TOWARDS PROTECTING HEALTH CARE IN KARACHI

A LEGAL REVIEW

A Report by the Research Society of International Law, Pakistan

VIOLENCE AGAINST HEALTH CARE MUST END

IT'S A MATTER OF LIFE & DEATH

RSIL RESEARCH SOCIETY OF INTERNATIONAL LAW PAKISTAN

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FOREWORD

Health Care in Danger (HCiD) is a global project of the International Committee of the Red Cross (ICRC) aimed at affording better protection to those who provide medical care, as well as their patients. Since 2011, the both the ICRC and the International Red Cross/Red Crescent Movement have been working on this crucial humanitarian issue in countries as different as Syria and Mexico, Brazil and South Sudan.

Within the HCiD framework, we engaged in humanitarian diplomacy with States and multilateral bodies, organized international expert workshops, produced a number of publications and provided concrete support to health-care structures in dire need of protection against violence. The introduction – with ICRC support – of improved safety management systems has led to a decrease in incidents targeting health-care staff and improved coverage of public health initiatives such as vaccination programmes. Notably, such interventions have been successful in some mega cities of the South, where urban healthcare is one of the most important development indicators.

The ICRC has historically been and remains committed to supporting health systems in emergencies. In South Asia, we have been treating victims of the conflict in Afghanistan since the 1980s, evacuated wounded from the north of Sri Lanka during the civil war there, and provided artificial limbs to hundreds of thousands of amputees. More recently, in Karachi, the ICRC has been providing training and expertise on the management of mortal remains to local stakeholders, opened an orthoprosthetic centre in cooperation with the Indus Hospital, and arranged seminars on emergency room trauma and war surgery.

The report which you are about to read has been produced by the Islamabad-based think tank Research Society of International Law in collaboration with the ICRC. Many health-care and government stakeholders in Karachi were consulted in the process of researching it in order to assure the inclusion of the views of those concerned. More than just a piece of research, this report is the first step to bringing about meaningful legal change in order to improve the protection for health-care workers and patients in Sindh.

Engaging with states and local organisations in order to reinforce legislation safeguarding health care has been one of the pillars of the HCiD project. The recommendations to that effect were laid out in the report from the Workshop on Domestic Normative Frameworks for the Protection of Health Care that was held in Brussels from 29 to 31 January 2014 under the auspices of the ICRC. Its participants included civil servants, members of national IHL committees or similar bodies, members of parliament, independent experts and representatives of expert organizations. ICRC research on domestic legal frameworks of 39 countries also fed into the recommendations.

The ICRC, given its expertise of 150 years of providing medical aid in problematic areas and its role as part of the world's largest humanitarian network, is ready to share its experience and provide support. However, it is the people and institutions of Karachi that can come up with a lasting solution to the unfortunate problem of violence against health workers and patients.

Having witnessed the level of sincerity and professionalism that characterizes our partners in Karachi, I am hopeful that this crucial humanitarian issue can be tackled successfully.

One thing is certain: this is a complex problem that requires hard work by all of us. This research is just a beginning of a longer process of designing and implementing solutions, and I hope we can keep working on it together.

Reto Stocker,
Head of Delegation,
ICRC Pakistan

EXECUTIVE SUMMARY

As part of the ICRC Health Care in Danger Project in Karachi, the ICRC partnered with the Research Society of International Law (RSIL) to conduct a review of the legal framework within which the Karachi healthcare sector operates, in order to identify gaps in the existing legal system and posit effective recommendations to enhance the security of health-care workers, establishments and medical transport. The report examines the unique legal framework which informs the provision of health-care services in Karachi and how this framework currently protects health-care providers (HCPs) and their patrons. Within this context, the general and specific risks and threats to the health-care sector are highlighted with a view to recommending legislative and administrative reform to counter them.

This analysis allows for a focused discussion of the current legal regime for the province of Sindh. In this regard, the fundamental rights afforded by the Constitution are examined to demonstrate the limited health-care guarantees that the State of Pakistan offers to its citizens. At the provincial level, the Sindh Health-care Commission Act of 2014 is analysed to assess the potential impact this legislation will have once the Commission is operational. The extent of its powers and duties regarding the protection of health-care professionals would go a long way towards improving security and augmenting health-care service delivery throughout the province of Sindh. Furthermore, the Sindh Injured Persons (Medical Aid) Act of 2014 imposes obligations on hospital staff to treat injured persons on a priority basis over any medico-legal formalities, a provision which would extend to police officials as well. The Injured Persons Act, importantly, also bars members of the police from interfering with the treatment of a patient at a hospital. This provision provides a legal footing to the protection from pressure and harassment that medical personnel have long demanded.

The criminal legal framework in Sindh is also analysed through two federal statutes: the Pakistan Penal Code and the Anti-Terrorism Act of 1997. The Code encompasses general offences which criminalize attacks or threats against health-care professionals and also covers damage to property. In the context of terrorism, the 1997 Act provides for enhanced sentences and specifically mentions damage to 'hospitals' as a form of terrorism. As a result of the general nature of the 1997 Act, numerous forms of violence and threats against health-care workers and medical transport also come within its ambit. In relation to the legal provisions regarding ambulances and 'emergency vehicles', the report examines the Provincial Motor Vehicles Ordinance of 1965 as well as the National Highways Safety Ordinance of 2000. The report culminates in a series of recommendations aimed at enhancing the current legal framework and existing administrative protocols.

AMBU

1. INTRODUCTION

1.1 THE ICRC HEALTH CARE IN DANGER PROJECT

The International Committee of the Red Cross' (ICRC) Health Care in Danger (HCiD) Project began in 2011 as an ICRC initiative to analyse the incidence of violence directed towards health-care professionals and their patrons. This analysis was intended to draw attention to the issue of violence impeding or preventing the provision of health-care services and provide domestic actors in the health-care sector with tools and remedies to curb the impact of violence on the same.

The HCiD project is a Red Cross and Red Crescent Movement project focused on improving security and delivery of impartial and efficient health care in armed conflict and other emergencies. In 2008, the ICRC undertook a study examining the effects of violence on the provision of health care in 16 States. Attacks were categorized into four types: "deliberate targeting for military advantage," "deliberate targeting for political, religious or ethnic reasons," "unintentional bombardment or shelling" and "looting of drugs and medical equipment".

The HCiD project brings together National Societies and various domestic stakeholders – such as policymakers, government health-sector personnel, military staff, humanitarian agencies and representatives of academic circles – in order to identify concrete measures and recommendations that authorities and/or health-care personnel can implement to ensure unimpeded delivery of health-care services.

The clear erosion of the protection of medical personnel is of concern not only in conflict areas and emergency situations but also in the context of large urban areas where crime or unrest is endemic. For several years, serious problems of violence against medical personnel, particularly in the emergency services, have also been observed in countries enjoying peacetime. Additionally, while health-care services may sometimes be affected by criminal activities, patients and their families also often create impediments to the provision of health-care services.

1.2 ICRC HEALTH CARE IN DANGER PROJECT - KARACHI

The ICRC commenced engagement on the issue of violence against health care in Karachi during the second quarter of 2014. The process involved a roundtable at Ziauddin Medical University, a workshop at the Mövenpick hotel and a series of bilateral meetings and consultations with over a hundred members of the medical profession, medical associations, colleges, hospitals, ambulance services, law enforcement agencies, political parties and the city administration.

Beginning in September 2014, a core team of academics from major universities in Karachi formulated and began implementing a holistic research project, aimed at documenting, analysing and mapping violence against health-care professionals in Karachi. The aim of this is to equip all those concerned with a tool for advocacy and a sound basis for consolidating policies for intervention.

To this end, the ICRC has partnered with the Research Society of International Law (RSIL) to conduct a review of the legal framework within which the Karachi health-care sector operates, in order to identify gaps in the existing legal system and posit effective recommendations for reform. Consequently, RSIL's legal analysis is aimed at generating legal recommendations to improve the security of health-care professionals, service delivery and so forth. Moreover, the legal research is intended to highlight potential areas of engagement, including legislative reform, analysis and improvement of physical security of structures, coordination mechanisms, procedural improvements, training of trainers and training of medical staff, curricula development for colleges and psycho-social support for staff.

1.3 RESEARCH AIMS AND PARAMETERS

The aim of this initiative is to review the existing legal framework informing the provision of health-care services in the context of Karachi in order to identify areas of growth and posit viable recommendations for reform. This review will encompass the legislative framework as well as the existing judicial precedents that relate to the delivery of health-care services in the city and in other parts of the country. The focus of this review is to develop indigenous solutions which are both practicable in the particular context of Karachi and which would effect positive change in the protective regime relating to the health-care sector.

Additionally, recognizing that institutional and stakeholder acceptance is essential to the success of this initiative, RSIL met with and interviewed numerous primary stakeholders engaged in the provision of health-care services in the city. These interactions provided invaluable insight into the prevalent practices currently in place to provide protection to HCPs and health-care establishments. Integral to this process were the recommendations RSIL was able to extract from these interactions, given the stakeholders' proximity to the issue of violence directed against health-care professionals and their patrons in Karachi. The findings made during the research phase have been incorporated into this report.

The recommendations provided in this report have considered the variety of groups the HCiD project seeks to protect[1] and have accordingly focused on health-care personnel, such as doctors, nurses, paramedical staff including first-aiders, support staff assigned to medical functions; the administrative staff of health-care facilities; medico-legal officers; university professors; and ambulance/emergency services personnel. Health-care establishments[2] include hospitals, clinics, laboratories, universities, first-aid posts, blood transfusion centres, and the medical and pharmaceutical stores of these facilities. Medical transport[3] includes ambulances, medical ships or aircraft, whether civilian or military; and vehicles transporting medical supplies or equipment.

Finally, the wounded and the sick[4] include all persons, whether military or civilian, who are in need of medical assistance and who refrain from any act of hostility.

1.4 RESEARCH METHODOLOGY

This report is based on research conducted between May and June 2015, and comprises the following:

Literature review: In order to inform this report, RSIL has reviewed academic pieces; reports of both public- and private-sector institutions engaged in related fields; and domestic and international studies relating to the issue of protecting HCPs.

Law review: RSIL has conducted a review of the legislative framework relating to the provision of health care in Pakistan; this review has included criminal, civil, labour, and business law statutes with a particular focus on the contexts of Karachi and Sindh.

Primary research: Primary data was collected from the offices of pertinent public-sector institutions operating in Karachi. These institutions include the Provincial Departments of Health and Law; public hospitals; private ambulance services operating in the city; health-care associations; local law enforcement; and legal practitioners with experience in this particular field. The data consisted of in-depth interactions with the primary stakeholders as well as documents provided to RSIL by the same.

1 International Committee of the Red Cross, (2011). Health Care in Danger: Making the Case. Geneva, p.14.
2 ibid, p.8.
3 ibid, p.18.
4 ibid, p.10.

2. CONTEXT

2.1 KARACHI: DEMOGRAPHICS AND SIGNIFICANCE

Karachi is the capital of the province of Sindh and Pakistan's most populous city, estimated to have a population of over 23.5 million inhabitants.[5] Located on the coast of the Arabian Sea, it is the country's primary port and a major transit hub for the Indian Ocean.

After the 1947 partition of the Indian subcontinent, large numbers of migrants from India arrived to settle in Karachi. Over the years, significant numbers also came over from East Pakistan (now Bangladesh) and continue to reside in the city. Along with these, almost every ethnic group in Pakistan can be observed in significant numbers. This ethno-linguistic diversity is coupled with religious and sectarian differences. Over 96% of Karachi identifies as Muslim, either Sunni or Shia. The remaining religious minorities include Christians, Hindus, Ahmediyyah, Parsis, and several other groups.

As Pakistan's first capital, before the capital was moved to Islamabad, Karachi has always remained a political battleground. This is not surprising, as numerous factors make Karachi an immensely important city to be at the helm of. From Karachi's ports supplying most of Pakistan and being the hub of Afghanistan transit trade to its vast resources, educated population and location, political dominance in Karachi has often meant national significance and international relevance.

2.2 VIOLENCE IN KARACHI – IMPACT ON THE HEALTH-CARE SECTOR

Mega cities pose an enormous challenge to administer and police. Karachi's vast population, immense demographic heterogeneity and decades of poor governance and ineffective law enforcement have led to a steady rise in criminal activity and a degradation of public service delivery in the city. Organized criminal entities cohering on ethno-linguistic, ideological or sectarian grounds have been operating in Karachi for decades. Law enforcement responses have often been subject to the political will of Islamabad before taking on criminal entities in the Province. However, major operations in the mid-90s were able to curtail violence and similar scale operations are being conducted now in 2015, resulting in a significant decrease in overall crime, especially targeted killings. These are certainly encouraging signs, yet enhanced law enforcement actions in Pakistan have often come at their own costs in terms of the protection of rights and adherence to the rule of law.

