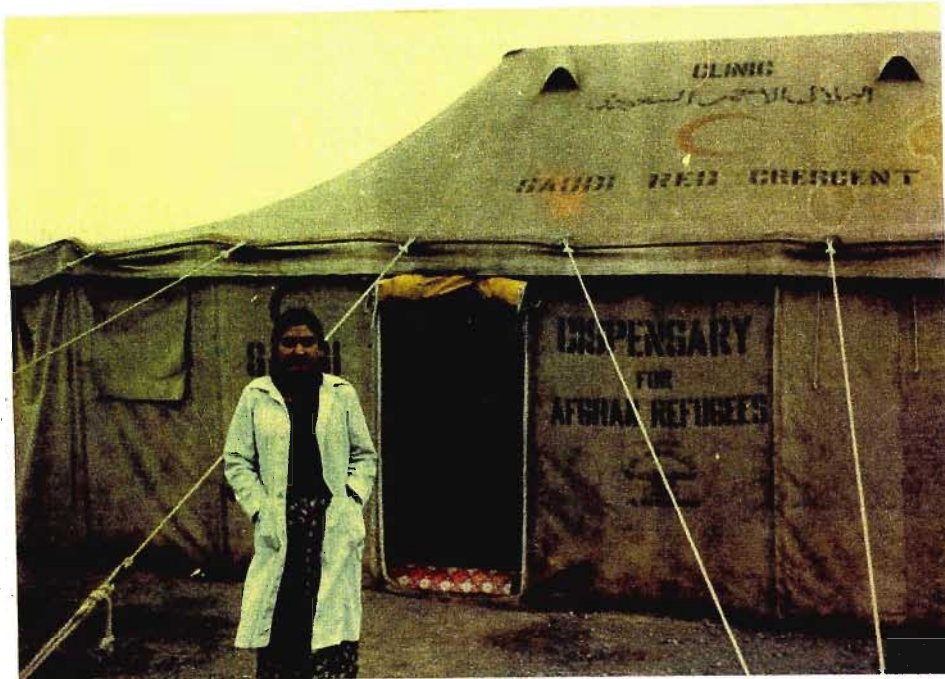
2.7.2 Role in International Relief Work

The IMA of South Africa has also played a significant role in humanitarian work in Afghanistan, Mozambique and Somalia.

Afghanistan

The plight and the needs of the Afghan *Mujāhidīn* are well known to all. This situation came about when Russia invaded Afghanistan in December 1979. There had been over three million refugees in Pakistan, housed in over 250 camps along the border. The Afghan refugee camps on the Pakistani side were visited by members of the IMA and

contacts established. Money was collected over a number of years and sent to the *mujāhidīn*.



Afghan Refugee Camp

Somalia

Muslim health care professionals, members of *Jamiatul Ulamā'* (Society of Muslim Theologians) Transvaal and the Africa Muslim Agency collectively assisted Somalia refugees on the north-eastern Kenyan border during November 1992. Food, clothing and medicines were transported to this almost inaccessible drought stricken area and relief work carried out at various camps. The famine refugees were both victims of civil war as well as those referred to as "Kenyan Somalis", victims of partition that took place many years ago. The feeding programme for starving individual consisted of "wet

feeding” with maize, cooking oil and sugar. The United Nations' (UN) relief workers employed the less effective “dry feeding” which has severe limitations. Medical relief work was taxing working under very primitive condition in soaring temperatures and with nearly 250 patients being treated daily. Medicines in large quantities had to be continually supplied from South Africa and this was generously supplied by Betabs Sales. The most common diseases seen were malnutrition and infectious diseases including tuberculosis.

Medical personnel working under the banner “Doctors Without Frontier” were resistant to IMA's presence and together with the United Nations High Commission for Refugees (UNHCR) attempted to abort IMA's activities by introducing unnecessary “red tape”. However, their efforts were in vain as the IMA work led to the establishment of a fulltime medical service co-ordinated by the Africa Muslim Agency (AMA).

Mozambique

The plight of the people of Mozambique was first brought to the notice of the IMA by the 1985 convention guest, Dr ‘Abd al-Rahmān Al-Sumait. IMA delegations were sent to Mozambique where they established contacts with government and Muslim organisations. Food, clothing and medical supplies have been sent on a regular basis. IMA members have been rendering voluntary medical care at the hospital in Nacala in Northern Mozambique. Committee members have made a few trips over the past six and a half years to Nacala to oversee the project. Dr Yahya Salim Abugran who is the resident medical officer at the Nacala Hospital has also visited South Africa. Dr Imtiaz

Sooliman summarises the contribution thus far as follows:

- December 1990 - supplied 54 tons of goods to Nacala
- January 1991 - responded to cholera epidemic
- February 1991 - responded to floods
- March 1991 - responded to train accident
- July 1991 - airlifted medicines and responded to malaria epidemic within 48 hours. During this period R 87 000 was contributed towards establishing wells throughout Mozambique.
- June 1992 - malaria medicines supplied to Maputo
- April 1993 - supplied Nacala with 4X4 vehicle, supplied R 100 000 worth of medicines, sutures, dressings and x-ray films.
- 1994 - doctors assisted at eye clinic in Nacala.

Dr E Mohamed summarises the recent contribution¹:

- December 1996 - doctors spent ten days on fact finding mission
- January 1997 - visited clinics and the hospital in Maputo and Nacala to assess needs.
- motivated local Muslim doctors to use a vacant fully equipped maternity clinic to serve the community.

1. Interview with Dr E Mohamed, August 1997.

- upon return recommended to assist with medicine and equipment
- July 1997 - supplied R 3 500 worth of suture material, gloves and HIV testing material to Nacala.

2.8 RELIGIOUS AIDS PROGRAMME (RAP)¹

RAP is a national organisation initiated by the government in May 1995 whereby all religious role players join the Minister of Health in consultation to define the possible role of religious organisations in various socio-health issues. Thus it was launched as a National NGO body under the auspicious of the Department of National Health in September 1996. It comprises of different religious organisations. Moulana E. Bham represents the Muslims nationally whilst Dr E. Mohamed is the IMA national representative serving on the National Council of RAP. There are also provincial representatives appointed by the IMA annually.

The National co-ordinator Dr N Swart has been going from province to province to set up regional inter-faith groups in order to launch the HIV/Aids programme of prevention and education. IMA regional representatives are also invited to these meetings. The programme involves volunteer training of at least one person per religious group who then co-ordinates and takes it to various community organisations and schools. At a national level the IMA and the *Jamiatul 'Ulamā'* in Gauteng are busy setting up

1. *Brochure of the 17th Annual Convention of the IMA, April 1997, p. 15.*

guidelines for Muslims. The programme, instead of focusing on sex education seminar, will entail a holistic approach to life skills including Islamic principles and guidelines on conduct and behavior of Muslims. The aim is to prevent drug abuse, promiscuity and permissiveness. Islamic Careline staff are involved in preparing manuals and workshops for this programme whereby school teachers (at least to 2 per school) will be invited to a workshop for training. The teachers will then take the manuals to their schools and *madāris* (Islamic schools) where the life skills programme will be implemented as part of the school's curriculum. At that stage the Department of Education will be approached for its assistance. It is envisaged that a booklet on "Life Skills Programme for Muslim School Children" will be compiled eventually. Adults will be made aware of this programme via the *masājid* (mosques).

2.9 VACCINATION FOR PILGRIMS

This service was first started 3 years ago by the Cape branch of the IMA¹ with the sanction of the Department of Health. Meningitis vaccination is administered by the IMA doctors at the Gatesville *Masjid* to all pilgrims who wish to take advantage of this service as a matter of convenience. A nominal fee is charged to cover the cost of the vaccine and the disposable materials used. In 1996 more than 1000 pilgrims were immunised against meningitis as it is a health requirement for all pilgrims going to the Middle East. Following its success in the Cape the Durban branch introduced this service the following year. The vaccination is administered by the IMA doctors during the *Hajj* (Pilgrimage) Seminar organised by the *Al-Anṣār* Trust at its venue in Durban. The Durban branch also

1. Interview with Dr MF Williams, August 1997.

offers this service in December to pilgrims who intend going for 'umrah (minor pilgrimage) during that period. The Gauteng branch hopes to introduce this service in their province from this year (1998) onwards.¹

The requirements by the Department of Health for this service are strictly adhered to by the IMA. Vials are kept under refrigeration and all syringe and needles are discarded after one use. Each health card issued to the pilgrim states the following: date of immunisation; batch number of vial; quantity given and signature of the administering doctor. A special IMA stamp is stamped on the health card to certify that the vaccine is given.² Some members of the general public do assist in this service by writing out the health cards, collecting the nominal fee, etc. Separate facilities for males and females are provided. This service is greatly appreciated by the general community as it saves them the inconvenience of specially going to the offices of the Department of Health for this vaccination. The IMA is represented on the South African *Hajj* and 'Umrah Council (Medical Desk)³ to oversee the health requirements for pilgrims. The aim is to provide medical service to all South African pilgrims at the two holy cities of Makkah and Madīnah during the pilgrimage season.

2.10 COMMUNITY RADIO STATIONS

The IMA is active on the airwaves on the community radio stations.⁴ In the Cape the IMA is invited by "Radio 786" from time to time to present a health talk to the general

1. Interview with Dr YM Essack, August 1997.

2. Interview with Dr MC Solwa, August 1997.

3. *Brochure of the 16th Annual Convention of the IMA*, July 1996, p. 5.

4. *Brochure of the 16th Annual Convention of the IMA*, July 1996, p. 5.

public since 1996 onwards. The IMA in Pretoria has started hosting a weekly programme called "Medically Speaking" on "Radio 1584" from March 1997.¹ This programme is hosted by Dr AA Hoosen on every Thursday between 8 p.m to 9 p.m. Relevant aspects on health are discussed to inform the public about community and general health. Specific diseases like Asthma, Diabetics, Angina, HIV, Aids, etc. are also discussed and in this regard the relevant medical specialists are invited as guest speakers for the programme. The public is invited to telephone the questions and queries during the programme and these are answered by the relevant speaker. In Durban, the IMA presented talks on various aspects of health twice a week on *Radio Al Ansar* which broadcasted only for one month during the holy month of *Ramadān* in January 1998. Thereafter, *Radio Azania* received a temporary licence for one month i.e. from 18 April, 1998 to 18 May, 1998. The IMA doctors also presented health talks and discussions on this radio station thrice a week, viz. Wednesday evenings, Saturday and Sunday mornings. The IMA hopes to continue with this service when *Radio Azania* hopefully obtains its permanent licence early next year (1999).

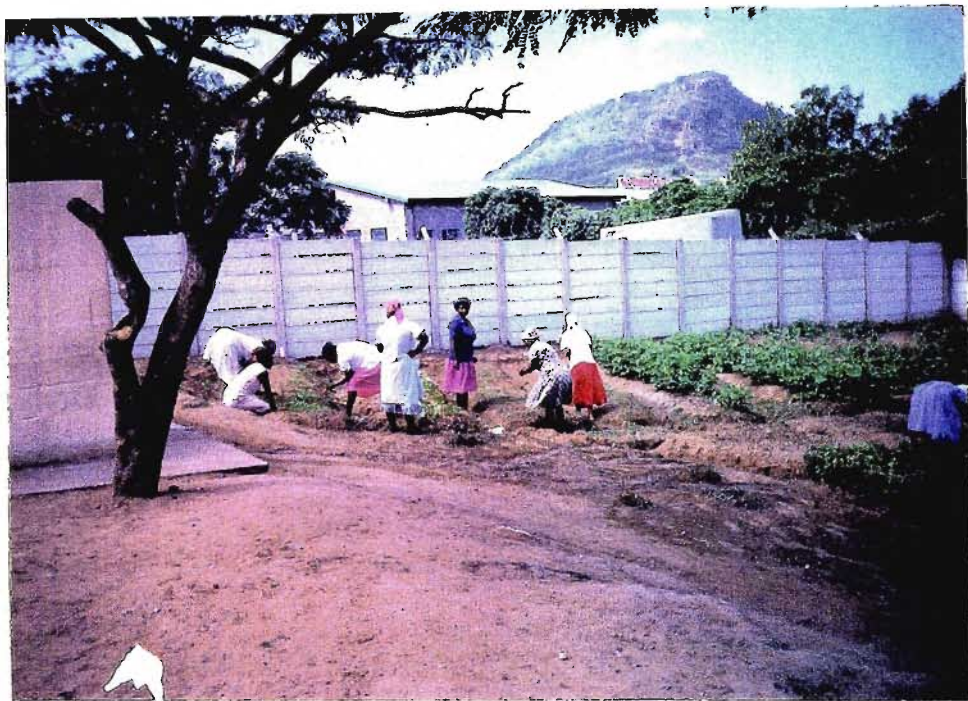
2.11 GENERAL

The IMA took up the issue of providing *halāl* food (meat slaughtered in accordance with Islamic rites) and the availability of prayer facilities regarding Muslim patients in private and provincial hospitals. It also made representation on numerous occasions to health authorities including the heads of Forensic Medicine in different parts of the

1. Interview with Dr AA Hoosen, August 1997.

country to facilitate post-mortems being performed on deceased Muslims as soon as possible.

An IMA Women's Wing was established in June 1990 in Durban.¹ Spouses of health care professionals and some professional women started this sub-committee. This was formed at the time of the tenth annual convention in June 1990. They are concerned with the social aspect of health and involve themselves in the clinics by providing vocational training, subsistence gardening, tuition for students, screening for disability and helping in eye tests, and adult literacy courses.



Subsistence Gardening

1. *Brochure of the 13th Annual Convention of the IMA*, July 1993, p. 27.

Chapter Three

IMA CLINICS

The IMA of South Africa has established primary health care clinics in various provinces of the country. These clinics provide comprehensive health care as is evident from the schematic representation below:

DISPENSING MORE THAN JUST MEDICINES

Ima clinics

DISPENSING MORE THAN JUST MEDICINES



3.1 MISSION STATEMENT OF THE IMA CLINICS

The Islamic Medical Association of South Africa is committed to provide comprehensive, holistic, health care through its clinics programme to all needy, disadvantaged persons. The members of the organisation are committed to take health care to the people and dispense more than just medicines.

IMA CLINICS

DISPENSING MORE THAN JUST MEDICINES



AREAS OF OPERATION

CLINICS

NATAL

PERMANENT

BRAEMAR
MARSHHILL
MALAGAZI
GLENDALE

MOBILE

INCHANGA
CANAAN SETTLEMENT
SQUATTER AREAS
DISASTER AREAS

CAPE

PERMANENT

CLAREMONT
AL-JAAMIA MUSJID

MOBILE

THE HOMESTEAD
CLINIC FOR
CHILDREN

TRANSVAAL

MOBILE

ORANGE FARM
DOORNKOP
SWANIEVILLE
LUNAR SAND
GRASMERE

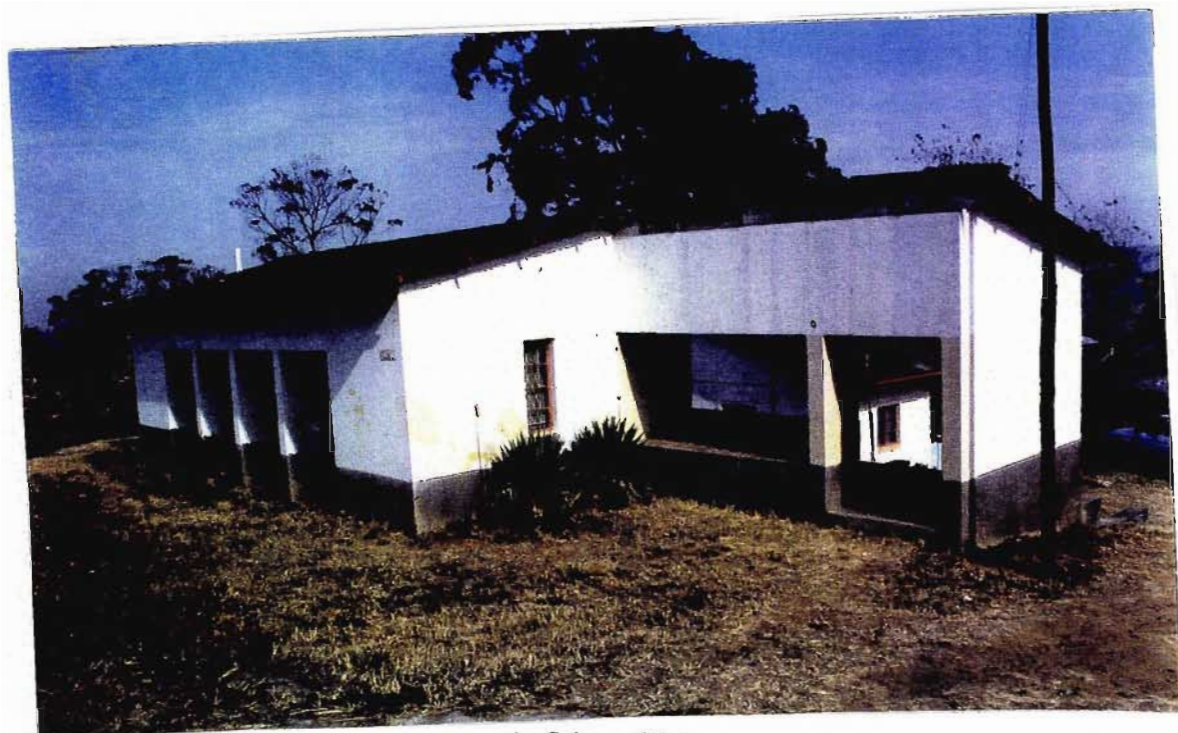
COST PER MONTH

R80 000 - R100 000

3.2 KWAZULU-NATAL CLINICS

As Salaam Clinic

This was the first clinic established in the country more than 24 years ago at Braemar, South coast, by the IMA which was then known as *Lajnatul Attiba*. It was established on a site where the Muslim Youth Movement (MYM) of South Africa was running the As Salaam Educational Institute. The buildings that were already in existence at that particular site comprised of a *masjid* (mosque), staff quarters, students residence and an unused dining room. A survey was first undertaken of the area on Sunday, 21 July 1974 by Drs GM Hoosen and YH Mahomed in order to assess the feasibility of establishing a clinic there. Their findings were submitted to the executive committee before a final decision was undertaken to start that clinic with the aim of rendering free health services to the indigent inhabitants of Braemar and its surrounding areas.¹



As Salaam Clinic

1. Interview with Drs GM Hoosen and FA Randeree, August 1995.

Necessary steps were then undertaken to establish the As Salaam Clinic. The unused dining room was converted for that purpose, and six cubicles were constructed for patient examination. At that stage, the executive committee decided not to approach the Muslim public for financial assistance to start the clinic as the project was an innovation in the community. The executive committee itself had to fund the establishment of that clinic and Dr YH Mahomed played a vital role in ensuring financial viability for the project. It was on Saturday afternoon, 3 August 1974, that the executive committee transported the necessary supplies to the clinic in preparation for the opening of the clinic on the following day. Medicines and equipment were donated by the late Dr MI Essack and Dr RA Karim and some of the necessary medicines were purchased by the core committee members.¹

On Sunday, 4th August 1974, the doors of the first clinic of *Lajnatul Atibba* were opened at As Salaam about 90km south of Durban.² It was a historic day for Muslim doctors in South Africa. Between 13h00 and 16h00 the core committee attended to 90 patients. Twenty patients were referred for follow up treatment and were asked to come on the following Sunday. Soon news of that clinic began to spread and patients flocked to it from far and wide. Mr Osman Randeree, who was employed by the MYM as the overseer at As Salaam, was responsible for converting the unused dining room into cubicles and his wife Zubeida acted as the first clinic assistant to the volunteer doctors. These two individuals also ensured the supervision of the clinic at that time.

