

STRATEGY BOOKLET / FIRST EDITION

Humanitarian Partnership and Strategic Management

Iranian Patriotic Doctors
during the Lion and Sun Movement

A narrative analysis and practical framework for treatment, collaboration
and accountable support for Iranian people.

PESTEL / SWOT & TOWS / LEWIN

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Secular Democratic Movement and National Consolidation

Contents

Read the analysis, then use the operational tools to screen partners, protect clinical decisions and review delivery over time.

Executive brief	3
1. Purpose, method and evidential limits	4
2. The humanitarian problem and political context	5
3. Political identity and impartial clinical care	6
4. PESTEL - the operating environment	7
5. SWOT and TOWS - choosing a workable strategy	9
6. Lewin's force-field analysis	10
7. Understanding partners' interests without surrendering the mission	11
8. A broad, mandate-based partner directory	13
9. A partner-selection and meeting algorithm	16
10. Funding treatment lawfully and preventing diversion	19
11. Clinical credibility, rehabilitation and data protection	21
12. Funding design and an illustrative pilot budget	22
13. Lobbying, media and diaspora engagement	24
14. The 90-day plan and ongoing review	25
15. Reusable agenda, agreement and review tools	27
16. The strategic argument	28
References and implementation sources	30

Author's strategy proposal. Political views are attributed to the author. Partner listings are candidates for engagement, not endorsements or confirmed funding. No patient or treating-clinician identities are included.

Executive brief

The practical question facing Iranian Patriotic Doctors is how to turn international concern into treatment that an injured person can actually receive. Expressions of solidarity, political introductions and media attention can help. They acquire humanitarian value when they produce a safe referral, a funded operation, a rehabilitation appointment or a reliable supply of an appropriate medicine. A strategy must connect these intermediate contributions to patient outcomes.

I support a secular democratic Iran and the transitional leadership of Crown Prince Reza Pahlavi. The coalition I describe includes republicans and constitutional monarchists who recognise the Iranian people's right to choose their future constitutional arrangements. Medical assistance must be available according to need, regardless of agreement with this political position. That is both a professional obligation and a foundation for credible partnerships.

This booklet recommends a protected humanitarian programme with its own clinical decisions, restricted budget, donor agreements and independent oversight. An associated civic programme may advocate democratic transition through a separate, lawful structure. A humanitarian organisation can advocate protection of patients and medical professionals; a registered charity's purposes and spending must also comply with the charity rules applicable to its jurisdiction. [5]

Four early priorities should govern the next 90 days: establish a lawful, bank-accepted delivery route; document unmet clinical needs through a safe pilot; convert selected partners' promises into dated commitments; and report expenditure and outcomes without exposing survivors or treating clinicians. A clinician's trust in a colleague is a starting point for verification, not a substitute for it.

Seven decisions to take immediately

1. Adopt a written rule that treatment is never conditional on political allegiance, faith, conversion, publicity or testimony.
2. Confirm the programme's legal identity, governing objects, accountable officers and authority to receive restricted donations. Do not advertise charity registration or tax relief that has not been established.
3. Appoint separate clinical, finance and compliance leads, with a small independent review function and a protected patient feedback route.
4. Obtain transaction-specific advice on the proposed payment and supply chain, then establish the bank's willingness to process it before promising cross-border funding.
5. Begin with a defined, affordable clinical pilot and release funds only against an approved care plan through the cleared route.
6. Screen prospective partners before meetings; end every useful meeting with an owner, deliverable and deadline.
7. Review a compact dashboard weekly, a partner portfolio monthly and the whole strategy quarterly or after a material event.

Decision rule: accept help when it improves patients' lives through an accountable route and preserves clinical independence. A large promise should never override a failed legal or patient-protection condition.

1. Purpose, method and evidential limits

This is a narrative analysis and an operational strategy proposal. It combines selected human-rights investigations, official sanctions and charity guidance, institutional descriptions of humanitarian mandates, medical donation guidance and the author's established civic outlook. Public sources were checked on 12 October 2026. It is not a systematic review, an audited account of Iranian Patriotic Doctors or a validated forecast of Iran's political future.

The paper uses PESTEL to examine the external environment; SWOT to distinguish internal capacity from external opportunities and threats; TOWS to turn that assessment into choices; and Kurt Lewin's force-field analysis to identify driving and restraining forces. The relevant management framework is Lewin's, sometimes misheard as Levine's. The tools organise judgement. They do not predict revolutions, establish legal permissions or replace clinical assessment. The original management papers were verified bibliographically; full-text appraisal was limited where access was unavailable. This independently published booklet has not undergone journal peer review. [13, 14]

The account of a carefully supervised network of trusted doctors comes from the author. Patient records, bank records, partner agreements, registration documents and independent audits were not available for this review. The strategy therefore proposes controls to make that account demonstrable; it does not certify existing controls or guarantee that diversion cannot occur.

Public investigations support the gravity of the January violence, but casualty documentation remains incomplete. Named organisations in the directory are candidates for appropriate engagement, not confirmed donors or partners. Their public mandates do not imply support for Crown Prince Reza Pahlavi, access to the programme's patients or readiness to fund it. Details of eligibility and local access must be established directly before implementation.

How to read the evidence

Type of statement	Meaning in this booklet	How it should be used
Documented public finding	An identified organisation reports evidence or an official body states a rule.	Cite the dated source; distinguish an investigative finding from a court judgement.
Author's position or account	Political outlook, professional judgement or a description supplied by the author.	Attribute it; do not present it as independently audited or universally shared.
Strategic inference	An interpretation of incentives, obstacles or likely trade-offs.	Test it through questions, small pilots and review.

Type of statement	Meaning in this booklet	How it should be used
Proposed operating rule	A recommended process, threshold, role or deadline.	Adopt only after local governance review; adjust to evidence and capacity.
Illustrative number	A sample score, budget or management target.	Use for planning; it is not a measured result, clinical rule or supplier quotation.

Legal guidance below identifies issues and authoritative sources. It cannot authorise a particular transfer. The responsible legal adviser, bank and, where necessary, competent authority must determine the actual route. Names, balances, thresholds and permissions need refreshing whenever the law or proposed transaction changes.

2. The humanitarian problem and political context

The Islamic Republic has governed Iran since 1979, approximately 47 years by this edition. The author's concern is the long conversion of religious authority into coercive state power, alongside economic deprivation and barriers to care. Criticism of that governing system should be precise. It must not assign guilt to Muslims as a population or treat faith as proof of political complicity.

Iran Human Rights reported on 17 September 2026 that it had documented more than 4,200 deaths during the January protests and at least 3,356 deaths on 8 and 9 January. It described these as minimum documented figures and identified military-grade weapons and serious obstacles to verification. Amnesty International and Human Rights Watch also documented mass killings and extensive use of lethal force. These sources support an urgent humanitarian response; they do not establish a final national toll or verify every individual referral. [1, 2, 3]

By October, survivors may need reconstruction, infection management, rehabilitation, pain care, psychological support and assistance returning to daily life. The continuing burden includes delayed consequences of wounds as well as immediate injuries during renewed violence. A patient may have an old fracture or disability that worsened because treatment was interrupted, medicines became unaffordable or mobility was lost. The programme should assess present need and the proposed intervention rather than demand a politically useful injury story.