The demographics of the city and its diversity in particular are significant in the analysis conducted under this report, given that an inordinate amount of the violence directed towards health-care professionals and their patrons is predicated upon interreligious, sectarian, or ethno-linguistic lines. In fact, key stakeholders[6] from the medical profession in Karachi have even posited that health-care professionals are at risk in Karachi less for their professions and more for their personal demographic affiliations. That having been said, there are various specific forms of violence, abuse, and harassment that health-careprofessionals face in the performance of their duties. Therefore, the following analysis of the forms of violence, threats, abuse and harassment faced by health-care professionals in Karachi is divided into general and specific risks/threats to such professionals. General risks/threats are ways in which organized criminal entities target health-care professionals, not for their professions but rather due to perceptions of wealth and affluence associated with doctors or because these professionals belong to a particular religious sect or ethno-linguistic group. Specific risks/threats, however, are targeted criminal acts aimed at health-care professionals by virtue of their medical responsibilities and duties.

5 World Population Review Karachi Statistics. Available at: http://worldpopulationreview.com/world-cities/karachi-population/ [Accessed 5-8-2015].
The most recent population census took place in 1998. A district-wise breakdown of the population of Pakistan is available at: Area and Population of Administrative Districts in Pakistan, Pakistan Bureau of Statistics, Available at: http://www.pbs.gov.pk/sites/default/files/population_census/Administrative%20Units.pdf [accessed 5-8-2015].

6 Representatives of RSIL and the ICRC engaged with several key stakeholders from the health-care sector in Karachi. As per the ICRC's policy for the HCiD project, neither these stakeholders nor the institutions they are associated with have been identified.

General risks/threats impacting health-care professionals in Karachi:

a) **Extortion:** Extortion or 'Bhatta' as it is known locally is a form of 'protection money' paid to a criminal entity, known as the 'bhatta mafia', who may threaten victims with kidnapping or murder or threaten members of their family.[7] The usual modus operandi in such crimes is that victims receive a 'parchi', which indicates that the mafia is aware of where the victim lives or where his/her children go to school.[8] Subsequently, a sum is indicated for regular payment by the victim to the mafia or a larger sum is intimated for a one-time lump sum payment. These mafias have at times demanded millions of rupees from doctors. It is estimated that at least 100-150 doctors in Karachi are paying bhatta to such nefarious entities.[9] This number is merely indicative and actual numbers may be much higher. It is also worthy of note that bhatta receipts have been known to finance terrorism amongst other forms of criminal activity in the city.[10]

b) **Kidnapping for ransom:** Doctors have been victims of kidnapping for ransom,[11] due in large part to the perception that doctors in the private sector are wealthy and able to afford high ransoms. Kidnappings may also occur due to failure to pay 'bhatta'.

c) **Targeted killings of doctors:** Doctors, like members of other professions, have also been victims of targeted assassinations. There is little evidence to suggest that doctors are targeted solely for their profession or for providing medical services to certain individuals. However, there is a perception that doctors are softer targets, more easily accessible due to the nature of their work.[12] On the other hand, evidence exists to suggest that doctors are targeted on sectarian grounds or their ethno-linguistic affiliation.[13] From January 2014 to September 2015, there were 15 incidents in which doctors were targeted, in which 15 doctors were killed and three injured.[14] Police sources note up to 26 killings of doctors in Pakistan in 2014 alone, mostly in Karachi.[15]

Specific risks/threats facing health-careprofessionals in Karachi

a) **Harassment of and physical attacks on health-careprofessionals by attendants:** Perhaps the most common form of violence or abuse against health-careprofessionals comes from attendants of patients or the heirs of recently deceased patients.[16] As discussed above, some violence or abuse is specific to doctors. However, in such incidents, often after the death of a loved one, attendants attack doctors, nurses, technicians and security personnel as well.[17] To protest such incidents, doctors and hospital staff have held strikes and closed down essential hospital functions.

b) **Pressure from law enforcement personnel and arrests:** Incidents have been reported in the media concerning pressure from police personnel on doctors regarding the performance of their

8 Ibid.
9 Ibid.
10 Apex Committee Formed to Probe Funding to Terrorists, June 25, 2015. Pakistan Today (Online). Available at: http://www.pakistantoday.com.pk/2015/06/25/city/karachi/apex-committee-formed-to-probe-funding-to-terrorists/ [Accessed 5-08-2015].
11 'Doctors in Pakistan Face Kidnapping 'Epidemic', March 24, 2015. Newsweek Pakistan. Available at: http://newsweekpakistan.com/doctors-in-pakistan-face-kidnapping-epidemic/ [Accessed 5-08-2015].
12 Tariq, Waleed. 25 March 2015. 'And Then There Were None,' Newsline Magazine (Online). Available at: http://www.newslinemagazine.com/2015/03/and-then-there-were-none/ [Accessed 5-08-2015].
13 Ibid.
14 South Asia Terrorism Portal. 'Doctors killed in Pakistan 2001-2015'. Available at: http://www.satp.org/satporgtp/countries/pakistan/database/Doctors_killed_Pakistan.htm [Accessed 5-08-2015].
15 Reuters, June 16th, 2015. 'Karachi doctors live in fear after spike in deadly attacks'. Dawn News (Online). Available at: http://www.dawn.com/news/1188546 [Accessed 5-08-2015].
16 Dawn News, 15 April, 2003. 'Karachi: Strike at CHK after lady doctor beaten up'. Dawn News (Online). Available at: http://www.dawn.com/news/95057/karachi-strike-at-chk-after-lady-doctor-beaten-up [Accessed 5-08-2015].
17 Husain, Shahid, August 25, 2012. 'Doctor beaten up after gunshot patient dies.' Dawn News (Online). Available at: http://www.thenews.com.pk/Todays-News-4-128052-Doctor-beaten-up-after-gunshot-patient-dies [Accessed 5-08-2015].

duties, especially in cases where doctors examine suspects or conduct autopsies in high-profile criminal cases. Specifically, medico-legal officers in government hospitals, who provide medical certificates and perform autopsies for the purposes of evidence at trial, have been known to have been at risk of such pressure.[18]

Furthermore, doctors have been arrested for treating patients; such arrests have occurred not only when a doctor may be treating a criminal but even when treating irregular Afghans in Karachi.[19]

c) **Targeting vaccinators:** Vaccinators, especially those involved in anti-polio vaccination drives, have been targeted throughout Pakistan and in Karachi as well.[20] In 2012 in Karachi, an incident involved the killing of a team of six anti-polio workers.[21] Fortunately, in various areas of Pakistan including Karachi, authorities have started providing police protection to vaccinators. However, instances still arise of anti-polio teams and their police guards being targeted.[22]

d) **Targeting ambulances:** Ambulance drivers have also been specifically targeted in Karachi, leading to the killing of several ambulance drivers over the past several years.[23] In some instances, ambulances have been caught in the cross-fire of gangs attacking each other or in police/paramilitary operations.[24] During larger-scale incidents such as strikes and riots, ambulances have been actively hindered from reaching injured persons.[25]

e) **Attacks on hospitals:** The 2010 bombings at the gates of Jinnah Hospital in Karachi led to 12 fatalities and numerous injuries.[26] This bombing followed another larger bombing moments earlier at Shara-e Faisal. Such incidents clearly indicate that hospitals are not immune to violence in Karachi and are targeted by criminals.

18 Ahmed, Noman, February 22, 2015. 'Murder he wrote: Medico-legal Officer blows the whistle on Police encounters'. Express Tribune (Online). Available at: http://tribune.com.pk/story/842623/murder-he-wrote-medico-legal-officer-blows-the-whistle-on-police-encounters/ [Accessed 5-08-2015].

19 Dawn News, October 24, 2002. 'KARACHI: PMA slams doctor's arrest'. Dawn News (Online). Available at:http://www.dawn.com/news/63186/karachi-pma-slams-doctor-s-arrest [Accessed 5-08-2015]. Also see: Daily Times, July 3rd, 2004. 'Two doctors detained for treating militants'. Daily Times (Online). Available at: http://archives.dailytimes.com.pk/main/03-Jul-2004/two-doctors-detained-for-treating-militants [Accessed 5-08-2015].

20 Durrani, Nawaz, May 19th, 2015. 'Battle Against Polio; Militant Killed, Cop Injured in Attack on Polio Team in Mardan.' Mirror Asia – Islamabad (Online). Available at: http://www.mirrorasia.com.pk/battle-against-polio-militant-killed-cop-injured-in-attack-on-polio-team-in-mardan/ [Accessed 5-08-2015].

21 Ibid.

22 AFP, January 26, 2015. 'Policeman protecting polio workers killed in Karachi'. The Nation (Online). Available at: http://nation.com.pk/karachi/26-Jan-2015/policeman-protecting-polio-workers-killed-in-karachi [Accessed 5-08-2015].

23 AFP, February 2, 2014. 'In the Line of Duty', Daily Times (Online). Available at: http://www.dailytimes.com.pk/sindh/02-Feb-2014/in-the-line-of-duty-ambulance-driver-killed [Accessed 5-08-2015]. Also see Geo News, June 06, 2013. '3 killed, four injured in Karachi Violence'. Geo News (Online). Available at: http://www.geo.tv/article-103995-3-killed-four-injured-in-Karachi-violence- [Accessed 5-08-2015].

24 Dunya News, March 6th, 2015. 'Karachi: Rangers kill at least 3 target killers'. Dunya News (Online). Available at: http://dunyanews.tv/index.php/en/Pakistan/265467-Karachi-Rangers-kill-at-least-3-target-killers [Accessed 5-08-2015].

25 Dawn News, May 13, 2007. 'Riots disrupt Karachi calm: 34 killed, 140 injured, rivals trade allegations'. Dawn News (Online). Available at: http://www.dawn.com/news/246766/riots-disrupt-karachi-calm [Accessed 5-08-2015].

26 Pak Tribune, 5 February, 2010. 'Twin blasts rock Karachi. 26 die, over 80 injured'. Pak Tribune (Online). Available at: http://paktribune.com/news/Twin-blasts-rock-Karachi-26-die-over-80-injured--224267.html [Accessed 5-08-2015].

3. THE LEGAL FRAMEWORK FOR HEALTH CARE IN SINDH

3.1 THE CONSTITUTION OF THE ISLAMIC REPUBLIC OF PAKISTAN

The Constitution of Pakistan, as the foundational legal instrument of the country, is the cornerstone upon which the country's legal framework is predicated and also provides for a series of fundamental rights which relate directly to the provision of health-care services and the protection of those involved in the provision of these services.

The rights enshrined in the Constitution include the right to life, provided by Articles 4(1) and 9; the inviolability of the dignity of man, provided by Article 14(1); the equality of citizens, provided by Article 25(1); and non-discrimination in access to public spaces, provided by Article 26(1). It must be noted, however, that several of the fundamental rights guaranteed by the Constitution are not unqualified, but instead operate "subject to law".

The Constitution also contains other provisions which directly relate to the protection of health-care professionals and their patrons; these provisions, incorporated into Chapter 2 of the Constitution, do not provide justiciable rights per se but are instead the "Principles of Policy" which require "each organ and authority of the State, and… each person performing functions on behalf of an organ or authority of the State to act in accordance with (these) Principles …"[27]

3.2 THE 18TH AMENDMENT

It is pertinent for this review to analyse the effect the 18th Amendment to the Constitution of Pakistan[28] has had on the legal landscape informing health care in Karachi. In our interactions with representatives from a public-sector health-care institution in Karachi, serious concerns were raised regarding the impact the Amendment has had on the provision of health-care services in the city.

The 18th Amendment was promulgated in 2010 by the National Assembly and wrought sweeping changes to the country's politico-legal context. Most pertinent to this analysis is the devolution of legislative powers from the federal to the provincial legislative assemblies. Prior to the Amendment's promulgation, the federal government possessed the legislative competency to legislate on a wide variety of portfolios, many of which directly impacted the provincial legal contexts. In addition to these legislative capacities, the 18th Amendment also devolved a number of public-sector institutions – including a number of public-sector health-care facilities – from the federal to the provincial governments, handing over effective control over hitherto federal resources and responsibilities to their provincial counterparts.

