PROTECTING HEALTH CARE IN KHYBER PAKHTUNKHWA

A LEGAL ANALYSIS

VIOLENCE AGAINST HEALTH CARE MUST END
IT'S A MATTER OF LIFE & DEATH

ICRC

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LIST OF ACRONYMS

AP	Additional Protocol
BHU	Basic Health Unit
CCTV	Closed-Circuit Television
CDA	The Civil Defence Act, 1952
DHQH	District Headquarter Hospital
ERSA	The KP Emergency Rescue Service Act, 2012
GC	Geneva Convention
HCiD	Health Care in Danger
HCPs	Heath Care Service Personnel
HRC	Human Rights Committee
HSRU	Health Sector Reforms Unit
ICCPR	International Covenant on Civil and Political Rights, 1966
ICESCR	International Covenant on Economic, Social and Cultural Rights, 1966
ICRC	International Committee of the Red Cross
KMU	Khyber Medical University
KP	Khyber Pakhtunkhwa
KTH	Khyber Teaching Hospital
LEAs	Law Enforcement Agencies
LRH	Lady Reading Hospital
MSF	Médecins Sans Frontières
NDMA	National Disaster Management Act, 2010
NIC	National Identity Card
PDMA	Provincial Disaster Management Authority
PEMRA	Pakistan Electronic Media Regulatory Authority
PMDC	Pakistan Medical and Dental Council
RHC	Rural Health Centre
THQH	Tehsil Headquarter Hospital
UDHR	Universal Declaration of Human Rights, 1948
UN	United Nations
WHO	World Health Organization

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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, both the ICRC and the International Red Cross and Red Crescent Movement have been working on this crucial humanitarian issue in countries from Syria and Mexico to Brazil and South Sudan.

Within the HCiD framework, we engage in humanitarian diplomacy with States and multilateral bodies, organize international expert workshops, produce a number of publications and provide 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 has improved the coverage of public health initiatives such as vaccination programmes. Notably, such interventions have been successful in some megacities of the Global South, where urban health care 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 Pakistan, the ICRC has been providing training and expertise to local stakeholders on the management of mortal remains, has been managing a network of orthoprosthetic centres across the country and arranged seminars on emergency room trauma and war surgery.

The ICRC's work on protecting health care from violence in Pakistan had so far focused on Karachi and included a large-scale public health study on patterns of violence, an analysis of the legal framework, development of training materials for de-escalating violence in health care settings and a media campaign on the right of way and respect for ambulances. The work carried out by the ICRC and its Karachi partners, with the support of the Sindh Government, has already attracted international attention and become a model for other countries to follow.

This report is the first step towards a comprehensive engagement for prevention of violence against health care in the Khyber Pakhtunkhwa province. A public health study carried out jointly with Khyber Medical University is due to be published soon, and the ICRC is piloting training sessions on de-escalating violence in healthcare settings together with Lady Reading Hospital in hope of eventually reaching all health cadres in the province.

Many health-care and government stakeholders in Peshawar were consulted in the research process

to assure the inclusion of the views of those concerned and a comprehensive overview of all the factors contributing to this multidimensional problem. We thank them for their openness and trust. The endeavour would not have been possible without the wholehearted support of Director Public Health Dr Shaheen Afridi and other officials at the KP Health Department.

One of the pillars of the HCiD is engaging with States and local organisations to reinforce legislation safeguarding health care. Recommendations to that effect were laid out in the report from the Workshop on Domestic Normative Frameworks for the Protection of Health Care, held in Brussels from 29 to 31 January 2014 under the auspices of the ICRC. The 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 from 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 Khyber Pakhtunkhwa that can come up with a lasting solution to the unfortunate problem of violence against health workers and patients.

Having witnessed the strong practical commitment of many health care professionals and administration officials who, with their actions, put into practice the prioritisation of health issues by the provincial government, I am confident that together we can succeed in making doctors, nurses, ambulance drivers and other allied health personnel feel safer at work in Khyber Pakhtunkhwa.

Reto Stocker,
Head of Delegation,
ICRC Pakistan

EXECUTIVE SUMMARY

The right to health, iterated in international obligations, also emanates as a fundamental right from the Constitution of Pakistan. This constitutionally protected right to the provision of health care is hindered when those who deliver these services are under attack. Thus, violence against health care affects the general public as much as it harms health care personnel. It is a growing humanitarian concern that must be tackled through law, policy and awareness campaigns.

In order to prevent violence against health care, the legal regime applicable to Khyber Pakhtunkhwa (KP), Pakistan, may be categorized into five broad themes: preparedness, training, monitoring violence against health care, respect for health care services and protection of health care. Even though there are laws relating to each of the themes, these laws need to be supported through policies, regulations, rules and better implementation by the concerned authorities. In some cases, the existing law may also need to be amended.

Preparedness entails that health care services be ready to handle predictable and unpredictable crises. A variety of laws regulate preparedness, such as the KP Emergency Rescue Service Act of 2012, the National Disaster Management Act of 2010 and the KP Medical Teaching Institutions Reforms Act of 2015. Yet health care services lack cohesion, coordination and adequate protection of their personnel and volunteers.

Similarly, training of health care personnel is regulated through the KP Medical Teaching Institutions Reforms Act of 2015, the KP Universities Act of 2012, the Pakistan Medical and Dental Council Ordinance of 1962 and other legislation. Courses should be conducted in medical ethics, awareness of rights and responsibilities, conflict resolution, responding to violence and contemporary challenges. Hospitals, universities and regulatory authorities, along with the KP Health Department, may ensure that the formal instruction of health care personnel includes such courses by making certification courses mandatory and/or including them in the compulsory modules.

Further, the KP Health Care Commission could serve as the centralized body for periodically collecting data from all health care facilities in order to monitor the situation and, more importantly, to take action as and when required. The Commission may formulate policies and mechanisms to be implemented when a situation arises, so that violence may be tackled proactively.

Respect for health care services entails that health care personnel be aware of their rights and responsibilities, while patients be aware of theirs. Moreover, all individuals need to fulfil their obligations in order to ensure respect for these services, which could potentially translate to improving the quality of health care and preventing violence against it. The Government of KP,

through the Health Department, may also explore adopting a protective emblem to be used uniformly by all health care facilities, personnel and transport, both public and private, to guarantee their identification by the public so that they may be afforded due respect and protection.

Lastly, although the protection of health care services is not comprehensively addressed by law, there are several penal provisions that criminalize certain conduct generally – such as in the Pakistan Penal Code of 1860 (PPC) – while other existing provisions could be extended to health care personnel in the public sector. These latter provisions, found in both the PPC and the Anti-Terrorism Act of 1997, create offences for acts committed against public servants, a category that could be interpreted to cover employees of government health care facilities. Therefore, despite the need for comprehensive legislation, existing criminal law mechanisms could be used to protect health care personnel.