1. Interviews with Drs GM Hoosen and FA Randeree, August 1995.
2. *Lajnatul Atibba Brochure* dated June 1976.

The clinic was operational every Sunday and was manned by volunteer Muslim doctors. A generous supply of medicines for patients at the clinic was provided regularly by the late Dr MI Essack. News of the opening of that clinic was reported in the local newspapers and this led to venomous attacks against *Lajnatul Atibba* and the Muslim doctors by non-Muslims. Their objections and criticisms were the same as before. The late Dr MI Essack penned an excellent response to expose the hollow arguments of the opponents. His letter was published in the *Natal Mercury*.¹ The initial success of that clinic can be gauged from a report that appeared in the *Natal Mercury* in which it was stated that "the clinic already has more than 100 patients, most of them African and has six treatment cubicles".² After only 3 sessions, the clinic was recognized as a centre which provided comprehensive health care at no cost, and the local populace turned up regularly in large numbers at the clinic for their medical needs. One month after the clinic became operational ie. from September 1974, Dr GM Hoosen began to perform circumcisions on children and young teenagers of the rural population on a fortnightly basis.

Here it ought to be noted that although the As Salaam Clinic was already in operation, it had not been officially opened and thus the executive committee met regularly at each others' homes in order to plan for its official opening. Invitations were sent to the Muslim public and it was on Sunday, 3rd November 1974, after *zuhr salah* (the afternoon prayer) that the clinic was officially opened at a ceremony performed by the late Dr MI

1. Essack, MI. "How the As-Salaam Clinic was conceived" in the *Natal Mercury*, 8 August, 1974.

2. "Muslim doctors start new clinic" in the *Natal Mercury*, 28 August 1974.

Essack. It was on that day that the Muslim public was given the opportunity to assess the work that was being carried out by the *Lajnatul Atibba*.¹

The guest speaker at the opening function was Dr DS Mall and about 200 people graced the occasion. The guests included amongst others, members of the MYM, religious personalities including the late *Mawlānā* Ahmed Adam Sabat, prominent business people like the late Mr AM Moolla and Mr S Vaid, prominent doctors like Dr RA Karrim, Dr D Mall, Dr Y Motala, as well as a number of other doctors. About 200 patients also attended the function. The function lasted about an hour and refreshments were provided by the core committee. Later during the afternoon, the core committee together with the visiting doctors attended to all the patients and finished late in the evening about 7 p.m.² This was undoubtedly another milestone in the history of *Lajnatul Atibba* and the IMA. The official opening of the clinic had been a huge success and the overwhelming positive response from the community encouraged the executive committee in their commitment to serve humanity as Muslims.



Dr Mall at Official Opening of the As Salaam Clinic

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1. *Brochure of the 10th Annual Convention of the IMA*, dated June 1990, p. 9.
 2. Interview with Dr YM Mahomedy, August 1995.

The As Salaam Clinic became a rallying point for the members of *Lajnatul Atibba* and its running was at that time the only activity that *Lajnatul Atibba* was then engaged in. That remained so for the following next five years. The clinic played a vital role in the transformation of *Lajnatul Atibba* into the IMA. The development and success of the clinic became entwined with the development and success of *Lajnatul Atibba*.

The committee drew up a list of about 30 doctors who volunteered to render service at the clinic on a roster basis. They were from the Durban area and most of them worked at King Edward VIII Hospital. Some of the voluntary doctors were YA Desai, M Motala, E Vanker, S Bemath, I Tayob, GA Karrim, A Mahomed and F Desai.¹

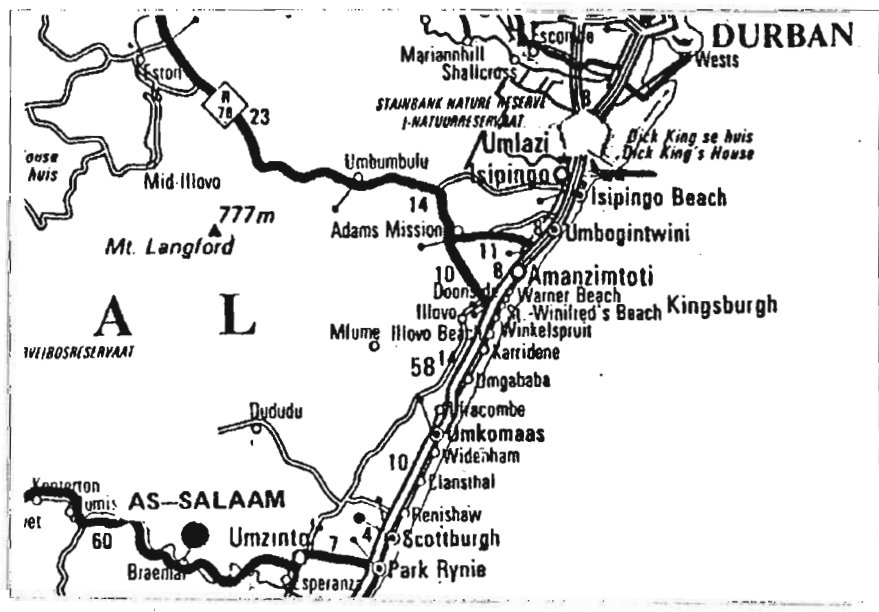
The travel time between Durban and the clinic was about 2 hours. This factor and the fact that the 3km dirt road to the clinic posed a serious hurdle especially on rainy days made doctors reluctant to volunteer their service on a regular basis. Consequently, the core committee members had to undertake that responsibility themselves. Sometimes medical students accompanied the doctors to the clinic. Surprisingly, a few doctors who had originally objected to the formation of IMDASA a few months earlier also did work on occasional weekends at the clinic on their own accord.² Most of the patients who attended the clinic were Africans and some Indians as well. The most common illness that was treated at the clinic was malnutrition and infectious diseases.

1. Interview with Drs GM Hoosen and YH Mahomed, August 1995.

2. Interview with Drs GM Hoosen and MAK Omar, August 1995.

The first few years entailed great hardships for these dedicated band of doctors who made personal sacrifices to ensure the smooth running of the clinic. For instance, As Salaam was 90km from Durban and it took about one and a half hours to get to Braemar - then there was the daunting 3km of hilly dirt road from the main road to As-Salaam itself which on a rainy day posed a serious hurdle to the attending doctor. Hence, during the rainy season, the doctor on duty had to first telephone As Salaam Educational Institute to find out if the road was accessible or not. Sometimes it was impossible to get to As Salaam and on occasions to even get out because the road got muddy. In fact, on a few occasions, the doctors' cars skidded and landed in a ditch. That meant that the doctor involved had to stay overnight at As Salaam and make the necessary arrangements for help the following day. Some of the doctors who recall such an experience are Drs S Bemath, GM Hoosen, MI Mulla and I Mayat.¹

Road Route to As Salaam From Durban



1. Interview with the core committee members, August 1995.

In view of the risks during inclement weather, services to the clinic were erratic. It often happened that the doctor on duty had to cover up for the previous week's intake thus doing a sort of double shift. Furthermore, the doctor on duty had to practically do everything on his own as there was no trained nurse at the clinic. This entailed, inter alia, the making out of patients cards, examining the patients, dispensing medicines and counselling the patients.¹

The clinic received the odd donations of medicines sporadically from some Muslim doctors, notably: Drs SA Jhazbhay, AH Solwa, AH Khatree and I Bhayat. As the local population became aware of the existence of the clinic the demand for its services grew and this created a need to solicit more funds for the clinic. Thus in order to publicise the activities of *Lajnatul Atibba* and to appeal for funds for the clinic, the executive committee finally decided in December 1974 to publish a brochure² which was the first publication ever of the IMA. This was accomplished in June 1976 and copies of the brochure were circulated among Muslim businessmen and doctors in order to solicit funds for the running of the clinic. The brochure contained pictures of the work being done at the clinic, information about the clinic, future plans, needs, estimated costs of the clinic and the vision for the future.³ The response was a little disappointing as only R2 500 was received from that effort. Nonetheless, the brochure served as a public relations exercise for the committee, allowing more people to evaluate the work of *Lajnatul Attiba*.

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1. Interview with Dr MH Khatree, August 1995.
 2. Interview with Dr YH Mahomedy, August 1995.
 3. See *Lajnatul Atibba Brochure* dated June 1976.

In the second year of the clinic a nutritional project was initiated whereby ProNutro and milk powder were bought from a company called Kupugani for free distribution to patients as a first step in its programme of preventive medicine to improve the health of the local populace. Minor surgical procedures also began to be performed by the attending doctors at the clinic.¹

One of the commonest conditions that was treated at the clinic was gastroenteritis which was caused by infected water and unhygienic living conditions, etc. Therefore in the third year of the clinic's existence a simple primary health care education programme was introduced at the clinic. This effort succeeded in eliminating that condition among the populace.²

By 1978, ie. the fourth year of the clinic, the number of patients stabilised to about 30 to 40 per session. To cater for this load and to intensify an active primary health care programme a resident sister was employed.³ Thus on 1 July 1978 Sister Elizabeth Msomi became the first qualified professional to be employed by the IMA in its commitment to serve the needy - another milestone for *Lajnatul Attiba*. The primary health care programme began in earnest and included hut visits as well. Ante-natal and post-natal care programmes were also introduced at the clinic. For the first time in that area an immunization programme was also set in place.⁴

1. Interviews with Drs MH Khatree and MAK Omar, August 1995.

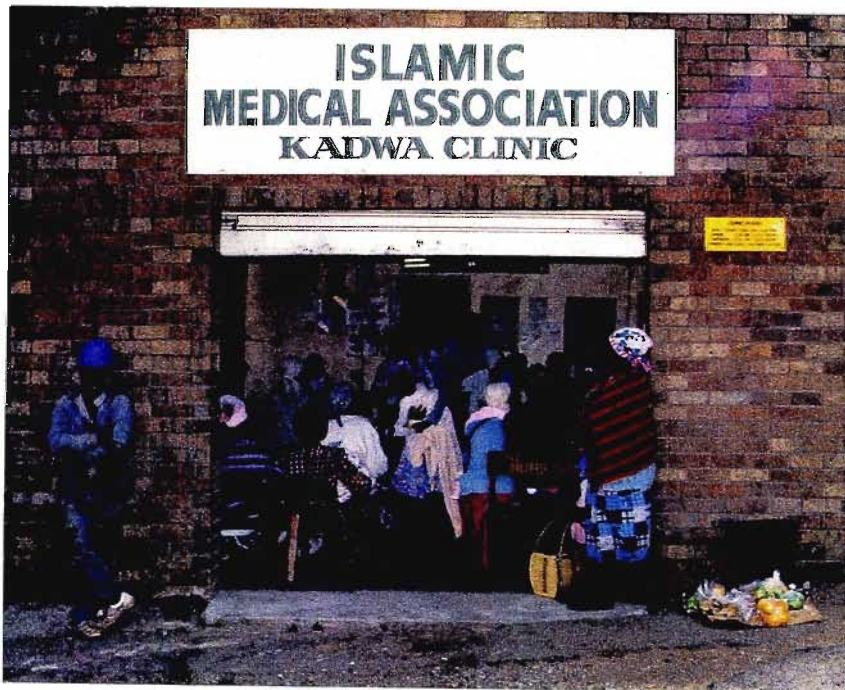
2. Interview with Dr FA Randeree, August 1995.

3. *IMA Clinics Brochure* dated December 1990, p. 9.

4. *IMA Clinics Brochure* dated April 1992, p. 3.

By 1979 the clinic was playing an increasingly greater role in screening patients who needed to be referred to a hospital. Very often the doctor himself transported the patient to the hospital in Scottburgh, South Coast, KZN, or even to King Edward VIII Hospital in Durban for further management.¹

The impact of the nutritional project and primary health care programme was so effective that by 1980 Kwashiorkor (protein calory malnutrition) was all but eliminated from around As Salaam.² The clinic, within 5 years of its inception had become very successful in providing health care to the populace and played a vital role in their lives. This was a remarkable achievement indeed for *Lajnatul Atibba* considering all the obstacles and hardships that were borne by these dedicated doctors right from its inception.



The IMA Kadwa Clinic

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1. Interview with Dr FA Randereee, August 1995.
 2. *IMA Clinics Brochure* dated December 1990, p. 9.

By 1990 the clinic became so successful that it established a satellite clinic behind Kadwa Stores in Braemar. The main reason for this was to make the clinic accessible to patients travelling from areas all around Braemar. This satellite clinic soon became very busy and negotiations with the Kadwa family for larger premises were undertaken. In May 1991 the IMA Kadwa Clinic was officially opened next to Kadwa Stores. This clinic has now replaced the As Salaam Clinic which was an integral part of the early history of the IMA of South Africa.¹

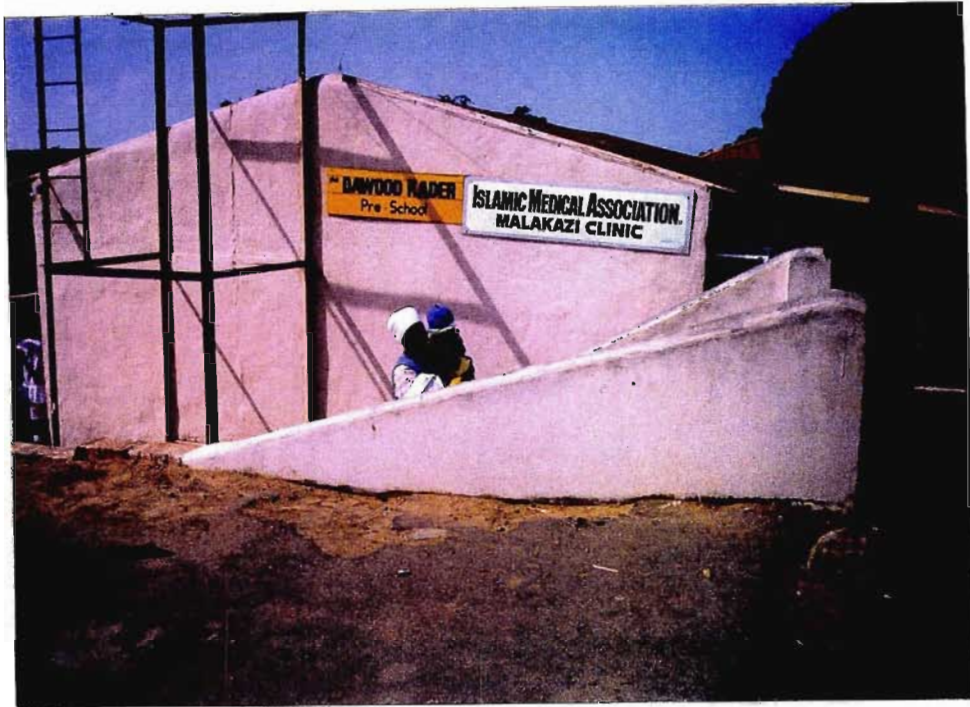
Malagazi Clinic

The Malagazi Clinic was established in 1978 by Messers. E Amod, F Bassa, I Vawda, M Moola, A. Patel, late D Timol, Aziz, E Vayez and Dr AB Asmall who were members of the Isipingo Branch of the MYM.² Initially they had installed two water tanks to provide free water to the people at the Malakazi squatter camp, who otherwise had to buy water from the nearby shop. Thereafter the Kader family of Malagazi donated a piece of land and the MYM collected funds to establish a *jamā'at khānā* (prayer-hall) and a clinic on it. Dr AB Asmall along with other Muslim doctors from the area provided free health services every Sunday at the clinic. These doctors also provided their own medicines for the patients. On 13th July 1980 this clinic was handed over to the IMA clinics committee. From then on the Malagazi Clinic was serviced by voluntary IMA doctors and prominent among them were the late Dr A Khan (until his demise) and Dr Y Motala

1. *Formation of the Islamic Medical Association of South Africa - Its Early Years*, op. cit., p. 43.

2. Interview with Dr AB Asmall and Mr. E. Vayez, October 1995.

of Shifa Hospital, Durban, (until his demise as well). Both provided regular sterling service to this clinic by doing a fixed weekly clinic on Fridays with their own medical supplies and nursing assistant. Hence it was called the Friday clinic by them initially.



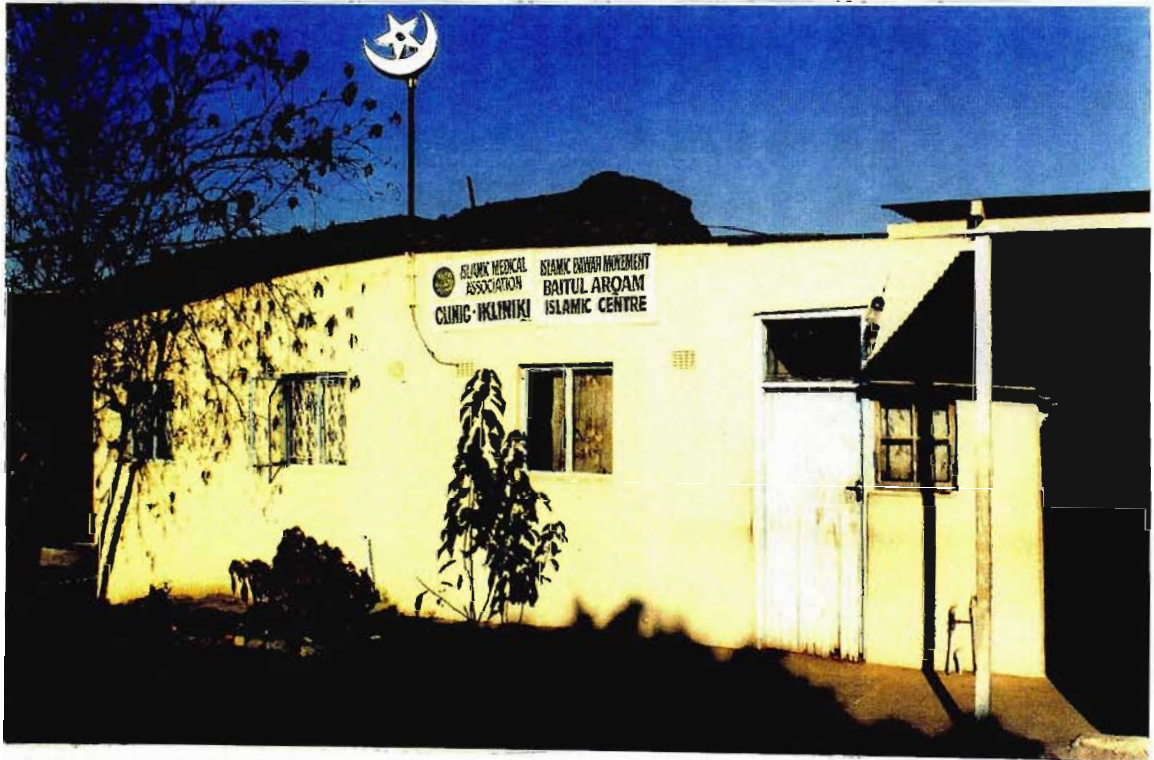
Malagazi Clinic

Marianhill Clinic

In 1979 Drs E Dada and Y Osman established the Islamic Dawah Movement (IDM) and the HS Ismail Family Trust allowed the use of an existing house for *da'wah* (Islamic missionary activity) and *madrasah* classes in the Marianhill area. In 1980 the IDM extended this house and established a *jamā'at khānā* and a clinic.¹ This clinic was run on Wednesdays by Dr E Dada and Dr Y Osman. They were assisted by Mr AG Mokoena who had some nursing experience and was the first *dā'iyah* (Muslim missionary) employed by the IDM.