The expression 'bankrupt country' conveys the author's assessment of deprivation and failed priorities. This paper does not establish formal sovereign insolvency or estimate national poverty. For programme decisions, measure the patient's inability to obtain a specific service, the local availability of that service and its verified cost. National rhetoric cannot substitute for a care budget.

Geopolitical overlap and humanitarian independence

The United States, Israel, European governments and Iranian democrats can have overlapping interests in reducing threats and protecting civilians. Their priorities are not identical. Nuclear proliferation, regional security, domestic politics, diplomatic stability and human rights may receive different weight. Assertions about a government's single motive require evidence; this strategy treats those interests as subjects for analysis. It does not claim that Iran possesses a nuclear weapon.

European policy also cannot be reduced to calls for restraint. The EU's March 2026 statement called for de-escalation, civilian protection and an end to repression, and supported investigations. Subsequent Council decisions maintained and expanded measures against perpetrators of serious human-rights violations. A meeting with European counterparts should recognise these positions while asking what practical medical access and accountability measures they will support next. [4, 15]

I regard the absence of a secure democratic settlement and the persistence of suffering as reasons to strengthen Iranian civic capacity. However, a medical programme should not make treatment depend on the success of negotiations, military action or a preferred political timetable. It should remain usable through ceasefire, renewed conflict, continuing repression or a period of transition.

Support for people to remain safely in their communities can meet humanitarian and European policy interests. It must preserve people's ability to seek protection when necessary. Describing Iranians as a 'refugee storm' risks reducing human beings to a border problem. The more defensible case is that affordable care, safety and livelihoods expand people's real choices; they must not become an excuse to deny asylum or return someone to danger.

3. Political identity and impartial clinical care

Iranian Patriotic Doctors' published statement links its health mission to territorial integrity, individual freedom, equal citizenship, separation of religion and government, and national cooperation associated with Crown Prince Reza Pahlavi. A July 2026 meeting report addresses aid to injured people, media cooperation, equitable health services and documentation training. These are the organisation's published descriptions, not an independent evaluation of delivery. [16, 17]

As described by the author, republicans and royalists can cooperate around transition and humanitarian responsibilities while retaining their constitutional preferences. That agreement should become a practical charter: no faction can influence triage, demand access to clinical identities or claim ownership of a survivor's story. The future political settlement belongs to Iranian citizens; the present clinical assessment belongs to qualified clinicians and the patient.

A structure that protects the mission

Function	Purpose and accountable owner	Funding and information boundary
Humanitarian programme	Clinical lead and independent oversight provide needs-based assessment, treatment support and rehabilitation.	Restricted clinical funds; minimum patient data; no payment for allegiance or political campaigning.
Civic advocacy programme	A separately governed, lawful programme advocates the author's democratic objectives.	Its own budget, consent lists and decision records; no reuse of clinical information to recruit supporters.
Shared enabling services	Defined finance, administration or communications support under written service arrangements.	Document costs and allocations; prohibit hidden cross-subsidy and role confusion.
Independent review	Reviewer examines decisions, complaints, conflicts and financial reconciliation.	Access necessary for review under confidentiality; no public disclosure of sensitive identities.

An internal separation may help an informal association organise its work, but it does not make political purposes charitable. If a UK registered charity is used, its objects, resources and campaigning must satisfy applicable charity law. The Charity Commission for England and Wales permits campaigning that supports charitable purposes and requires independence from party politics; a political purpose cannot itself become a charitable purpose. The appropriate legal structure needs advice before implementation. [5]

An independent humanitarian host may be a useful early route when it has relevant objects, jurisdictional permissions, bank acceptance and a genuine ability to oversee the programme. A host must retain its own duties and approve the work. It cannot simply lend a charity number or bank account to an association. A written agreement should cover control of grants, reporting, unspent funds, shared costs and termination.

Humanitarian partners such as MSF and the ICRC operate through independent mandates and access arrangements. They should be approached about patient needs, clinical referrals or protection concerns within their remit. They must be free to decline political affiliation, co-branding or endorsement. Working with them is compatible with the author's declared political views when the collaboration protects their independence. [18, 19]

This approach makes national solidarity concrete: a clinician can oppose authoritarian government while treating a patient who holds a different belief. Medical need should not become an audition for citizenship.

4. PESTEL - the operating environment

PESTEL examines political, economic, social, technological, environmental and legal pressures. For this programme the useful output is a set of decisions with indicators. The following assessment combines documented restrictions and humanitarian mandates with the author's strategic judgement. It is a living management framework, not a quantified country-risk index.

Factor	Relevant pressure	Management response and early indicator
Political	Repression, disputed legitimacy, competing diaspora factions, foreign security priorities and uncertain access to patients.	Protect clinical independence and Iranian agency. Watch interference with referrals, threats to staff and attempts to trade aid for endorsement.
Economic	Patients' inability to pay; unstable purchasing power; bank reluctance; finite donations and hidden follow-up costs.	Verify care costs locally and budget the whole pathway. Track cleared funds, cost changes, unfunded approved cases and follow-up affordability.
Social	Grief, distrust, disability, stigma, religious persecution and disagreement over the future political system.	Use equal eligibility rules and accessible patient communication. Monitor complaints, geographic gaps, gender and disability barriers, and pressure for publicity.
Technological	Communications outages, insecure record sharing, weak clinical documentation and equipment maintenance limitations.	Minimise data; use approved secure systems, role-based access and a tested continuity plan. Track lost contacts, missing records and device repair capacity.
Environmental	Displacement, damaged services, power interruption, climate hazards and transport disruption can interrupt recovery.	Map delivery alternatives and local continuity of care. Check safe travel, medicine storage, accessible facilities and dependence on a single location.
Legal	Financial and trade sanctions; counter-terrorism controls; charity purposes; data protection; professional and local rules.	Obtain route-specific clearance and retain required records. Track licence conditions, screening changes, bank refusals and upcoming legal review dates.

The legal dimension interacts with every other factor. A donation can be clinically valuable yet unusable because the payment chain has not been cleared. A communications system can improve coordination while increasing surveillance exposure. A politically powerful sponsor can open doors while making a neutral clinical provider unwilling to participate. Management must consider these interactions before celebrating a single apparent advantage.

Three scenarios for planning

Scenario	Likely programme problem	Prepared response
Continuing repression with intermittent communication	Long-term injuries remain hidden; safe follow-up is uneven.	Maintain a small, protected referral service; prioritise continuity and rehabilitation; publish aggregate evidence only.
Renewed large-scale violence or war	Emergency need rises while staff, transport and payment capacity deteriorate.	Activate clinician-led emergency referral and an already cleared contingency budget; coordinate with capable providers; suspend unsafe routes.
Negotiated opening or democratic transition	Demand, new institutions and external offers expand faster than verification capacity.	Scale in phases; preserve common eligibility rules; transfer learning into accountable health-system reconstruction.