While initially viewed as a positive move towards greater provincial autonomy, the 18th Amendment impacted the provision of health-care services in Sindh – and Karachi in particular – in ways which were not predicted ex ante: prior to the Amendment's promulgation, the leadership of federal health-care establishments operating in Karachi frequently communicated with the Federal Ministry of Health and drew upon the resources and expertise of the latter. The devolution of health-care services from the centre to the provinces, however, also placed the burden of effecting the mandate of health care on the provinces. In the context of Sindh, this raised serious concerns: according to input from representatives of a major public-sector health-care establishment, the provincial government was far more susceptible

27 Article 29, The Constitution of the Islamic Republic of Pakistan, 1973 as amended
28 The National Assembly of the Islamic Republic of Pakistan, (2010). Report - The Constitutional Amendment Bill, 2010. Islamabad. Available at: http://www.na.gov.pk/uploads/documents/report_constitutional_18th_amend_bill2010_020410_.pdf.

to influence from local political interest groups. Further, according to these representatives, the provincial government also had at its disposal far fewer resources to allocate towards improving the provision of health-care services in the city of Karachi.

3.3 HEALTH-CARE LEGISLATION IN KARACHI

The legal framework informing the provision of health-care services in Sindh is a complex welter of legislation, several instruments of which date back to the country's colonial period. More recently, however, the Sindh legislative assembly has been very proactive in legislating upon almost every aspect of the provincial health-care industry.[29]

According to medical personnel we interacted with, the Sindh Department of Health, along with the Department of Law, has traditionally been proactive in legislating to address the needs of the medical community in Karachi. However, serious concerns have been raised by both members of the medical community as well as public-sector officials regarding the implementation of existing legislation. It must be noted that much of the existing legislation which applies to the health-care sector in Sindh, including both provincial as well as federal laws, does not directly address the issue of violence directed towards health-care professionals and their patrons.

The most significant piece of recent legislation is arguably the Sindh Health-care Commission Act, 2014,[30] which empowers the provincial government to establish a Health-care Commission. The Act was modelled on the Punjab Health-care Commission Act, 2010 and was promulgated with a view to improving the quality of medical services provided in the province.

The Act does address the issue of violence directed towards health-care professionals, obliging health-care establishments to provide their employees with physical and legal protection and to curb the incidence of harassment of HCPs. However, as its primary focus is not on the physical protection of HCPs and their patrons, it does leave certain areas unaddressed. For instance, the Act does not take up the issue of violence directed at patients or their visitors, despite the added vulnerability patients experience when patronizing health-care establishments. Our research has indicated that while the Act has been promulgated by the provincial legislature, it has yet to be put into effect. Further, in our consultations with representatives of the medical profession, it was apparent that most were unaware of the Act's existence.

The Injured Persons (Medical Aid) Act, 2004[31] was a federal law promulgated to address concerns arising out of the intersection of law enforcement investigations and the provision of health-care services. The Act prioritizes the provision of medical aid to injured persons over the completion of "medico-legal formalities".[32] Following the promulgation of the 18th Amendment, where legislative competencies relating to health care devolved to the provinces, the Sindh legislative assembly promulgated the Sindh Injured Persons (Medical Aid) Act, 2014,[33] which mirrors the language of the federal statute and incorporates this protection into the provincial legal context.

29 Cf, Pas.gov.pk, (2015). Welcome to the Website of Provincial Assembly of Sindh. [online] Available at: http://www.pas.gov.pk/index.php/home/en.
30 The Sindh Health-care Commission Act [Sindh Act No.VII of 2014]. Available at: http://www.pas.gov.pk/uploads/acts/Sindh%20Act%20No.VII%20of%202014.pdf.
31 The Injured Persons (Medical Aid) Act [Act No.XII of 2004]. Available at: http://www.na.gov.pk/uploads/documents/1321335195_122.pdf.
32 §3, Ibid.
33 The Sindh Injured Persons (Medical Aid) Act [Act No.XX of 2014]. Available at: http://www.pas.gov.pk/uploads/acts/Sindh%20Act%20No.XX%20of%202014.pdf.

3.4 CRIMINAL LAW IN KARACHI

The criminal legal framework in the province of Sindh operates to criminalize violent expressions of any kind; as such, it ostensibly addresses the issue of violence against health-care professionals and their patrons. However, these laws focus less on protecting medical personnel or patients and more on prosecuting and penalizing those who commit violent acts against them. This distinction is pertinent, as certain provisions of these laws can, in effect, also be used to proceed against health-care personnel providing medical aid to those suspected or convicted of criminal activity.

The Pakistan Penal Code, 1860[34] is the primary criminal statute in Pakistan; a federal statute, the Code dates back to the colonial regime and its colonial origins must be noted in any review of the instrument. As such, while it represents the basis upon which Pakistani criminal law is founded, it nonetheless can arguably be difficult to reconcile its text with more contemporary conceptions of criminal justice.

The Anti-Terrorism Act, 1997[35] is the primary legal instrument relating to militant violence; another federal Statute, the Act dates back to the rise in intercommunal violence in Karachi in the 1990s and is significant – particularly in light of the fact that a significant amount of the violence directed at health-care professionals and their patrons in Karachi is predicated upon communitarian lines and thus falls within the ambit of the Act. The Act defines "terrorism" extremely broadly, encompassing a number of offences – such as extortion and kidnapping for ransom. This is pertinent as, in our interactions with representatives of the medical profession the incidence of kidnappings for ransom and extortion were cited as significant concerns of health-care professionals operating in the Karachi metropolitan area. As discussed by these stakeholders, doctors were particularly vulnerable, as they were perceived as being "lucrative" targets for these criminal activities.

34 The Pakistan Penal Code [Act No.XLV of 1860]
35 The Anti-Terrorism Act [Act No.XXVII of 1997]

4. REVIEW OF THE LEGAL FRAMEWORK FOR HEALTH CARE IN SINDH

4.1 THE CONSTITUTION

The following is a review of the Constitution of the Islamic Republic of Pakistan, 1973 (Constitution), with a focus on those provisions which have a direct bearing on the issue of violence perpetrated against HCPs and their patrons. The Constitution speaks in generalities, laying down in broad strokes the keystone upon which the entire domestic legal framework rests. As such, while it may lack the finer resolution needed to address the specific issues of violence against health-careworkers in the city of Karachi, it nonetheless supplies the legal underpinnings for providing the necessary legal protection.

The provisions of the Constitution which relate to the protection of HCPs and their patrons can be grouped into two broad categories: the fundamental rights which, as touched upon above, are justiciable and can directly be relied upon before the courts to effect protective outcomes for medical personnel and their patients; and the principles of policy which, albeit not directly justiciable, can nonetheless be relied upon to bolster legal protection before the courts. It is necessary to point out, however, that several of the fundamental rights enshrined in the Constitution are not absolute but are instead subject to qualifications.

Article 4(1):

4. Right of individuals to be dealt with in accordance with law, etc.

(2) In particular :-

(a) *no action detrimental to the life, liberty, body, reputation or property of any person shall be taken except in accordance with law;*

Unlike the other fundamental rights enshrined in the Constitution, Article 4 is contained in the Part I: Introductory section of the Constitution. According to this article, persons are protected from any unlawful actions which adversely affect the security of their person, reputation or property. According to ICRC-supported research on violence against health care in Karachi,[36] 30% of HCPs reported instances of verbal abuse and 6% reported instances of property damage. Almost two thirds of HCPs (65.6%) had either experienced or witnessed some kind of violence, while 33.5% had experienced some form of violence directly.

In light of the findings of the APPNA Institute's research, the protection provided by Article 4(1) comprehensively addresses the issue of violence against medical personnel and their patients and provides a basis upon which subsequent legal protections can be founded. Article 4(1) is, however, subject to qualification: the use of the phrase "except in accordance with law" leaves open the possibility for legislative restrictions on the exercise of this right.

Article 9:

9 Security of person.

No person shall be deprived of life or liberty save in accordance with law.

Article 9 enshrines the "right to life" in the Pakistani legal context, protecting persons from arbitrary deprivation of life or liberty. Much like Article 4(1), Article 9 is subject to the caveat "save in accordance

36 Baig, L., Shaikh S, Ali SK, Polkowski M and Jamali, S.,. (2015). Violence against Health Care: Results from a Multi-Centre Study in Karachi.

with law"; further, it only addresses the specific issue of threats against a person's life.

Article 25(1):

25 Equality of citizens.

(1) *All citizens are equal before law and are entitled to equal protection of law.*

Article 26(1):

26 *Non-discrimination in respect of access to public places.*

(1) *In respect of access to places of public entertainment or resort not intended for religious purposes only, there shall be no discrimination against any citizen on the ground only of race, religion, caste, sex, residence or place of birth.*

Article 33:

33. Parochial and other similar prejudices to be discouraged.

The State shall discourage parochial, racial, tribal, sectarian and provincial prejudices among the citizens.

Articles 25(1), 26(1), and 33 all address the differential treatment of members of the populace; this is pertinent as, in our interactions with members of the medical profession in Karachi, serious concerns were raised regarding access to health care for members of particular religious, sectarian or ethno-linguistic groups. Article 26(1) does not address access to medical care, but the superior courts have read Article 26(1) with the other anti discrimination provisions of the Constitution, thereby broadening the ambit of the article in question.

It is pertinent to note that these three articles of the Constitution only apply to citizens of Pakistan, as opposed to the broader category of "individuals" or "persons". Further, Article 33 is one of the fundamental principles of state policy which falls within PART II, CHAPTER 2: PRINCIPLES OF STATE POLICY of the Constitution. This chapter is more aspirational in nature and, rather than creating justiciable rights,[37] is instead contingent upon the "availability of resources".[38]

Article 38(d):

38. Promotion of social and economic well-being of the people.

The State shall:

(d) *provide basic necessities of life, such as food, clothing. housing, education and medical relief, for all such citizens, irrespective of sex, caste, creed or race, as are permanently or temporarily unable to earn their livelihood on account of infirmity, sickness or unemployment;*

Article 38(d) obliges the State to provide the basic necessities to citizens who are unable to provide for the same. While pertinent in considering an enabling framework for ensuring the protection of medical personnel and their patients, it should be noted that this provision is limited to the citizenry. Article 38(d) also only applies to citizens who are unable to provide for themselves, as opposed to all citizens or persons. Further, Article 38(d) is another of the fundamental principles of State policy: while these principles are intended to inform State action and decision-making, they are framed as aspirational goals whose realization is subject to the availability of resources.

37 Article 30(2) of the Constitution of the Islamic Republic of Pakistan, 1973
38 Article 29(2), Ibid

4.2 THE SINDH HEALTH-CARE COMMISSION ACT, 2014

As touched upon earlier, the Sindh Health-care Commission Act focuses primarily on improving the quality of health-care services provided within the province; while it does address the issue of violence against HCPs and their patrons, it does so only as a corollary of the intended qualitative improvements.

The Provincial Assembly of Sindh promulgated the Sindh Health-care Commission Act, 2014, modelling it on the Punjab Health-care Commission Act, 2010.[39] The Act established the Sindh Health-care Commission, a public entity tasked with "(improving) the quality of health care services and clinical governance…"[40] and granted it significant, far-reaching powers to ensure that the health-care services being provided in the province are uniformly maintained and adhere to certain standards. The Commission thus presents an opportunity for provincial governmental actors to effect the necessary regulatory and policy changes in order to ensure the safety of health-care personnel and their patients.

Under the Act, the Commission is responsible for registering, regulating and monitoring the provision of these services, and encompasses providers of homoeopathic and traditional treatments as well as providers of allopathic health care. This recognition of the role providers of traditional medicine play in the overall health-care sector is consistent with the perspective held by the ICRC.[41] The Commission is also tasked with preparing and administering accreditation mechanisms for HCPs, and is granted the capacity to impose pecuniary punishments on those found to be in violation of the Act or any rules or regulations passed thereunder.[42]

The Commission is empowered to evaluate the performance of HCPs in light of standards it prepares, and to take cognizance of instances where such service providers lapse in the provision of health care.[43] To do so, the Commission relies on input from a Technical Advisory Committee (TAC), established by the Commission pursuant to section 10 of the Act, and on inspections conducted by the Inspection Team pursuant to section 22 of the Act.