1. Interview with Drs E Dada and Y Osman, October 1995.

After a while they got other doctors from Chatsworth and Shallcross to assist in providing voluntary medical service to the people. Medicines were provided by these doctors. This service was subsequently extended to Saturday mornings. Sometimes medical students also assisted at the Clinic. In 1982 the IMA clinics committee officially took over the running of this clinic.¹



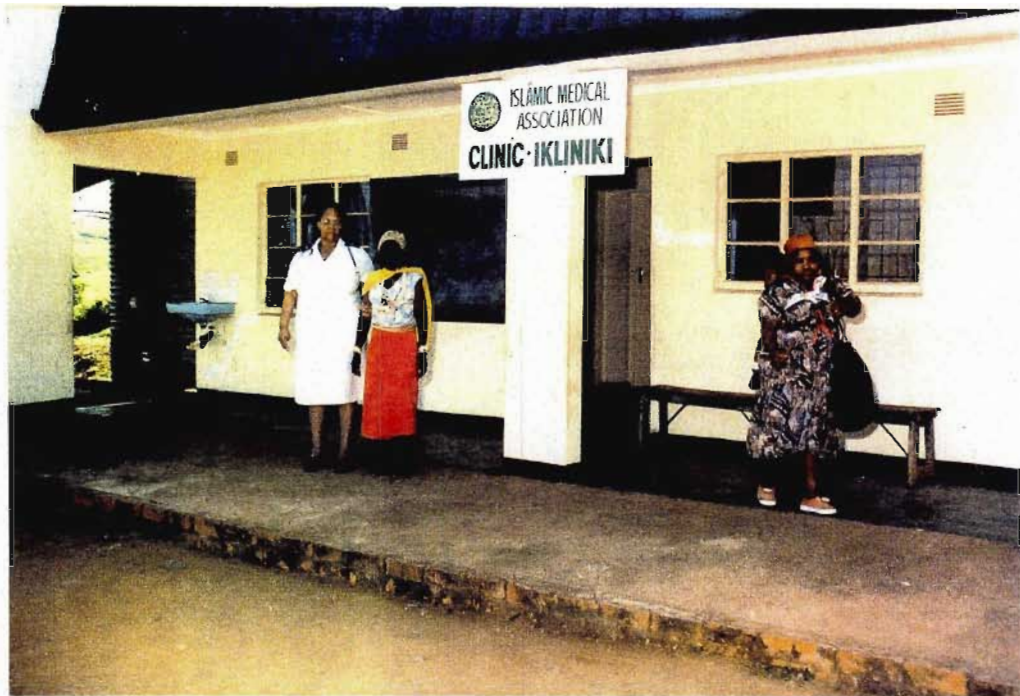
Marianhill Clinic

Glendale Clinic

In 1989 the S.A. Red Cross built the Glendale clinic near Stanger on land donated by the Jeewa Family. However, since the Red Cross was unable to run it the Jeewa Family requested the IMA to take it over. Thus on the 1st of July 1990, the Glendale Clinic became the fourth clinic in Natal to be run by the IMA clinics committee.²

1. Interview with Drs E Dada and Y Osman, October 1995.

2. *Brochure of the 12th Annual Convention of the IMA* dated April 1992, p. 3.



Glendale Clinic

Mobile Clinic

In October 1992 Be-Tabs Sales, a Muslim Pharmaceutical Company based in the Transvaal (now Gauteng) province, donated a mobile clinic to the IMA clinics committee in Natal. This unit provides health care to certain informal squatter settlements, rural areas and also assists in providing emergency medical relief to people residing in areas ravaged by political violence and natural disasters such as floods.¹ Presently the mobile unit provides regular weekly health care to the Canaan settlement (Clare Estate) and at Inchanga. It is also used at various social events and community functions to provide

1. *IMA Clinics Brochure* dated August 1994, p. 17.

medical service including a screening service at the Flea Market in Durban started by the medical students wing of the IMA (Islamic Society, Medical School, University of Natal).



Mobile Clinic

3.3 SUMMARY OF THE KWAZULU NATAL CLINICS' ACTIVITIES

Since 1986 full time, qualified nursing sisters have been employed in all the clinics and in 1987 the first full time doctor was employed to service the clinics. By 1990 two doctors were employed by the clinics committee. Currently, five fully trained professional nursing sisters, four *da'wah* workers and a handful of general staff are being employed. The average number of patients treated per month is nearly 5 000. Patients are charged a very nominal fee and the shortfall of income is made up by regular donations from the IMA members and the Muslim community. The reason for charging a nominal fee is to prevent abuse and also for patients to value and appreciate the service. The fee is

deposited into the clinic fund so that more patients can benefit from the service. Thus no money is taken by the IMA. An annual dinner is also held in order to raise funds for the clinics. The services provided by the clinics in KwaZulu Natal may be summarised as follows:¹

- a. Health Education - general hygiene, nutrition, drugs and alcohol abuse, etc.
- b. Immunisation - against diseases such as tuberculosis, poliomyelitis, measles, tetanus, diphtheria, whooping cough, etc.
- c. Antenatal Care
- d. Well-baby clinic
- e. Feeding Schemes - mealie meal porridge and Pro-Nutro.
- f. Relief Work - emergency relief to refugees of natural disasters and violence in conjunction with ISRA.
- g. Symptomatic Medical Care - cold, flu, influenza, diarrhoea, respiratory tract infections, hypertension, etc.
- h. Dental Care - operates once a week and is run by the dental sub committee.
- i. Ophthalmology Assessment - eye assessments are routinely provided at the clinics and patients requiring further assessments are referred to an optician.
- j. Vocational Training - educational programme on utilization of natural resources such as gardening and teaching of skills such as sewing, etc.
- k. Training of Community Health Workers - people drawn from the community are trained at the clinics and upon completion of the course receive certificates of

1. *IMA Clinics Brochure* dated October 1996, pp. 31-35.

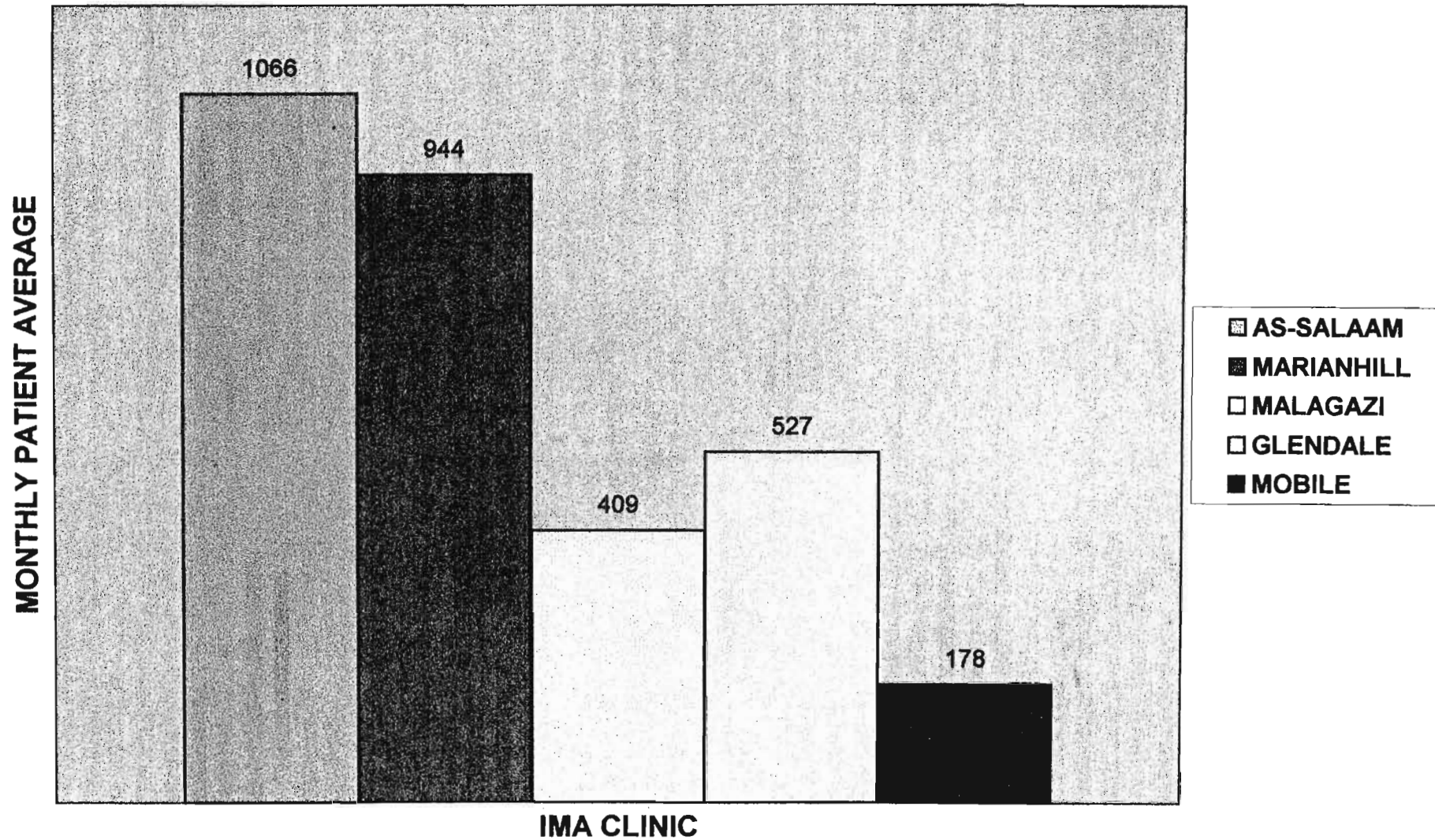
competence. They then return to their communities and assess simple medical and health related issues and provide advice to their people.

1. Screening - for diabetes, high blood pressure, etc. conducted at social and community functions by the mobile clinic.



Teaching of Sewing Skill

IMA CLINICS KZN MONTHLY PATIENT AVERAGE (JAN-DEC '97)



3.4 GAUTENG CLINICS

Evaton Clinic

Early in 1983 the IMA branch in Lenasia established a clinic at a then cost of about R 10 000 in the business complex of Evaton to serve the disadvantaged community. Patients were treated by the attending IMA doctor on Saturday afternoons between 2:00 pm to 5:00 pm. A part-time Sister used to assist by preparing the clinic and the patients. Concerned community persons would bring the elderly and the debilitated patients by microbus to the clinic for treatment. The IMA doctors would volunteer their services on a roster basis. About 5 to 10 patients used to be treated during these sessions and no fee was charged. Medicines were donated by the Muslim doctors. The most common ailments that were treated were skin problems, high blood pressure and malnutrition. Medicines to the value of about R 30.00 (present value R 100.00) per patient were dispensed and an average of about 50 patients a month were treated.¹

In September 1984 there was political rioting against the apartheid laws of the country and in the process a fire burnt down the clinic.² Medicines and basic equipments to the value of R 1 500 (present value R15 000.00) were destroyed in the fire. The area thereafter became politically volatile and the IMA felt that it was unsafe to restart the clinic in the area.

1. Interview with Dr H Tayob, October 1997.

2. Interview with Dr A Bhabha, October 1997.

Zakaria Park Clinic

Subsequently in 1985 another clinic was started at Zakaria Park in Lenasia. Unfortunately this clinic did not function well because there was no form of transport services available for patients to come to the clinic. Therefore it became impractical to operate the clinic and it ceased to exist at a later stage.

Mobile Clinic

In 1991, Be-Tabs Sales decided to contribute to the health care of the underprivileged and sponsored a mobile clinic and requested IMA to operate and manage it.¹ The IMA branch in Gauteng accepted this offer for the following reasons: it would be able to serve many different areas thus having greater flexibility; certain areas were politically volatile due to the apartheid laws of the country and therefore it would be safer to operate a mobile clinic rather than to establish a permanent one as the case in Evaton proved; the provincial health service was at that time in the process of setting up clinics in certain areas and it would not be proper to duplicate these services; finally, a mobile unit would assist in providing medical services in such areas where little or no health services existed. In August 1991 the mobile clinic became operational and a full time primary health care nurse was employed. A driver was also employed and he was also entrusted to do the clerical work as well as give moral talks to patients on alcohol and drug abuse, promiscuous behavior, etc. Informal settlements in the Transvaal region which had little or no health care services were identified. The mobile clinic began serving these areas

1. *IMA Gauteng Clinics Brochure* dated May 1996, p. 5.

on a daily basis from Mondays to Fridays and once a month, on Sundays, it was despatched to the Pretoria region.¹

From June 1994 onwards a full time qualified Sister with specialisation in primary health care has been employed. The IMA voluntary doctors provide supervisory assistance to the mobile clinic. The Civic Association for the different areas allocate a special site for the mobile clinic and they provide security as well. The mobile clinic provides the following services:²

- a. promotive - health education including basic principles of hygiene, sex education, first aid, modifying help seeking behaviour, etc.
- b. preventive - screening for important common conditions pertinent in S.Africa, eg. cancer of the cervix, hypertension, case finding for malnutrition, diabetes, family planning and spacing, etc.
- c. curative - treating acute, sub acute and chronic conditions that are amenable to some form of cure, common cold, flu, influenza, upper and lower respiratory tract infection, S.T.D., hypertension, diabetes, infectious diseases, ante-natal services, etc.
- d. rehabilitative - patients with handicap or disability and disfunction are referred to the appropriate facility or allied medical discipline eg. physiotherapy, etc.
- e. acute emergencies like stroke, angina, trauma (assault) etc - the Sister attends to such emergencies as best as possible and patients are transferred to the nearest hospital for further treatment.

1. Interview with Dr Y Essack, June 1996.

2. Interview with Dr Y Essack, October 1997.

- f. vocational training - this is available for those who require it, viz. nursing and medical field eg. medical students (elective primary health)
- g. screening programme - done on ad hoc basis at various social and community events like ANC Health Day, Laudium Health Day, etc.

Conditions that are resistant to treatment and those conditions that are beyond the scope of primary health care are referred for specialist assessment and management at the nearest state hospital. The services of the mobile clinic are also requested on many occasions to assist at various community events over the weekends, eg. Sports Day of schools, community Fun Days, etc.



Mobile Clinic

The hours of the mobile clinic are from Monday to Friday from 9:00 a.m. to 5:00 p.m. and one Sunday a month in Pretoria from 9:00 a.m. to 5:00 p.m. and community and social events over weekends. A nominal fee is charged in order to prevent abuse and also for patients to value and appreciate the service. The fee is deposited into the clinic fund so that more patients can benefit from the service. Thus no money is taken by the IMA. An average of about 30 to 40 patients a day are attended to at the mobile clinic and between 150 to 200 patients per week and about 800 patients a month. Due to shortage of space only acute and chronic ailment patients cards are kept by the mobile clinic.¹

The bulk of the medicines are bought by the IMA and some medicines are sponsored by Be-Tab Sales and private Muslim doctors. Most of the medicines dispensed are generic medicine. A comprehensive stock of medicines is kept by the mobile clinic. The average value of medicines dispensed per patient is between R 25.00 to R 30.00. The value of medicines dispensed per week to patients is about R 6 000.00 and per month is about R 23 000.00. The average administration cost of the mobile clinic per month is about R 10 000.00 which includes salaries, medicines purchased, petrol and service of mobile vehicle, printing, stationery and sundries. Annual fund raising dinners are held in order to collect funds for the mobile clinic and also some members of the Muslim public donate monies on a monthly basis through a debit order. In this way the IMA procures funds for the mobile clinic. Thus far over the last 5 years medicines to the value (market) of over R 450 000 have been dispensed to thousands of patients among the poor, needy and disadvantaged communities. The mobile clinic presently serves the Pretoria, Witwatersrand and Vaal areas.²

1. Interview with Dr Y Essack, June 1996.

2. Interview with Dr Y Essack, June 1996.

A second mobile clinic of the IMA is equipped and ready to service the Joubert Park region in conjunction with the Hillbrow Provincial Hospital outreach programme. A go ahead from the Hillbrow Hospital is being awaited before this can become operational.

3.5 WESTERN CAPE CLINICS

Mobile Clinic

In 1986 the IMA branch in Cape Town, following the unrest at Crossroads squatter camp initiated a medical relief programme for the unfortunate victims of the violence. Initially the medical relief work was conducted from tents, then a caravan was used and later a truck was converted into a mobile clinic. Daily forays were made by voluntary doctors into the troubled areas with the mobile clinic. During the height of the unrest when no persons, not even the emergency vehicles like ambulances and fire brigades were allowed into the troubled areas, the IMA made special arrangements with the relevant authorities to enter these unrest areas with police escort in order to provide medical assistance to unrest victims and needy people.¹ The IMA was the only organisation that provided medical assistance to the unrest victims.

After the unrest the mobile clinic was used at Nyanga, Gugulettu and Crossroads. Unfortunately the truck broke down. In 1991 the IMA Cape Town branch purchased a new mobile clinic to replace the old one. However, the violence in the townships around Cape Town prevents the mobile clinic from entering the areas. The mobile clinic was

1. Interview with Dr A Dhansay, October 1997.

primarily employed on Saturday afternoons for the “street children” of Cape Town at the grounds of St. George's Cathedral¹ - this was conducted in conjunction with the Cathedral and local shelter authorities until December 1994 when it was transferred to Gauteng.

The mobile clinic was extensively used at every march and political rally held during the period 1986-1994. In fact during the 1994 election period it was one of the major role players for providing safety and medical assistance in case of any violence erupting in the Cape Flats areas. Its services were also employed at the Annual Spring Fair which is held every September at the Habibia School where medical assistance and screenings were provided to the general public over the three day period. This service is still provided by the IMA although the mobile clinic is not in operation due to the violence in the Cape areas. Hence plans were made to establish a permanent clinic in Cape Town.



Mobile Clinic

1. *Brochure of the 13th Annual Convention of the IMA* dated July 1993, p. 31.

Claremont Clinic

A permanent clinic was finally built at the *Al- Jāmi' Masjid*, Claremont in March 1993. Sessions are held on Saturday afternoons. Indigent patients from Khayelitsha are regularly treated at the *masjid*.

IMA members are also in attendance at the *Bayt al-Aman*, a Muslim old age home, and also at *Al-Mā'ūn* Orphanage.¹

3.6 IMACSA

In October 1993 a National Clinics Committee was formed and is called the IMA Clinics of South Africa (IMACSA).² The main objective of this social welfare wing of the IMA is to co-ordinate all clinic activities throughout the country, especially with respect to fund raising. This has resulted in the IMACSA obtaining an official fund raising number in KwaZulu Natal. This has also resulted in the clinics becoming more community orientated by dispensing more than just medicines.

3.7 OUTREACH SERVICES

The IMA as part of its involvement in the health care of the community particularly in rural areas has embarked on an outreach service programme in various parts of the country over the last number of years. A few of these services are highlighted below.

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1. *Brochure of the 13th Annual Convention of the IMA* dated July 1993, p. 31.
 2. *IMA Clinics Brochure* dated August 1994, p. 19.