The organisation need not choose one scenario as a forecast. It should identify actions valuable in all three: lawful finance, independent clinical decisions, protected records, credible partners

and resilient follow-up. A quarterly PESTEL review should ask what changed, which assumption failed and which decision must change now.

5. SWOT and TOWS - choosing a workable strategy

SWOT separates internal strengths and weaknesses from external opportunities and threats. For Iranian Patriotic Doctors, the items below are hypotheses informed by the author's description. Leadership should verify them against actual volunteer availability, accounts, patient outcomes and partner feedback before treating them as established capabilities.

Category	Working assessment	Evidence needed
Strengths	Specialist clinical knowledge, diaspora language skills, national motivation and relationships with trusted doctors.	Verified credentials, available hours, reliable referral histories and documented outcomes.
Weaknesses	Possible dependence on a few volunteers, uncertain unrestricted funding, uneven case records, blurred political and clinical roles.	Capacity map, legal documents, backlog, reconciled accounts, role descriptions and absence cover.
Opportunities	Professional networks, disability organisations, faith communities, diaspora philanthropy, humanitarian programmes and public concern.	A specific eligible offer, named decision-maker, due-diligence result, delivery route and deadline.
Threats	Patient intimidation, fund diversion, sanctions breaches, politicised aid, data exposure, fraud, misinformation and staff exhaustion.	Incident log, screening results, donor conditions, security review, reporting completeness and workload.

TOWS turns this list into strategic combinations. Its value is that a weakness becomes a management assignment and an opportunity becomes a testable proposal. The matrix is a planning device; it does not prove that a partner will agree. [14]

Combination	Strategic choice	First action and accountable lead
Strengths + opportunities	Use clinical expertise to make a precise, costed case for a small treatment and rehabilitation pilot.	Clinical lead prepares an anonymised needs summary; partnerships lead seeks an eligible funder and delivery partner.
Strengths + threats	Use specialist review and local professional judgement to reduce false claims, inappropriate treatment and unsafe publicity.	Clinical lead establishes peer review, conflict declarations and consent controls.
Weaknesses + opportunities	Seek finance, compliance and administration support rather than relying solely on more doctors.	Governance lead tests an accountable humanitarian host or a defined support agreement.

Combination	Strategic choice	First action and accountable lead
Weaknesses + threats	Reduce activity to the scale that can be safely supervised and funded; separate civic campaigning from clinical resources.	Board approves a capacity ceiling, a reserve policy and rules for pausing routes.

I would select a 'small, verifiable and expandable' strategy over an immediate national promise. The initial commitment should be a complete pathway for a manageable number of people, including follow-up. Expansion then depends on demonstrated delivery and the ability to retain supervision as volume grows.

A useful stop rule is to decline new commitments when there is no lawful delivery route, no credible treating provider, no funded follow-up or no available reviewer. A waitlist should be honest about its limitations and include referral alternatives where available. Its size is not evidence of successful care.

6. Lewin's force-field analysis

Lewin's field perspective draws attention to the forces that hold an organisation in its current pattern. Here the desired change is from urgent but fragmented offers of help to a reliable, accountable treatment pathway. Pushing harder for donations may not work if the restraining forces are bank refusal, uncertain legal status, weak case records or fear among local clinicians. [13]

Illustrative forces to test with the team

Driving force	Initial strength*	Restraining force	Initial strength*
Severe unmet patient need	5	Threats to patients and treating clinicians	5
Diaspora clinical knowledge	4	Unclear legal or bank-accepted payment route	5
Donor and professional solidarity	4	Incomplete records and limited review capacity	4
Shared concern for human rights	4	Political branding incompatible with partner mandates	4
Potential for local treatment and rehabilitation	3	Volunteer overload and fragmented coordination	4

*Scores of 1 to 5 are workshop prompts proposed by the author, not measured data. Do not subtract totals to predict feasibility: a single unresolved legal prohibition or serious protection risk can block an activity regardless of the apparent balance.

Reduce the strongest restraint first

For the payment obstacle, the intervention is a clear legal and banking dossier, a named accountable entity and a fully described payment chain. Its test is whether a compliant route is actually usable. Another press interview will not solve that problem. For political incompatibility, the intervention is a needs-based project with separate clinical governance and transparent limits on affiliation. Its test is whether independent providers can participate without endorsing the movement.

For fear and weak records, ask local clinicians what minimum evidence can be collected safely and who must hold it. Protecting someone from unnecessary disclosure improves the chance of reliable follow-up. It must not be used to conceal payment recipients from legally required checks. For overload, delegate administration, limit meeting time and maintain a rota with absence cover.

Lewin's change logic can be adapted as a cycle: first challenge the habit of measuring success by contacts and promises; then test a new referral and funding process; finally stabilise the useful parts through roles, records and review. Stabilisation should preserve learning. An emergency environment requires revising arrangements when conditions change, rather than freezing an unsafe process.

At a monthly workshop, assign an owner to each of the two most important restraints. Record the intervention, deadline and evidence that would show improvement. At the next workshop, compare the evidence with the earlier assumption. A field analysis that produces no changed decision is only a diagram.

7. Understanding partners' interests without surrendering the mission

A partner's interests should be explored directly rather than inferred from its name, faith or national origin. Humanitarian bodies may seek access and impartiality; professional organisations may prioritise medical ethics and colleague protection; religious bodies may emphasise conscience and community service; public authorities may consider regional stability and displacement. These are possible areas of interest, not evidence of a hidden motive.

The practical question is where their mandate overlaps with a task that the programme can legitimately perform. A human-rights organisation may help substantiate attacks on medical care while being unable to fund surgery. A disability charity may offer training or equipment expertise but have no current Iran programme. A donor may offer money but require governance that the association has not yet established. Each needs a different proposal.

Partner group	Possible legitimate interest	Offer to explore	Conditions to establish
Independent humanitarian providers	Access, impartial care and protection of medical work.	Clinical referrals, technical advice or a suitable service pathway.	Their mandate, capacity and independence; no political endorsement expected.

Partner group	Possible legitimate interest	Offer to explore	Conditions to establish
Christian humanitarian and religious-freedom bodies	Relief, conscience, protection of persecuted communities and public witness.	Inclusive clinical sponsorship, advocacy or introductions.	No conditional conversion, religious screening or use of patients as evidence of religious success.
Baha'i institutions [41, 57]	Equality, protection from persecution and constructive social participation.	Rights advocacy, dialogue or expert introductions.	Respect their institutional non-partisan boundaries; ask about permitted activity rather than assuming political alliance.
Muslim humanitarian bodies	Relief, dignity and community solidarity.	Inclusive support within the donor's lawful objects.	Agree an equitable clinical pathway and compatible donation terms; no collective accusation against Muslims.
Diaspora civic and professional networks	Connection to Iran, credible impact and participation.	Recurring donations, specialist review, translation and skills.	Declare conflicts, factional conditions and donor restrictions; separate professional service from political recruitment.
European and other public authorities	Civilian protection, accountability, security and stability.	Medical-access measures, policy engagement or eligible programme funding.	Preserve protection rights; do not accept migration containment as a substitute for patient welfare.
Media and public communicators	Verifiable public-interest information and responsible reporting.	Aggregate clinical evidence and consented, safe interviews.	Editorial independence, verification and a patient-protection review.