Abdul Majeed Goraya/ICRC

1. INTRODUCTION

Recent times have highlighted the unfortunate phenomenon of violence perpetrated against health care personnel (HCPs). Health care facilities, personnel and medical transport are widely known to be legally protected against attacks. However, these protected personnel and objects today face grave danger, as direct attacks against health care facilities,[1] on HCPs[2] and against paramedics and ambulance staff[3] – inevitably harming patients, too – are more than just an intermittent feature in the news. Disturbingly, these acts are not limited to any single situation but rather are committed in all types of contexts: during an armed conflict, in other emergencies and even during times of peace, thereby emphasizing the gravity of the situation and stressing the urgency required to address this humanitarian challenge.[4]

For a better understanding of the issue at hand, the definition of violence as provided by the World Health Organization (WHO) may be relied upon:

> The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.[5]

Much like other parts of the world, Pakistan, too, has seen various types of violence perpetrated against the healthcare profession. One form of these acts is pre-meditated violence, such as bomb attacks,[6] *qatl*[7] and abduction for ransom.[8] In contrast are instances of reactive violence, that is, those triggered in retaliation to a sudden provocation. For instance, a disturbing finding from a 2015 study in Karachi, Pakistan, was the fact that 65.9% of the HCPs surveyed had either experienced or witnessed violence, while 33.5% had experienced various forms of it – verbal or physical against themselves or damage to the health care facility.[9] This study revealed that 82% of violent acts against health care took the form of verbal abuse.[10] It further showed that violence against health care was primarily perpetrated by attendants accompanying patients to health care facilities,[11] with emergency rooms and ambulance services being the main sites for such acts.[12]

Other than causing physical and/or psychological harm to the victims personally, violence against

1 Al Jazeera, "Syria War: Air Raid Hits Children's Hospital in Aleppo", Al Jazeera (19 November 2016) <http://www.aljazeera.com/news/2016/11/air-strike-hits-children-hospital-syria-aleppo-161118163200380.html> (all internet sources accessed between April and August 2017); MSF, "Syria: MSF-Supported Hospital Bombed in Hama Governorate" (31 March 2017) <http://www.doctorswithoutborders.org/article/syria-msf-supported-hospital-bombed-hama-governorate>; Al-Shuaib Mosawa and Rod Nordland, "Bombing of Doctors without Borders Hospital in Yemen Kills at least 15", The New York Times (15 August 2016) <https://www.nytimes.com/2016/08/16/world/middleeast/yemen-doctors-without-borders-hospital-bombing.html>

2 "Patients burning in their beds, medical staff that were decapitated and lost limbs, and others who were shot from the air while they fled the burning building. At least 42 people were killed, including 24 patients, 14 staff and 4 caretakers," MSF, "Afghanistan: MSF Releases Internal Review of the Kunduz Hospital Attack" (5 November 2015) <http://www.msf.org/en/article/afghanistan-msf-releases-internal-review-kunduz-hospital-attack>; see also MSF, "Public Release of Initial MSF Internal Review" (5 November 2015) <http://www.msf.org/sites/msf.org/files/msf_kunduz_review_041115_for_public_release.pdf>

3 Gareth Evans, "Assaults on Ambulance Staff Reach Six-Year High", BBC News (Wales, 2 November 2016) <http://www.bbc.com/news/uk-wales-37834285>; "Ambulance Staff Body-Cams 'to Tackle Paramedic Attacks'", BBC News (England, 24 August 2016) <http://www.bbc.com/news/uk-england-37165119>

4 ICRC, Health Care in Danger: Making the Case (August 2011)

5 WHO, Health Topics: Violence <http://www.who.int/topics/violence/en/>

6 BBC, "Pakistan Hospital Bomb Attack Kills Dozens in Quetta", BBC News (8 August 2016) <http://www.bbc.com/news/world-asia-37007661>

7 Equivalent to the offence of 'homicide' in Pakistan penal laws; see the Pakistan Penal Code, 1860, S. 300

8 Reuters, "Karachi's Doctors Live in Fear After Spike in Deadly Attacks", Dawn News (Karachi, 16 June 2015) <https://www.dawn.com/news/1188546>; News Desk, "Famed Gynaecologist Dr. Mehmood Aleem Killed:, Samaa News (Faisalabad, 26 July 2017) <https://www.samaa.tv/pakistan/2017/07/famed-gynecologist-dr-mehmood-aleem-killed/>; ICRC, "Pakistan: Karachi Says No To Violence against Health Care Workers", Safeguarding Health in Conflict " (7 December 2016) <https://www.safeguardinghealth.org/pakistan-karachi-says-no-violence-against-health-care-workers>

9 ICRC, Violence against Health Care: Results from a Multi-Centre Study in Karachi, ICRC, Geneva, October 2015, p. 19

10 ICRC, Violence against Health Care: Results from a Multi-Centre Study in Karachi, ICRC, Geneva, October 2015 pp. 19-20

11 ICRC, Violence against Health Care: Results from a Multi-Centre Study in Karachi, ICRC, Geneva, October 2015, p. 21

12 ICRC, Violence against Health Care: Results from a Multi-Centre Study in Karachi, ICRC, Geneva, October 2015, p. 22

health care has additional far-reaching effects. It could potentially result in health care facilities closing, being understaffed, or being unable to provide adequate services not just in everyday circumstances but also during manmade or natural disasters.[13] Therefore, it is an issue that needs to be tackled expediently and in accordance with law.

This report aims to identify and analyse the factors that instigate violence against health care in the province of Khyber Pakhtunkhwa (KP), Pakistan. It focuses on the applicable legal regime and the provisions that may be utilized to address and prevent such violence.

This report sheds some light on the ICRC's Health Care in Danger project in KP and then elaborates on the research methodology employed. It concludes with an overview of the applicable legal framework. Section 2 enumerates the various causes of violence against health care in KP. Sections 3 and 4 address all the contributing factors identified in the preceding section, with an emphasis on legal recommendations and the way forward. Section 5 concludes by proposing a comprehensive legislative framework on violence against health care.

1.1. HCID IN KHYBER PAKHTUNKHWA

Like the rest of the country, KP, the north-western province of Pakistan bordering Afghanistan, is unfortunately not immune from violence against health care.[14] The ICRC initiated HCiD in KP in 2017 to assess the causes of violence against health care and to assist in minimizing them by emphasizing prevention, protection and de-escalation approaches. This report is an attempt to identify solutions from within the concerned community, in accordance with the applicable legal regime.

1.2. RESEARCH METHODOLOGY

This work is an empirical study of the legal framework regulating the health care system in KP. The data presented herein has primarily been gathered through semi-structured interviews with stakeholders[15] in the health sector. In meetings with experienced health professionals, the research team posed certain fixed questions to all the interviewees and let their answers structure the rest of the conversation.

Another important phase of this research is the normative aspect, where best practices and norms that contribute to preventing violence against HCPs are identified from national and international law regarding health care services. This study identifies deficiencies in the legal regime pertaining to healthcare in KP.

1.3. THE LEGAL FRAMEWORK ON THE RIGHT TO HEALTH

The right to health and the provision of health care services in all contexts, guaranteed by both

13 Vincent Bernard, "Editorial: Violence against Health Care: Giving in is Not an Option", International Review of the Red Cross, 2013, No. 889

14 AFP, "Stethoscopes and AK-47s: Peshawar Medics Face Kidnap Epidemic", Dawn News (Peshawar, 24 March 2015) <https://www.dawn.com/news/1171565>

15 KP Health Department; Lady Reading Hospital, Peshawar; Khyber Medical University, Peshawar; Traffic Police, Peshawar; Traffic Police, Abbottabad; Rescue 1122; Edhi Foundation, Peshawar; KP Police, Peshawar

international law and the municipal law of Pakistan, is undermined when those who provide these services are themselves in danger.[16] Therefore, preventing violence against health care is crucial to ensure access to adequate health care for patients. This section is dedicated to first indicating the international and domestic legal sources ensuring the right to health, and then to outlining the legal framework that regulates health care services in KP.