3.7.1 Specialist Clinics

A team of IMA medical specialists volunteered their professional services to assist the poor and underprivileged people irrespective of colour, race and religion in the Northern Cape Province over the weekend 5 April 1997. This was in response to a request for specialist medical assistance from the Department of Health and Welfare of the Province of the Northern Cape. A team of 7 specialists were sent by the IMA to Calvinia in the Hantam region of Northern Cape. The team comprised of a urologist, surgeon, gynaecologist, paediatrician, physician, ophthalmologist and an anesthetist.

Patients were especially brought from all over the region to be attended by these specialist doctors. These patients had been attended to by general practitioners, clinic sisters and hospital doctors and were in need of specialist opinion or treatment. Over 60 patients were treated and 14 surgical operations were performed on Saturday, 5 April 1997.¹ The staff at the hospital were co-operative and the patients were very appreciative. A theatre-trained sister and a laboratory technician assisted the team of doctors. The IMA was the first organisation that was approached by the Provincial Government of the country for medical assistance. This indicates the respect and confidence it enjoys among all sectors of society as well as at government level.

1. *Bulleting of the IMA (BIMA)* dated April 1997.

3.7.2 Eye Clinic

The IMA in Ladysmith held an Eye Clinic at the Bergville community health centre on 8 June 1996. This was a free screening service for people with eye problems in the community. The health care personnel providing the service were greeted by a queue of over 60 people and such was the enthusiasm of the people despite the cold weather that by the end of the day 243 people were seen. Statistics from the screening programme make interesting reading. There were 68 patients with cataracts who required surgery and were given referral letters for this. Eighty-four (84) patients had some visual disability requiring either reading spectacles, distance spectacles or bifocals. There were diabetic patients who required medical attention to prevent further deterioration in vision. In addition squint problems were also diagnosed.¹

Overall, 180 of the 243 patients attending had some form of visual disability. This represented 75% of the people who were screened. It must be emphasized that Bergville is a rural area and hence this survey highlighted once again the lack of basic medical services in rural areas and the need for community based projects to try and improve the health needs of the people.

3.7.3 Dental Clinic

The Olivershoek Clinic is a small clinic which serves a rural population in terms of its basic medical care and is located at the foothills of the Drakensberg. A team of IMA dentists from Ladysmith and Estcourt held a Dental Clinic at this place on 27 October

1. *Bulletin of the IMA (BIMA)* dated August 1996.

1996. This voluntary service was advertised via the local schools and satellite health clinics. Upon arrival the team was greeted by 40 patients and within half an hour the total number had swelled to 70 patients. Extractions were done, some patients were given advise and in some cases arrangements were made for referral for specialist care. Overall 70 patients were attended to. Although the service dealt mainly with extractions it highlighted the need for proper dental education in the region with the emphasis being on prevention rather than extraction.¹

3.7.4 Home Care Nursing Programme

In September 1993 the IMA of Western Cape embarked on educating volunteers in the community irrespective of race, colour and religion to care for their own sick, disabled, bedridden and terminally ill patients. A ladies' group was formed consisting of registered nurses, physiotherapists, oral hygienists, doctors, housewives and others. The format for the course was workshopped and topics covered included course content, record keeping, venues, volunteers and area co-ordinators.

The first public meeting was held on 16 October 1993 whereby it was realized that information regarding HIV and AIDS as well as the bathing of an infected individual was needed. Subsequently a meeting was held on 6 November 1993 attended by approximately 60 ladies at which an educational film on HIV and AIDS as well as precautions to be taken during bathing were discussed.

1. *Bulletin of the IMA (BIMA)* dated November 1996.

The first actual Home Care Nursing course was held on 18 November 1993 where 36 ladies attended.¹ Courses are now being held at different venues around the Western Cape arranged by the area co-ordinator. Workshops have been held at 13 different areas thus far. The present 4 hour course content included the following:

- a. Bed bath and bed making with the patient in bed
- b. Washing of hair in bed
- c. Mouth care
- d. Lifting, turning and positioning of the unconscious and stroke patient
- e. Basic physio-therapy and ambulation for the stroke patient

Reference booklets are issued at the end of the course for a small donation to cover the cost of photocopying. Each course is followed two weeks later with a presentation of a certificate. Thus far about 255 people have been trained. A similar programme called Frail Care was launched by the IMA of Gauteng in April 1997.² This programme involves helping and advising families with members who are incapacitated and who need assistance in their management at home. There is also a programme for hospice training available to all members of the wider community, to train them to manage their frail and terminally ill patients at home. Participants in these programmes are sufficiently trained to care for the terminally ill or bedridden patients within their homes or take care of such patients among their families, friends, relatives or even their neighbours. These self-help programmes conducted by the IMA in different parts of the country contribute directly in making health care available and affordable to the various communities.

1. *Bulletin of the IMA (BIMA)* dated April 1995.

2. *Bulletin of the IMA (BIMA)* dated April 1997.

Chapter Four

ACADEMIC ACTIVITIES OF THE IMA

From the time of its establishment, the IMA has been involved in various academic activities and one of its primary aim has been to publish works in general concerning Medicine and Islam and on specific issues relating to medical ethics and the Islamic viewpoint. It also wanted to initiate a culture of academic research amongst its members.

4.1 BOOKS

Thus far the IMA has published three books and they are:¹

1. *Darwinism on Trial* by Mrs. KS Nadvi was published in 1986. In this work the question of evolution is discussed in two parts - the first discusses the subject in the light of recent scientific discoveries and the second discusses the Muslim view point. This is a lucid and researched account of the creed of “scientific evolution”. It contains a scholarly critique of the supposed evolution of human beings out of lower categories of creation, and elucidating the *Qur'ānic* perspective upon this “enigmatic” area.

1. Amod, F. *Formation of the Islamic Medical Association: The Early Years*. Durban. Islamic Medical Association of South Africa. 1996, p. 54.

2. *Biomedical Issues - An Islamic Perspective* by AFM Ebrahim was published in 1988. This work is presented into four parts and covers such topics as Islamic ethics, Islam and health, reproductive control, biotechnical parenting and abortion. It is a well researched book which deals with the dilemmas that Muslims are faced with on the issues of birth control, abortion and surrogate motherhood and other related issues. It is compulsory reading for those who wish to gain an Islamic perspective regarding these issues.
3. *Formation of the Islamic Medical Association of South Africa - The Early Years* by Farouk Amod. This publication traces the arduous journey of the organisation during its formative years and elaborates on some of its activities. It is, in effect, the history of the formation of the IMA. It was published in 1996.

4.2 BOOKLETS

A number of booklets dealing with a variety of pertinent issues have been published and they are:¹

1. *Family Planning and Abortion - The Islamic Viewpoint*. This publication is the transcribed version of a talk given by *Qādī* Mujāhidul Islām to Muslim health workers in Durban in 1979. It was jointly published with the Muslim Students' Association (MSA) of South Africa in December 1980. It was the first IMA

1. *Formation of the Islamic Medical Association of South Africa: The Early Years* op. cit., pp. 54-56.

booklet to be published. This task was accomplished as a result of a questionnaire that was submitted to the *Mawlānā* by the doctors. His tape recorded answers and discussions were subsequently translated from Urdu into English by *Mawlānā* Yūnus Patel and Dr Adam Harneker and was then published. It is a simple reference work in response to the complex question of family planning. Its chief merit is in providing solutions to the question of contraception and family planning devices, presented in the form of questions and answers.

2. *Muhammad (s.a.w.s.) - The Married man* by A El Kadi was first published in March 1981. It is an excellent synopsis on the life of the Holy Prophet Muhammad (s.a.w.s.). In December 1993, it was reprinted under the title *Muhammad (s.a.w.s.) The Family man*. The ennoblement of women and the elevation of the institution of marriage at the hands of the Holy Prophet Muhammad (s.a.w.s.) is the primary focus of this study. It is compulsory reading for those who seek to understand the intrinsic truth in the Prophetic maxim : "Marriage constitutes one-half of *dīn*".
3. *Islamic Code of Medical Ethics - Kuwait Document*. This publication was compiled by the International Organisation of Islamic Medicine at the first International Conference on Islamic Medicine in January 1981 in Kuwait. It was published as a booklet by IMA of South Africa in May 1982. This book outlines, inter alia, the definition of the medical profession from the Islamic viewpoint, the characteristics of a medical practitioner, the mutual relationship between practitioners, the relationship between doctor and patient and the sanctity of

human life. It is an important handbook for the Muslim medical practitioner, providing valuable guidance for a doctor's day to day professional activity.

4. *The Qur'ān and Modern Science* by M Bucaille is the transcription of a talk which was given by the author describing his original work *The Bible, Qur'ān and Science* which was first published in May 1982.
5. *Islamic Medicine - Some Thoughts* is a selection of papers on the concept of Islamic Medicine. It was first published in May 1983 and reprinted in July 1993 under the title *Reflections on Islamic Medicine*. This work consists of five pertinent essays dealing with the concept of Islamic Medicine by leading Muslim medical scholars and practitioners. It also gives an insight into the need for evolving Islamic institutions with their own specific Islamic medical textbooks.
6. *Islam and Science*. This is a collection of four papers on the theme of its title. It was published in April 1984. This work presents a case for "Islamic Science". It succeeds in making a justification of the "scientific method" through recourse to *Qur'ānic* data relevant to modern science, and ultimate recognition of the Holy Prophet Muhammad (s.a.w.s.) as the initiator of the age of empirical knowledge.
7. *Fasting and the Patient - Some Guidelines* was published in 1984. This publication is based on the findings of two symposia hosted by the IMA of South Africa. It serves as a guideline for both the patient and physician. A revised updated version was reprinted in December 1995. It is an important work

providing solutions to the dilemmas faced by the fasting patient. It also provides useful information about the general rules of fasting, medical issues related to women, marital and miscellaneous issues relevant to concerned Muslims.

8. *The Alcohol Content of Some Commonly Available Medicines* by CM Dangor was published in December 1984. It is a comprehensive collection of alcohol containing medicines, including the percentage content and a list of some alternatives.
9. *Hajj - What does it mean?* by M Coovadia was published in 1987. This publication attempts to give meaning to the rituals of *hajj* with the aim of inspiring Muslims to transform themselves for their own betterment as well as that of humanity in general. This concise work explains the meaning and importance of Islam's fifth pillar i.e. the *hajj* (the Pilgrimage to Makkah). The significance of each of the rites of *hajj* is presented in a way that succeeds in reminding the reader of Islam's transcendental dimension as well.
10. *The Shari'ah and Organ Transplant* by AFM Ebrahim and AA Haffejee was published in March 1989. In this publication, the concept of brain death is explained and the different *Shari'ah* viewpoints on organ transplantation are discussed.
11. *Islamic Jurisprudence and Blood Transfusion* by AFM Ebrahim was published in June 1990. This study represents the deliberations of two prominent Muslim

- Jurists on this topic - their *fatāwā* (rulings) represents the *ijmā'*, (consensus) of Pakistan and Arab scholars. It also touches upon the reality of blood banks and the religious factor involved.
12. *A Practical Guide for Managing Drug Abuse* by M Coovadia was published in May 1991. This study, *inter alia*, contains a diagnosis of drug abuse and provides certain practical guidelines in assisting those caught in the web of such aberrations. The exposition of the Islamic attitude vis-a-vis the consumption of intoxicants confers added meaning to the seriousness of the subject.
 13. *Towards a Health Policy for South Africa* was published in 1991 as an IMA Working document on this pertinent issue.
 14. *Islamic Guidelines on Animal Experimentation* by AFM Ebrāhim and AI Vawda was published in July 1992. The use of animals in biomedical research and teaching is a controversial issue. This work attempts to extrapolate certain Islamic guidelines on the subject of animal experimentation from related teachings in the *Qur'ān* and *Sunnah*.
 15. *The Muslim Patient - A Guide for Health Care Professionals* by F Haffejee was published in February 1993. This concise work outlines the basic religious precepts which concern the day to day behaviour of each Muslim individual - it is valuable reading for non Muslim and even Muslim health care professionals. It forms an essential prerequisite for establishing a harmonious interaction

between medical personnel, pharmacists, allied health attendants and their patients and users of services.

16. *A Healthy Diet - Islam shows the Way* by MAK Omar was published in October 1994. This work looks at eating behaviour in the light of the *Qur'ān* and *Sunnah*. Modern diets being high in total fat, saturated fat, cholesterol, sugar, salt, alcohol, calories and low in fibre content are quite different from any consumed by our ancestors of the pre-industrial era. There is little doubt that a change in dietary habits would go a long way towards minimising the risk of developing cardiovascular and other degenerative diseases. In fact the kind of eating behaviour prescribed by the *Holy Qur'ān* and exemplified by the Holy Prophet (s.a.w.s.) would certainly fit the requirements of the ideal diet.

17. *Ethics of Medical Research* by AFM Ebrahim, HA Randeree and AI Vawda was published in October 1994. This publication looks at the need for assessment of Medical research and the development of an appropriate code of ethics of Medical Research from an Islamic perspective. Today, more than ever before, medical research is regarded by many as being undertaken with the primary purpose of controlling and manipulating life and death. Hence the need for assessment of medical research and the development of an appropriate code of ethics of medical research from an Islamic perspective.

18. *Death and Dying: Advising Patient and Family* by AFM Ebrahim, GM Hoosen and H Hathout was published in July 1995. This study attempts to extrapolate

certain guidelines from the broad teachings of the *Qur'ān* and *Sunnah* that could effectively be used when communicating with the terminally ill patient and his/her family. Moreover, since there is growing pressure on governments in every part of the world to legalise euthanasia, Islam's stance on this issue has also been dealt with in this publication.

19. *Code of Health Care Providers* - IMA of South Africa. This publication provides guidelines for health care providers, based on the broad teachings of the Noble Qur'an and Sunnah, on such issues which relate to their personnel conduct, the manner of conducting their practices, relationships with their patients, relationship amongst themselves, and their role within the community. The Prophet Muḥammad (s.a.w.s.) is reported to have said: "*The din (way of life) is naṣīḥah (advising and reminding each other of one's duties).*" Thus in the light of the spirit of advising and reminding each other of the duties as health care providers, the Council of the Islamic Medical Association of South Africa resolved to hold workshops in the different provinces so as to formulate a code of conduct for health care providers. Workshops were held in Gauteng, Western Cape and KwaZulu Natal. Compilations from the different workshops were then collated for this publication and published in 1996.

4.3 JIMASA (JOURNAL OF THE IMA OF SOUTH AFRICA)

The forerunner of this journal was the publication of the annual convention papers in a book form. *JIMASA* now publishes these and other articles pertinent to

Islamic medicine. *JIMASA* Vol. 1, No. 1 was published in April 1987 and to date twenty-one issues have been published. Prior to this, a number of issues of the *Journal of the IMA of North America (JIMA)* were reproduced with permission and distributed to its members.

In 1995, a research sub-committee was formed and it was resolved that *JIMASA* should take on a new format. The new format of *JIMASA* Vol. 2, No. 1 appeared in March 1996. From then onwards it was resolved to bring out 3 issues of *JIMASA* per year in the months of March, August and December.¹ The journal publishes articles on general health, purely medical articles, a book review, report back on medical conferences by members, articles on Islam and Muslim society and on contemporary issues. Articles are contributed by both local and overseas writers.

4.4 *BIMA (BULLETIN OF THE IMA)*

Bulletin of the IMA of South Africa is published regularly by the National Executive of the IMA. It carries news of activities, motivational articles and from time to time policy statements. It is published every two months and its first copy appeared in January 1980.²

1. *Formation of the Islamic Medical Association of South Africa: The Early Years*, op. cit., p. 57.

2. *ibid*, p. 57.

4.5 PAMPHLETS

A number of pamphlets have been produced for distribution to the general public on topical issues - these include the following:¹

1. Immunisation - The Medical Facts.
2. Fasting - Medical Guidelines.
3. Giving up smoking for *Ramādān*? Give it up for good.
4. What you need to know about AIDS.
5. Some health guidelines for *Ramādān*.

4.6 GENERAL

4.6.1 The Oath of the Muslim Physician

In May 1984 the IMA printed "The Oath of the Muslim Physician". This was available either for framing or mounting. This oath was taken for the first time by Muslim doctors at the annual convention in 1984.² This oath has now been slightly modified and reprinted in 1995 as "The Oath of the Muslim Health Professional".³

1. *Formation of the Islamic Medical Association of South Africa: The Early Years*, op. cit., p. 57.
2. *ibid*, p. 57.
3. See appendix D.

4.6.2 Medical Research

The IMA has stimulated research in Islamic Medical Ethics and in Islamically related medical topics such as:

1. The use of honey in gastro-enteritis
2. Alcohol contents of medicines
3. Management of the fasting patient
4. Use of honey in diabetes

The results of the research were as follows: Honey can be used for bacterial gastroenteritis; medications that have alcohol were identified and advice was given on alternative medications; patients with various disease conditions were given guidelines as to how they could fast; glucose tolerance test was done to assess the effects of honey on glucose levels - it was found that it does not have a detrimental effect.

4.6.3 Students' Electives

The IMA has facilitated the local students to do electives at the Al-Akbar Institute in the USA, Islamic Hospital of Amman in Jordan, to the Rustenburg Group practice of Dr S.A. Thokan as well as at the IMA Clinics in Durban and Johannesburg.

4.6.4 Public Education

It has also been involved in public education in the form of:

1. Symposia on topics such as “The Child in Islam”, “Drug Abuse”, “AIDS”, “Fasting”, “Islamic Medical Ethics”, “Surrogate Motherhood”, “Abortion”, etc.
2. Publication of health education literature.

4.6.5 Promoting the Establishment of IMA in Neighbouring Countries

The IMA has played a leading role to expand the idea of an IMA throughout the region of Southern Africa. This was accomplished by personal visits and through the bi-annual SAIYC Conferences in the neighbouring countries. It has gone beyond the borders of South Africa into neighbouring countries and in fact associations have been launched in Malawi, Mauritius and Tanzania.

4.6.6 Participation in International Conferences

The IMA members delivered many papers on various topics at many international conferences and conventions throughout the world.

4.6.7 International Links

The IMA works closely with the following organisations and institutions:

- a. Federation of Islamic Medical Associations (FIMA) and through it to IMAs of 14 countries.
- b. Health workers in Zimbabwe, Malawi, Mauritius, Mozambique and Australia.
- c. Institutions
 - Yarsi School of Medicine, Jakarta, Indonesia
 - Islamic Hospital, Amman, Jordan
 - Al-Akbar Clinic, Florida, USA
 - Afghan Surgical Hospital, Peshawar, Pakistan.
- d. International Relief Organisations - Islamic Relief Agency (ISRA), Khartoum, Sudan (registered with the United Nations), and Africa Muslim Agency of Kuwait.

4.6.8 IMA Health Manifesto

In 1991, the IMA prepared a working document on a health policy for the new South Africa. The proposals included the following aspects, viz. a National Health Policy; Administration;

Finance; Primary Health Care; Medical Training; Social Issues; Environmental Abuse and Pharmaceutical Policy. The draft document was then workshopped at its 11th Annual Convention which was held at Lenasia, Gauteng Province, from 31 May 1991 to 2 June 1991. Amendments to the document were then made and the final document of the IMA Manifesto on Health was then submitted to the Department of Health in South Africa in that same year.¹ The IMA was the first organisation in the country to submit a health policy for the nation to the new democratic government.