The Act also enables the Commission to impose fines in instances where an HCP is found to be in violation of the Act itself, or any rules, regulations, standing orders, and instructions issued thereunder.[44] Finally, the Act enables the Commission to "perform such functions and exercise such powers as may be required"[45] to ensure that the Commission's goals are realized; obliges "all executive authorities and law enforcement agencies (LEA) of the Government" to "act in aid of the Commission";[46] and enables the provincial government to "make such order… (as may be) necessary for the purpose of removing (any difficulties faced in giving effect to the provisions of the Act)".[47]

i. **The preamble:**

AN ACT to improve the quality of health care services and banning quackery in the Province of Sindh in all its forms and manifestations;

WHEREAS it is expedient to make provision for the improvement, access, equity, and quality of health-care service, to ban quackery in all its forms and manifestations and to provide for ancillary matters;

39 The Punjab Health-care Commission Act, 2014 [Act XVI of 2014]
40 §4(1) of the Punjab Act
41 "RECOMMENDATION (6): *When appropriate, traditional medicine should be included in the sphere of protected health-care activities and measures should be taken to facilitate access to this type of medicine by the population at large". The International Committee of the Red Cross, (2014). The Implementation of Rules Protecting the Provision of Health Care in Armed Conflicts and Other Emergencies: A Guidance Tool. The Domestic Implementation of IHL. [online] Geneva: The International Committee of the Red Cross, p.370. Available at: https://www.icrc.org/en/download/file/5426/hcid-guiding-tool-icrc-eng.pdf.*
42 §4(2), Ibid
43 §§4(7) and (8), Ibid
44 §4(2)(g)
45 Supra at 2
46 §36, Ibid
47 §39, Ibid

As has been discussed earlier in this report, the focus of the Act is less on providing protection to medical personnel and their patients and more on the qualitative improvement of the health-care sector in the province. That said, however, it is possible for the statute – and more particularly "the quality of health-care services" – to be interpreted in a manner more conducive to a protective regime.

ii. Key definitions:

§2(l) *"accreditation" means the process of accepting or declaring the health care establishment providing services in accordance with the standards and accepted medical, allopathic, homeopathic or Tibb-i-Unani protocols, guidelines or tools;*

Under the Act, the Commission is tasked with operating accreditation programs and accrediting HCPs, enabling the Commission to prescribe criteria which HCPs must comply with if they are to continue operating. This represents a potential inroad into incorporating more stringent protection of actors in the health-care sector, by requiring health-care institutions to take necessary measures to ensure the safety and security of those operating within the health-care sector in order to be accredited.

§2(v) *"clinical governance" means a systematic approach to maintaining and improving the quality of patient care;*

The Act defines the term "clinical governance" with reference to the maintenance and improvement of standards of patient care. The term first gained traction following the "Bristol Heart Scandal" at the Bristol Royal Infirmary where, over the course of five years, over thirty babies undergoing heart surgery died due to poor clinical protocols.[48] The concept has since been incorporated into the standard operating procedures of the British National Health Service and includes protocols for managing risks for both patients as well as health-care providers.

The NHS's model for clinical governance, however, focuses predominantly on the management of clinical risks – such as those incurred during risky or maladministered procedures or of infection – and does not adequately address the issue of violence towards health-care actors which is a primary risk in the context of Karachi. The term "clinical governance" has thus developed and been used in a particular context; as such, it might not provide an appropriate means of addressing inadequate safety and emergency management protocols in health-care establishments.

It must be noted that interactions with stakeholders in the Sindh medical infrastructure have indicated that developing such protocols has been sporadic: while some health-care institutions have prepared standard operating procedures in case of violent emergencies, these have been the exception rather than the norm. Furthermore, as has been expressed in interactions with these stakeholders, even in institutions with emergency protocols in place, drills are infrequently conducted.

§2(xiv) *"grading" means the ranking of the health-care establishments made on the basis of the tools;*

Tied in §2(i) above, this provision enables the Commission to "grade" the performance of health-care institutions. Whereas at present the statute does not provide sufficient clarity on how this is to be carried out or on the possible results of such grading, it does represent an area where the Commission may incorporate safety standards and risk management protocols into its assessment of a health-care establishment.

48 The Telegraph, (2010). Bristol Heart Scandal. [online] Available at: http://www.telegraph.co.uk/news/health/news/7914795/Bristol-heart-scandal.html.

Further, the compliance of health-care institutions could be incentivized by associating governmental rewards – or penalties as the case may be – based on the institution's "grade" for the comprehensive security framework it implements. The Act already empowers the Commission to impose pecuniary penalties on entities found to have violated the provisions of the Act or the rules and regulations promulgated thereunder. By relying upon this provision, the Commission could prepare safety protocols for health-care establishments and ensure compliance therewith.

> §2(xv) *"health-care establishment" means a hospital, diagnostic centre, medical clinics, nursing home, maternity home, dental clinic, homeopathic clinic, Tibb clinic, acupuncture, physiotherapy clinic, pharmacy or any system of the treatment.*
>
> (a) *wholly or partly used for providing health-care services; and*
>
> (b) *declared by Government, by order published in the Official Gazette, as a health-care establishment;*

The Act defines the term "health-care establishment" expansively, incorporating the majority of institutions engaged in the health-care sector in the province. Reference to emergency services providers and ambulance services is, however, conspicuously absent from the definition.

In our interactions with provincial stakeholders from the health-care sector, the argument has been presented that first responders often do not provide more than the most rudimentary of medical attention. However, excluding them from the ambit of the Act would arguably disincentivize them from improving the services they currently provide and instituting additional measures to ensure the safety of their personnel.

Similarly, vaccination teams are not incorporated into the definition of the term; this is of particular concern as members of these teams – as well as the families of children who are administered vaccines – are targeted by militant groups. While the definition of the term "health-care establishment" might not be the appropriate provision within which to refer to first responders or vaccinators, the fact that the Act remains silent on their role is of some concern.

> §2(xvi) *"health-care services" means services provided for diagnosis, treatment or care of persons suffering from any physical or mental disease, injury or disability, including procedures that are similar to forms of medical, dental or surgical care but are not provided in connection with a medical condition and includes any other service notified by Government;*

This provision ties in with section 2(xv) discussed above in that it defines "health-care services" in a far broader manner than is suggested by the definition of the term "health-care establishment", implying legislative recognition of the fact that a significant portion of the health-care services in the province are provided by private or traditional sources and as such do not fall within the governmental regulatory framework. Given this more expansive definition for "health-care services", amending the definition of the term "health-care establishment" to encompass the spectrum of "health care services" would provide more internal consistency within the legislation and would draw all other, alternate, sources of health-care services within the rubric of the Act.

> §2(xix) *"license" means license issued by the Commission under section 13 for the use of any premises or conveyance as a health-care establishment and "licensed" and "licensing" shall be construed accordingly;*

The Act establishes the Commission as the license-issuing institution, enabling it to maintain certain standards in the provision of provincial health-care services. In this regard, the definition of the term "license" ties in with those provided for "health-care establishment" and "health-care services" discussed above in that, by employing the phrase "any premises or conveyance" it implies that the Act will apply to emergency vehicles as well as static health-care institutions.

This implicit application to emergency services providers and ambulance services, expressed in the definition of "health-care services" under §2(xvi), is not reflected in the more constrained definition of the term "health-care establishment", which does not discuss first responders, ambulance services or the like. Given their implicit incorporation in §§2(xvi) and (xix), it is surprising that the definition of "health-care establishment" under the Act is silent with regard to first responders.

At present, the statute does not address the issue of the several ambulance services operating throughout the Karachi metropolitan area. Ambulance drivers and first responders have also fallen victim to the violence towards health-care professionals in Karachi, and the proliferation of private ambulance services operating in the city combined with the current lack of a regulatory framework for such services leave these health-care personnel providing emergency services vulnerable.

iii. The functions and powers of the Commission

§4(1) *The Commission shall perform such functions and exercise such powers as may be required to improve the quality of health-care services and clinical governance and to ban quackery.*

This provision provides the Commission with significant administrative capacity to achieve the stated goals of the Act. While, as discussed above, the Act focuses predominantly upon qualitative improvements to the health-care sector in Sindh, it is possible to interpret the provisions of this Act in a manner more consistent with protecting HCPs and their patrons. In that light, therefore, this provision provides the Commission with sweeping powers to "exercise such powers as may be required" to effect the necessary outcomes.

§4(2) *Without prejudice to the generality of the provisions of sub-section (1), the Commission shall –*

(a) …
(b) *grant, revoke and renew licenses to persons involved in the provision of the health-care services and to vary terms and conditions and purposes of the licenses;*
(c) *monitor and regulate the quality and standards of the health-care services developed by Government;*
(d) *operate accreditation programmes in respect of the health-care services and grant accreditation to such health-care service providers who meet the prescribed criteria and standards;*
(e) *enquire and investigate into maladministration, malpractice and failures in the provision of health-care services and issue consequential advice and orders;*
(f) *impose and collect fees and charges on registration, licensing and accreditation under this Act;*
(g) *impose and collect penalties on violation, breach or noncompliance of the provisions of this Act, rules, regulations, standing orders and instructions issued from time to time;*
(h) *advocate rights and responsibilities of recipients and providers of the health-care services;*
(i) *hold seminars, conferences and meetings on developing awareness about provision of high-quality health-care services;*
(j) …

(k) *coordinate, liaise and network with any person, agency or institution;*
(l) …
(m) …
(n) …
(o) *issue regulations, guidelines, instructions and directives to persons involved in the provision of health-care services;*
(p) *grade health-care establishments…*
(q) …

Section 4 of the Act is a critical component of the overall statute, establishing the powers and functions of the Commission; in this regard, the section grants the Commission with significant and broad-ranging powers which enables it to achieve the stated goals of the Act. §§4(2)(b) through (d) and (f), read with §§2(i), (xiv), and (xix) of the Act, establish the Commission's role as the licensor and regulator for the provincial health-care sector. In this regard, there is some operational overlap between the role of the Commission under the Act and that of the Pakistan Medical and Dental Council (PMDC), established under the Medical and Dental Council Ordinance, 1962.[49] The Ordinance, however, is a federal statute: given the effect of the 18th Amendment where the provincial legislatures have gained legislative primacy over the portfolio of health care, and the fact that the Act antedates the Ordinance by over sixty years, a convincing case can be made that the regulatory and licensing role in Sindh has been transferred from the PMDC to the Commission.

As touched upon above, the Commission is empowered under section 4 to investigate instances of maladministration and "failures in the provision of health-care services and issue consequential advice and orders" (subsection (e)) and impose penalties to noncomplying health-care establishments (subsection (g)). This provides the Commission with a potent tool to ensure that HCPs are not only preparing violent emergency protocols for themselves but are also adopting and adhering to the same.

The Commission is also empowered to conduct awareness campaigns in order to boost the visibility of issues affecting the provision of health-care services in the province (subsections (h) and (i)); given that greater public awareness of violence against health-care actors was a consistent theme in our interactions with representatives of the medical profession in Karachi, these provisions enable the Commission to address the issue within the bounds of the statute.

Further, as evinced by our interactions with the stakeholders, there have been instances in the Karachi metropolitan area where private emergency vehicles have been exploited for criminal activities. An awareness campaign encompassing emergency service providers, highlighting the necessity for respecting – and not exploiting – the insignia associated with emergency medical care and transport, would thus prove invaluable in curbing such incidents.

In order to effect its statutory mandate, the Commission is also capable of liaising with other public and private entities (subsection (k)); this is pertinent as, in consultations with the stakeholders, the issue of inefficiencies between medical professionals and LEAs has often resulted in inordinate delays in the provision of health-care services. Several instances were cited where, following a militant attack or similar emergency, large numbers of LEAs and first responders would arrive at the scene, contributing to the disorder in the situation and – in the case of vehicles – actually making it more difficult for injured persons to be transported to health-care establishments for treatment.

49 The Medical and Dental Council Ordinance (Ord. No.XXXII of 1962)

§4(6) *Notwithstanding anything contained in any other law, the Commission may –*

(a) *on a complaint by any aggrieved person; or*

(b) *on a complaint by any aggrieved health-care service provider;*

(c) *on a reference by Government or the Provincial Assembly of Sindh; or*

(d) *on a motion of the Supreme Court of Pakistan or the High Court made during the course of any proceedings before it,*

undertake investigation into allegations of maladministration, malpractice or failures on the part of a health-care service provider, or any employee of the health-care service provider.

This provision enables the Commission to investigate instances of maladministration or "failures on the part of a health-care service provider or any employee thereof". This subsection, however, does not oblige the Commission to conduct such inquiries; the use of the term "may" implies an exercise of discretion on the part of the Commission. While it is understandable that the legislators did not intend for the Commission to be overwhelmed in pursuing endless investigations, within the socio-political context of Karachi – where certain health- care establishments have become heavily politicized or which inordinately identify with a particular ethno-linguistic community – an unhappy scenario can be envisioned wherein the Commission may – for political reasons – opt not to conduct certain investigations.