1.3.1. Right to Health under International Law as Applicable to Pakistan

The "right to health" first recognized in Article 25 of the Universal Declaration of Human Rights (UHDR) in 1948 was later enshrined in the International Covenant on Economic, Social and Cultural Rights (ICESCR)[17] in 1966, under Article 12. The UN Economic and Social Council understands health to be a fundamental right "indispensable for the exercise of other rights."[18] On the other hand, although the right to health itself is not expressly enunciated under the 1966 International Covenant on Civil and Political Rights (ICCPR),[19] the Human Rights Committee (HRC) has stressed that the expression "inherent right to life" in Article 6 "cannot be properly understood in a restrictive manner." The Committee suggests some positive steps States should take to protect the right to life, including "to reduce infant mortality…increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics."[20] Thus, the right to life and the right to health are essentially interlinked.

In addition to the above-mentioned core human rights treaties, humanitarian law instruments also obligate States to ensure the protection of the wounded and sick during times of armed conflict.[21] The Geneva Conventions of 1949 specifically provide special protections for medical facilities, personnel and transport[22] and require that medical ethics and medical neutrality be respected.[23] That said, States, in principle, must take measures during times of peace to ensure the continuity of health care services in times of conflict.

As Pakistan is party to all of these human rights[24] and humanitarian law[25] instruments, it is essential that the relevant international obligations be incorporated into domestic law.

1.3.2. Domestic Law of Pakistan

Although, the 1973 Constitution of Pakistan (the Constitution) does not explicitly mention a "right to health" within the chapter dedicated to Fundamental Rights, such a right has been judicially interpreted as arising from the right to life and the dignity of man, as guaranteed in Articles 9 and 14 of

16 ICRC, Health Care in Danger: Making the Case, ICRC, August 2011, p. 4
17 International Covenant on Economic, Social and Cultural Rights, 16 December 1966, 999 UNTS 3 (entered into force 3 January 1976)
18 UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4, para. 1 <http://www.refworld.org/docid/4538838d0.html>
19 International Covenant on Civil and Political Rights, 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976)
20 UN Human Rights Committee (HRC), CCPR General Comment No. 6: Article 6 (Right to Life), 30 April 1982, para. 5 <http://www.refworld.org/docid/45388400a.htm>
21 Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, 12 August 1949, 75 UNTS 31 (entered into force 21 October 1950) [hereinafter "GC I"]; Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea, 12 August 1949, 75 UNTS 85 (entered into force 21 October 1950) [hereinafter "GC II"]; Geneva Convention Relative to the Treatment of Prisoners of War, 12 August 1949 75 UNTS 135 (entered into force 21 October 1950) [hereinafter "GC III"]; Geneva Convention Relative to the Protection of Civilian Persons in Time of War, 12 August 1949, 75 UNTS 287 (entered into force 21 October 1950) [hereinafter "GC IV"]
22 Arts. 19, 20, 23, 24, 26 and 35 of GC I; Arts. 36, 37 of GC II; Arts. 18, 20 of GC IV; Jean-Marie Henckaerts and Louise Doswald-Beck (eds), Rules, Vol. I of Customary International Humanitarian Law, Cambridge University Press, Cambridge, 2005 [hereinafter "ICRC Customary Law Study"], Rules 25, 28, 29, 30
23 ICRC Customary Law Study, Rule 26
24 ICCPR ratified on 23 June 2010; ICESCR ratified on 17 April 2008
25 GCs I, II, III, IV ratified on 12 June 1951

the Constitution, respectively.[26] The Sindh High Court, in a 2017 judgment, held that "health care service undeniably falls within meaning of the [sic] 'life' as guaranteed and protected by the [sic] Article 9 of the Constitution."[27] This assertion was based on the Apex Court's dictum laid down as follows:

> "Life" includes all such amenities and facilities which a person born in a free country is entitled to enjoy with dignity, legally and constitutionally…the word "life" in the Constitution has not been used in a limited manner. A wide meaning should be given to enable a man not only to sustain life but to enjoy it.[28]

Therefore, the right to life is not limited to mere breathing but rather includes all such facilities which a citizen born in a free country is entitled to enjoy with dignity.[29] One of the amenities, as referred to by the Supreme Court, is manifest in the right to health, which culminates as soon as a person attains the status of citizen and must be given without any discrimination whatsoever. The duty of the State to ensure the right to health "does not come to an end [by] only inaugurating a 'building' as a 'hospital' but it continues till the object whereof is achieved, which undeniably could be nothing but to serve the people by providing health services."[30]

In addition to the "right to health" guaranteed under Articles 9 and 14 of the Constitution in view of the above-cited precedents, Article 38(d) of the same mentions the "provision of basic necessities of life [as] another Principle to aspire to."[31] Even though it cannot be held up as a right in a court of law, the provision of basic necessities of life within Article 38(d) is a principle for the State to consider when making policies. Moreover, policy principles aid in interpreting the general scheme[32] and ethos[33] of the Constitution and are understood as directives for the State.[34] Basic necessities include "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."[35]

Accordingly, many aspects of health care services are covered within domestic legislation. This ranges from regulating the registration of HCPs[36] to setting the standard for their training[37] and establishing bodies for disaster management at various levels of the federation.[38]

Prior to 2010, health remained a federal legislative subject. However, the 18th amendment to the Constitution empowered the provinces to legislate on this subject within their jurisdictions.[39] The prevailing situation is that certain provisions related to the health sector are found within national laws,[40] while the majority of the health-related statutes for each of the federating units have either been adapted[41] from federal to provincial, or the provinces have passed the legislation themselves.[42]

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26 M/S Getz Pharma (Pvt) Ltd. v. Federation of Pakistan, PLD 2017 Karachi 157
27 Nadir Ali v. Medical Superintendent, Civil Hospital, Larkana, PLD 2017 Karachi 448
28 Shehla Zia v. the State, PLD 1994 SC 693, pp. 712, 714
29 Nadir Ali v. Medical Superintendent, Civil Hospital, Larkana, PLD 2017 Karachi 448
30 Ibid, para. 6
31 Chamber of Commerce and Industry, Quetta, Balochistan v. Director General, Quetta Development Authority, PLD 2012 Quetta 31, para. 10
32 Ghulam Mustafa v. Province of Sindh through Secretary, Education Department, 2010 CLC 1383
33 Re: Suo Motu Case No. 10 of 2009, 2010 SCMR 885
34 Syeda Shazia Irshad Bokhari v. Government of Punjab, PLD 2005 Lahore 428
35 Art. 38(d) of the Constitution of Pakistan, 1973
36 Pakistan Medical and Dental Council Ordinance, 1962
37 KP Medical Teaching Institutions Reforms Act, 2015
38 National Disaster Management Act, 2010
39 Constitution (Eighteenth Amendment) Act, 2010, S. 101
40 Pakistan Medical and Dental Council Ordinance, 1962
41 West Pakistan Vaccination Ordinance, 1958
42 Khyber Pakhtunkhwa (KP) Blood Transfusion Safety Authority Act, 2016