4.6.9 Submissions on Ethical Issues

The IMA in accordance to one of its aims and objectives also responds to ethical issues that arise from time to time which affects the society at large and in particular the Muslim community. Some of them are as follows:

1. **OBJECTION TO THE ENACTMENT OF TERMINATION OF PREGNANCY LEGISLATION**

On 15 October 1996, the IMA lodged an objection to the Committee on Health to the South African Parliament against the enactment of Termination of Pregnancy Legislation based on the provisions of the Termination of Pregnancy Bill which was published in the *Government Gazette* on Friday, 27 September 1996.²

1. See appendix E for the full document.

2. See appendix F for the full document.

2. REPORT ON THE HEALTH AND HUMAN RIGHTS VIOLATIONS IN SOUTH AFRICA

A fourteen page report on the health and human rights violations in South Africa was submitted to the Truth and Reconciliation Commission on 25th May, 1997.¹ The main reason for the objection was that the Bill freely allows abortion on demand, whereas Islam allows it only under certain conditions.

3. BILL ON EUTHANASIA AND THE ARTIFICIAL PRESERVATION OF LIFE

On 31st July 1997, the IMA submitted its response to the Bill on Euthanasia and the Artificial Preservation of Life to the South African Law Commission in Pretoria.²

1. See appendix G for a brief summary of this report.

2. See appendix H for the IMA response.

Chapter Five

EVALUATION OF THE IMA IN LIGHT OF THE RECONSTRUCTION AND DEVELOPMENT PROGRAMME (RDP)

The former South African racist government, through its apartheid policies, succeeded in exercising control over health care professionals and facilities. Its racist legislations resulted in the segregation of health services with the result that people could receive the necessary medical attention only at the centres that were allocated for them on the basis of their racial groupings.¹ In this chapter an attempt is made to evaluate the IMA in light of the RDP.

5.1 THE RDP

The RDP is an integrated, coherent socio-economic policy framework. It seeks to mobilise all the people and the country's resources toward the final eradication of apartheid and the building of a democratic, non-racial and non-sexist future. The RDP has been drawn up by the African National Congress (ANC) – led alliance in consultation with other key mass organisations, a wide range of non-governmental organisations (NGOs) and research organisations who assisted in the process.² It was drawn up at the beginning of 1994 and its implementation began with the present ANC led government which came into power in April 1994 in the first democratic election of the country.

1. *A National Health Plan for South Africa* - An ANC document. May 1994.

2. *The RDP - A Policy Framework* - An ANC document. 1994.

The RDP covers a wide range of services including health, welfare, housing, transport, employment, water and sanitation, etc. This dissertation is focussed on health issues and hence only such programmes of the RDP which fall within the ambit of a non-governmental organisation (NGO) are being addressed in this chapter. Other aspects relating to hospitals, private practice, pharmacy, accidents, emergency and rescue services, health technology, environmental health, occupational health, etc. are beyond the scope of any NGO, including the IMA.

5.2 HEALTH PRINCIPLES AND PROGRAMMES

In order to be able to assess the role of the IMA in light of the RDP, it is imperative to tabulate some of the pertinent health principles and programmes as envisaged by the RDP. They are as follows:¹

1. Every person has the right to achieve optimal health, and the ANC is committed to the promotion of health, using the Primary Health Care (PHC) approach as the underlying philosophy for restructuring the health system. PHC will form an integral part, both of the country's health system, and of the overall social and economic development of the community. The RDP must significantly shift the budget allocation from curative hospital services towards PHC to address the needs of the majority of the people.

1. See *A National Health Plan for South Africa*, op. cit. and *The RDP - A Policy Framework*, op. cit. for the full version.

2. Free health care will be provided in the public sector for children under 6 yrs, pregnant and nursing mothers, the elderly, the disabled and certain categories of the chronically ill.
3. Preventive and promotive activities, school health services, antenatal and delivery services, contraceptive services, nutrition support, curative care for public health problems and community based care will also be provided free of charge in the public sector.
4. Priority will be given to primary care facilities and personnel in rural and impoverished urban areas. The aim is to reduce inequalities in access to health services, especially in the rural areas and deprived communities.
5. All categories of health personnel should have experience of working in rural settings.
6. There will be a focus on the prevention and control of major risk factors and diseases, especially AIDS, tuberculosis, measles, gastro-intestinal disease, trauma, carcinoma of the cervix, hypertension, diabetes, heart disease and common cancers.
7. Health workers at all levels will promote general health and encourage healthy lifestyles.

8. Attention will also be given to health education on sexuality, child spacing and substance abuse.
9. Within the health system health workers must respect the rights of all people to be treated with dignity and respect. A Charter of Patients Rights will be introduced.
10. There is a need to develop new models of oral health care appropriate to South African conditions, by giving priority to comprehensive preventive, promotive and curative primary health care. Selected screening programmes will be carried out to determine and monitor the oral health treatment needs of all South Africans.
11. To ensure that people with terminal or incurable illness receive affordable and effective care by encouraging and assisting families and communities to care for people in their own homes, also encouraging and supporting religious groups and NGO's such as hospice movement working in the field of palliative care.
12. Rehabilitation service will promote the development of self-help initiatives by assisting people with disabilities to gain the necessary skills and attitudes to sustain such initiatives.
13. To improve the provision of equipment for people with disabilities.
14. Development of comprehensive women's health care services, including

- contraceptive services. Giving priority to cost effective screening programmes for diseases which affect women (eg. carcinoma of the cervix).
15. Preventive and promotive health programmes for children must be improved. Breast-feeding must be encouraged and promoted and the code of ethics on breast-milk substitutes enforced.
 16. Clinics will offer a comprehensive range of preventive, promotive, curative and rehabilitation services but at a less specialised level than the Community Health Centres (CHCs). Clinics will normally only be open on week days but this can be negotiated with the local communities. All clinics must have water, electricity and communication systems.
 17. It is important to uphold the principles of promoting research that aims at improving the health of people in South Africa. The research process and the appropriate application of research can enhance human potential and improve the quality of life for all South Africans.

5.3 THE RDP *VIS-A-VIS* IMA CLINICS

At the very outset, before evaluating the role of the IMA Clinics in light of the RDP, it ought to be noted that the IMA Clinics have come into operation from 1974 onwards whilst the aims and objectives of the RDP were put into place in 1994. Thus the RDP cannot be used as a yardstick to measure the success or failure of the IMA in delivering

health services to the people in South Africa. However, this evaluation will enable one to have a fairly clear picture of the role played by the IMA Clinics in catering for the health needs of the poor and disadvantaged people and in particular the rural communities in South Africa.

5.3.1 Right to optimal health

All the IMA Clinics are engaged in PHC activity. The first IMA Clinic that was established in a rural area in August 1974, more than two decades ago, catered for the disadvantaged people by providing them with voluntary health care services. In fact within 4 years of its inception the IMA employed its first qualified Sister to earnestly promote the PHC programme which included hut visits as well. Since 1986, full time qualified nursing Sisters have been employed in all the clinics thus enhancing the PHC services to the community. Hence it can be rightly stated that the IMA began its own RDP more than two decades ago.

5.3.2 Free health care services

The IMA Clinics, unlike the government clinics, do not get any funds for its activities from the government or provincial treasury. Being a NGO, it solely relies on the generosity of its members and the Muslim public at large for funds to operate all its clinics. Therefore its financial resources are very limited and it is always obliged to make regular appeals for donations in various ways. Hence it cannot afford to provide a totally free health care service. It is compelled to levy a nominal amount (presently

an amount of R 15.00) to prevent abuse of the services as well as to make the patients value the services. The fee is not compulsory as those who cannot afford this levy are treated free of charge and in some cases the fee is reduced to accommodate the patients. The average cost to the IMA per patient is R 22.00. The fee collected from the patients is utilised to purchase medicine thus more patients can benefit from the voluntary services and no money is taken by the IMA. Surprisingly more patients come to the IMA Clinics than the nearest government clinics for various reasons.

5.3.3 Preventive and promotive activities

These services are provided at all IMA Clinics, as already outlined in chapter three of this dissertation, with the exception of school health services which falls outside the ambit of the IMA and maternity (delivery) services for which no facilities exist at the clinics. However pregnant women are referred to the nearest hospital for all maternity (delivery) needs.

5.3.4 Primary care facilities and training of health care workers

Since its inception more than two decades ago, all IMA clinics have been PHC orientated and have been providing voluntary health services to deprived communities, particularly in rural areas thus affording access to health services to the local populace. Also, personnel employed at the clinics are from the local areas. Furthermore, the IMA with the aid of a grant from Parke Davis (a pharmaceutical company) has been providing training for health workers from the local populace to empower them to take care of the

health needs of their own community. The training enables them to assess simple medical and health related issues and provide advice to their people.

5.3.5 Health care personnel's experience of working in rural settings

The IMA arranges student electives in all its clinics throughout the country and provides vocational training for students in the nursing and medical field (elective primary health). This service was introduced in the late 1980s. Also medical students from the IMA Students' Wing are encouraged to assist in the clinics thus gaining valuable experience in their profession. Furthermore, IMA doctors volunteer their specialised services in the various specialist clinics that are held in the rural areas from time to time, eg. Specialist Clinics, Dental Clinic, Eye Clinic, etc. (as discussed in chapter three of this dissertation) thus gaining experience of working in rural settings.

5.3.6 Prevention and control of major risk factors and diseases

Nursing staff at the clinics enlighten patients on diabetes and other diseases. The IMA, noting the threat that AIDS poses, has published pamphlets on AIDS, both in English and Zulu, and these were distributed to patients and the local populace at large. The IMA Mobile Clinic also assists in screening people for hypertension, diabetes and cholesterol. This service is provided on weekends at flea markets and at other social and community functions.

5.3.7 Promotion of general health and encouragement of healthy lifestyles

At all IMA Clinics patients are educated on general hygiene, general health, breast feeding, healthy eating habits, simple dietary recommendations, etc. with the aim of promoting general health and encouraging healthy lifestyles.

5.3.8 Health education on sexuality, child spacing and substance abuse

Nursing staff give talks to patients on sexual behaviour, promiscuity, family planning and spacing, drug and alcohol abuse, smoking, etc. In fact, the IMA has held symposium on “Drug Abuse” and “Aids” in order to conscientise both the health care providers and the general public. Also, the IMA has distributed its publication of health education literature over the years to the public and patients.

5.3.9 Respect for patients’ rights

The IMA recognises the rights of patients. This is embodied in its own “Oath of the Muslim Health Care Professional”. Also, it has produced and published an 18-page booklet entitled “Code for Health Care Providers” which not only highlights the rights of patients but the obligations to patients by the health care providers and offers practical guidelines in this regard.

5.3.10 Oral health care

This service was initially provided at IMA Clinics on a weekly basis, but due to limited resources, this service is provided occasionally. However, screening is conducted at the clinics whenever resources are available. The IMA is aware of the importance of such services and should funding become available, it will reinstate such services.

5.3.11 Caring for the terminally ill

This service is provided by the IMA as outlined in detail in chapter three of this dissertation under the sub-heading "Home Care Nursing Programme".

5.3.12 Rehabilitation services

It has not been possible for the IMA to provide rehabilitation services because of the lack of qualified personnel and resources. However, on April 4, 1998, the IMA - Durban Branch organised a presentation on occupational health. The talk was given by a qualified occupational therapist and it is hoped that in due course the IMA will be in a position to cater such services at its clinics.

5.3.13 Provision of equipment for people with disabilities

The IMA Azaadville Branch loan equipments like wheelchairs, crutches, walking sticks and commodes to patients with disabilities. These equipments are costly and as such

cannot be supplied to all IMA Clinics, but whenever some of these equipments are donated to the IMA, they are loaned for a nominal fee to patients with disabilities.

5.3.14 Development of comprehensive women's health care services, including contraceptive services

IMA Clinics provide services to all types of patients and hence it is not practically possible to provide comprehensive women's health care services. Such service can only be fully provided at hospitals and Community Health Centres. However some aspects of women's health are provided at all IMA Clinics as discussed in chapter three of this dissertation. It is not possible to screen women patients for cancer of the cervix due to the cost involved in processing such screening.

5.3.15 Preventive and promotive health programmes for children

This is being done by the IMA with its emphasis on breast feeding. In fact the IMA's slogan which is displayed at its clinics is "Breast is Best".

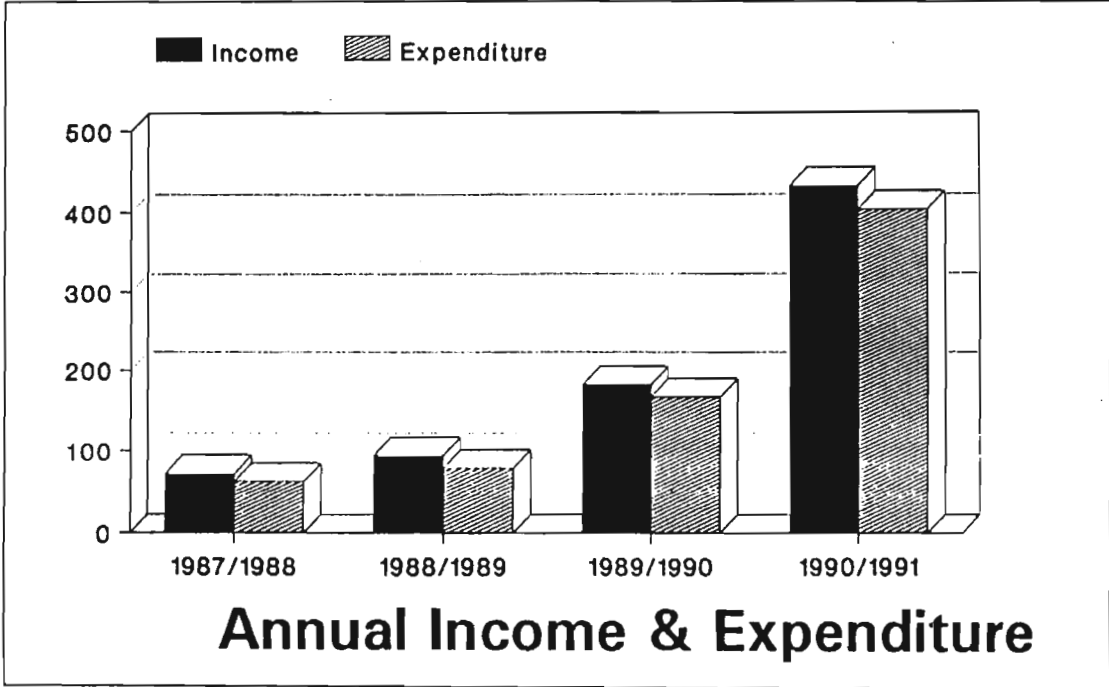
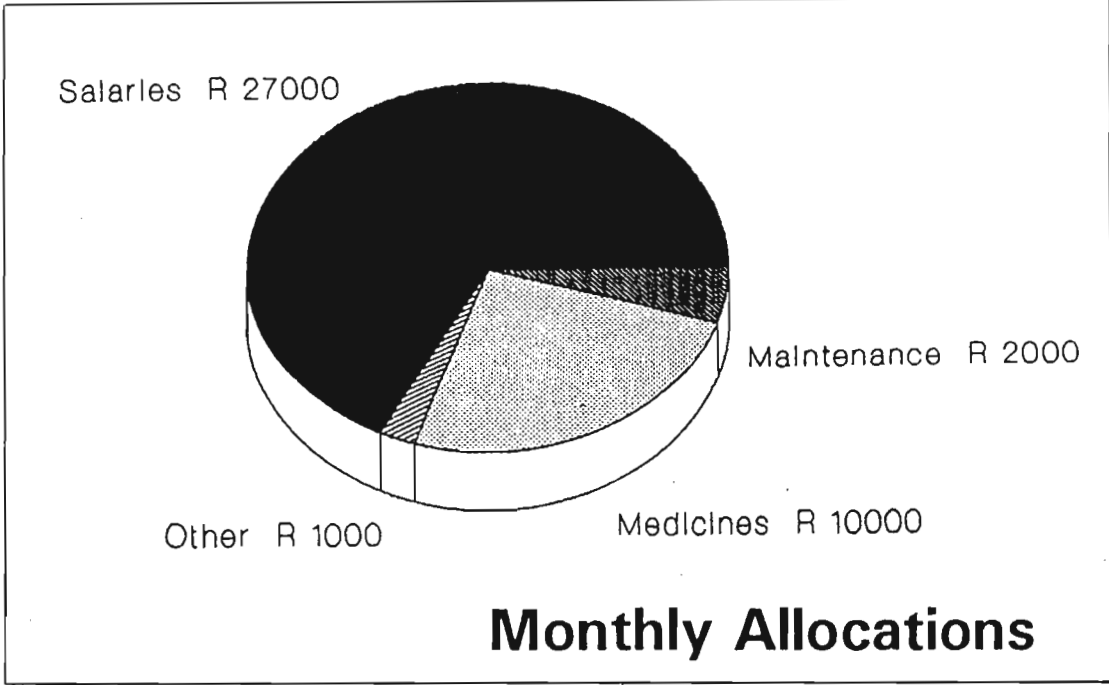
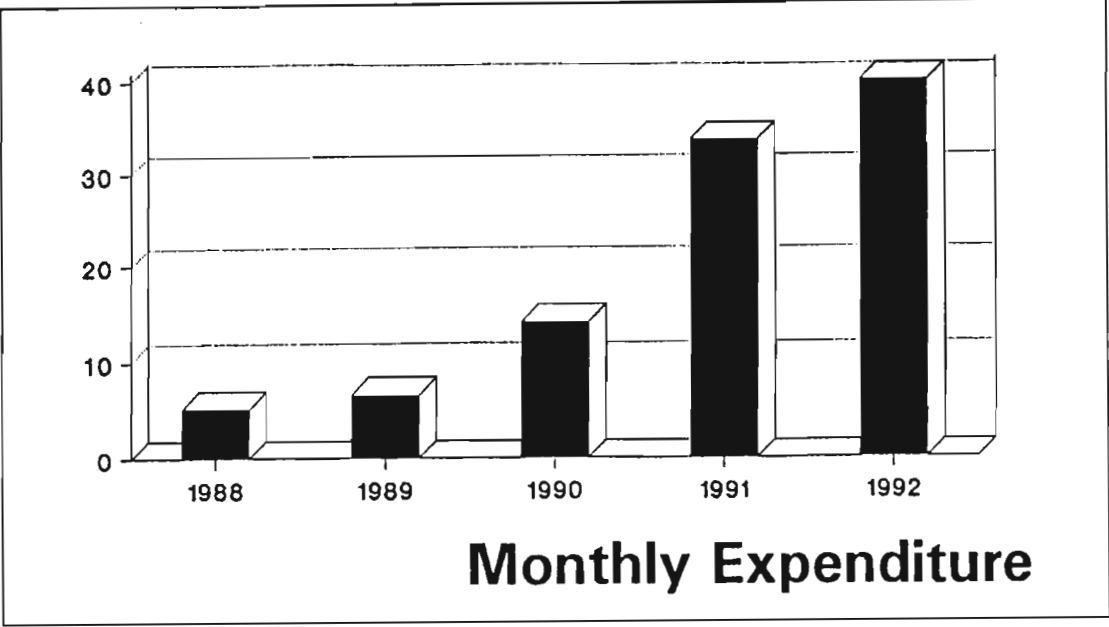
5.3.16 Water, electricity and communication systems

IMA Clinics are open on Weekdays from Monday to Friday from 8.00 am to 4.00 pm and on Saturdays from 8.00 am to 1.00 pm. All clinics have electricity, water and communication systems to ensure an adequate delivery of health services.