Finally, this section is anomalous in that it uses the term "health-care service provider" instead of "health-care establishment"; as defined in the Act, the former term refers to an "owner, manager or incharge of a health-care establishment…"[50] It is unclear from the language of the text why the complaints mechanism under section 4(6) was limited to "health-care service providers" and not "health-care establishments", given that, while the former are undoubtedly responsible for much of the services provided by such institutions, the final responsibility for the same rests with the institution – i.e. the health-care establishment – itself.

§4(7) *The Commission shall take cognizance of any case of harassment of health-care service provider or damage to health-care establishment property and may refer such a case to the competent forum.*

This provision is one of the most critical subsections of the Act, as it relates to the specific issue of violence directed against medical professionals and their patients; under this provision, the Commission shall "take cognizance" of instances of harassment of health-care personnel or damage to property in health-care establishments. This is arguably the only provision which directly addresses the issue of violence directed towards health-care professionals; however, mention should be made of the phrasing of the section and its use of the mandatory "shall".

While harassment is certainly an issue in the provincial health-care context, the term might not adequately address the magnitude of crisis in parts of Sindh. According to ICRC-supported research on violence against health care in Karachi,[51] 30% of HCPs reported instances of verbal abuse and 6% reported instances of property damage. Almost two thirds of HCPs (65.6%) had either experienced or witnessed some kind of violence, while 33.5% had experienced some form of violence directly. While the definition of the term "harassment" can be stretched to encompass instances of physical violence, it is not necessarily the most accurate term which could be used in the circumstances.

50 Cf §2(xvii) of the Sindh Health care Commission Act, Act VII of 2014

51 Baig, L., Shaikh S, Ali SK, Polkowski M and Jamali, S.,. (2015). Violence against Health Care: Results from a Multi-Centre Study in Karachi.

The study referred to above focused on the city of Karachi, which has experienced a tremendous amount of violence directed towards health-care personnel, and consultations with members of the medical fraternity in the city have shown that the issue has gone beyond what would ordinarily be considered "harassment". Rather than attempt to artificially extend the definition of the term "harassment" and thus dilute its effect, it would thus be prudent for the text to be amended to incorporate incidents of overt violence as well.

Further, while the provision empowers the Commission to take cognizance of instances of harassment or property damage, it does not provide a mechanism whereby the Commission may then act upon instances where harassment or property damage has, in fact, occurred. The text prompts the Commission to "refer such cases to the competent forum" but fails to clarify what exactly is the "competent forum". In instances of criminal acts such as harassment or property damage, the competent "forum" would presumably be the criminal courts; however, the statute fails to provide for how the courts may be seized directly without the intervention of LEAs.

If, on the other hand, the text is referring to LEAs, the term "forum" would be a misnomer. While this may arguably be a result of poor drafting, the text does not provide the clarity necessary for the Commission to act; as a recently promulgated instrument, the Act has not generated any jurisprudence which would explicate the matter. As it stands, therefore, the subsection fails to provide a mechanism by which such instances can be referred to "the competent forum" or, indeed, to identify which forum is the competent one.

Finally, the provision uses the term 'may', implying a discretionary exercise, as opposed to the more binding 'shall'; while the legislature may not have wished for the complaints-redressing mechanism under this subsection to become overwhelmed with litigation, given the socio-political context of Sindh, it would be prudent to limit the exercise of the Commission's discretion to a minimum.

§4(13) *The Commission shall frame the guidelines to save health-service providers from harassment, undue pressure and damage to property in performing their professional duties.*

§4(14) *The security and protection while on duty of the health-care workers should be the responsibility of the organization availing itself of their services.*

Much like subsection 4(6), these two provisions are critically important in the context of violence towards actors in the health-care sector. Under subsection 4(13), the Commission is obliged to prepare guidelines for the protection of health-care personnel encompassing the issues of harassment, undue influence and property damage. These guidelines, however, are recommendatory – as opposed to mandatory – in nature, and thus do not create binding obligations for compliance upon HCPs.

It must be noted that the term "health-care worker" has not been defined in the statute though it has been employed throughout the text of the Act. Ordinarily, in the absence of a statutory definition, the ordinary meaning of the term would be employed but, given the Act's peculiar lack of reference to emergency service providers and vaccination teams, this absence of definitional clarity makes it more difficult for the Act to be applied to these categories of health-care professionals.

Finally, reference to patients is also conspicuously absent from this provision; given the vulnerable nature of patients and the duty of care owed to them by health care professionals, it is surprising that this subsection would not extend the protective obligations of the health-care organization to those

receiving treatment therefrom.

§4(15) *The organizations, public or private, government, local, provincial or federal, for which the doctors and health-care workers are working must provide them full protection, both physical and legal.*
§4(16) *In case of physical injury incurred while performing the duties, the –*
(a) *doctors and health-care workers should be fully compensated;*

Subsection 4(15) places an explicit, statutory obligation upon the institutions to ensure the physical and legal protection of the health-care professionals in their employ, and subsection 4(16) encourages these institutions to compensate their health-care personnel for any physical injuries incurred in the course of their duties. Subsection 4(15), however, much like subsections 4(13) and (14) above, does not refer to patients but focuses instead on protection for health-careworkers.

It must also be noted that subsections 4(15) and (16) relate only to physical and legal protection: as our consultations with primary stakeholders – including a former ambulance driver – have suggested, the risks posed to health-care professionals in the Karachi context as well as the nature of the work itself also have a significant psychological impact on health-care actors.

Interactions with members of the medical profession have identified incidents of post-traumatic stress disorder (PTSD) in emergency health-care providers, as well as incidents of other anxious disorders as a result of working in the health-care sector in Karachi. Mental health, according to these stakeholders, is still a nascent field in Pakistan and often inadequate attention is given to psychological concerns in contrast to the more overtly physical effects of a violent incident.

4.3 THE SINDH INJURED PERSONS (MEDICAL AID) ACT, 2014

As discussed earlier in this report, the Sindh Injured Persons (Medical Aid) Act, 2014 replaces its federal predecessor, the Injured Persons (Medical Aid) Act, 2005, and focuses its application upon the province of Sindh. The Act does not directly address the issue of violence towards the health-care sector, but nonetheless contains certain provisions which can be employed to effect the protection of patients within the provincial legal context.

§3 ***Injured persons to be treated on a priority basis.***
Where an injured person is brought to a hospital, he shall be provided medical aid without delay on a priority basis over all other medico-legal formalities.

This section prioritizes the provision of medical aid to patients who are in critical need thereof; this is pertinent in light of the fact that representatives of a major public-sector health-care establishment have expressed concerns regarding interference by LEAs in the provision of medical aid to patients suspected of involvement in criminal activity. Patients suffering from gunshot wounds, for instance, often elicit this added layer of scrutiny from LEAs, and their conduct of investigations has been cited as interfering with the provision of critical medical aid.

§4 ***Non-interference by the police .***
No police official or officer shall interrupt or interfere during the period an injured person is under treatment in a hospital except with the written permission of the incharge of the hospital (…)

In a similar vein as section 3 above, this section prevents LEAs from interfering in the treatment of a person at a health-care establishment. The caveat incorporated into this section, however, makes this protection contingent upon the written permission of the person in charge of the health-care establishment. Accordingly, this allows for the possibility whereby such a person, prompted by LEAs, may decide to prioritize investigations conducted by LEAs over the provision of health-care services to the patient.

4.4 THE ISLAMABAD MANDATORY VACCINATION AND PROTECTION OF HEALTH WORKERS ACT, 2015

The Islamabad Mandatory Vaccination and Protection of Health Workers Act, 2015 is a bill introduced in the National Senate on April, 13 2015. While the bill has yet to pass both houses of the federal legislature, the instrument gives HCPs the right to expect cooperation while carrying out their duties. Further, the bill obliges the federal government to afford protection to HCPs while they perform their duties.

§11 **Protection of health workers.**

(1) *Every person shall facilitate a health worker while performing functions under this Act.*

(2) *The Federal Government shall make arrangement wherever necessary for the protection and security of health workers in performance of their functions under the Act.*

It should be noted, however, that at present this bill only applies to the federal capital of Islamabad and only provides protection to HCPs in their capacity under the auspices of the law. Nonetheless, the instrument creates explicit obligations on the government to ensure the protection of health workers in the pursuance of their official functions.

One area of growth regarding the Act, however, is the fact that it only extends protection to health workers: health-care professionals risk being targeted regardless of whether or not they are 'performing their functions'. Consequently, a protective framework cannot be as restrictively framed. It is essential for the drafters of any proposed legislation to realize that – in the context of Karachi – the need for safety and security extends to the personal lives for many health-care professionals.

In our interactions with representatives of the medical community, several instances were cited of doctors being targeted outside their health-care establishment or in their personal lives. As touched upon above, much of this violence was due to the fact that doctors were perceived as being more affluent, thus making them attractive targets for crimes such as extortion or kidnapping for ransom. Further, a significant number of attacks on doctors were predicated upon sectarian or intercommunal differences and often took place outside their places of work. While it is necessary to recognize the responsibilities HCPs have towards their patients, it should be noted that a not-inconsiderable amount of violence directed towards them occurred while they were 'off-duty' and not during the performance of their official functions.

4.5 INTERNATIONAL LAW AND THE SINDH PROTECTION OF HUMAN RIGHTS ACT, 2011

Before engaging in an analysis of the Sindh Protection of Human Rights Act, 2011,[52] it is pertinent to first discuss the intersection of international law with the domestic – and more specifically provincial – legal framework.

As a dualist state, Pakistan incorporates international law into the domestic legal context in a two-stage process; the international legal instrument is first signed and ratified, following which implementing

52 The Sindh Protection of Human Rights Act (Act No.XIII of 2011)

legislation is promulgated by the pertinent legislative assembly to give the international legal obligations domestic effect. This raises some concerns as, while Pakistan may be party to any number of treaties or conventions, it is only when the pertinent implementing legislation is passed that the international legal commitments the State of Pakistan has taken upon itself become directly implementable in the national legal context.

Thus, while Pakistan is party to the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR), there is, at present, no existing legislation which fully encapsulates the obligations set forth in either Convention. In realizing the rights enshrined in the two Covenants in the domestic context, therefore, reliance must therefore be placed upon existing domestic legal instruments which contain the same or similar rights-affirming provisions. As discussed earlier, the Constitution provides for some of the rights expressed in the two Covenants; however, the applicable constitutional provisions are – for the most part – qualified 'subject to law'. That said, however, it is pertinent to note that the superior courts have recognized the role international human rights law plays in the domestic legal framework. In Contempt of Court Proceedings Against Syed Yusuf Raza Gilani, Justice Nasir-ul-Mulk of the Supreme Court – when examining the scope of rights not defined or described in domestic legislation – stated that "(b)y not defining the (right) the legislature perhaps intended to give it the same meaning as is broadly, universally recognized and embedded in our own jurisprudence…".[53] Relying upon this decision, a strong argument can thus be made that the rights not explicitly enshrined in the domestic legal context can, nonetheless, be extrapolated from 'their broad, universal' meanings.

The Sindh Protection of Human Rights Act, 2011[54] also provides a means of ingress for international human rights law into the domestic legal context. The Act aims to "to provide for protection of the human rights in the Province of Sindh"[55] and, to this end, establishes the Sindh Human Rights Commission.[56] The Commission is empowered by the Act to inquire into petitions presented to it by any person(s) or to examine, on its own accord, violations of human rights;[57] this provides another forum through which health-care professionals and their patients can have their grievances addressed. Following its own investigations, the Commission can then recommend the necessary steps needed to the Government in order to rectify the situation.[58]

Of particular interest is the obligation the Act places upon the Commission to study treaties and international instruments and to advise the Government on how best to implement them[59]. This appears to represent tacit acceptance of the edicts of the core human rights treaties, while affirming any reservations Pakistan may have to these instruments, thus providing a mechanism whereby international legal obligations – which may not be reflected in existing domestic legislation – can nonetheless be given effect.

The Commission is also obliged to generate awareness regarding the content of international human rights and promote awareness of the safeguards available to persons under the human rights regime[60]. This provides the Commission with a potent tool to generate awareness regarding the specific concerns of health-care and emergency service providers, highlighted by the stakeholders in Karachi.