Freedom of conscience is a condition of good care

Some Iranians may reconsider religion following experiences of coercion in its name. This paper does not provide a population estimate or forecast widespread conversion to Christianity. Christians, Baha'is, Muslims, Jews, Zoroastrians and people without religious belief should all be free to participate in a democratic future.

A Christian organisation's sincere faith is compatible with humanitarian cooperation. The unacceptable condition is making care depend on conversion, worship, religious testimony or access to a vulnerable patient for recruitment. The same rule applies to any faith and to secular political organisations. Patients should be able to refuse spiritual or political engagement without losing access to the agreed service.

A useful meeting question is: 'Would this offer remain available to an equally needy patient who does not share your beliefs or our political views?' Another is: 'What do you need to report to your members or funder, and can we meet that requirement with protected aggregate information?' Written answers clarify compatibility before money or reputational dependence develops.

8. A broad, mandate-based partner directory

This directory maps 31 external organisations and networks, alongside Iranian Patriotic Doctors itself. It is deliberately broad, not exhaustive. A public mandate is evidence of an organisation's purpose, not confirmation of a current grant, referral service or partnership. The proposed requests below are the author's recommendations. Contact through the linked official source and ask for the relevant country, programme, partnerships or advocacy team.

Status A means public material describes relevant activity in Iran. Status B means a relevant wider mandate is verified, but a programme suitable for these patients has not been established. Status C means advocacy, professional or diaspora engagement is the principal fit; direct treatment funding should not be assumed. No entry indicates that the organisation supports this paper's political position.

Clinical, humanitarian and multilateral organisations

Organisation and source	Evidence and status	Proposed first request; main limit
Medecins Sans Frontieres / Doctors Without Borders [18]	Iran medical activities described. A	Ask whether an individual needs assessment or referral falls within current projects. MSF is independent; it is not a presumed grantmaker to IPD.
International Committee of the Red Cross [19]	Iran healthcare, rehabilitation and response described. A	Discuss a suitable protection or rehabilitation pathway. Its established partnerships and confidentiality govern access.
International Federation of Red Cross and Red Crescent Societies [20]	Iran emergency appeal and wider humanitarian network. A	Ask about a relevant response channel or technical support. It operates through National Societies and approved arrangements.
World Health Organization [21]	Iran health and emergency work described. A	Seek technical coordination, standards or contact with an appropriate health-response team. It is not a direct personal treatment fund.
UNICEF [22]	Iran child health and protection programme. A	Explore appropriate child-focused pathways and safeguarding. Its mandate and existing country arrangements apply.
UNHCR [23]	Refugee protection and services in Iran. A	Ask about eligibility or referral for a displaced person within its mandate. It is not a general fund for every Iranian national.
World Food Programme [24]	Refugee and conflict-affected population support in Iran. A	Explore whether eligible nutrition or household support can complement recovery. It does not replace orthopaedic treatment funding.
International Organization for Migration [25]	Iran migration-related health activity publicly reported. A	Ask about relevant migrant-health coordination or referral. Eligibility and programme scope must be confirmed.

Organisation and source	Evidence and status	Proposed first request; main limit
UN Office for the Coordination of Humanitarian Affairs [26]	Humanitarian information and coordination. B	Seek the appropriate coordination or information channel. It is not a routine source of individual clinical grants.
European Commission DG ECHO [27]	Regional financing documents include Iran. A	Explore partnership through an eligible implementing organisation. Formal criteria and current calls govern funding.

Rehabilitation, professional expertise and human rights

Organisation and source	Evidence and status	Proposed first request; main limit
Humanity & Inclusion [28]	Rehabilitation and disability inclusion expertise. B	Ask about technical advice, disability inclusion or an eligible delivery partner; Iran access is unconfirmed here.
CBM UK [29]	Disability inclusion and development remit. B	Explore accessible programme design and technical connections; suitable Iran funding is unconfirmed.
Physicians for Human Rights [30]	Medical evidence and human-rights documentation. C	Seek ethical documentation training or policy collaboration; no assumption of surgical sponsorship.
British Medical Association [31]	UK professional representation and advocacy. C	Request engagement on medical neutrality and colleague protection, with a concise evidence brief.
World Medical Association [32]	International medical ethics and professional policy. C	Seek relevant policy engagement through its member structures; it is not an emergency payment service.
British Orthopaedic Association [33]	Orthopaedic professional network. C	Explore specialist volunteers, educational advice or a carefully defined clinical collaboration.
Royal College of Surgeons of England [34]	Surgical professional and educational remit. C	Explore training, governance advice or professional introductions; its approval and capacity are needed.
Amnesty International [2]	Iran investigations and human-rights advocacy. C	Offer protected evidence of barriers to care or abuse; treatment funding is not its principal role.
Human Rights Watch [3]	Iran investigations and international advocacy. C	Explore substantiation and public policy attention; retain its independence and source-protection rules.
Iran Human Rights [1]	Iran documentation and accountability advocacy. C	Discuss safe evidence and relevant international advocacy; do not assume a clinical grant programme.
Center for Human Rights in Iran [35]	Iran rights advocacy, including health and disability issues. C	Explore evidence-based communications and introductions; distinguish advocacy from clinical service delivery.

Faith-based and diaspora networks

Organisation and source	Evidence and status	Proposed first request; main limit
Caritas Internationalis [36]	Catholic humanitarian confederation. B	Ask which member, if any, has an eligible route for inclusive medical support. No current suitable Iran pathway confirmed.
Christian Aid [37]	International poverty relief and justice remit. B	Explore a compatible implementing partner or technical introduction; eligibility and capacity need confirmation.
World Council of Churches [38]	Ecumenical network with health and public engagement activity. C	Explore dialogue, professional contacts or public advocacy, without implying endorsement of transition leadership.
CSW [39]	Iran-focused freedom-of-religion-or-belief advocacy. C	Seek inclusive rights advocacy or policy introductions; it is not a general treatment fund.
Article18 [40]	Religious-freedom work concerning Iran. C	Explore protection evidence and communications; patients' clinical needs must remain independent of religious identity.
Baha'i International Community [41]	Iran persecution, equality and international advocacy. C	Explore human-rights dialogue through representative offices; respect institutional limits on political participation.
Islamic Relief Worldwide [42]	Faith-inspired international humanitarian work. B	Ask whether its objects and current arrangements permit an inclusive clinical project. Iran access is unconfirmed here.
Muslim Aid [43]	Humanitarian relief and development remit. B	Explore an eligible medical or rehabilitation proposal with transparent conditions. No suitable Iran route confirmed here.
Public Affairs Alliance of Iranian Americans [44]	Iranian-American public engagement network. C	Ask about appropriate civic or policy introductions; do not assume agreement with the author's constitutional preference.
United for Iran [45]	Iran civic and human-rights work. C	Explore complementary rights expertise or diaspora engagement; independent priorities may differ.
Iranian Patriotic Doctors [16, 17]	Author's coordinating organisation and published health/transition mission. C	Organise qualified clinical volunteers and an accountable humanitarian programme. Legal status and audited capacity need confirmation.