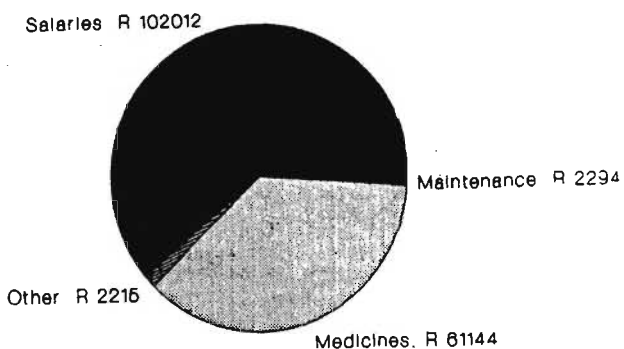
5.3.17 Promotion of research that aims at improving the health of people

The IMA Research Committee has published over 18 booklets on health issues (as discussed in chapter four of this dissertation) but to date no research has been done with regards to Clinics, viz. disease profile, impact of the clinic on the rural community, etc. Such research could assist in evaluating and improving the state of health of the community. The Research Committee needs to look into this type of research.

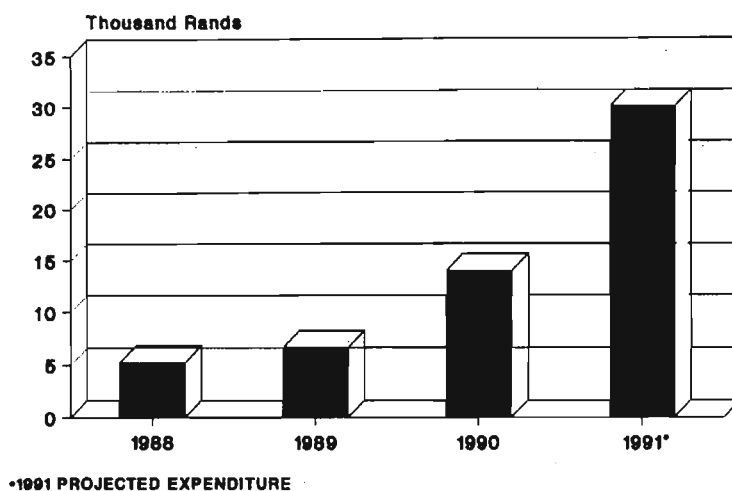
Whilst a qualitative evaluation of IMA Clinics has been made in this chapter, it is difficult to evaluate quantitatively the contributions made by such clinics over the last two decades in view of the fact that statistical data is only available from 1990 onwards. Hence an accurate assessment of the financial contributions made by IMA Clinics towards providing the nation with health services cannot be accurately made. Nonetheless the following statistical data does provide a fairly good assessment:



EXPENDITURE Mar 89-Feb 90 (R167 665)

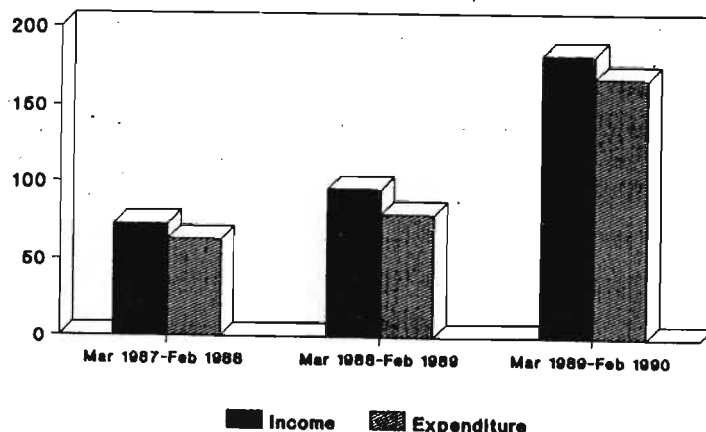


MONTHLY EXPENDITURE



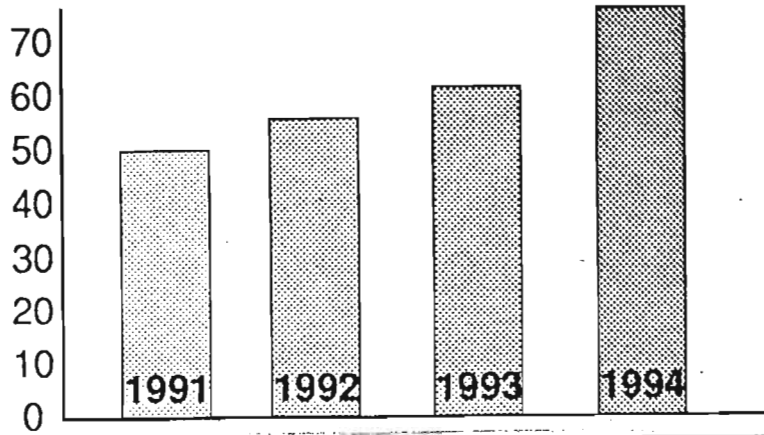
*1991 PROJECTED EXPENDITURE

ANNUAL INCOME AND EXPENDITURE (Thousand Rands)



MONTHLY EXPENDITURE OVER FOUR YEARS

1000 OF RANDS

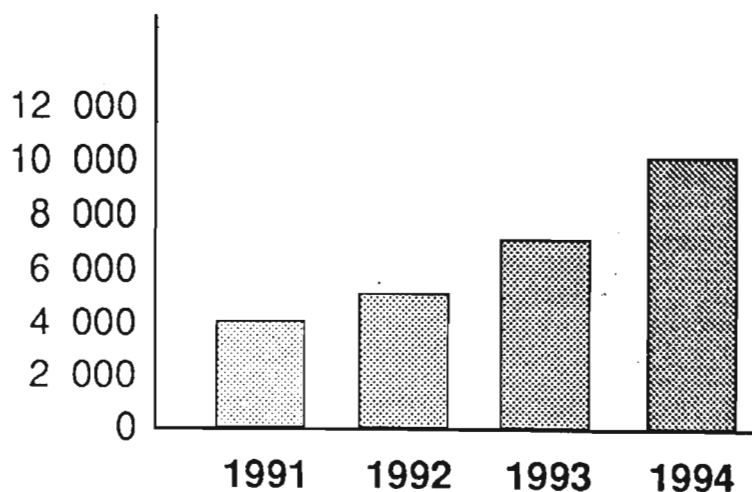


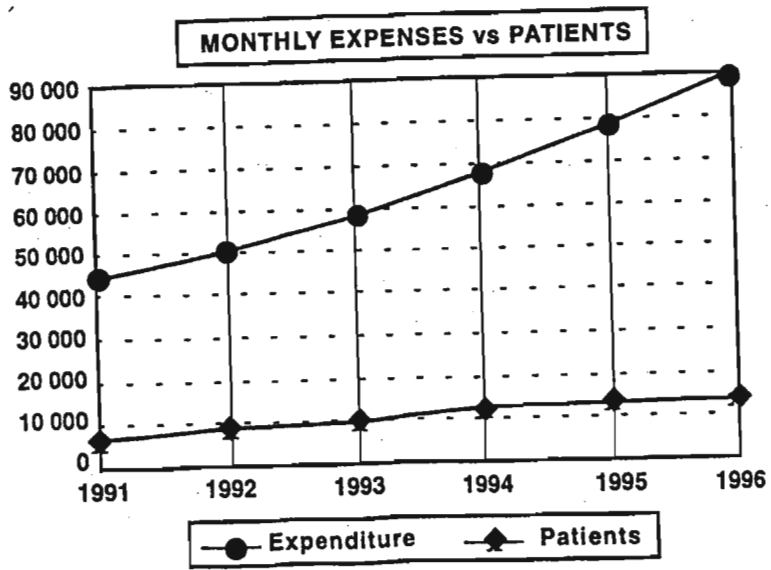
BUDGET

MONTHLY EXPENDITURE BREAKDOWN

SALARIES	R30 000 - R35 000
MEDICINE	R25 000 - R30 000
MAINTENANCE	R2 500
OTHER	R2 500

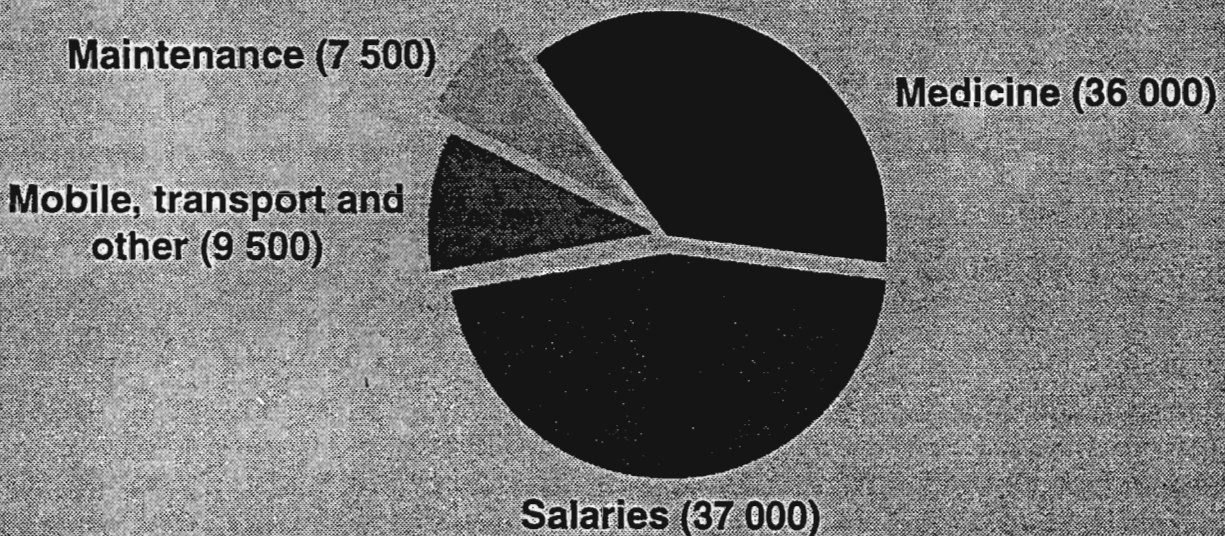
MONTHLY PATIENTS STATISTICS OVER FOUR YEARS





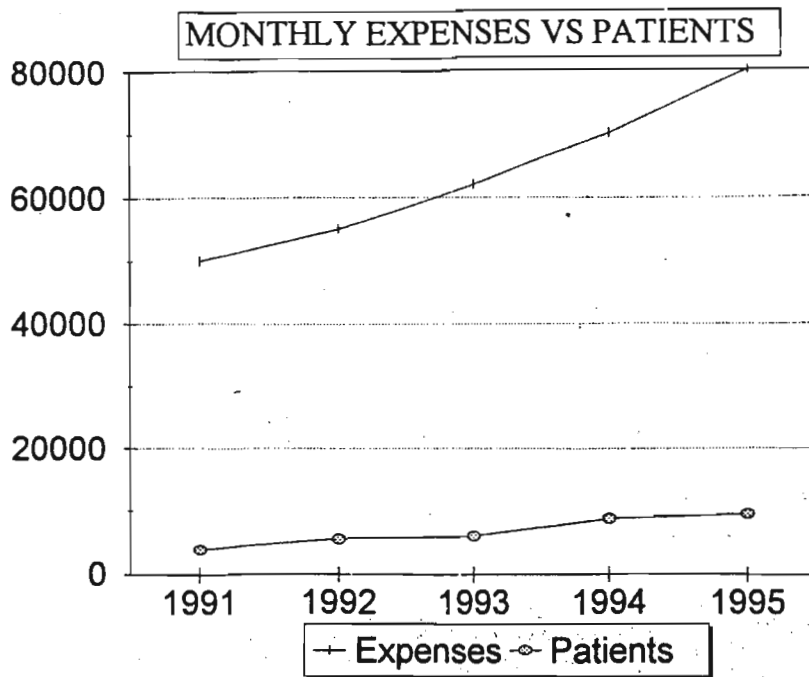
BUDGET

MONTHLY EXPENDITURE BREAKDOWN



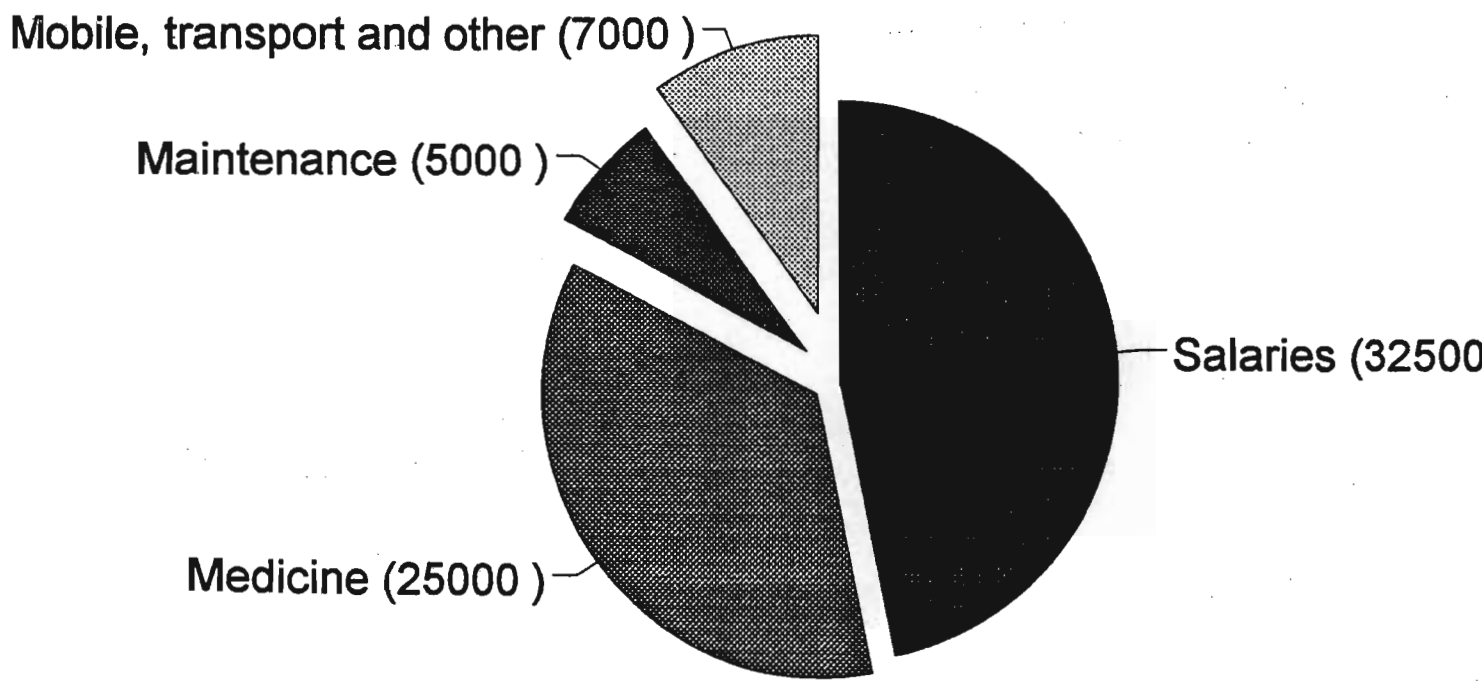
"DISPENSING MORE THAN JUST MEDICINE."

ima clinic



BUDGET

MONTHLY EXPENDITURE BREAKDOWN



CONCLUSION

When one examines the early history of the IMA, which was then called *Lajnatul Atibba*, one has to acknowledge the courage and conviction, vision and foresight of the founding members of this organization. Today it has become a successful, dynamic and respected organisation whose support is sought by others. It was established to provide a forum for Muslim health care workers to develop their Islamic consciousness by providing voluntary medical service to all in need, irrespective of race, colour and religion. Its success can be judged by its multifarious activities. Its membership has now grown to 1 500 with 25 branches countrywide. The last two branches have been formed in areas where Muslim communities were previously non-existent, viz. in Welkom, Orange Free State which was a “whites only” province under the apartheid government until early 1994. The other in Umtata (in the former Transkei), Eastern Cape, whose members are predominantly from abroad, viz. Pakistan, Bangladesh, Uganda, India and Lesotho thus showing the international character of the IMA and the universality of Islam.

The IMA was the first organisation in South Africa to submit a health policy for the nation to the new democratic government which came into power in April 1994.

In January 1981 the IMA planted the seed for the formation of FIMA (Federation of Islamic Medical Associations) which was a first of its kind in the world, and played a very pivotal role in bringing about its formation in December 1981 thus earning the admiration and respect of many international medical organisations.

In 1979, that is, within the first five years of its existence, the IMA was the first to take the initiative in drawing up a detailed questionnaire on Islamic Medical Ethics which was submitted to different Muslim institutions throughout the world for clarification and guidance on problem issues. Although in September 1981 a more comprehensive questionnaire was circulated locally and internationally to individual jurists and organisations, a poor response has been received thus far. However its Research Sub-Committee needs to pursue this further especially in light of advances being made today in the field of medical science and technology, eg. genetic engineering, cloning, etc. A suggestion would be to introduce a few problem issues from the questionnaire in the programme of the annual conventions and have a session set aside for this, thus stimulating further research and possible clarification and guidance.

Whilst the IMA needs to be lauded for the sterling services it is providing to people in need in terms of health services there are a few aspects that need to be looked into by its members in order to further enhance the quality of its service. The following are some observations and suggestions:

- (i) The IMA is well known in the communities it serves, ie. in the rural and impoverished urban areas and in the general Muslim community throughout South Africa. However its presence needs to be felt in the other sectors of society where it is not really known. A suggestion would be to establish contacts with other NGOs like South African National Cancer Association and South African National Council for Alcohol and Drug Abuse (SANCA) and perhaps work together in areas of common interest

thus complimenting their services. Another suggestion would be to invite some participants from different cultural, racial and religious backgrounds to their workshops and conventions in order to interact with the other various groups in society. This would be of benefit to both.

- (ii) There is a need to improve oral health care services at the clinics as it is provided occasionally. Perhaps a group of dentists within the IMA could be given the task of looking into ways and means of improving the services. Regarding the limited resources of the IMA, a motivated request could be made to local, provincial or even central government to assist with resources, viz. they provide the equipment and IMA provides the personnel and service.

- (iii) Rehabilitation services are not provided at the clinics because the IMA does not have the qualified personnel or the resources for this service. However a recent presentation on occupational health by a qualified therapist arranged by the Durban branch could lead to a structured service at the clinics in the future. The IMA could pursue this and perhaps for the near future seek volunteer qualified therapists from non members, ie. from the general public. This could serve as good PRO for the IMA in that other communities would become aware of the activities of the IMA. The service could be provided on a weekly or fortnightly basis or even once a month at the clinics. Maybe a request could also be made to provincial hospitals in the areas close to the clinics to assist on some kind of a roster

basis at the clinics or even allow students of occupational therapy to do some of their intern service at the clinics.

(iv) Regarding the provision of equipment for disabled people, it is noted that the Azaadville branch makes some equipments available to the clinics on a limited scale from time to time. Unfortunately this is not adequate to meet the demands at times. An idea would be for the IMA to make an appeal to the general public for donations of equipments that people may no longer require and this could be given on loan to patients who need it. Such an appeal would also make the public aware of the IMA and the services it provides.