53 Suo Moto Case No.4 of 2010 (Contempt of Court Proceedings Against Syed Yusuf Raza Gilani), PLD 2012 Supreme Court 553, at paragraph 27.
54 The Sindh Protection of Human Rights Act [Act No.XIII of 2011]
55 The Preamble, Ibid
56 §3(1), Ibid
57 §4(i)(a), Ibid, Cf. §4(i)(b)
58 §(4)(ii), Ibid
59 §4(vi), Ibid
60 §§4(viii) and (ix), Ibid
61 §2(iv), Ibid

The Act, however, is not the panacea needed for comprehensively implementing human rights norms in the provincial context: firstly, the Act limits the definition of "human rights" to the rights to "life, liberty, equality and dignity guaranteed by the Constitution… and enforceable by law".[61] This restricts the ambit of international human rights law only to the four rights specified and also only in the manner they are effected in the domestic context. Nonetheless, the Act can be read in a manner which gives greater effect to the international human rights obligations Pakistan has adopted and, in turn, in a manner which bolsters the provincial legal regime protecting HCPs and their patrons.

4.6 THE CRIMINAL LAW FRAMEWORK IN SINDH

4.6.1 The Anti-Terrorism Act, 1997

As mentioned above, the 1990s saw a rise in sectarian violence in the city of Karachi – primarily between the Sunni and Shia denominations of Islam. In response to the hitherto-unprecedented levels of violence, the incumbent federal government promulgated the Anti-Terrorism Act, 1997 (ATA) and established a parallel judicial system thereunder. The Anti-Terrorism Courts were designed as 'fast-track' courts, wherein proceedings were expedited, the rules of evidence were loosened, and the penalties prescribed for offences were harsher. In establishing the overall ATA regime, the federal government clearly intended to present a strong response to intercommunal violence and to suppress sectarian conflict in the city.

In the years since its promulgation, the ATA has seen a number of amendments, with the definition of the term "terrorism" growing to encompass a number of offences which – arguably – do not fall within 'traditional' conceptions of the term. Section 6 of the ATA provides a definition of the term "terrorism" and as such represents the core of the statute. The expansiveness of the definition of "terrorism" – while raising certain concerns – does, however, also enable the statute to encompass the issue of violence against health care, and could allow the statute to be used to minimize the risks posed to health-care professionals and their patrons.

The definition of the term 'terrorism' encompasses acts or threats which are 'designed to coerce and intimidate or overawe a section of the public';[62] which 'intimidates and terrorizes the public';[63] or which may result in damage to property,[64] among others. The definition also applies to acts or threats involving anything which results in 'death';[65] 'grievous violence or harm to a person';[66] 'grievous damage to property';[67] 'hostage taking or kidnapping';[68] 'the use of explosives';[69] 'the incitement of inter-communal antipathy';[70] 'a serious risk to the safety of a section of the public or which prevents the general public from engaging in their day to day lives';[71] and 'extortion'.[72]

It is clear, therefore, that 'terrorism' – as defined by the ATA – covers a host of criminal matters which directly relate to the issue of violence against health-care actors in the city of Karachi. Of particular note are subsections 6(2)(e) and (k) which relate to kidnapping for ransom and extortion. In our interactions with representatives of the medical community in Karachi, the incidence of kidnappings for ransom and extortion were cited as significant concerns of health-care professionals operating in the Karachi

62 §6(1)(a) and (b) of the Anti-Terrorism Act, 1997 [Act No.XXVII of 1997] as amended
63 §6(1)(b), Ibid
64 §6(1)(b), Ibid
65 §6(2)(a) and (d), Ibid
66 §6(2)(b), Ibid
67 §6(2)(c), Ibid
68 §6(2)(e), Ibid
69 §6(2)(ee), Ibid
70 §6(2)(f), Ibid
71 §6(2)(i), Ibid
72 §6(2)(k), Ibid

metropolitan area. As discussed by these stakeholders, doctors were particularly vulnerable to these crimes, as they were perceived as being 'lucrative' targets for these criminal activities.

Similarly, subsection 6(2)(i) of the ATA, which relates to serious risks to the safety of a section of the public which prevents it from engaging in day-to-day life directly relates to the issue of violence against health care, particularly as it is bolstered by subsections 6(1)(a) and (b), both of which pertain to intimidating sections of the public. In our interactions with HCPs in Karachi, serious concerns were raised about the broader impact that isolated incidents of violence were having on the provision of health-care services within the city. Sporadic incidents of violence were often cited as discouraging health-care professionals from working at health-care establishments situated in 'violent hot spots' and dissuading people in need of medical attention from patronizing these establishments. Anecdotes were provided by the stakeholders of people who, having suffered injuries in militant attacks in the city, preferred to be taken to hospitals further away than to receive medical treatment from health-care establishments in high-risk areas.

A series of other elements presented in the definition of 'terrorism' are also pertinent to discussions on the issue of violence against health care in the context of the city of Karachi. Given the incidence of religious, sectarian, and ethno-linguistic tensions prevalent in the city, concerns have been raised by the primary stakeholders regarding health-care establishments which identify inordinately with a particular community. Interactions with members of the medical community in Karachi have raised the issue of particular health-care establishments – or departments in such establishments – where patients seeking medical attention have been turned away for their sectarian, ethno-linguistic, or political affiliations.

Subsection 6(1)(a)(c) of the ATA directly addresses several concerns raised by the health-care sector in Karachi and provides as follows:

> §6(1)(a)(c) *(The term "terrorism" refers to the use or threat of action which)involves grievous damage to property, including government premises, official installations, schools, hospitals, offices or any other public or private property including damaging property by ransacking, looting or arson or by any other means;*

The subsection's application to actions or threats which 'involve grievous damage to property', as well as its references to 'government premises', 'public or private property', and – most significantly – hospitals enables it to encompass the spectrum of violent incidents which impact the provision of health-care services in the city of Karachi. According to the APPNA Institute's study,[73] 13% of hospital staff reported incidents involving damage to property, whether in conjunction with verbal and/or physical abuse.

The expansiveness of the ATA's language, as touched upon above, is useful in the context of violence against health care in Karachi in that it provides LEAs with a basis upon which to construct criminal proceedings against persons committing such violent acts. While the statute has historically not been used in this manner, it nonetheless presents the criminal justice system with a potent tool to address the issues raised in the context of Karachi.

The caveat to the ATA's use as a protective tool as regard sviolence against health care in Karachi is the fact that it also criminalizes the"aid and abetment"[74] and"harbouring"[75] of those who have committed an

73 Baig, L., Shaikh S, Ali SK, Polkowski M and Jamali, S.,. (2015). Violence against Health Care: Results from a Multi-Centre Study in Karachi.
74 §21-I, the Anti-Terrorism Act [Act No. XXVII of 1997] as amended
75 §21-J, Ibid

offence under the statute. While neither the statute itself nor the jurisprudence which has developed thereunder specifically addresses the criminality of medical aid being provided to such an offender, the current governmental stance undoubtedly leans heavily in that direction. Further, United Nations Security Council Resolutions 1267, 1333, and 1373 all oblige States to "(r)efrain from providing any form of support, active or passive, to entities or persons involved in terrorist acts…"[76] and to deny Al Qaeda, the Taliban, and their affiliates "sanctuary".[77]

Given the current security climate in the country, an interpretation of the provisions of the ATA which favours criminalizing medical treatment to terrorists enjoys considerable traction amongst LEA and military stakeholders. It is thus pertinent to note that, given the ATA's lack of clarity on this issue, it is possible to envision a scenario wherein an HSP is proceeded against under the ATA for providing medical aid to militants.

4.6.2 The Pakistan Penal Code, 1860

As touched upon above, the Pakistan Penal Code, 1860 (PPC) is the primary criminal statute in Pakistan and criminalizes the range of violent physical expressions. In particular, the Code criminalizes the offences of 'hurt'[78] – i.e. the intentional causing of injury; kidnapping for ransom;[79] 'criminal force'[80] – i.e. the intentional use of force to cause 'injury, fear, or annoyance'; 'assault'[81] – i.e. instilling the fear of use of criminal force in another; 'extortion'[82] – i.e. instilling fear of injury in another in order to extract valuable security therefrom; 'criminal intimidation'[83] – i.e. threatening another's person, reputation, or property in order to compel them to act in a certain way; and anonymous criminal intimidation.[84] Collectively, these offences address the spectrum of concerns members of the medical community in Karachi interacted with raised vis-à-vis the impact of violence on the provision of health-care services in the city.

It was noted by several of the stakeholders interacted with that doctors were particularly at risk of incidences which would ostensibly fall within the ambit of 'extortion', 'criminal intimidation' or 'kidnapping for ransom'; perceived as being more affluent, doctors were often forced to appease criminal elements subjecting them to the use or threat of use of force.

It is our considered opinion, however, that the Code is a blunt instrument for addressing the specific issue of violence against health care in the context of Karachi: firstly, the Code has been in effect for over 150 years and has had little measurable effect on the incidence of violence directed towards health-care professionals and their patrons. The Code, as the primary criminal statute, is also contingent upon law enforcement agencies giving it effect; as such, it does not speak to health-care establishments and the steps these could take in order to minimize the risks posed to actors in the health-care sector.

As touched upon above, the Code is also a colonial statute, and as such has been framed with particular politico-legal goals in view: at the time of its promulgation, the British colonial regime had just suppressed the 1857 Mutiny and had little interest in constructing a rights-effecting criminal justice

76 Article 2(a), UNSC Res. 1373, (28 September 2001), UN Doc. S/RES/1373. Available at:http://www.un.org/en/sc/ctc/specialmeetings/2012/docs/United%20Nations%20Security%20Council%20Resolution%201373%20(2001).pdf.
77 Cf. UNSC Res. 1267 (15 October 1999), UN Doc. S/RES/1267. Available at:http://www.un.org/ga/search/view_doc.asp?symbol=S/RES/1267(1999). and UNSC Res. 1333(19 December 2000), UN Doc. S/RES/1333. Available at:http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N00/806/62/PDF/N0080662.pdf?OpenElement.
78 §332 of the Pakistan Penal Code, 1860 [Act XLV of 1860]
79 §365, Ibid
80 §350, Ibid
81 §351, Ibid
82 §383, Ibid
83 §503, Ibid
84 §507, Ibid

framework. The primary focus was instead on maximizing the power of the colonial state and as such the Code was designed with this goal in mind.

Thus, while the Code does – in fact – ostensibly address the majority of the stakeholder's concerns, its approach to the issue of violence against health care is far from nuanced. Further, it does little to address the specific issue of inter-communal violence – a primary motivation in many attacks on health-care professionals – and the rights of patients in need of emergency medical attention.

4.7 THE LEGAL FRAMEWORK FOR EMERGENCY SERVICES:

At present, there is no legal instrument regulating the provision of ambulance services in Karachi, and this critical absence was noted by all the stakeholders interacted with. While the Aman Foundation, a private ambulance service, has attempted to prepare a draft emergency services coordination bill and to lobby for its promulgation before the provincial legislature, there is at present no legal mechanism informing the conduct and regulation of emergency service providers in the city.

The existing legal framework in Karachi refers, at best, only tangentially to such emergency service providers, providing certain exceptions to the traffic rules but doing little else to effectively ensure the protection of emergency service providers.

4.7.1 The Provincial Motor Vehicles Ordinance, 1965

The Provincial Motor Vehicles Ordinance, 1965[85] allows for a transport vehicle to be driven without a permit in case of an emergency, and also exempts emergency vehicles from applicable traffic rules.

§44 **Transport vehicles not to be used or driven without permit.**

(1) *No owner of a transport vehicle shall use or permit the use of, and no driver of a transport vehicle shall drive or cause or permit to be driven, the vehicle in any public place, save in accordance with the conditions of a permit authorizing the use or driving of the vehicle in such place granted or countersigned by a Regional or Provincial Transport Authority:*

…

(3) *Sub-section (1) shall not apply:*

(c) *to any emergency vehicle,*

…

(e) *to any transport vehicle used solely for conveyance of corpses.*

§96 **Power to make rules.**

(1) *Government may make rules for the purpose of carrying into effect the provisions of this Chapter.*

(2) *Without prejudice to the generality of the foregoing power, such rules may provide for all or any of the following matters, namely;*

…

(e) *the exemption from all or any of the provisions of this Chapter of emergency vehicles and other special classes of vehicles, subject to such conditions as may be prescribed).*

Driving a vehicle without the proper permits is also allowed during an emergency for the conveyance of persons suffering from sickness or injury:

§106 **Using vehicle without permit.**

(1) *Whoever drives a motor vehicle or causes or allows a motor vehicle to be used or lets out a motor vehicle for use in contravention of the provisions of sub-section (I) of section 44 shall be punished*

85 The Provincial Motor Vehicles Ordinance (Ord. No.XIX of 1965)

with imprisonment for a term which may extend to six months, or with fine which may extend to five hundred rupees, and if having been previously convicted of such an offence, shall again be guilty of an offence punishable under this section, shall be subject for every such subsequent offence to imprisonment for a term which may extend to two years, or with fine which may extend to one thousand rupees, or with both.