It is pertinent to note that this report is limited to the legal framework as applicable to the health sector in the province of KP. It shall therefore rely upon and refer to the Constitution, national laws that apply to the whole of Pakistan and KP provincial laws, as required.[43]

43 See Annex 1 for a Complete List of Statutes reviewed for compiling this report

2. FACTORS CONTRIBUTING TO VIOLENCE AGAINST HEALTH CARE

As explained above, violence may manifest itself in intimidation or assault against HCPs or patients and damage to or looting of medical equipment,[44] as well as more serious forms of violence, in peacetime and during armed conflicts and other emergencies. Thus, urgent action by the State, the health sector and the community is required. However, in order to identify practical and feasible measures to prevent violence against health care personnel, it is first necessary to determine the factors that contribute to this situation. Examining the problem from the perspective of both patients and HCPs illustrates how violence is not necessarily pre-meditated but often occurs at the spur of the moment.[45] This section elaborates on these factors as deduced from the various consultations held with health sector contacts based in Peshawar.

2.1. UNSATISFACTORY TREATMENT

A primary cause of violence is unsatisfactory treatment accorded to the patient or their accompanying attendants. For the purposes here, unsatisfactory treatment includes substandard care, inefficient services and dismissive attitudes exhibited by HCPs. Hospitals are ill-equipped to such a degree that friction between the patients or their attendants and HCPs or health care facilities is triggered right at the entrance of emergency wards. The friction grows as they proceed to registration and up until the time they are discharged or referred for further treatment. It is important to mention that "ill-equipped" does not necessarily mean a shortage of medical supplies. It also includes insufficient manpower or structural defects in the placement of related departments within the facility, without adequate directions displayed to guide patients or attendants from one place to another.

2.1.1. Inadequate Management

There are situations that necessitate an attendant to accompany patients; for instance, when a hospital is insufficiently staffed and/or equipped, or it is structured in such a way to make it impossible for a patient to manage by themselves. If the patient's ailment renders them incapable of walking, they may require multiple attendants. Therefore, instead of one person, the hospital receives small groups, including worried family members who arrive to inquire after the patient. This not only results in overcrowding, it may also leave critical or serious patients overshadowed among a crowd of essentially irrelevant people. Moreover, it adds to the burden on the particular HCP who eventually deals with this group, as they now have to satisfy or respond to a minimum of two or three people instead of a single patient.

Another factor that contributes to overcrowding is the fact that the public are unaware of the nature of ailments requiring emergency care. This means that a person feeling any sort of discomfort will in the first instance go to the emergency ward and add to the already chaotic situation, leaving the staff to direct patients to relevant departments.

Thus, overcrowding may not be due to the number of actual patients, but could be a problem created inadvertently. Nevertheless, it still stretches a hospital to its limits and takes a toll on the HCPs

44 Fiona Terry, "Violence against Health Care: Insights from Afghanistan, Somalia, and the Democratic Republic of the Congo", International Review of the Red Cross, 2013, No. 889, pp. 25, 26

45 ICRC, Violence against Health Care: Results from a Multi-Centre Study in Karachi, ICRC, Geneva, October 2015 pp. 19, 23

employed there, thereby resulting in unsatisfactory treatment.

2.1.2. Disregard of Medical Ethics

Numerous interviews revealed that a general disregard of medical ethics by HCPs is common, specifically gaps in empathetic communication with patients. This, in turn, enrages patients and/or their attendants. Such disregard may not be intentional; rather, there are multiple factors leading to it:

- first and foremost, medical ethics are not included universally in the formal education of HCPs;
- understaffed and overcrowded hospitals contribute to HCPs acting curtly and insensitively to patient needs/queries;
- at times, the patients or attendants may refuse to understand the information being presented and get riled up, eliciting a strict response from the HCP.

Furthermore, impartial medical treatment is at the cornerstone of respect for health care services. It is undermined when the "privileged" demand preferential treatment from doctors, a common occurrence according to stakeholders. This practice has many adverse effects. It incites the "less-privileged", voids the impartiality of health care and may also lead to commotions or general distrust in the medical profession as a whole.

Therefore, to tackle the overarching concern of violence against health care personnel, it is imperative to get to the root of the matter and address the issues which create that problem.

2.1.3. Unreasonable Expectations

Patients exhibit a dangerous tendency of approaching qualified doctors or physicians only when their ailment reaches a critical stage. They might have ignored the symptoms or sought treatment from an unqualified person, especially in rural areas. They have unreasonable expectations that qualified HCPs can cure them under every circumstance; if not met, such expectations result in aggression towards these personnel.

2.2. MISUSE OF AMBULANCES

Ambulances provide vital services by quickly responding to emergencies, carrying patients to nearest hospitals, and if properly equipped, keeping them stable en route. Thus, they should generally be a sign of hope for the society and be trusted among the people.

Unfortunately, interviews showed that there are multiple reasons to disrespect and distrust ambulance services. One factor is that an ambulance may be stolen or misused by the employees for their personal chores. Ambulance drivers may also misuse the sirens for the purpose of speeding when the vehicle is not transporting a patient. There is even the remote but highly dangerous possibility that an ambulance could be used to carry weapons or used as weapons themselves. Another aspect is the deficiency in civic sense and lack of empathy among the general public for the patient being transported by ambulance. Such disrespect and lack of awareness routinely manifests

itself when ambulances are obstructed in traffic and not allowed to pass. Most of the time, motorists do not realize the critical service an ambulance is providing. Instead of letting them pass, motorists overtake or even tailgate speeding ambulances just to get through traffic themselves.

2.3. NATURAL AND MANMADE DISASTERS AND OTHER EMERGENCIES

Disasters, whether natural or manmade, require HCPs to be specially trained in order to deal with them not just at the professional but also on a more personal level. KP, along with the rest of the country, has endured the 2005 earthquake that measured 7.6 on the Richter scale and took the lives of 70,000 people,[46] the 2010 floods that cost 1,600 lives while directly affecting over 14 million people,[47] and deteriorating security over the past years.[48] Despite the government's effort to contain the high level of weaponization in society,[49] it remains an alarming situation in certain areas.

For instance, interviewees recalled situations where they were forced at gunpoint to perform medical procedures or had to operate on a patient while gunshots were fired in the waiting area, with terrified people trying to barge into the operating room to seek refuge. One HCP recounted his experience of being intimidated by an armed perpetrator to not treat a rival, while a police officer kept his weapon trained on the perpetrator and instructed the HCP to continue. Another interviewee narrated an incident where a patient begged him to perform a minor procedure, while others fled upon receiving credible information of an explosives-laden ambulance headed their way, and gave in to the patient's plea despite being terrified for his life. An HCP recollected how a proscribed organization threatened that his child would be kidnapped because he had performed his duty of tending to the victims of a bomb attack.

These are some of the many events that put HCPs at the centre of precarious situations with strong psychosocial impacts. On top of the absence of a mechanism to provide counselling to people at the forefront of such situations, there exists a trend of trivializing these issues. This trend was repeatedly observed within the health sector itself and requires immediate attention.