(v) The clinics during the many years of being in operation could have provided a wealth of statistical information for research purposes, eg. disease profile of patients, patient population in terms of race, age and gender groups, identifying lifestyle diseases and infectious diseases, cost of running a clinic, assess quality of PHC service and health education of populace, monitor level of immunisation amongst the populace, etc. Unfortunately little has been recorded or formally presented. The Research committee needs to pursue this type of research as such data could be invaluable to improving the health of South Africans. Also such research could assist the IMA to evaluate the services it provides at the clinics.

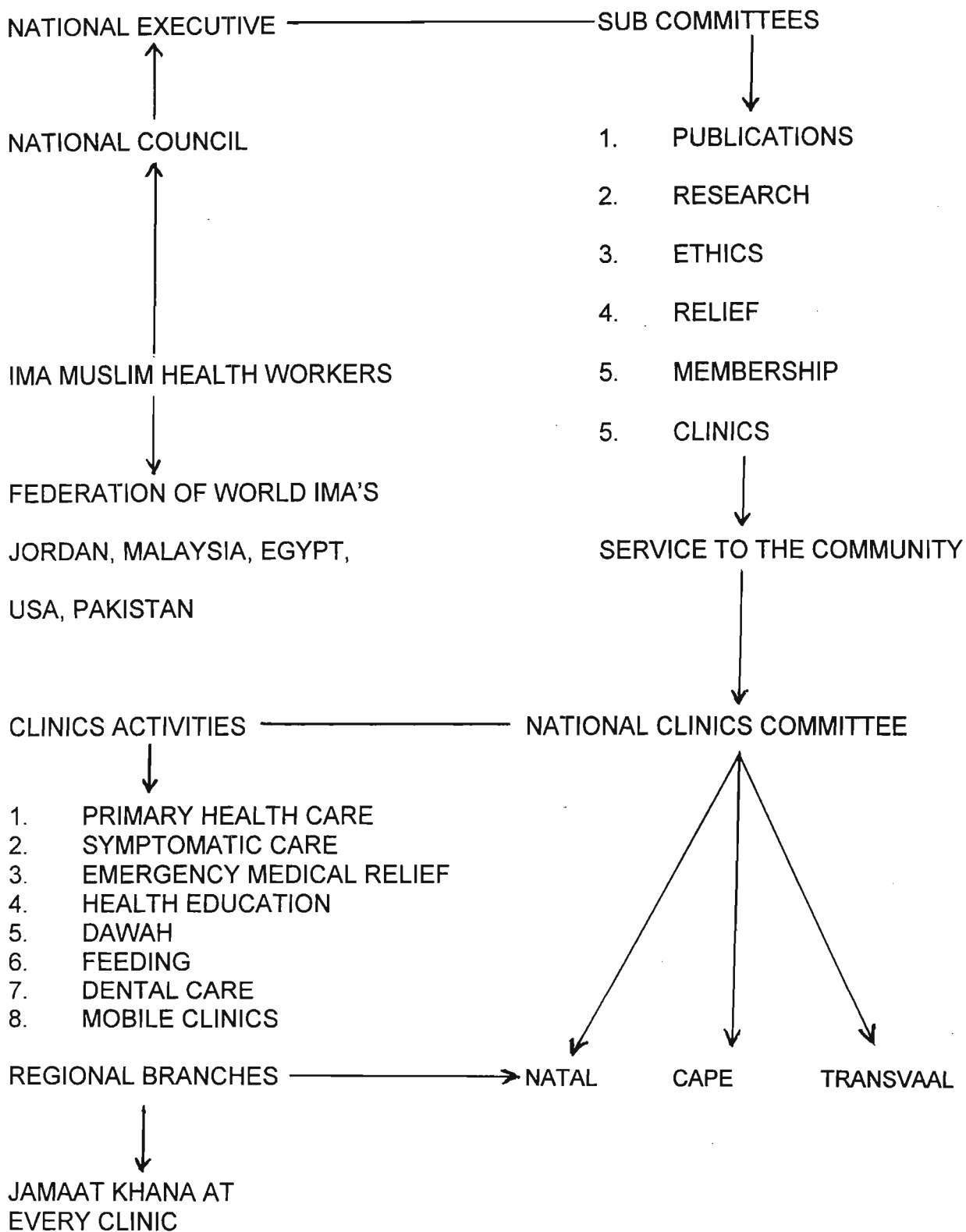
With regards to the RDP of the country which was initiated in April 1994 by the new

democratic government it can be stated that the IMA has been implementing it for health services since its inception more than twenty years ago as was pointed out in chapter five of this dissertation. The IMA Clinics project has been by its very nature a Primary Health Care activity since its inception in 1974. Its emphasis at the clinics has always been “beyond symptomatic care” with its motto “dispensing more than just medicines”. The clinics service areas where there is little or no evidence of government involvements, viz. rural and impoverished urban areas (permanent and mobile clinics) thus duplication of services have been avoided. The clinics have provided a venue for the training of Primary Health Care workers (student electives) who then have provided an invaluable service on return to their communities. Also with the aid of a grant from Parke Davis the IMA has been providing training for health workers from the local populace to empower them to take care of their own community by assessing simple medical and health related issues and provide advice to their people. The inclusion of a “Code of Conduct” in the delivery of health care to patients at the clinics ensures that patients are treated with dignity and respect. The IMA has been one of the first medical organisation to draw up a code for health care providers and the first to publish an 18-page booklet in this regard. All IMA clinics have the necessary infrastructure (water, electricity, communication system) to ensure an adequate delivery of health services. In fact the clinics activities have grown so much that it became necessary in October 1993 to separate this as a separate entity of the IMA. This led to the formation of the IMA Clinics of South Africa (IMACSA) with its own National Executive, finance, constitution and administration. This has now become the social welfare wing of the IMA and from this one can also judge the expansion and growth of this organization.

The clinics are not only supplementing the country's PHC programme in providing health care services to those in need but are also contributing immensely to the RDP of the country. Upon perusal of the statistical data available from 1990 onwards we see that financially the IMA has contributed millions of rands in health services thus saving the government a fortune on health services. How many more millions have been spent by the IMA in providing voluntary health services to the needy is anyone's guess as there are no official statistics available since its inception in 1974 till 1990. Apart from the services it provides at the clinics, the IMA since 1985 onwards has been providing relief aid both locally and internationally in the form of medicines, medical services, donations in cash and kind valued over hundreds of thousands of rands.

Presently the IMA has one permanent office in Durban located at Mariam Bee Sultan Islamic Centre, Kenilworth Road, Overport. There are two part time offices – one in Cape Town and the other in Johannesburg. Judging from the present structure of the organization together with a list of all members of the National Executive since its inauguration in March 1981, it can truly be said that this organisation has grown from humble beginnings to greater achievements, its potentials vast and its future bright.

IMA STRUCTURE



IMA OFFICIALS – PAST NATIONAL EXECUTIVE MEMBERS

	<u>1981/82</u>	<u>1982/83</u>	<u>1983/84</u>
President:	G.M. Hoosen	G.M. Hoosen	A. Moosa
Vice President:	A. Moosa	A. Moosa	M.H. Coovadia
Secretary:	M.H. Khatree	M.I. Rawat	M.I. Rawat
Min. Secretary:	M.A.K. Omar	M.I. Mulla	F.I. Tayob
Treasurer:	F.A. Randeree	F.A. Randeree	M.I. Mulla
	<u>1984/85</u>	<u>1985/86</u>	<u>1986/87</u>
President:	M.H. Coovadia	M.H. Coovadia	Y. Omar
Vice President:	Y. Omar	Y. Omar	A. Harneker
Secretary:	I. Mayet	I. Mayet	I. Cajee
Min. Secretary:	M.S. Laher	M.S. Laher	S. Essack
Treasurer:	A.F. Kaka	A.F. Kaka	A.F. Kaka
	<u>1987/88</u>	<u>1988/89</u>	<u>1989/90</u>
President:	M.F. Williams	M.F. Williams	M.I. Rawat
Vice President:	M.R. Khan	M.R. Khan	A.A. Hoosen
Secretary:	A. Harneker	A. Harneker	M.F. Mulla
Min Secretary:	A. Adams	A. Adams	A.K. Peer
Treasurer :	O.Brey	O. Brey	I.E. Osman

	<u>1990/91</u>	<u>1991/92</u>	<u>1992/93</u>
President:	M.I. Rawat	M.H. Khatree	A. Goolam Mahomed
Vice President:	A.A. Hoosen	A. Goolam Mahomed	H. Patel
Secretary:	A.K. Peer	A.K. Peer	M. Tikly
Min. Secretary:	M.I. Mulla	H. Patel	I. Mayet
Treasurer:	I.E. Osman	I.e. Osman	S. Moosa

	<u>1993/94</u>	<u>1994/95</u>	<u>1995/96</u>
President:	A. Goolam Mahomed	S.A. Wadee	S.A. Wadee
Vice President:	S. Wadee	A. Harneker	A. Harneker
Secretary:	M Tikly	A. Karjiker	R. Ismail
Min. Secretary:	I. Mayet	R. Solomon	F. Williams
Treasurer:	S. Moosa	A. Dhansay	A. Dhansay

	<u>1996/97</u>	<u>1997/98</u>	<u>1998/99</u>
President:	M.I. Mulla	M.I. Mulla	H. Tayob
Vice President:	M. Tikly	M. Tikly	E. Mahomed
Secretary:	H.A. Randeree	H.A. Randeree	F. Bulbulia
Min. Secretary:	M Thandar	MC Solwa	A. Pandor
Treasurer:	Y Solwa	Y Solwa	S. Jina

Christian Medical Fellowship of South Africa



Christian Medical Fellowship of South Africa

VICE-PRESIDENTS include:
 D M du Toit, MB, ChB
 R P Gräbe, MB, ChB, MMed
 E L Karlsson, MB, BCh, FRCOG
 A F Malan, MB, ChB, MMed
 H Robertson, MB, ChB, MMed
 G Ter Haar, Arts Examen Nederland

- The Christian Medical Fellowship is convinced that medicine is a calling that offers unique opportunities for witness to our Saviour, Jesus Christ, in loving deed and word.

We are also aware that the special demands and rewards of our profession tend to militate against a consistent and vital Christian witness. We need one another to 'spur one another on toward love and good deeds'. (Heb 10:24 NIV)

- Christian doctors need to unite for mutual help and encouragement and also to stimulate Christian thinking in medical affairs. Out of this need doctors formed this Fellowship in 1950 and there are hundreds of members scattered throughout South Africa now. These members are involved in all spheres of medical practice – specialists, general practitioners, missionaries, medical administrators and lecturers.

- The Fellowship is a full member of the International Christian Medical and Dental Association which represents doctors on all continents.

- Activities for doctors include meetings and dinners in the major centres as occasion affords and an annual conference. Regional weekend conferences are encouraged.

- At medical schools, an active Christian witness is vital and this is encouraged as much as possible. A major feature in the student work is the annual conference. A part-time travelling secretary helps to co-ordinate the student work.

- A Newsletter keeps members informed of activities and members' movements. Also distributed to all members is the quarterly journal of the British counterpart, and other publications as well. Student members receive 'Nucleus', the British student magazine with articles of current interest and concern.

- The Fellowship welcomes *all* registered members of the medical profession who are in sympathy with its aims and who subscribe to the membership declaration. CMF is non-racial and non-denominational. Membership is also open to students registered at a medical faculty who are of like mind.

- Recently provision has been made for other registered graduate members of the Health Team to become members.

APPLICATION FOR MEMBERSHIP

TO: The Secretary
 Christian Medical Fellowship
 PO Box 36365
 Menlo Park
 0102 Pretoria

CMF - CGB
 ☒ 1540 KLOOF 3640
 ☒ 7646858 FAX 7646857

NAME:

PERMANENT ADDRESS:

QUALIFICATIONS (with dates and name of University)

TEL:

In joining the Christian Medical Fellowship I declare my faith in God the Father and in God the Son, the Lord Jesus Christ, Who is my Saviour. I desire to be ruled by God the Holy Spirit speaking through the Bible, the divinely appointed authority in matters of faith and conduct.

SIGNED:

DATE:

Please fill in the enclosed membership fee form and return it with this application.

APPENDIX B

WHY A MUSLIM LAJNATUL ATIBBA

AS — SALAAMU — ALAIKUM

IN THE HISTORY OF MAN, RELIGION WAS FOR A LONG TIME THE GUIDE TO ALL TRUTHS, INCLUDING SCIENCE. HOWEVER IN THE 19TH CENTURY THERE WAS A REVERSAL AND SCIENCE BECAME " THE RELIGION OF THE WESTERN MAN ". SCIENCE FURTHER WENT ON TO UNDERMINE THE VALIDITY OF RELIGION TO SUCH AN EXTENT THAT RELIGION NO LONGER REMAINED RELEVANT TO MANY.

THERE IS A LARGE BODY OF MUSLIM DOCTORS IN WHOM THERE IS GROWING SCEPTICISM AND WHO ARE CONFUSED ABOUT THE ISSUES THAT DIVIDE OR DEFINE THE RELATIONSHIP BETWEEN SCIENCE AND RELIGION. IN ISLAM THERE IS NO SEPARATION BETWEEN THE SPIRITUAL AND THE MATERIAL. FOR A MUSLIM THE MATERIAL WORLD IS NO MORE THAN A VISIBLE MANIFESTATION OF GOD'S POWER OF CREATION. IN ORDER TO UNDERSTAND IT (AND THIS IS OBLIGATORY FOR MUSLIMS) IT IS NECESSARY TO PROBE INTO ALL ASPECTS OF THIS CREATION. THE SCIENTIFIC ACCOMPLISHMENTS OF EARLY MUSLIMS IS A TESTIMONY TO THIS TRUTH AND DEMONSTRATES THAT RELIGION IS NOT AN IMPEDIMENT TO SCIENTIFIC ADVANCEMENT, BUT INSTEAD STIMULATES IT. ONE OF THE MAJOR AIMS OF LAJNATUL ATIBBA WOULD BE TO HELP RECREATE THAT ATMOSPHERE AND FEELING AMONG THE MUSLIM DOCTORS AND TO REVIVE THE SPIRIT OF INQUIRY IN ORDER TO STIMULATE SCIENTIFIC RESEARCH. A VERY GREAT NEED OF THE DAY IS TO MAKE MUSLIMS REGAIN THEIR LOST CONFIDENCE AND TO PREPARE THEM TO FACE THEIR FUTURE WITH DYNAMISM AND A SENSE OF PURPOSE.

WE, THE MUSLIM DOCTORS OF SOUTH AFRICA, NEED A FORUM FOR CONTACT AT PROFESSIONAL AND SOCIAL LEVEL AND FOR PROMOTING AN UNDERSTANDING AND APPRECIATION OF ISLAM AND CREATING AN ISLAMIC CONCIIOUSNESS. TO REALISE SUCH A FORUM WE NEED TO COME TOGETHER TO SHARE OUR THOUGHTS AND TO PARTICIPATE IN FORMULATING OUR STRATEGIES, AIMS AND ACTIVITIES. INSHA-ALLAH WE HOPE TO DO SO IN THE NEAR FUTURE.

"AND HOLD FAST ALL TOGETHER TO THE ROPE WHICH ALLAH STRETCHED OUT FOR YOU AND BE NOT DIVIDED AMONG YOURSELVES."

(QURAN IV : 175)

P.S. LAJNATUL ATIBBA IS THE ARABIC FOR DOCTORS' COMMITTEE

No.	Venue	Date	Convenor	Theme	Guest
1	Natal Medical School, Durban	14-15 March 1981	M.H. Khatree	Inaugural Launch of the IMA of S.A.	Mawlana Mansur al-Haq & Yunus Patel
2	Natal Medical School, Durban	29-31 May 1982	M.H. Khatree	no formal theme	no official guest
3	Lenasia	21-22 May 1983	H. Tayob	no formal theme	Drs M Escudero and A. Elkadi
4	Natal Medical School, Durban	06-08 April 1984	Y. Osman	Social Illness - Islam A Solution	Dr A.R. Al-Sumait
5	Cape Town	12-14 April 1985	A. Harnekar	Islam and Health Care	Dr Omar Hassan Kasule
6	Lenasia, Transvaal	14-16 March 1986	M. Coovadia	Islam and Health Care	Professor Hossam & Sakina Fadel
7	Natal Medical School, Durban	04-06 April 1987	A. Peer	no formal theme	Mawlana Ebrahim Moosa
8	Cape Town	11-13 March 1988	F. Patel	no formal theme	Dr M. Makeen
9	Roshnee, Transvaal	10-12 March 1989	A. Bayat	no formal theme	Dr Gamal Badawi
10	University of Durban-Westville	22-24 June 1990	H.O. Bux	Freedom Thru Knowledge	Dr & Mrs. A.Elkadi & Mrs A. Lemu
11	Lenasia, Transvaal	31 May - 02 June 1991	H. Tayob	Social Dilemmas in Medicine	Professor A. Al Abdullah & Mr.F. Murad
12	University of Cape Town	10-12 July 1992	A. Dhansay	For Every Ailment : A Cure	Professor Ali Mishal & Dr. A.Elkadi
13	M.L. Sultan Tech., Durban	08-11 July 1993	A.I. Vawda	Islam & Medicine : The Way Forward	Professor Malik Badri
14	Pretoria	08-10 October 1994	R. Carrim	"A Mercy Unto Everything"	Prof. Sumaya Keshawa & Dr.A.Alkhalifa
15	Cape Technikon, Cape Town	07-09 July 1995	T. Hayat	Ethical Issues, Sports & Health	Prof.G.I. Serour & Mrs M El Chabrawichi
16	University of Natal, Durban	04-07 July 1996	H.A. Randeree	Family Health	Prof. M.Badri, Sr. Heba R. Ezzat, Dr A.Albar
17	Magaliesburg	26-28 April 1997	M. Tikly	Health Challenges	Skh. A.I.Ali & A.H. Quick, Hz.M.Idrees

Oath of a Muslim Health Professional



In the name of Allah, Most Gracious, Most Merciful.
Praise be to Allah, the Sustainer of His Creation, the All-Knowing.
Glory be to Him, the Eternal, the All-Pervading.
O Allah, Thou art the only Healer,
I serve none but Thee, and, as the instrument of
Thy Will, I commit myself to Thee.
I render this Oath in Thy Holy Name and I undertake:

To be the instrument of Thy Will and Mercy, and, in all humbleness, to exercise justice, love and compassion for all Thy Creation; To extend my hand of service to one and all, to rich and poor, to friend and foe alike, regardless of race, religion or colour; To hold human life as precious and sacred, and to protect and honour it at all times and under all circumstances in accordance with Thy Law; To do my utmost to alleviate pain and misery, and to comfort and counsel in sickness and in anxiety; To respect the confidence and guard the secrets of all my patients; To maintain the dignity of the health profession, and to honour the teachers, students, and members of my profession; To strive in the pursuit of knowledge in Thy name for the benefit of mankind, and to uphold human honour and dignity; To admit my mistakes, and to forgive the wrongs of others; To be ever-conscious of my duty to Allah and His Messenger (S.A.W.S.), and to follow the precepts of Islam in private and in public.

O Allah grant me the strength, patience and dedication to adhere to this Oath at all times. Ameen.

PROPOSALS

1. National Health Policy

A mixed health policy, not very dissimilar to the existing system, which allows both the public and private sectors to exist and operate side by side is, in our opinion, ideally suited to the South African situation. Of necessity, the existing advantage to a particular race will have to be removed so as to advantage the entire community.

The public health sector, servicing 80% of the population, must be brought within the reach of the majority. In such instances where its facilities in terms of staff, stocks and services are inadequate, the necessary steps must be taken to improve them. In places where such facilities are absent, they must be instituted. On the whole they must become accessible and affordable to all as well as relevant to the needs of all.