(2) *Nothing in this section shall apply to the use of a motor vehicle in an emergency for the conveyance of persons suffering from sickness or injury or for the transport of materials for repair or of food or materials to relieve distress or of medical supplies for a like purpose; provided that the person using the vehicle reports such use to the Regional Transport Authority within seven days.*

4.7.2 The National Highways Safety Ordinance, 2000

Continuing in a similar vein as the Provincial Motor Vehicles Ordinance is the National Highways Safety Ordinance, 2000;[86] the Ordinance applies to "national highway(s)"[87] and also allows fire engines, ambulances and police vehicle on duty to ignore traffic signs:

§49 **Duty to obey traffic signs:**

(1) *Every driver of a motor vehicle, in charge of an animal-drawn vehicle, rider of a bicycle or a pedestrian, shall drive the vehicle and use the national highways in conformity with any indication given by a mandatory or a regulatory sign including road markings set forth in parts II, III and V of the Seventh Schedule applicable to it and shall comply with all directions given by any electrical traffic signalling device or by any police officer in uniform engaged in the regulation of traffic.*

(2) *In sub-section (1) mandatory traffic sign and "regulatory traffic sign" shall include any circular disk displaying a device, word or figure and having a red border, erected for the purpose of regulating road vehicle, traffic under sub-section(1).*

(3) *Provisions of this section shall not apply to a fire engine and ambulance on emergency run or a police vehicle on duty.*

The Ordinance also provides in its eighth schedule ("for drivers of road vehicles") that drivers must give way to ambulances and other emergency vehicles on duty:

8th Schedule, Part II:

(xvii) *Give way to ambulance, fire engine and police vehicle, funeral precession and other emergency vehicle on emergency run.*

The traffic laws described above do little to facilitate the movement of emergency service providers within the city, most of whom are subject to the vagaries of motorists' good will when navigating the roads in Karachi. Further, serious concerns were raised by members of the medical profession – including representatives of and ambulance service – over the complete lack of any overarching coordinative mechanism between health-care establishments, the private ambulance services operating within the city, and LEAs. Incidents have been cited where, due to a lack of such a coordination mechanism, these various entities have contributed to delays in the provision of emergency medical care, resulting in fatalities.

86 The National Highways Safety Ordinance, 2000 (Ordinance No.vXL of 2000). Available at: http://nhmp.gov.pk/wp-content/uploads/2014/04/NHSO-2000.pdf.

87 §2(1)(xxxv), Ibid

5. AREAS OF REFORM AND RECOMMENDATIONS

In addition to the legislative changes described in the Legal Review section, RSIL also posits the following recommendations for reform. For the purposes of the HCiD initiative, RSIL has narrowed down the two most frequently cited concerns of the health-care services community in Karachi and provided recommendations tailored to address them.

5.1 THE LACK OF A REGULATORY FRAMEWORK FOR EMERGENCY SERVICES

1. As discussed above, there is currently a complete absence of a regulatory framework addressing the provision of ambulance and emergency services in Karachi. In recent years, there has been a proliferation of private ambulance services, incorporated or registered under a myriad of regulatory frameworks[88] but with no overall framework informing their operation, resulting in little homogeneity in the services they provide. The provinces of Khyber-Pakhtunkhwa and Punjab have promulgated Emergency Rescue Service Acts, which both establish as well as regulate public sector emergency service providers. A similar framework needs to be developed and adopted in Karachi as well. Interactions with the primary stakeholders have raised concerns regarding ambulance drivers causing more harm than good to the patients – for example by driving erratically or panicking, etc. This is compounded by the harm ambulance drivers may cause by not knowing proper first aid techniques, particularly in instances where damage is suspected to the central nervous system and where shifting the patient may cause irreparable damage. All ambulance drivers and technicians must thus have attained a particular level of education and should have successfully completed training programmes designed to teach them the skills necessary for them to perform their functions. These skills could include advanced driving , navigation, and route-mapping skills; basic first aid; sensitivity training for engaging in patient triage or dealing with patients or their families; skills in deescalating potentially violent situations; communication skills; and basic vehicle maintenance skills. A private ambulance service has prepared a draft Sindh Emergency Medical Services Act which provides an invaluable legal intervention in addressing the current lack of regulation; however, the organization is currently engaged in lobbying for the bill to be presented before the provincial legislature and it remains to be seen how the bill will affect the provincial legal framework. Moreover, the bill itself focuses on regulating the provision of emergency services in the city of Karachi; as such, there exists a gap in the law regarding the specific qualifications and training of emergency services personnel that must be addressed.

2. The Health Department must also provide for comprehensive awareness-building programmes in order to better inform the public about emergency services and raise awareness about what the citizenry should do when encountering an emergency vehicle on the road. Particular attention should be given to this area by the traffic police when conducting vehicular licensing tests, and a specific traffic violation should be instituted for individuals obstructing the right of way of emergency vehicles. Traffic police should also immediately direct traffic to facilitate the movement of emergency vehicles. These interventions should be backed by legal measures affording right of way to ambulances on emergency runs.

3. Harassment and abuse of ambulance drivers and other first responders has been cited as a concern by the primary stakeholders. Such attacks often go unreported by emergency service providers, however, who often fear losing their jobs or retribution. In addition to training and

88 For example, some private ambulance services have been incorporated as limited liability concerns while others have been registered as charitable trusts.

governmental awareness-building programmes, systems providing for anonymous complaint submission by victimized emergency service providers – with tangible outcomes for offenders – would further engender confidence in first responders.

4. As discussed above, several ambulance services operating in Karachi are private trusts registered under one of the following: section 42 of the Companies Ordinance, 1984; by execution of a trust deed under the Trusts Acts, 1882 and 1908; the Societies Registration Act, 1860; and the Voluntary Social Welfare Organizations Ordinance, 1961. These statutes enable these institutions to acquire vehicles and other materials tax free, as per the operation of the Income Tax Ordinance, 2001 and the Income Tax Rules, 2002. While ostensibly this may be viewed in a positive light and as an incentive for further philanthropic efforts, in Karachi there is no regulatory framework ensuring that such assets are registered. This has allowed numerous organizations to start their own ambulance services, often surrounded by a great deal of opacity, and eroding public trust in emergency service providers in general. Further, there have been instances of criminal or ideologically-motivated groups operating ambulance services in the city.

5. As touched upon above, there is at present little coordination between ambulance services and law enforcement agencies. In fact, senior stakeholders in the private ambulance sector have noted that there is a distinct lack of coordination and communication between the different law enforcement agencies themselves. This lack of coordination causes severe problems; ambulances are often barred from entering certain areas, and following a serious medical emergency, dozens of ambulances often arrive on the scene, adding to the bedlam and impeding one another's efforts. One stakeholder noted incidences where emergency/trauma department health-care providers have refused to cooperate with the ambulance services. To this end, coordination mechanisms between ambulance services and HCPs would prove invaluable in bridging the operational gaps between the two.

6. It should be noted that the Sindh Injured Persons (Medical Aid) Act, 2014 already provides that injured persons are to be treated on a priority basis and that LEAs are prohibited from interfering with the provision of emergency medical aid. As discussed in the Legal Review above, the present legal framework – while providing stakeholders with potent tools to effect positive change – is not entirely adequate in addressing the issues plaguing the health-care sector in Karachi. This is particularly apparent in the context of emergency service providers and their associates. Consequently, in the light of this gap, a specific legal instrument regulating the operation of such first responders would prove invaluable.

7. As has been repeatedly discussed above, there is at present an absolute vacuum in the law relating to emergency service providers. While the existing law can, to a certain degree, be employed to address the concerns raised, there is at present no framework providing for first responders in Karachi. Despite the conspicuous absence of such legislation, however, the need for the same is nonetheless keenly felt. As touched upon above, stakeholders from a private ambulance service interacted with had discussed efforts on their part to lobby for a bill regulating the provision of emergency health-care services in Karachi, sharing a draft of the bill with RSIL. Stakeholders from the provincial Health Department also showed a desire to draft and see enacted such an instrument, though they were unable to provide reasons for the current absence of such legislation.

5.2 INCREASED SECURITY FOR HEALTH-CARE PROVIDERS, ESTABLISHMENTS AND EMERGENCY SERVICES

1. Section 4(2)(d) provides the Sindh Health-care Commission with broad powers to 'accredit' health-care services being provided and to prescribe criteria and standards for such accreditation. Given this broad ambit, it is recommended that the Commission ensure that all institutions providing medical training for health-care professionals (including doctors, dentists, nursing staff, ambulance drivers/first responders) must also provide a compulsory course on the dangers faced by prospective HCPs, and how to minimize the risks posed to themselves and their patients. For doctors, this course could be provided in the year they first start seeing patients (this would be the third year in most MBBS programmes in Pakistan) as part of their core curriculum. The purpose of these sessions would not be to intimidate or alarm the students, but rather to instruct them on the genuine risks associated with the profession – particularly in the context of Karachi.

The course could include:

i. A representation of the on-the-ground realities of health-care services in Karachi: i.e. the risks they might face; the security provided to them; and standard operating procedures to be instituted in case of a violent emergency. This is not an exhaustive list, but reflects the consensus presented by the stakeholders interacted with.
ii. The medico-legal framework within which health-care professionals operate, which protocols to follow when required, and how to ensure that LEAs do not interfere with their provision of medical services while – at the same time – similarly refraining from interfering in LEA investigations.

2. Current HCPs should be required to complete this training by the health-care establishment they are employed by, in partnership with a medical school/university if necessary. To this end, the Commission could make the maintenance of practitioners' licenses contingent upon completing this course.

3. Hospitals must provide health-care professionals with the option of anonymity. According to senior stakeholders in the medical profession interacted with, the primary violent threat to doctors is sectarian violence, where doctors affiliated with a particular religious sect are identified and targeted by their family names. In order to minimize this risk, health-care establishments must allow health-care professionals in their employ to use their only their first names in all their dealings with the establishment and patients.

4. Health-care establishments should also institute protocols managing the risks posed to health-care professionals when conducting patient intake. These protocols should address issues such as identifying potentially violent patients or situations (potentially with reference to psychological or criminal histories if possible), and should provide health-care professionals at risk with swift and effective methods of reducing these risks – such as informing security personnel of the potential risks or only seeing such patients with an orderly present. These protocols must, however, balance the need to minimize the risks posed to health-care professionals and other patients with the need to maintain the 'risky patients'' own privacy. To this end, restrictions on the use of this privilege should also be formulated in order to prevent misuse or abuse, such as the need to have at least two permanent health-care establishment

employees recommend that the patient poses such a risk before instituting the necessary security measures.

5. Senior officials from the emergency/trauma departments of health-care establishments; ambulance services; and law enforcement agencies should meet periodically in order to prepare emergency strategies addressing mass casualty incidents and coordination.
   i. Consultations with representatives from a private ambulance service cited instances of such coordinative programmes; these stakeholders noted, however, that such initiatives were always voluntary, infrequent, and had little impact on the overall regulation of emergency health-care services in the city. Legislative change must therefore be effected to ensure that such coordinative mechanisms are both effective and comprehensive.
   ii. If law enforcement officials have concrete intelligence regarding a potential emergency, they should immediately inform ambulance services and health-care establishments in order to allow them to prepare the necessary resources to address the emergency.
   iii. Health-care establishments should expect a large volume of ambulances during an emergency and should coordinate amongst themselves and with emergency service providers. This coordination should incorporate geographical considerations, the number of patients each establishment can absorb, the particular areas of specialization of each health-care establishment, and the specialized equipment available to these establishments among other, pertinent, factors.

6. All health-care establishments must ensure that a medico-legal officer is on duty at all times. Barring that, such establishments must designate another, alternate health-care professional – if such is possible – to serve as a medico-legal officer on a rotating basis until a permanent medico-legal officer can be found.

7. It is essential that any incidence of violence directed towards a health-care professional or a person seeking medical attention must be dealt with in the severest manner possible under the law.[89] As discussed in the Legal Review section above, the ATA represents a potent tool with which to prosecute perpetrators of such violence; it does, however, present a relatively 'blunt' instrument when dealing with violence against health care and if the Act were to be used in this manner its use must be nuanced.