Another aspect of natural or manmade disasters and other emergencies, according to the stakeholders interviewed, is that they lead to a mass influx of patients at health care facilities, with patients generally flocking to the structurally largest facility regardless of the distance or the number of other smaller facilities along the way. Moreover, gaps in coordination among various relevant departments involved in emergency and rescue services also contribute to creating a mass influx at one facility. When health care facilities are overcrowded, ill-equipped to deal with huge numbers, or run out of supplies after treating so many people, they may also be subjected to violence by those who do not receive adequate services.

46 Tariq Naqash, "Remembering Oct 8, 2005: The Day the Earth Shook", Dawn News (8 October 2015) <https://www.dawn.com/news/1211695>

47 BBC, "Pakistan Floods 'Hit 14m People'", BBC News (6 August 2010) <http://www.bbc.com/news/world-south-asia-10896849>

48 "Qissa Khwani: from a Bazaar of Storytellers to Site of Bomb Blasts", The News (24 December 2012) <https://www.thenews.com.pk/archive/print/403325-qissa-khwani-from-a-bazaar-of-storytellers-to-site-of-bomb-blasts>; Zahir Shah Sherazi, "Twin Church Blasts Claim 80 Lives in Peshawar", Dawn News (22 September 2013) <https://www.dawn.com/news/1044668>; "Remembering Lives Lost in the Peshawar School Attack", Dawn News (13 June 2017) <https://www.dawn.com/news/1223313>

49 Irfan Ghauri, "De-weaponization Bill: Weapon-Free Pakistan?", The Tribune (18 January 2011) <https://tribune.com.pk/story/105034/time-to-de-weaponise-pakistan-sattar/>

These situations are not helped by media hyperbole, which decreases confidence in health care facilities and personnel. Coupled with the commotion inevitably created by consolatory visits from officials, this impedes the provision of health care services.

2.4. GAPS IN LEGAL AWARENESS AND IMPLEMENTATION OF THE LAW

A recurring trend observed across the health sector is a gap in legal awareness on the part of HCPs, the general public and other parties. A person who is unaware of their own rights or their responsibilities towards others may never ask for those rights or could breach those responsibilities. Therefore, violence may be accepted as a foregone conclusion by HCPs, while patients generally approach them with the expectation of being mistreated, creating situations that may be easily aggravated.

This trend is then worsened by weak implementation of the law. The law, although it might be insufficient in certain aspects, addresses numerous issues and could improve the situation to a certain extent if implemented in letter and spirit. Take, for instance, the issue of obstruction of ambulances, which may be fined under the Provincial Motor Vehicles Ordinance of 1965.[50] However, the traffic police rarely impose the fine for various reasons. For instance, they may lack the manpower, or the roads are so congested that obstruction is unavoidable. As for penal laws, proceedings may drag on for long periods of time with no certainty of conviction, thereby putting an HCP under greater risk if the defendant is a hardened criminal. Furthermore, when a patient is the aggressor, HCPs may not feel comfortable taking legal action, as it might diminish the trust people have in the medical profession.

Although the trends that emerged during interviews paint a grim picture of the situation in the health sector and among the public, they remain solvable. The solutions present themselves from within the existing law, which nonetheless requires some amendments and better implementation. An approach to these solutions needs to be multidimensional and interdisciplinary to tackle the diversity of issues highlighted. This report seeks to provide some suggestions to that end.

50 Provincial Motor Vehicles Ordinance, 1965, Twelfth Schedule - Part I (Moving Violations) at Serial No. 7; see also Traffic Warden, "Traffic Violations: Moving Vehicles", official website <http://ptpkp.gov.pk/index.php?page=6>

3. PREVENTING VIOLENCE AGAINST HEALTH CARE: ADDRESSING THE CAUSES

The factors highlighted in the preceding section are multifaceted and interlinked, and the same is true for the recommendations proposed here to address them. These recommendations may be considered in isolation or in conjunction with each other.

3.1. PREPAREDNESS

A prevention approach reduces the frequency and severity of potential crises, thereby minimizing the likelihood of situations turning violent. Pre-hospital services, accident and emergency departments, and disaster management are three crucial health care services where preparedness would reduce violence against them. Each of these is discussed below.

3.1.1. Ambulance and Pre-Hospital Services

There are numerous examples of scenarios that lead to violence against first responders, which may be briefly enumerated here:

- An ambulance does not arrive swiftly, resulting in aggression against the ambulance driver by the patient's family. This delayed response could be caused by traffic jams or stops at checkpoints rather than a problem attributable to the ambulance service.
- An ambulance is unable to handle a patient, maybe because the first responder is not trained or the ambulance is not adequately equipped.
- There is more than one victim and not enough ambulances or paramedics. Alternatively, different ambulance services arrive at the scene, resulting in a commotion because they cannot provide a similar standard of care.
- Paramedics or ambulance drivers behave discourteously toward the patient's family.
- Ambulance service employees or ideologically motivated groups misuse ambulance sirens, thereby costing the trust of the people.

There are multiple ambulance services that operate in KP.

The KP Emergency Rescue Service (Rescue 1122) was established in 2012 for "maintaining a state of

preparedness to deal with emergencies…[and] recommending measures to be taken by related organizations to avoid or combat emergencies."[51] Among the numerous aims and objectives of Rescue 1122, provisions exist that, if adhered to, would simultaneously mitigate and prevent violence against personnel, for instance:

- "To provide timely response, rescue and emergency medical treatment to the victims of an emergency including medical and surgical emergencies;
- To establish a system for rapid communication, exchange of information and quick response to combat or deal with an emergency;
- To play a lead role and coordinate the working of other organizations or agencies which have lawful authority to respond to an emergency;
- To impart training and grant certificates to rescuers, volunteers and other private persons for due performance of emergency management duties;
- To ensure minimum standards and code of conduct to be followed by rescue vehicles, ambulances and patient transportation services;
- To coordinate and maintain an effective liaison with all other organizations managing emergencies."[52]

Rescue 1122 is adequately staffed, has the infrastructure to provide quality ambulance services and exhibits the capacity to deal with mass casualty situations. In such cases, it coordinates with other ambulance services and takes the operational lead, as mandated by law.[53] It also communicates with other relevant departments, such as police, army and hospitals so that patient transfer may be expedited and rescuers remain aware of the situation at each hospital. The vehicles, including ambulances and fire trucks, are sufficiently equipped to deal with a variety of situations and are staffed, as required, by personnel specially trained at the Pakistan Emergency Services Academy in Lahore, Pakistan. Measures to increase ease of access to congested or narrow areas as well as mountainous terrain are in the pipeline.[54] Moreover, Rescue 1122 has contingency plans for areas where a potential disaster might occur. To this end, makeshift centres are available in those areas with services on standby, thereby reducing the response time.

There are other ambulance services run by volunteer or not-for-profit organizations, such as the Edhi Foundation, Al-Khidmat Foundation, Chippa, etc. Regardless of the fact that their services are essential, and they have large fleets of ambulances and equally large numbers of volunteers serving with them, these organizations regulate themselves, thereby their services may not be uniform with those of Rescue 1122.

Moreover, health care facilities with accident and emergency units may also have ambulances and paramedics staff, managed by a supervisor or a chief paramedic.