We feel that the existing public health services with appropriate modifications can serve as a foundation for the development of an adequate public health sector.

At the same time, the private sector should continue to develop along three main strands:

a. **Private practice and private hospitals** for those who choose to avail themselves of these facilities.

b. **Socio-religious based practice.** This includes the "mission" clinics and hospitals as well as the various voluntary bodies engaged in the care of the sick, the elderly and the handicapped etc.

c. **Industry-based sector.** This would be the factory clinics and hospitals of the industries and mines. Industrial medicine is an entity in itself with its own primary health care programme - best managed by itself but with checks and legislation from the Ministry.

The private sector has a role and it is important to acknowledge this role, to supervise it and to broaden it. Its supervision is essential as a consumer protection facility. However, its scope needs to be widened to include participation in the primary health care programme with for example, growth monitoring, immunisation etc.

2. Administration

The administration of the health system needs restructuring and integration into a single Ministry of Health with a hierarchy allowing for centralised policy making and planning and decentralised implementation. Autocracy must be removed and the administration must become participatory with representation of health workers and the general public. The bureaucracy of the health system must be in the hands of those best qualified for the job.

3. Finance

80% of South Africans depend on the public sector for their health needs. Therefore it is vital for the State to provide the basic medical health care facilities. We are in agreement with the opinion that basic fundings must come from taxation. However, the public sector could generate extra funds to boost their services by becoming competitive with improved professional management and work incentives and thus woo patients from the private and industrial sector who may or may not be members of a health insurance scheme, but who would pay for services received.

We also agree that a State controlled Central Medical Fund based on compulsory health insurance of all working people would be more cost effective than Private Medical Aid Societies.

4. Primary Health Care

There is dire need for a well structured and adequately staffed and financed Primary Health Programme. With proper implementation such a programme could eliminate a large proportion of preventable diseases which is consuming our manpower and financial resources.

The GOBI FFF WHS programme would be the cornerstone of the Primary Health Care Programme. However, added emphasis would be required in the occupational health sector, in the recreational field, in the nutritional field and in the transformation of life style and values to one more conducive to better health, both mental and physical, of both the individual and the society. The ideal Primary Health Care programme must address both the extremes of the health spectrum and must be structured in such a way that we do not end up substituting diseases of affluence for diseases of poverty. We need to work towards a balanced, harmonious healthy society.

5. Medical Training

The existing medical training programme is imported from the West and is suited for the needs of the West. It does not cater for the needs of the vast majority of South Africans. The entire Medical Education Programme needs to be reviewed and one, more appropriate for the needs of South Africa to be identified and implemented. In particular, we need to look at the selection criteria, medical curriculum and compulsory community service.

6. Social Issues

Certain specific social issues relating to health need to be critically assessed. For example:

a. Alcohol

Noting that

- i. Alcohol accounts for over 50% of motor vehicle accidents and for about 50% of fatal motor vehicle accidents (Retief F, Proc. Alcohol and Drug Conf. 1983).
- ii. Alcohol related diseases and conditions constitute the fourth largest cause of death in South Africa (ibid).
- iii. 15% of patients admitted to a general hospital have an alcohol related illness and disability.

v. It costs over R237 million per year to treat White and Coloured alcoholics alone. Not to mention the hundreds of millions needed for the treatment of the alcohol-related illnesses and disabilities.

vi. Alcohol is directly related to untold financial and social misery to family, employers and society.

We therefore advocate that

- i. There should be prohibition on promotion of alcohol in the media, in public places and in the sporting arena.
- ii. Alcohol should not be allowed at all State and public functions.
- iii. There should be an intense awareness campaign of the ravages and damages of alcohol.
- iv. Deterrent and not token sentences should be imposed in alcohol related crimes.

b. Drugs

The ravages of drugs on the self and on society are even worse than alcohol and we advocate more radical and drastic measures to curtail and eliminate their use and abuse.

c. Smoking

The harmful effects of cigarette smoking to the smoker and to those in his surrounds are well documented. Therefore we advocate that:

- i. The promotion of cigarettes in the media, in public places and in the sporting arena should not be allowed.
- ii. Cigarette smoking should be prohibited in all public gatherings and transportation.
- iii. There should be an aggressive awareness campaign of the harmful effects of smoking.

d. Sexually Transmitted Diseases

STDs (AIDS represent just one extreme of the spectrum) are primarily problems associated with morality. Homosexuality, promiscuity and

prostitution can only flourish openly and without societal disapproval in a society that is morally bankrupt.

We strongly advocate that moral uprightness and chastity should be strongly promoted at every level including schools. The State must play an active role in this campaign.

e. Abortions

Any gains made by improved medical care in perinatal and infant mortality has been more than wiped out by the loss of human life through abortions.

Except for authentic medical reasons, abortion per se should be prohibited.

f. Care of the Indigent

It is our belief that the care of the aged, the orphans and the handicapped is, in the first instance, the duty of the family. In the event that the family be unable to perform its duty then it becomes the responsibility of the community. However, this does not absolve the State from ultimate responsibility if the community is unable to respond.

At the same time we advocate the establishment of a national pension fund to which all workers would contribute, and subsequently draw from it in their hour of need.

7. Environmental Abuse

All forms of environmental abuse leading to pollution of air, water, fauna and flora must be identified and rigidly prevented.

8. Pharmaceutical Policy

The pharmaceutical policy and the role of pharmacists are vital in assisting us to achieve our goal for health care to become affordable and accessible.

There is a need for a national drug policy:

- a. to develop an Essential Drug List which will be available at all health service outlets;
- b. to encourage adequate local production and distribution of drugs of high quality;
- c. for the control of price, useage and prescription of medicines.

The role of pharmacists needs to be reoriented to:

- a. play an active role in preventative health care;
- b. be involved in community education programmes by implementing an awareness campaign on the misuse and abuse of medicines and the hazards thereof;
- c. monitor therapeutic drug useage and abuse;
- d. be the first line of treatment for minor ailments.

* * * * *

In formulating this document we have considered the proposals of others and have incorporated those that satisfy our criteria as enunciated in the *Preamble*. In addition, we have included in our *Proposals* such issues which we felt needed to be addressed and on which others have been silent.

ISLAMIC MEDICAL ASSOCIATION OF SOUTH AFRICA

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Mr Edzi Ramaite
Secretary - Portfolio
Committee on Health - Parliament
P.O. Box 15, Cape Town, 8000

15 October 1996

Dear Mr Ramaite

re: **OBJECTION TO THE ENACTMENT OF TERMINATION OF PREGNANCY LEGISLATION**

The Islamic Medical Association of South Africa, hereby lodges an objection to the enactment of **TERMINATION OF PREGNANCY LEGISLATION** based on the provisions of the **TERMINATION OF PREGNANCY BILL** which was published in the Government Gazette on Friday, 27 September 1996.

The bases of the said objection are, inter-alia, the following:-

- (a) Clause 2(a) of the Bill allows for abortions until the first twelve weeks of gestation upon the request of the pregnant woman. This has the potential of abortions being used as a contraceptive measure rather than other established, safe and non-invasive means, as evidenced by developments in Japan, Russia and Greece. This will undoubtedly be to the detriment of the health of the woman concerned.
- (b) The bill enables a registered mid-wife to perform the abortion. By virtue of its potentially complicated nature, the dangers inherent in that practice are significant. The inability of a mid-wife to diagnose and properly treat complications such as uterine haemorrhage and the prospect of perforation of the uterus, inter-alia, are realistic consequences, and further endangers the health of the woman concerned. This places such a facility almost in the same class as 'backstreet abortions' in that the complications that result will place the same added burden on specialist facilities.
- (c) Clause 2 (b) (iii) countenances abortions between twelve and twenty weeks of gestation on the recommendation of a social worker on grounds of economic and /or social conditions associated with poverty and / or impecuniosity of the woman. The Bill does not explain what constitutes adequate economic means to sustain a pregnancy. It is clear that the large majority (approximately eighty percent) of South Africans are economically disadvantaged. It would therefore be unconstitutional to utilise social adversity as a catalyst for terminating pregnancy. The solution to the problem of economic adversity is eradicating and not exacerbating it.
- (d) The provisions of Clause 6 (1) are unconstitutional to the extent that they deny the husband locus standi. The frustration of the father's and / or husband's rights to object to the abortion could result in the deterioration, if not break-down of family relationships.
- (e) Clause 6 (2) arrogates to minors the right to choose abortions without consulting their partners. This could encourage sexual promiscuity, breakdown of the family unit and attendant psycho-social trauma. Also, uncontrolled sexual behaviour will accelerate the transmission of sexually transmitted diseases including HIV, with the resultant added burden on health care services.
- (f) Clause 7 (3) as read with clause 11 (c) constrains a conscientious objector to refer a woman who seeks an abortion, to a person who undertakes same, under threat that to do

otherwise would amount to an offence that attracts sanction. This is unconstitutional and infringes upon the religious and other rights of such objectors.

The Bill and the intended Act are premised on certain fallacies, discussed below:-

1. Legalisation of abortions will not necessarily decrease the number of 'back street abortions' eg. in Sweden, there was an increase of 'back street abortions' after abortion on demand became available.
2. The already overcrowded and impoverished South African Health Care Services will be unable to cope with the demands arising, inter-alia, out of the anticipated need to create abortion facilities, the potential increase in complications arising out of nursing personnel undertaking the procedure, and the rapid rise in sexually transmitted diseases resulting from promiscuity.
3. Elective termination of pregnancy by doctors in hospitals also carries a significant health risk related to anaesthesia, perforation of the uterus, future development of breast cancer, infertility and ectopic pregnancies.
4. The American Psychiatric Association investigated the problems associated with "Post Abortion Syndrome". Guilt, anger and destruction of the integrity of the family were found to be real consequences. These and other consequences will necessitate post abortion treatment and the "vicious cycle" will continue at substantial expense to the State and therefore the taxpayer.
5. The ethos of health care in the new South Africa, out of necessity, needs to be directed at primary health care. The **TERMINATION OF PREGNANCY BILL** is in direct conflict with this ethos. This bill negates the entire principle of "prevention is better than cure" by directing efforts at treating the symptoms and not eradicating the cause. The solution is not to move abortions from the "back street" to the "front street", but to address the causes of why women seek abortions. In keeping with primary health care values, emphasis should be on education directed at responsible sexual behaviour and birth control.
6. The proposed Bill will destroy any moral code that exists in South African society. South Africa is in Africa and traditional African life has a high moral code with strong family traditions and mutual respect. This Bill goes against the grain of African culture, and panders to alien values being introduced with resultant destruction of local customs, values and self esteem.

Rather than advocating abortion on demand, Islam emphasizes the prevention of unwanted / unplanned pregnancies by:

- (i) advocating education of the people with emphasis on chastity.
- (ii) limiting sexual intercourse only within the institution of marriage.
- (iii) providing education and proper contraceptive means to married couples.

Islam does recognise the need to perform abortions in certain specific instances eg:-

- (i) where a mother's health will be seriously endangered by continuation of the pregnancy;
- (ii) there exists an abnormality in the foetus which is incompatible with its continued existence;
- (iii) where the pregnancy resulted from rape or incest.

This letter is intended as a contribution by the Islamic Medical Association of South Africa and it would appreciate an opportunity of giving evidence before any Inquiry or Commission that you might appoint to investigate the feasibility or otherwise of legitimising abortion.

Yours faithfully
ISLAMIC MEDICAL ASSOCIATION

REPORT ON THE HEALTH AND HUMAN RIGHTS VIOLATIONS

IN SOUTH AFRICA

A fourteen page report on the health and human rights violations in South Africa was submitted to the Truth and Reconciliation Commission on the 25 May 1997.⁹ The following is a brief summary of this report.

This submission sets out to establish

“as complete a picture as possible of the causes, nature and extent of gross human violations of human rights which were committed during the period 1 March 1960 to the cut-off date of 10 May 1994, and which contains recommendations of measures to prevent the future violations of human rights.”

The report cites examples (case histories) for each of the following categories listed below, in relation to violations of health and human rights in South Africa.

- a. violation of health and human rights by health professionals (directly or indirectly) of his/her patient and/or citizen.
- b. violation of health and human rights by the state and/or the individual/s acting on behalf of state (directly or indirectly) of the patient and/or citizen.

- c. violation of health and human rights by the state (directly or indirectly) of the health professional by the state or individuals acting on behalf of the state.
- d. violation of health and human rights of the patient/citizen and/or the health professional by the community based organisations (CBO's), (NGO's and Professional Bodies (directly or indirectly) acting on behalf of or collaborating with the state.
- e. violation of health and human rights of the patient/citizen/student and/or the health professional by the Medical/Health institutions (directly or indirectly) acting on behalf of or collaborating with the state.
- f. violation of health and human rights of the patient/citizen and/or the health professional by the multinationals companies (directly or indirectly) acting on behalf of or collaborating with the state.

The report concludes with recommendations which are listed below.

1. Since in the past there had been a lack of State acknowledgement of IMASA contributions in the arena of health and in its small attempt in counteracting the measures and effects of apartheid on health; the State now is obliged to support the health care facilities pioneered by IMASA in the disadvantaged communities.

⁹ IMA Report on Health and Human Rights violation in S. Africa, May 1997.

2. Based on the fact that this report clearly highlights health and human right violations in the various categories, hence individuals or groups who were responsible for violations of health and human rights, should be committed to pay reparations to the victims (monetary or otherwise), and also with a public apology.
3. The multinationals and other companies that have been proved to have violated health and human rights, should in addition to a public apology, demonstrate not only in words, but in deeds, its intentions of its company policy, as well as reparations for the individual victims that can be identified. Where the individual victims cannot be identified, the remuneration's should be in the form of contributions to NGO/CBO Primary Health Care units and or Primary Health Care Trainee Programmes aimed at empowering the disadvantaged.
4. The IMASA thus proposes that the TRC motivates the formation of Health and Human Rights Committee (HHRC), which should be composed of progressive health care workers, representative of the community, religious leaders, relevant organizations (NGO's/CBO's) which are stake holders.
5. Inculcate a culture of health human rights and ethics and introduce this as compulsory subject at all medical and health science institutions.
6. The oath taking ceremony should be reviewed. Perhaps after the oath has been taken by each potential health professional he/she should sign the register and receive the oath in written form to become policy.
7. This HHRC should be autonomous and be funded by the State/Province and other Funders to :
 - 7.1 investigate, analyse and record the violations of health and human rights in South Africa.
 - 7.2 facilitate reparations to the victims or next of kin or the disadvantaged groups where individuals cannot be recognised.
 - 7.3 prepare the motion to charge the individuals and/or groups that were found guilty of violations of health and human rights and failed to conform with the requirements of the Internal Health Guidelines.
 - 7.4 formulate the draft guidelines for the implementation, management of HHR victims, prevention and the ongoing monitoring of HHR violations.

7.5 incorporate strategies that enables the health professionals not to turn a blind eye with reference to violations of HHR by placing the international code of health and ethics before any party politics.

7.6 introduce measures whereby the world community can demonstrate that international as well as national professional associations will maintain the willingness and commitment to support and protect health professionals against reprisals who implement out principles of international code of health and ethics, without fear of intimidation and victimisation.



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31ST JULY 1997

MR. W. HENEGAN
THE SECRETARY
SOUTH AFRICAN LAW COMMISSION
PER TELEFAX: (012) 320 0936
PRETORIA

**SA LAW COMMISSION'S DISCUSSION PAPER 71 - PROJECT 86 - EUTHANASIA
AND THE ARTIFICIAL PRESERVATION OF LIFE - ISLAMIC MEDICAL
ASSOCIATION'S SUBMISSIONS**

PREAMBLE

In response to the discussion paper 71 on Euthanasia and the artificial preservation of life, the Islamic Medical Association of South Africa (IMA) makes the undermentioned submissions.

Our submission is based on the principle of "the common good". This accords with Islamic Law (SHARIAH) which influences our daily activities. We believe that an individual's personal autonomy or right to self-determination should be exercised within certain legal and moral constraints. The absence of control mechanisms could result in anarchy. We believe in the creation of a new South Africa where order and compassion would prevail. Absolute individual autonomy must be superseded by the interests of the general populace where the two are in conflict.

In South Africa, we must endeavour to find our own solutions. Whilst foreign systems may be examined, we must be cautious not

to adopt "failed" ideologies. We should not discard Africanism and proven principles which have emanated from "African soil", easily. Let us rather restore the beauty within those principles which have become tarnished through abuse by an unappreciative government.

In our respectful opinion, the interest of a terminally ill patient is not necessarily fostered by hastening his death. Islamic law equates active inducement of death to an act of murder. The title "euthanasia or mercy killing" does not derogate from the fact that even if such conduct was decriminalised it would still amount to the "killing of a human being".

RECOMMENDATIONS

The IMA recommends that the following amendments be made to the proposed Draft Bill on the Rights of the terminally ill.

Definitions - Section 1

- I.(1)(i) no objection.
- (ii) no objection.
- (iii) should read: "life sustaining medical treatment DOES NOT include maintenance of artificial feeding".

(iv) should read: "palliative care" means treatment and care of a terminally ill patient, not with a view to cure the patient, but rather to relieve suffering, maintain personal hygiene and provide basic nutrition.

(v) no objection.

(vi) no objection.

Conduct of a medical practitioner in the event of clinical death
- Section 2

2.(1) should read: For the purpose of this Act, a person is considered to be dead when two medical practitioners who have not less than three years experience each as such and who have knowledge and experience of assessing brain stem death agree and confirm in writing that a person is clinically dead according to the following criteria for determining death:

(2) substitute "all forms of treatment" with "life sustaining medical treatment".

Mentally competent person may refuse treatment - Section 3

no objection.

Conduct of medical practitioner in relieving distress - Section

4

no objection.

Cessation of life - Section 5

should read as follows: "Should a medical practitioner be requested by a patient to make an end to the patient's suffering, or to enable the patient to make an end to his or her suffering by way of administering or providing some or other lethal agent, the medical practitioner shall not give effect to that request." (The remaining part of Section 5 should be deleted)

Directives as to the treatment of a terminally ill person -
Section 6

no objection.

Conduct in compliance with directives by or on behalf of
terminally ill persons - Section 7

no objection.

Conduct of a medical practitioner in the absence of a directive -

Section 8

no objection.

Powers of the Court

Option 1: Section 9

no objection.

Option 2: Section 10

delete.

Interpretation - Section 11

no objection.

Short Title

Section 12 - Option 1

no objection.

Section 12 - Option 2

delete.

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B. INTERVIEWS CONDUCTED WITH THE FOLLOWING:

Doctors: G.M. Hoosen, A.A. Hoosen, M.H. Khatree, M.A.K. Omar, F.A. Randeree, Y.H. Mahomedy, M. Khan, A.B. Asmal, H.A. Randeree, Y. Osman, E. Dada, A. Dhansay, S.A. Wadee, M.F. Williams, A.K. Peer, M.C. Solwa, Y. Omar, E. Mahomed, Y. Essack, H. Tayob, A. Bhabha, H. Laher and M.A. Seedat.

And with Mr.: E.M. Jadwat, M. Hansa, E. Vayej, D. Desai, Advocate A.B. Mohamed, Attorney S.E. Lockhat, Professor S.S. Nadvi, I. Sabat, M.I. Sayed, A. Variawa and A.W. Khan.

And with Messers: S. Tayob, Z. Baxter, C. Haywood, N. Soomar and F. Hoosen.