How to use the directory

Choose a small first portfolio rather than contacting every entry. Seek one suitable delivery partner, one finance or governance partner, one rehabilitation adviser and one credible advocacy connection. Verify the named entity, remit, current access, officer, conditions and official contact route. Re-screen it before receiving funds or signing an agreement.

Organisations working inside Iran may cooperate with public institutions or the Iranian Red Crescent. That does not by itself establish IRGC control, and an international logo does not by itself establish a safe route for this programme. Examine the actual service, counterparties, ownership and payment chain. Public source material should not be used to make unsupported accusations about named organisations.

Where a candidate's site or programme information could not be accessed in this review, it has not been elevated to a confirmed delivery partner. Further diaspora organisations, local faith communities and assistive-technology networks can be added after the same checks. Broad inclusion is useful when it widens capacity without weakening accountability.

9. A partner-selection and meeting algorithm

Time is a scarce clinical resource. Screening should determine whether a conversation can produce a useful contribution before it becomes a succession of ceremonial meetings. The algorithm below is a proposed management tool. It ranks organisations' offers; it must never rank patients' entitlement to care.

Stage 1: define the need before the contact

Write a one-page problem statement: who needs what service, how need will be assessed, which delivery route is available, what the cost assumptions are, and what contribution is being sought. Use aggregate or fictionalised examples for first contact. Decide whether the request concerns a humanitarian service, professional support, media work or civic advocacy. A single meeting should not quietly mix all four.

Stage 2: apply six non-negotiable gates

Gate	Pass condition	Fail or unresolved condition
Identity and authority	Legal identity and authorised representative are verified.	Hold the proposal until clarification; do not release funds or data.
Lawful activity and route	Relevant sanctions, banking, supply and jurisdictional requirements can be met.	Hold for advice or decline an unlawful route; urgency does not override law.
Clinical independence	Care follows need and professional judgement.	Decline conditions requiring political loyalty, conversion or inappropriate treatment.
Patient and staff protection	Safe consent, minimum data and realistic risk controls are agreed.	Hold unsafe disclosure or decline a coercive condition.
Accountability and conflicts	Terms, fund ownership, conflicts and reporting responsibilities are clear.	Clarify or decline opaque money, hidden obligations or unverifiable intermediaries.
Practical capacity	A relevant deliverable, decision-maker and feasible delivery pathway exist.	Seek a narrower offer or park a purely symbolic conversation.

A failed gate cannot be compensated by a high weighted score. 'Unresolved' means no decision yet, not permission. The team can continue other useful work while the relevant specialist resolves the issue.

Stage 3: score the offer against the defined task

Criterion	Weight	Question for a score from 0 to 5
Finance or equivalent usable resources	25	Can it provide a cleared grant, pay an approved service or remove a real cost?
Delivery relevance	20	Does the offer match the required care, rehabilitation or support task?
Timeliness	15	Can a decision and delivery occur within the clinically relevant window?
Rights and clinical independence	15	How well do the terms protect equality, consent and professional decisions?
Governance and reliability	15	Are authority, track record, reporting and delivery responsibilities credible?
Useful networks and communications	10	Can it make a verified introduction or communicate accurate evidence safely?

Score = sum of each weight multiplied by its rating divided by 5; maximum 100. Record the evidence and confidence behind each rating. Zero means no useful contribution for that criterion, not that the organisation lacks moral value. Missing evidence receives an explicit 'unknown', and the proposal remains provisional.

Proposed thresholds: 75 or more merits a defined pilot; 60-74 merits one focused clarification or a limited task; below 60 normally goes to the low-time portfolio. A specialist advocacy offer should instead be scored against an advocacy task with openly adjusted weights. Do not penalise a medical ethics body for being unable to fund surgery, then reject its useful policy contribution.

Worked examples - fictional, not assessments of named organisations

Offer	Ratings in criterion order	Score	Decision after all gates pass
Treatment sponsor with a usable funding route	4, 4, 4, 5, 4, 2	79	Pilot a defined package; confirm evidence and conditions first.
Equipment offer with weak delivery and maintenance arrangements	2, 3, 2, 5, 3, 2	56	Clarify whether local purchase and fitting could produce a better offer.
Publicity forum with little clinical resource	0, 1, 2, 4, 2, 5	38	Limit clinical-team time; assess separately if a genuine advocacy task exists.

Stage 4: use a 30-minute first meeting

Minutes	Agenda	Required output
0-5	Confirm roles, mandate and shared patient need.	A clear scope and the appropriate decision-maker.
5-12	Present the defined proposal and protected evidence.	Agreement about the problem and the type of contribution.
12-20	Test money, services, introductions or media support.	A concrete offer, conditions, timeline and approval route.
20-26	Check legal, clinical, data and reporting boundaries.	Known blockers and the person responsible for resolving each.
26-30	Agree the next step.	One deliverable, one owner and one deadline, or a decision to close.

Ask directly: 'Can you fund this defined package, or connect us to someone authorised to consider it?' 'Can you provide suitable services or equipment with delivery and follow-up?' 'Can you make a warm introduction to a relevant policy office?' 'Can you publish an accurate statement or support a protected media briefing?' 'What do you expect in return?' 'Who decides, by when, and what evidence do they require?'

Stage 5: control follow-up and opportunity cost

Send or agree a concise meeting record through the authorised organisation's usual process: deliverable, owner, deadline, conditions and confidentiality. Suggested management targets are a record within two working days, a decision date within ten working days where realistic, and closure or reclassification after 30 days without a substantive response. These are proposed service standards, not promises that external bodies will comply.

Until evidence supports more time, cap routine external meetings for the clinical lead at two 30-minute meetings per week. Delegate screening and administration. A useful starting allocation for non-clinical coordination time is 50% delivery and follow-up, 20% governance and finance, 20% targeted partnerships and 10% public communication. Reallocate during emergencies. This is a management choice, not a rule for a clinician's patient-facing time.

Do not convert political visibility into an invented monetary value. For finance and delivery tasks, compare the realistic probability of a cleared contribution, the useful amount or service capacity, the time to delivery and the staff hours required. For advocacy, identify an observable outcome such as a relevant meeting, a submitted evidence brief or a policy response. A photo with a prominent figure is not a completed treatment or an adopted policy.

10. Funding treatment lawfully and preventing diversion

The statement that charity work under the name of Iran is completely banned is incorrect as a general proposition. UK guidance contains humanitarian and medical licensing grounds; U.S. guidance recognises relevant exemptions and authorisations; some international agencies continue work in Iran. These provisions have conditions and do not authorise every transfer, supplier, bank, service or recipient. [6, 7, 8, 9]

Financial restrictions, trade controls, counter-terrorism law, donor-country law and local requirements can overlap. A UK permission does not automatically resolve an American or European restriction, and vice versa. A humanitarian purpose alone does not prove a transaction lawful. Bank acceptance is a separate practical requirement, even when an adviser identifies a legal basis.