51 KP Emergency Rescue Service Act, 2012, Preamble
52 KP Emergency Rescue Service Act, 2012, Section 4
53 KP Emergency Rescue Service Act, 2012, Sections 17 and 18
54 Information was obtained on the condition of anonymity upon the understanding that internal policies or programs under consideration would not be divulged.

3.1.1.1. Gaps in Implementation of Law

Despite the positive image that Rescue 1122 creates, it may be noted that the KP Government was required to establish a KP Emergency Service Academy by the KP Emergency Rescue Service Act in 2012,[55] and this academy still does not exist. A designated academy within the province would be beneficial, as it would provide frequent refresher or specialized training for employees who now must travel to Lahore, Pakistan, where the academy caters to other provinces as well. Moreover, even though the legal provisions and mechanisms exist to train first responders, it is not clear whether such training includes communication skills and strategies for de-escalating violence, whether perpetrated by a patient, family member, or even a mob of protestors. An important component of such training should be encouraging ambulance drivers to realize how misuse of sirens creates a negative perception in society and thereby leads to disrespect of the entire service.

Furthermore, no provision exists in the Act of 2012 to regulate the proper purposes for which an ambulance may be used. The only provision that could be used to judge whether a first responder has acted without lawful authority obligates the first responder to "perform such field duties and functions as are assigned to him by the [KP Emergency] Council."[56] This is still insufficient to judge misuse of an ambulance. Hence, a provision governing proper uses and penalizing improper uses of ambulances needs to be incorporated into the law. That said, vehicles could be installed with trackers to monitor their location and to check if they are being used by employees for personal errands or unscheduled stops.

Lastly, the critical, coordinated services provided by Rescue 1122 are limited to the six districts where it is operational, and an expansion to four other districts is still in the planning phase. It should be noted that KP has 24 districts. While Rescue 1122 has been operating in KP for just 5 years and has contingency plans for areas where it does not have a designated station, expansion to other regions is imperative and should be simple, as the Emergency Rescue Service Fund is aided by the Federal and KP governments.[57]

With regard to hospitals' paramedical staff and ambulance services, coordination, staffing and expertise are crucial. KP medical teaching institutions, under their operative law, are required to have a hospital director, a nursing director, medical director, dean and finance director.[58] However, there is no requirement for a "paramedics director" who could supervise and monitor these functions. The Peshawar High Court has observed this and held that:

> Paramedical staff of the institution has been left astray (by the Act) …there is uncertainty and frustration that to whom they are answerable…there is no reference of paramedical staff performing functions falling within the responsibilities of other medical and nursing wings…clinical functions cannot be suitably and adequately discharged without cooperation and coherence of paramedical staff…in view of this deficiency, [government of

55 KP Emergency Rescue Service Act, 2012, Section 15
56 KP Emergency Rescue Service Act, 2012, Section 14(3); the KP Emergency Council established under the KP Emergency Rescue Service Act, 2012, Section 5
57 KP Emergency Rescue Service Act, 2012, Section 16
58 See the KP Medical Teaching Institutions Reforms Act, 2015

KP] shall make suitable amendment in the impugned Act for provision of Director of Paramedical Staff.[59]

No amendment to that effect has yet been drafted.[60]

3.1.1.2. Recommendations

For uniformity and better preparedness, the KP government through the Health Department should issue notifications or directives prescribing the minimum standards for all volunteer ambulance services. In order to issue any order, rules, regulations, notification or bylaw in the exercise of statutory power, the Health Department is required to consult the Law Department.[61]

To address the factors outlined above and prevent violence against ambulance service staff and vehicles, it is vital that these ambulance services possess:

- internal mechanisms for mapping the geographical areas they currently serve or can serve, so they can reduce response times;
- the capability to communicate and coordinate internally and with other relevant government departments, organizations and law enforcement and security agencies in the field during an emergency, thereby reducing the chances of getting stuck in traffic or at checkpoints or overcrowding at one hospital (which was mentioned above as a reason for violence against and disrespect of health care facilities and emergency staff);
- ambulances that are outfitted with a minimum requisite level of equipment to provide basic medical relief and keep a patient stable en route to a health care facility;
- ambulances with trackers and proper procedures to monitor their use;
- standard operating procedures known to each member of the organization;
- adequate opportunities to receive professional training in their field, including ways to de-escalate violent situations; and
- contingency plans for any eventuality and adequate preparation.

Another route could involve creating links between all ambulance services – both the private/charitable ones and Rescue 1122.[62] This would entail that all organizations be reachable by one designated Universal Emergency Dial-In Number[63] and operated through Rescue 1122. These volunteer organizations would then not be required to have their own coordination and mapping mechanisms. This would both save them money – essential, considering that they depend on donations – and address the root causes of violence.

Such an approach would be beneficial for Rescue 1122 as well, giving it greater reach in areas where these services already operate and where Rescue 1122 does not. It is not suggested that these

59 Dr Iftikhar Ahmad v Government of Khyber Pakhtunkhwa, PLD 2016 Peshawar 212, para. 42
60 Latest amendment passed on 23 May 2017, came into effect 30 June 2017, vide KP Act No. XXIV of 2017 <http://www.pakp.gov.pk/2013/acts/the-khyber-pakhtunkhwa-medical-teaching-institutions-reforms-amendment-act2017/>
61 The KP Government Rules of Business, 1983; Rule 12(4)
62 See ICRC, "Consolidation and coordination of emergency medical services in El Salvador", Ambulance and Pre-Hospital Services in Risk Situations, ICRC, November 2013 [21]
63 See the KP Emergency Rescue Service Act, 2012, Section 17(3)

services be integrated in to Rescue 1122; rather, they could work through a liaison.[64] Moreover, volunteers working with the Edhi Foundation *et al.* could be trained by these professionals as part of Rescue 1122's mandate to "encourage, facilitate and train staff of non-governmental organizations … for emergency management."[65] Such training may be conducted in the field, at designated premises, or through the development and dissemination of training manuals so that any issues that arise because of deficient training may also be addressed.

The liaison between private entities and the public sector could perhaps also be brought within the scope of the KP Health Foundation (the Foundation), established under the KP Health Foundation Act of 2016. The Foundation has the authority to promote, facilitate, coordinate and oversee public-private partnerships,[66] meaning an agreement between a health agency[67] and any private entity to deliver health care services and develop and improve infrastructure.[68] Moreover, a health agency is fully empowered to enter into such agreements with private parties "under mutually agreed terms and conditions in one or several health projects" with the Foundation's approval.[69] However, the Foundation is still in its formative phase,[70] and its scope remains to be seen.

A third option, which could very well be pursued in addition to the above suggestions, is for the government to adopt legislation on volunteer services in this field, through which it could:

- recognize the crucial function they perform;
- make it mandatory to respect them and afford them legal protection against violence; and
- set the requisite minimum standards to be observed.[71]

The Act of 2012 creates an obligation for motorists, other persons and the traffic police to make all possible efforts to allow clear and unimpeded passage of Rescue 1122 ambulances and emergency vehicles that have their warning lights or sirens activated.[72] A wilful or unreasonable violation of any provision of this Act is an offence punishable by imprisonment and/or a fine.[73] However, it has hardly been enforced. Moreover, a similar provision needs to be made for all ambulance services.