8. According to the Prime Minister's National Emergency Action Plan, 2014, security concerns for vaccinators were one of the primary causes for incomplete vaccine coverage for the population.[90] This is particularly relevant in the context of Karachi where, since June 2012, safety and security concerns have been cited as the major cause for missed vaccinations.[91] In 2014, there were 29 confirmed cases of polio in Karachi and six polio workers were killed.[92] These recommendations must extend to polio vaccination teams. In this case, the roles of the health-care establishment and department officer in charge will be conveyed to the Prime Minister's Polio Monitoring and Coordination Cell, which supports the Prime Minister's Focal Person for Polio Eradication.[93]

89 Several of the stakeholders interacted with suggested 'guilty until proven innocent' measures to address violence directed against health-care service providers.
90 Government of Islamic Republic of Pakistan, (2014). National Emergency Action Plan 2014 for Polio Eradication. pp.13-18.
91 ibid at p. 12
92 Haider, S. and Khan, S. (2014). Lost - The battle against polio. Dawn. [online] Available at: http://www.dawn.com/news/1151027/lost-the-battle-against-polio.
93 ibid at pp. 17 and 18

5.3 LEGISLATIVE REFORM

1. As discussed above, it is possible to creatively reinterpret certain provisions of the existing law to address the concerns raised regarding violence against the health-care sector in Karachi. However, the existing legislation only extends so far; certain areas – particularly the regulation of emergency services – currently remain completely unaddressed in the existing laws. Further, reading the existing legislation in such a manner often represents a departure from both the letter of the law as well as the jurisprudence developed thereunder.

2. In order to effectively address the legal concerns regarding violence directed towards HCPs and their patrons, it is thus necessary to effect amendments to the existing legal framework. Such changes can be wrought in three major ways:
   i. Notifications may be issued by the Sindh Health Department; these notifications are administrative actions and may be issued to promulgate rules (such as those promulgated under section 41 of the Sindh Health-care Commission Act) which further flesh out the existing legal framework. These notifications, as administrative actions, are relatively easier to enact and build upon the existing legal framework. Notifications, however, are relatively specific in their application; any notifications issued under a statute are confined to the subject matter and overarching language of the statute itself and, as has been discussed earlier, the existing legislation which could be employed in this manner does not adequately address several of the concerns raised in our review. Notifications, however, do represent a potent stop-gap solution.
   ii. Amendments may be made to the existing legislation; at present, the Sindh Health-care Commission Act and the Sindh Injured Persons (Medical Aid) Act both represent the most pertinent legal instruments. Both statutes have their limitations, however – the Health-care Commission Act is focused almost exclusively on qualitative improvements to the provincial health-care regime while the Injured Persons Act only prohibits interference with the provision of medical aid.
   iii. Finally, and most significantly, a new piece of legislation could be drafted; this instrument would potentially reflect the recommendations contained in this Report and be 'purpose-built' to address the specific issue of violence perpetrated against health-care professionals and their patrons in the city of Karachi. Such an instrument, however, should also ideally be drafted to address similar incidents in other jurisdictions should the need arise. Such proposed legislation would ideally expand upon existing legislation such as the PPC and the ATA, with the offences provided for therein considered to have been aggravated should they materially affect the provision of health-care services in Karachi. This would enable prosecutors to rely upon the pre-existing legal standards and procedures in such offences, which would help protect the instrument from abuse and would enable the Courts – already well-versed in interpreting and applying the pre-existing criminal legal principles – to easily adopt the new statute.

6. CONCLUSION

The health-care crisis in Karachi has long since escalated to crippling levels, with the threat of violence directed towards health-care professionals and those in their care tangibly affecting the provision of health-care services in the city. Several of the issues plaguing the health-care sector in Karachi, such as the incidence of intercommunal violence, are beyond the scope of purely legal solutions and require instead a multi-faceted approach. Generating awareness on the vulnerability health-care professionals experience and emphasizing their neutrality in political, ethno-linguistic, sectarian or religious conflict would go a long way towards effecting the uninterrupted provision of health-care services and engendering public sympathy with health-care actors and their patrons; simultaneously, effectively prosecuting and punishing individuals who threaten health-care personnel and their patients would help deter the future incidence of violence against health care in the city.

Further, the conspicuous absence of a regulatory framework informing emergency services and emergency protocols in health-care establishments represent critical gaps in the legal framework; given the proliferation of private ambulance services in the city and the heterogeneity of health-care establishments, there is a critical need for strong oversight and regulation of the health-care industry in Sindh. Such regulation would not only improve the efficiency of service but would also help minimize the risks posed to medical personnel and those in their care.

There is a plethora of existing legislation in Sindh relating to the health-care sector; this corpus, however, has proven inadequate at addressing the issue of violence against health care. Given both the pressing need for such services in Karachi and the concurrent risks associated therewith, proactive measures must be taken in order to ensure that the situation does not deteriorate further.

8.شعبہ صحت کا تحفظ: سندھ کے حوالے سے ایک قانونی تجزیہ
ریسرچ سوسائٹی آف انٹرنیشنل لاء، پاکستان کی رپورٹ

آئی سی آر سی نے کراچی میں جاری اپنے ''طبی امداد خطرے میں'' پروگرام (Healthcare in Danger Project) کے ایک حصے کے طور پر ریسرچ سوسائٹی آف انٹرنیشنل لاء کے تعاون سے کراچی کے شعبہ صحت سے منسلک قانونی ڈھانچے پر نظر ثانی کا اہتمام کیا تا کہ شعبہ صحت سے منسلک کارکنوں، اداروں اور ٹرانسپورٹ کی سیکورٹی میں اضافے کے لیے موجودہ قانونی نظام کے اندر موجود نقائص کی نشان دہی اور بہتری کے لیے سفارشات تجویز کی جاسکیں۔ یہ رپورٹ کراچی میں صحت عامہ کی سہولیات کی فراہمی سے متعلق قانونی امور اور شعبہ صحت کے اہلکاروں اور ان کے معاونین کے تحفظ کے حوالے سے موجودہ قانونی ڈھانچے کے کردار اور اہمیت کا جائزہ لیتی ہے۔ اسی تناظر میں شعبہ صحت کو درپیش عمومی اور خصوصی خدشات کو ان کے تدارک اور قانونی اصلاحات کے نقطہ نظر سے اجاگر کیا گیا ہے۔

یہ جائزہ صوبہ کے موجودہ قانونی ڈھانچہ پر ایک بامقصد بحث کی راہ ہموار کرتا ہے۔ اس سلسلے میں ریاست پاکستان کی طرف سے اپنے شہریوں کو فراہم کردہ محدود ضمانت صحت کو سامنے لانے کے لیے آئین میں تجویز کردہ بنیادی حقوق کا جائزہ لیا گیا ہے۔ صوبائی سطح پر سندھ ہیلتھ کیئر کمیشن ایکٹ 2014ء کا جائزہ لیا گیا تا کہ کمیشن کے روبہ عمل ہونے پر اس قانون سازی کی امکانی افادیت کا تجزیہ کیا جاسکے۔

یہ کمیشن شعبہ صحت کے اہلکاروں کے تحفظ کے لیے تفویض کردہ اختیارات اور فرائض کے باعث سیکورٹی میں بہتری اور سندھ بھر میں صحت کی سہولیات کی فراہمی کے سلسلے میں انتہائی اہمیت کا حامل ہوگا۔ زخمی افراد کے علاج سے متعلق سندھ کا 2014ء کا قانون (The Sindh Injred Persons - Medical Aid) act 2014 طبی عملے کے لئے زخمی افراد کے فوری علاج کو کسی بھی متعلقہ قانون، رسمی کاروائی یا دیگر تقاضوں پر فوقیت دینا لازم قرار دیتا ہے، پولیس حکام بھی اس سے مبرا نہیں۔

زخمی افراد کے علاج سے متعلق قانون پولیس حکام کو ہسپتال میں دورانِ علاج کسی بھی قسم کی مداخلت سے بھی خاص طور پر روکتا ہے۔ یہ قانون شعبہ صحت سے منسلک اہلکاروں کے دیرینہ مطالبے کے عین مطابق ان کو غیر ضروری دباؤ اور ہراساں کیے جانے سے بچاتا ہے۔ اس میں دو الگ الگ وفاقی انتظامات پاکستان پینل کوڈ اور انسدادِ دہشت گردی ایکٹ 1997 کے تحت جرائم سے متعلق سندھ کے قانونی ڈھانچے کا جائزہ لیا گیا ہے۔ اس کوڈ کا دائرہ کار شعبہ صحت کے اہلکاروں کے خلاف دھمکیوں، حملوں اور عمومی دست درازیوں کی مجرمانہ حیثیت طے کرنے کے علاوہ جائیداد کے نقصان تک محیط ہے۔ دہشت گردی کے ضمن میں 1997ء کا ایکٹ خصوصی اضافے کے ساتھ ہسپتالوں پر کئے گئے حملوں کو دہشت گردی کی ایک شکل قرار دیتا ہے۔ 1997ء کا ایکٹ عمومی طور پر بھی شعبہ صحت سے منسلک اہلکاروں اور ٹرانسپورٹ پر کئے گئے تشدد اور دھمکیوں کی مختلف صورتوں کو اپنے دائرہ کار میں سمیٹ لیتا ہے۔

یہ رپورٹ ایمبولینسوں اور ایمرجنسی گاڑیوں سے متعلق قانونی احکامات کے لیے صوبائی موٹر وہیکل آرڈیننس 1965ء اور نیشنل ہائی وے سیفٹی آرڈیننس 2000ء کا بھی جائزہ لیتی ہے۔ رپورٹ موجودہ قانونی ڈھانچے اور انتظامی معاملات کی اصلاحات پر مبنی سفارشات کے ایک سلسلے پر منتج ہوتی ہے۔

8. THE HEALTH CARE IN DANGER PROJECT: WHAT NEEDS TO BE DONE?

Violence, both real and threatened, against health-care workers, facilities and beneficiaries must be recognized as one of the most serious and widespread humanitarian concerns of today. As this and other pieces of research have shown, there is an urgent need to secure the safety of the wounded and the sick, and of health-care personnel, health-care facilities and medical vehicles during emergencies. More must be done to ensure that the wounded and the sick have timely access to health care and that the facilities and personnel to treat them are available, adequately supplied with medicines and medical equipment, and secure. Safeguarding health care cannot be addressed by the health-care community alone. Governments, administrations, law enforcement authorities and armed forces must assume this responsibility as well.

To increase awareness of this issue and generate action to improve it, the ICRC is seeking support for the following initiatives:

1. **Building a community of concern**
   The ICRC aims to mobilize support for this issue from within the International Red Cross and Red Crescent Movement and among the health-care community, medical aid organizations, military forces, and governments around the world. Working together to enhance respect for the law, this community should cultivate a culture of responsibility among all concerned to safeguard health care.

2. **Regular and methodical information gathering**
   In order to better understand and react to attacks on patients, health-care workers and facilities, and medical vehicles, reports of incidents should be more systematically collected and centralized with the data of other organizations.

3. **Consolidating and improving field practices**
   The ICRC has undertaken many initiatives to improve access to and safeguard health care in the various contexts in which it is working. Experiences and best practice need to be shared more widely within the International Red Cross and Red Crescent Movement and broader health-care community to encourage more and better initiatives on this front.

4. **Ensuring physical protection**
   Hospitals and other health-care facilities in countries affected by armed conflict or other violence will be assisted in organizing the physical protection of the premises and in developing procedures for notifying others of their location and of the movements of their vehicles.

5. **Facilitating safer access for Red Cross and Red Crescent staff and volunteers**
   The ICRC will encourage greater involvement of Red Cross and Red Crescent staff and volunteers in collecting data on, and responding to, threats to patients, health-care staff, volunteers, health-care facilities and medical vehicles.

6. **Engaging with States**
   All States that have not yet introduced domestic legislation to safeguard health care in situations of armed conflict and other emergencies will be encouraged to do so. This includes enacting and enforcing legislation on limiting use of the red cross and red crescent emblems.
7. **Engaging with national armed forces**
   All national armed forces that have not yet incorporated provisions into their standard operating procedures with respect to safeguarding health care will be encouraged to do so. These standard operating procedures must address, among other issues, management of checkpoints to facilitate the passage of medical vehicles and entry into health-care facilities.

8. **Engaging with professional health-care institutions and health ministries**
   Increase dialogue with health ministries and health associations to generate solidarity on this issue and improve reporting on, and responses to, violence against health-care workers, facilities and beneficiaries.

9. **Encouraging interest in academic circles**
   Assist universities, other educational institutions and think tanks to incorporate modules on the implications of, and means to address, violence against patients and health-care workers and facilities into courses in public health, political science, law and security studies.

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