A route-specific legal and banking dossier

Question	Information to assemble	Responsible decision
Who is acting?	Legal entities, officers, registration, governing purposes and jurisdictions.	Governance lead and legal adviser confirm authority.
What is the activity?	Specific assessment, treatment, medicine, equipment or professional service.	Clinical lead defines need; adviser classifies restrictions.
Who benefits and who supplies it?	Patient eligibility, provider identity, relevant ownership and control, suppliers and intermediaries.	Compliance review with proportionate protection of sensitive records.
How will money move?	Donor, recipient, banks, intermediaries, currency, charges and required reporting.	Legal basis and bank willingness verified for the actual chain.
What permission applies?	Relevant exemption, general licence or specific licence, scope, expiry and conditions.	Written determination; obtain required permissions before the prohibited activity.
What will demonstrate delivery?	Approved budget, invoices, service confirmation, reconciliation and independent checks.	Finance lead and reviewer agree the evidence and timing.

The UK Iran sanctions regime and the nuclear sanctions regime both require attention. Official nuclear guidance includes restrictions affecting transfers and services; its current provisions must be checked rather than assuming that an unlisted doctor or an ordinary medical device is sufficient to clear the route. OFSI handles financial sanctions, while trade and other permissions have their own competent authorities. [6, 7, 8]

UK amendments effective on 29 September 2026 introduced further financial, trade and transport restrictions. Current Treasury guidance also addresses a presumption of denial for applications made by certain designated Iranian banks. That notice identifies a 22 October 2026 expiry for a particular banking general licence; this does not establish the scope or expiry

of any permission for the proposed medical project. The adviser must assess the actual proposal against current rules, applicable permissions and their conditions. [55, 56]

OFAC General License E and relevant Iran guidance may be relevant where there is a U.S. nexus. Eligibility, limits, exclusions and reporting must be checked against the current text. It is not a universal international permission and should not be copied into a grant agreement as though it clears every bank or counterparty. [9]

A patient-to-payment workflow

1. Receive the referral with a safe contact method and a minimum clinical summary; acknowledge what the programme can and cannot provide.
2. Ask a qualified local clinician to assess current need and identify urgent local care. Emergencies should not wait for the donor meeting or an investigation of political provenance.
3. Prepare a documented care plan, including alternatives, estimated cost, rehabilitation and follow-up. Separate a reported injury mechanism from findings that have been examined.
4. Obtain independent clinical review when proportionate to complexity, cost or uncertainty. Declare financial and personal conflicts.
5. Verify the provider, supplier, relevant ownership and payment route, applying required sanctions and other checks. Keep identifying information restricted to authorised people who need it.
6. Approve the clinical commitment and funding through separate accountable roles. Record the legal basis and any conditions before transfer.
7. Pay an approved service or supplier through the cleared route where feasible; use proportionate milestones and an emergency approval procedure established in advance.
8. Confirm receipt and service delivery, reconcile invoices, check a proportionate sample independently and arrange clinical follow-up.
9. Investigate anomalies, protect the patient from losing essential continuity where possible, suspend unsafe routes and make legally required reports.

Trust is built by matching the approved need, payment and delivered service. Useful checks include a verified invoice, confirmation by the treating provider, a safe patient confirmation and review of cost or outcome anomalies. A patient should not have to produce graphic photographs, identifying social-media posts or testimony about repression to validate an ordinary care episode.

Charity Commission and OFSI guidance support proportionate due diligence and monitoring of end use. This paper's control design adds independent approvals and documented reconciliation for the proposed programme. It reduces risk; it cannot certify that funds will never be diverted. [8, 10]

Never relabel an Iranian transaction, split it to avoid a legal threshold, conceal the true recipient, use an opaque intermediary or assume cash or cryptocurrency solves sanctions. Sensitive patient information can be protected while counterparties are disclosed to banks, advisers and authorities where required. If there is no lawful workable route, pursue care through a capable existing humanitarian provider or defer the funding commitment honestly.

11. Clinical credibility, rehabilitation and data protection

The programme's clinical purpose should be expressed in terms of assessed problems and outcomes. Potential referrals include gunshot-related fractures, retained fragments, infection, nerve injury, impaired mobility, psychological distress and aggravation of earlier disease or injury. None of these descriptions establishes a treatment recommendation for an individual. Appropriate imaging, examination, local expertise and patient preferences govern care.

Clinical triage and administrative review serve different purposes

Clinical situation	Programme action	Administrative boundary
Possible threat to life or limb, severe infection or another emergency	Qualified local clinician directs immediate appropriate assessment and care.	Do not wait for partner scoring or proof of protest participation. Use an established emergency funding process when lawful and available.
Time-sensitive problem with potential deterioration	Arrange prompt local assessment and a realistic, reviewed pathway.	Prioritise clearance and funding in parallel; record delays and capacity limits.
Chronic reconstruction, rehabilitation or ongoing pain	Assess function, reasonable options and continuity; plan resources over time.	Include follow-up costs and review need rather than prioritising media visibility.
Unclear mechanism or aggravation of previous injury	Assess present findings and needs while documenting uncertainty.	Do not fabricate attribution or exclude clinically justified care merely because a political narrative is unproven.

An assessment fund can support careful evaluation before deciding on expensive treatment. It should fund a defined professional task with a documented result. A request for funds must distinguish clinical necessity, financial eligibility and evidence of the historical event. These are related questions but require different evidence.

Rehabilitation should begin in the plan rather than appear as an afterthought. A wheelchair or walking aid is useful when it suits the person, can be fitted and taught safely, and has maintenance and follow-up support. WHO's wheelchair and device-donation guidance provides a basis for appropriate provision. Medicines and devices should meet recipient needs and applicable standards; a shipment of unsuitable goods creates work without improving care. [11, 12, 46]

A minimum, protected case record

Record a programme case identifier; safe contact preferences; a minimum demographic and clinical summary; financial need; relevant examination or imaging findings; the plan and alternatives; consent; the accountable clinician; approvals; the cost and payment reference; and follow-up outcomes. Keep the identifying key and financial due-diligence information accessible only to authorised roles. Pseudonymised records remain personal data when re-identification is possible.

For a UK-based programme, health data require an appropriate Article 6 lawful basis and Article 9 condition. Record the controller, purposes, retention, access rights and any

international-transfer requirements. Do not assume ordinary consent, a messaging app or encryption alone resolves every obligation. Where European rules apply, assess those as well. [47, 48]

Consent for treatment, programme administration, sharing records, legal evidence and publicity should be distinct. Refusing an interview or photograph must not reduce clinical eligibility. Before public use, review whether details, locations or unusual injuries could identify a person even after removing the name. Do not publish a roster of treating doctors in Iran or live referral routes.

Evidence about torture or abuse requires a separate professional and legal pathway. The Istanbul Protocol supplies a relevant international framework. Participation must be safe, informed and voluntary, and it must not become a condition for receiving treatment. Routine clinical records should not be rewritten to strengthen a political case. [49]

The complaint process should allow a patient to question allocation, a provider or a donor condition without retaliation. An independent reviewer must be able to investigate safely. Protect staff as well: establish workload limits, escalation, absence cover and psychological support where available. The sustainability of the service is itself a patient-safety issue.