3.1.2. Accident and Emergency Services in Health Care Facilities

Some reasons behind aggression against hospital emergency services and their staff are:

- perceived unsatisfactory treatment from uninterested or overburdened HCPs, substandard care, or inefficient services resulting from a health care facility's poorly planned structure;[74]
- overcrowding, which may be caused by numerous factors, such as multiple attendants per

64 KP Emergency Rescue Service Act, 2012, Section 4(o)
65 KP Emergency Rescue Service Act, 2012, Section 4(m)
66 KP Health Foundation Act, 2016, Section 7
67 "Health agency means the Health Department or any of its attached department, sub-ordinate offices, autonomous bodies under its administrative control or any other organization or institution owned and controlled by Health Department", KP Health Foundation Act, 2016, Section 2(f)
68 KP Health Foundation Act, 2016, Section 2(j)
69 KP Health Foundation Act, 2016, Section 8B
70 Bureau Report, "New MD Appointed for Health Department", The News (24 September 2016) <https://www.thenews.com.pk/print/152200-New-MD-appointed-for-Health-Foundation>
71 See ICRC "Columbian Red Cross volunteers: rights and protection", Ambulance and Pre-Hospital Services in Risk Situations, ICRC, November 2013 [24]
72 KP Emergency Rescue Service Act, 2012, Section 25
73 KP Emergency Rescue Service Act, 2012, Section 27
74 See Section 2.1. of this Report

patient, lack of awareness on the part of the public as to the purpose of an emergency wing,[75] or the lack of another health care facility in the area with the capacity to tend to emergency cases;
- armed persons entering the premises, thereby indicating lapses in or a complete absence of security; and
- pressure on HCPs to treat members of rival groups.[76]

These issues may be addressed in a variety of ways relating to preparedness. However, in order to understand the need for accident and emergency services to be prepared for both predictable and unpredictable crises, it is first important to understand the general status of public-sector health care services in KP.

KP, unlike other parts of the country, abandoned the previous system of classifying hospitals based on location and instead shifted to classifying[77] health care facilities according to the number of beds and treatment capacity.[78]

The levels of health care may be divided into three tiers:
- Primary care facilities: Basic Health Units (BHU) and Rural Health Centres (RHC) that provide basic and essential inpatient care, while mostly operating as outpatient facilities. They also work on prevention and promotion with community outreach programs.
- Secondary care facilities: Tehsil Headquarter Hospitals (THQH) and District Headquarter Hospitals (DHQH) that provide both outpatient and inpatient care and also have the capacity for specialist care. Their services are curative in nature.
- Tertiary care facilities: including affiliation with teaching hospitals that provide support to DHQHs for specialized inpatient care.[79]

Regardless of the number of hospitals in the province,[80] all secondary care facilities providing should have accident and emergency services – that is, have the infrastructure for an emergency ward, if not already available or adequately equipped or staffed.[81] This would be one way of ensuring provision of services to larger geographical areas and more of the populace, in turn reducing overcrowding of one facility because other facilities in the area do not have emergency wards.

With respect to the priority of medical aid over legal formalities at emergency units, the law mandates awareness campaigns for the public, police and medical professionals concerning medicolegal

75 See Section 2.1.1. of this Report
76 See Section 2.4. of this Report
77 Health Department, Government of KP, vide Notification dated 28 April 2017 <http://www.healthkp.gov.pk/wp-content/uploads/2017/04/Categorization-of-HF.pdf>
78 Dr. Inayat Thaver and Dr. Muhammad Khalid, "Secondary level Minimum Health Services Delivery Package for Secondary Care Hospitals (MHSDP)" Final Report (2 November 2016) <http://www.healthkp.gov.pk/wp-content/uploads/2017/02/Final-Report-MHSDP-SC-KPK-2-11-16-accepted-changes-formatted.pdf>
79 Dr. Inayat Thaver and Dr. Muhammad Khalid, "Secondary level Minimum Health Services Delivery Package for Secondary Care Hospitals (MHSDP)" Final Report (2 November 2016) [24] <http://www.healthkp.gov.pk/wp-content/uploads/2017/02/Final-Report-MHSDP-SC-KPK-2-11-16-accepted-changes-formatted.pdf>
80 KP Health Department, "Khyber Pakhtunkhwa Government Health Facilities" GIS Map <http://www.healthkp.gov.pk/wp-content/uploads/2017/05/Final-Map.pdf>
81 The KP Government Strategy for Minimum Health Services Delivery Package for Secondary Care (2010 to 2017) outlines these goals comprehensively. See Dr. Inayat Thaver and Dr. Muhammad Khalid, "Secondary level Minimum Health Services Delivery Package for Secondary Care Hospitals (MHSDP)" Final Report (2 November 2016) <http://www.healthkp.gov.pk/wp-content/uploads/2017/02/Final-Report-MHSDP-SC-KPK-2-11-16-accepted-changes-formatted.pdf>

procedures.[82] But the law is silent on whose duty such awareness campaigns are. This is one provision that must be amended.

3.1.2.1. Recommendations for Accident and Emergency Services:

There are nine teaching hospitals in the province, primarily regulated under the KP Medical Teaching Institutions Reforms Act of 2015. Medical teaching institutions that include "health related teaching institutions and their affiliated teaching hospitals in the public sector"[83] have been established for undertaking "all functions required for providing health facilities to the people of KP".[84]

With respect to the recommendations below, teaching hospitals are empowered to regulate these functions autonomously,[85] as shown by 20 new appointments for institution-based practice at the Lady Reading Hospital (LRH) in Peshawar in June 2017.[86] Moreover, the government could encourage teaching to adopt sound policies through notifications[87] and rule making.[88] For other hospitals run by the government itself, it is within the government's domain to establish policies and regulations for them,[89] which could be done in consultation with relevant stakeholders.

An accident and emergency unit should have the following capabilities with regard to preparedness:

I. Security Measures and Risk Analysis

The first measure that needs to be put in place at health care facilities is a proper, comprehensive plan for security. At all teaching hospitals, this function vests in the Hospital Director,[90] who is responsible to the Board of Governors.[91] The Board of Governors itself is empowered to make policies[92] and regulations for carrying out the purposes of the Act.[93] Thus, a policy directing investment in passive security measures, such as CCTV cameras in the emergency unit or other sites susceptible to violence, could be drafted and implemented in consultation with the Finance Director.[94] A hospital's leadership could also implement security checks at the gates and a strict no-tolerance policy against carrying firearms onto the premises. Teaching hospitals strictly forbid employees from bringing firearms and weapons onto the hospital premises, and a violation could result in immediate suspension.[95] A similar policy needs to be adopted with respect to any person carrying a firearm. Further, a panic button could be installed to alert law enforcement authorities as soon as a weapon is detected.

Furthermore, facilities need to analyse the types of risks they face and the frequency of such risks, and then adopt adequate preventive strategies. They should also ascertain the potential consequences of such events and devise countermeasures to mitigate those consequences.