12. Funding design and an illustrative pilot budget

The strongest funding request is a defined care pathway with credible oversight. Request funds for assessment, treatment, rehabilitation, transport when clinically necessary, administration and verification. Concealing the costs of accountability can produce an attractive appeal and an unsustainable programme. Donors should see the real relationship between delivery and support costs.

Do not promise that every pound goes to surgery if finance, interpretation, lawful transfers and follow-up also need funding. Specify which gift is restricted to patient care, which supports the clinical programme's enabling work and which belongs to a separate civic programme. Preserve donor restrictions and decide in advance what happens to unspent money when access fails or a case changes.

A planning example: a GBP 50,000 initial fund

This is an illustrative allocation, not money already raised, a market price survey or a promise to treat a fixed number of patients. It assumes that a lawful delivery route and responsible entity can be established. Actual costs require quotations and clinical assessment; complex reconstruction can exceed the average allocation.

Budget line	GBP	Share	What it is intended to cover
Verified clinical assessments and diagnostics	5,000	10%	Defined consultations, necessary investigation and reviewed plans.
Approved treatment support	25,000	50%	A costed mix of eligible care episodes; no guaranteed case count.
Rehabilitation and suitable assistive products	8,000	16%	Fitting, training, therapy, repairs and follow-up where needed.

Budget line	GBP	Share	What it is intended to cover
Necessary access and patient support costs	2,000	4%	Approved transport, interpretation or other justified access costs.
Legal, finance, data and independent verification	5,000	10%	Proportionate programme oversight and documented lawful delivery.
Contingency and continuity reserve	5,000	10%	Cost changes, complications or continuity obligations under an approved policy.
Total	50,000	100%	Reconcile each commitment and expenditure against its funding restriction.

Match the funding instrument to the contribution

Contribution	Agreement should specify	Suitable result to report
Restricted grant	Purpose, eligible costs, legal route, tranches, oversight, conditions and unspent-fund rules.	Cleared funds, verified expenditure and protected clinical outcomes.
In-kind goods	Recipient need, product standard, delivery, customs, fitting, maintenance and disposal.	Appropriate products delivered and usable, with follow-up.
Professional services	Credentials, defined scope, time commitment, indemnity and conflicts.	Completed reviews, education or technical support.
Introductions or advocacy	Target office, precise ask, consent to represent the programme and deadline.	A genuine introduction, meeting, submission or substantive response.

Support from diaspora individuals can be valuable through modest recurring contributions and professional time, reducing dependence on one sponsor. Finance officers should still know who is donating where required, examine unusual conditions and follow proportionate source-of-funds checks. A foreign state's offer deserves the same scrutiny, including reputational and clinical-access consequences.

A reserve policy should cover existing obligations rather than reward accumulation. Review unrestricted liquidity, restricted cash, commitments and expected inflows separately. A large restricted bank balance can coexist with insufficient funds for the next follow-up appointment. Scale patient commitments only to cleared and available resources, not verbal pledges.

13. Lobbying, media and diaspora engagement

Political access can strengthen humanitarian delivery when it removes a barrier, protects clinicians or prompts a responsible public response. The organisation should know which problem a lobbyist or introducer is expected to solve. Access without a clear ask can consume clinical time and encourage dependence on personalities.

For a humanitarian programme, appropriate policy requests may concern transparent medical channels, implementation of existing exemptions, protection of medical staff, access for independent providers and credible investigation of attacks on patients. Political campaigning for democratic transition belongs within the separately governed civic programme where lawful. A partner should never be asked to conceal which role it is supporting.

Four practical public-policy requests

1. Ask the relevant authorities for clear, usable guidance on humanitarian medical payments and supplies, with an accountable point of contact for route-specific questions.
2. Ask professional and public bodies to support protection of patients, confidentiality and healthcare workers from intimidation or interference.
3. Ask capable humanitarian providers and public funders to examine rehabilitation, disability and continuing care needs within their mandates.
4. Ask relevant rights mechanisms to receive protected, properly consented evidence and maintain attention to accountability.

In the UK, the constituent's MP is a legitimate entry point, followed by relevant parliamentary offices, committees or cross-party groups according to their actual remit. EU delegations, appropriate public authorities and UN human-rights mechanisms provide other channels. The official MP finder and European Parliament delegation information should be used to verify current offices rather than relying on remembered names. A public letter should request a specific action, accurately identify the signatories and contain no unconsented patient details. [50, 51]

Before retaining a lobbyist, verify the entity, relevant experience, conflicts, fees, funding source, scope and any applicable registration or disclosure duties. Require a written brief and observable deliverables. Do not use gifts, hidden payments or promises of political benefit to obtain access. Never promise donors influence over clinical priorities, officials or future Iranian institutions.

A communications package that can be reused

Prepare a two-page briefing with the dated evidence of suffering, an aggregate needs profile, the clinical programme's governing rules, the lawful route being sought or used, and the precise request. Keep a longer source annex available. Use a single authorised spokesperson for programme facts, with a correction process when a number or claim changes.

Persian-language and international outlets, including Radio Farda and Iran International, can be approached through their official editorial routes. Publicity should respect editorial independence and fact-checking. A clinical briefing should report the programme's own

denominator: referrals received, assessments completed, approved plans, treatment delivered and follow-up available. It should not generalise those cases into a national injury rate. [58, 59]

Diaspora engagement should offer clearly defined roles: recurring donor, qualified reviewer, administrator, interpreter, rehabilitation adviser or policy introducer. Membership in a political circle is not evidence of clinical competence or clearance to handle records. Verify qualifications and conflicts for the role, and provide an induction on confidentiality and boundaries.

My earlier writing on strategic autonomy and national responsibility argues for cooperation without surrendering Iranian agency or equal citizenship. Those principles apply here: accept support that serves the people, maintain the ability to refuse harmful conditions, and assess the effect of collaboration rather than the symbolism of affiliation. This is continuity with the author's own outlook, not evidence about any external organisation's intentions. [52, 53]

14. The 90-day plan and ongoing review

The timetable below is a proposed plan beginning when leadership adopts the strategy. It assumes a small coordination team and does not promise that a licence, grant or external agreement can be obtained within a set period. Where a condition remains unresolved, continue independent preparatory work and hold the affected commitment.

Period	Deliverables	Owner	Readiness condition
Days 1-14	Charter; legal-identity review; roles and conflicts; needs statement; patient-data plan; proposed payment-chain dossier.	Governance, clinical and compliance leads.	Responsible entity and boundaries are defined; no cross-border funds promised without a route.
Days 15-30	Bank and legal route review; initial partner screening; approved case template; protected referral and complaints process.	Finance and partnerships leads, with clinical reviewer.	Required permissions and practical access are established for each activity.
Days 31-60	Begin an affordable pilot where cleared; close first partner commitments; reconcile each service; check safe follow-up.	Clinical and finance leads.	No unresolved high-risk gate; resources and reviewer capacity cover the obligations.
Days 61-90	Review costs and outcomes; obtain independent sample checks; report aggregate results; decide whether to scale, revise or pause.	Oversight group and independent reviewer.	Delivery evidence, ongoing capacity and a credible continuity budget support the decision.

A compact management dashboard

Measure	Definition	Review and use
Referral-to-assessment time	Time from receipt to appropriate clinical assessment; report emergency and non-emergency cases separately.	Weekly; investigate avoidable delay without inventing a universal clinical deadline.

Measure	Definition	Review and use
Funded pathways	Number of reviewed care plans with cleared resources for the agreed episode and follow-up.	Weekly; distinguish approved, funded and actually delivered care.
Delivery and reconciliation	Services confirmed and payments matched to budgets and invoices.	Weekly; investigate missing evidence and anomalies.
Functional follow-up	Available patient-reported function, mobility or pain outcomes using appropriate local measures.	At clinically suitable intervals; state missing follow-up and avoid unsupported causal claims.
Equity and access	Where safely collectable, gaps by geography, age, gender, disability or access barrier.	Monthly; use needs and safety, not religious or political profiling.
Partner conversion	Screened contacts resulting in a defined, completed useful contribution.	Monthly; distinguish a pledge from cleared money and an introduction from a policy result.
Liquidity and obligations	Cleared resources, restricted balances, commitments, reserves and forecast costs.	Weekly; prevent overcommitment.
Protection and complaints	Incidents, patient concerns, coercive conditions and safe resolution.	Immediate escalation when needed; monthly learning review.
Staff capacity	Actual review, coordination and clinical availability, with absence cover.	Weekly; cap commitments when capacity is inadequate.

Suggested initial process targets include no disbursement without recorded authority and a lawful route, no use of identifiable material for publicity without an appropriate protection and consent review, and no new commitment without a named accountable clinician and a realistic follow-up plan. These targets should be audited proportionately and revised if they produce avoidable barriers to essential care.

At day 90, ask three questions: did verified care reach patients; did the organisation preserve rights and clinical independence; and can the same quality be sustained at a larger scale? More money is not sufficient evidence for expansion. The decision should include the reviewer workload, the reliability of local services and what happened when a case did not proceed as expected.

Over six to twelve months, establish more resilient governance, broader professional cover, rehabilitation partnerships and a repeatable reporting cycle. If political transition begins, carry the lessons into equitable public health reconstruction. The official Iran Prosperity Project provides a broader reconstruction reference; this booklet does not claim that its proposed programme has been formally adopted by that project or Crown Prince Reza Pahlavi. [54]

15. Reusable agenda, agreement and review tools

These templates are management aids, not completed legal agreements or approved clinical protocols. Keep sensitive identifying fields in an authorised private system. Public copies should contain no patient, clinician, bank or live-route identifiers.

Partner intake - one-page record

Field	What to record
Entity and representative	Verified legal name, jurisdiction, official contact route, mandate and authority to make the offer.
Defined task	The patient-service, professional, communications or civic task under consideration.
Concrete contribution	Amount and restrictions, appropriate goods, defined hours, warm introduction or public action.
Counterpart interest	What it wishes to achieve and what it requests in return. Record statements, not assumed motives.
Gates and evidence	Pass, fail or unresolved for each gate, with the source and responsible reviewer.
Score and uncertainty	Ratings, weights, confidence, evidence gaps and whether a different task needs different weights.
Decision and next step	Pilot, clarify, park or decline; deliverable, accountable owner and date.
Review	What was actually delivered; continued compatibility; pause or renewal decision.

Minimum clauses for a proposed collaboration

1. Purpose, scope, legal entities and authorised representatives.
2. Needs-based eligibility, clinical independence and non-discrimination, including freedom to refuse religious or political engagement.
3. Exact contribution, restrictions, delivery responsibilities and realistic milestones.
4. Applicable permissions, required screening and a duty to report material changes.
5. Financial controls, eligible costs, reconciliation, independent verification and unspent-fund arrangements.
6. Data-controller roles, minimum sharing, security, retention, international transfers and separate publicity consent.
7. Conflicts, safeguarding, complaints, incident escalation and proportionate audit access.

8. Honest attribution: no unapproved logos, endorsement claims or representations of political alignment.
9. Suspension and termination rights, dispute handling and continuity for patients already receiving care.

Weekly 20-minute coordination agenda

Minutes	Topic	Decision
0-5	Urgent clinical and protection concerns.	Responsible person and immediate action through existing authority.
5-10	Funded plans, unresolved clearances and cash commitments.	Proceed, clarify or hold each affected commitment.
10-15	Partner deliverables and staff capacity.	Complete one next step, delegate it or close an unproductive contact.
15-20	Follow-up, reconciliation, complaints and learning.	Record correction, owner, deadline and any change to the operating rule.

Questions for a monthly partnership review

What contribution reached the intended service? What did it cost in money and staff time? Which condition changed? Did the collaboration preserve clinical independence and patient protection? Is the counterpart still within the agreed remit? Does another organisation offer a more practical route? Should the relationship continue, narrow, pause or end?

Where a relationship ends, close it with a record of obligations, restricted funds, data retention and patient continuity. Do not interpret a neutral provider's refusal to endorse a movement as hostility to Iranian people. Its constraints may be precisely what makes it a credible humanitarian partner.

16. The strategic argument

Iranian people should not have to wait for geopolitical agreement before their suffering is recognised. They also should not be asked to exchange conscience, privacy or political freedom for medical care. A patriotic clinical network earns authority by demonstrating that it can protect those principles when resources are scarce and emotions are intense.

For me, secular democracy means that citizenship does not depend on religious obedience and government must answer to the people. Support for Crown Prince Reza Pahlavi's transitional leadership can coexist with republicans' participation and the public's eventual constitutional choice. The humanitarian expression of that position is equal treatment: the programme should remain defensible to a patient who disagrees with me.

International partnerships can strengthen this effort through money, professional time, suitable products, policy access and credible communication. Their value depends on what reaches people, what conditions accompany it and whether the organisation retains the capacity to say no. Shared interests can support a project without requiring shared political identity.

The most useful strategic sequence is to define need, establish authority and a lawful route, protect the clinical decision, choose a compatible contribution, deliver a complete care episode and learn from the result. PESTEL helps anticipate the pressures; SWOT and TOWS help choose the response; Lewin's analysis identifies the restraint that must change; and a disciplined partnership process protects scarce time.

What should strengthen Iranian Patriotic Doctors is therefore more than money or prominent allies. It is a reliable institution: one able to turn solidarity into documented care, correct its mistakes, protect its people and remain accountable through uncertainty. That is an immediate humanitarian service and a practical contribution to the civic culture of a future free Iran.

References and implementation sources

The numbered sources support the associated factual statements and descriptions of institutional mandates. Proposed processes, scores, budgets and time allocations are the author's recommendations. Standing web pages were reviewed on 12 October 2026 unless otherwise stated. A listing does not establish grant eligibility, political endorsement or a confirmed partnership. Current legal texts and responsible authorities must be consulted again before implementation.

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