82 KP Injured Person and Emergency (Medical Aid) Act, 2014, Section 10
83 KP Medical Teaching Institutions Reforms Act, 2015, Section 2(i)
84 KP Medical Teaching Institutions Reforms Act, 2015, Section 4(a)
85 See the KP Medical Teaching Institutions Reforms Act, 2015, Preamble
86 Ashfaq Yusufzai, "Specialist Doctors Quit Jobs to Join LRH", Dawn News (9 June 2017) <https://www.dawn.com/news/1338434>
87 KP Government Rules of Business, 1983; Schedule II, Health Department, item No. 12: Regulation of medical and other professional qualification and standards
88 KP Medical Teaching Institutions Reforms Act, 2015, Section 23
89 KP Government Rules of Business, 1983; Schedule II, Health Department, item no. 12: Regulation of medical and other professional qualification and standards
90 KP Medical Teaching Institutions Reforms Act, 2015, Section 11(d)
91 KP Medical Teaching Institutions Reforms Act, 2015, Section 10(5)
92 KP Medical Teaching Institutions Reforms Act, 2015, Section 7(1)(b)
93 KP Medical Teaching Institutions Reforms Act, 2015, Section 24
94 KP Medical Teaching Institutions Reforms Act, 2015, Section 15; see also LRH Medical Teaching Institution Regulations, 2016, Regulation 10(d)
95 Employee Handbook for KP Medical Teaching Institutions, Rule xvi under General Policies

Contingency planning is an important aspect of managing security and undertaking risk analysis. This means having a clear plan in case a risk materializes and neither the prevention nor the mitigation measures prove sufficient, or a situation arises that was not considered. All HCPs need to be aware of these plans and be assigned duties well in advance. There should also be routine reviews of the plans and training sessions for personnel.

ii. Continuity of Services:

An emergency ward should be equipped and staffed in a way to respond to mass influx situations as well as the daily patient traffic. Category A and B health care facilities are intended to serve a huge number of people,[96] and this should be reflected through adequate preparedness.

Preparedness includes sufficient medical supplies and human resources,[97] with contingency planning in case of a crisis of such a magnitude that it depletes in-house supplies. This requires identifying a regular source of supplies and alternatives in case the supply chain is broken. One possibility is a Memorandum of Understanding among geographically close hospitals to share or pool resources during emergencies. The plan must be feasible, assign specific duties to each staff member within respective hospitals and, most importantly, include training the staff to be prepared in case of any eventuality.

Human resources includes not just doctors or physicians, but also nurses, technicians, laboratory assistants and all other support staff, such as orderlies and helpers. Shifts[98] should be planned so that an appropriate number of HCPs are on duty at all times. These functions are also vested in the hospital director at teaching hospitals,[99] while a nursing director[100] is responsible for "ensuring adequate nursing staffing for all clinical needs."[101] Commendably, LRH[102] and Khyber Teaching Hospital (KTH)[103] each appointed a director of human resources to manage adequate staffing. Moreover, the medical director[104] appointed at all teaching hospitals is responsible for all clinical functions including "ensuring timely, appropriate management of patients."[105]

96 Category A facilities: 350 beds, serving 1 million people (14 in the province); Category B facilities: 210 beds, serving half a million people (13 in the province); Category C facilities: 110 beds, serving 300,000 people (26 in the province); Category D facilities: 40 beds, serving 100,000 people (63 in the province)

97 For instance, with respect to preparedness at LRH, a Hospital Management Committee consisting of heads of all departments and led by the hospital director is obligated to meet once a month to discuss and resolve non-clinical issues such as space, building maintenance, information services, procurement and materials management, patient flow, parking, etc. LRH Medical Teaching Institution Regulations, 2016, Regulation 18

98 For instance, at LRH (Regulation 23) the working schedule is:
Regular working hours for employees will be from 8:00 am to 4:30 pm, including a 30-minute lunch break, five days a week. However, hours may vary for employees working in shift-based departments, as the hospital operates in three shifts.
Employees' working hours shall be determined by their department manager or supervisor. Medical staff, including consultants and house staff, and essential staff may be required to attend work weekends and nights, as determined by the department head and the medical director, in order to provide complete medical service to patients at all times. Such attendance would be on a roster basis, ensuring that each medical staff member is treated equitably and not overworked. (LRH Medical Teaching Institution Regulations, 2016)

99 KP Medical Teaching Institutions Reforms Act, 2015, Section 11(d)

100 KP Medical Teaching Institutions Reforms Act, 2015, Section 14

101 KP Medical Teaching Institutions Reforms Act, 2015, Section 14(7)

102 LRH, director of human resources, <http://www.lrh.gov.pk/index.php?option=com_content&view=article&id=85&Itemid=496>

103 KTH, Human Resource Department MTI, <http://kth.gov.pk/management/director_human_resource>

104 KP Medical Teaching Institutions Reforms Act, 2015, Section 12

105 KP Medical Teaching Institutions Reforms Act, 2015, Section 13(b)

Such measures ensure the presence of sufficient staff at a health care facility to deal with a large number of patients without overburdening or overwhelming a few. A lighter workload could also translate into a better attitude toward patients and attendants, thereby addressing the causes of reactive violence against these personnel.

iii. Internal and External Communication and Coordination:

Preparedness also includes internal coordination between various hospital departments, such as emergency wards and surgical wings. For this, hospital layouts need to be planned properly so that patients are transferred from emergency to surgery without delays or obstacles. Where layouts are not satisfactory, there still need to be effective means to communicate, coordinate and transfer patients. At teaching hospitals, such functions are vested in the Hospital Director,[106] who may update the Board at the meetings[107] and propose such a policy.[108] Such measures would also reduce the number of attendants required with each patient. Periodic internal reviews of internal and external communication and coordination are essential. Where a certain facility is not available at a hospital, there must be systematic cooperation and coordination with other facilities, as well as enough ambulances to transfer patients.

Just as crucial is the hospital's external coordination with first responders. Emergency staff need to be prepared for receiving patients as they are brought in by ambulances. Immediate measures are needed to ensure that ambulance entrances are vacant and off-limits for any other vehicles or people. Rescue 1122 already has a mechanism to coordinate with hospitals, however, as previously mentioned, it is not the only ambulance service. The complexity of coordinating with multiple ambulance services is yet another reason for ambulance services to use one universal phone number and consolidate under the same coordination mechanism. Until that happens, or if the coordination mechanism used by Rescue 1122 cannot be extended to other ambulance services, hospitals could allocate a line to be used by ambulance services and designate call operators accordingly. All of these steps would ensure the provision of quality care to patients and prevent overcrowding of a single hospital, thereby protecting emergency wards and personnel from violence.

iv. Public Awareness:

General public awareness of the purpose of an emergency ward must be increased so that people requiring outpatient services do not come to the emergency ward. Hospitals should also have a separate, dedicated, accessible emergency entrance, with signs distinct from those for the hospital's general entrance. LRH mandates that only two attendants are allowed per patient,[109] but this mandate must be enforced. One way could be to place personnel the entrance to ensure adherence to this rule, in addition to providing orderlies, stretchers and wheelchairs to eliminate the need for

106 KP Medical Teaching Institutions Reforms Act, 2015, Section 11(d)

107 KP Medical Teaching Institutions Reforms Act, 2015, Sections 10(4) and 10(5); see also Section 6(6) and Section 6(7), which provide that meetings may be held as frequently as required, but at least once every three months. Moreover, special meetings may also be convened at the request of one-third of the board members to consider of any important or urgent matter.

108 KP Medical Teaching Institutions Reforms Act, 2015, Section 7(1)(a) and 7(1)(b)

109 "Importance Instructions: Accident and Emergency Unit only provides examination and treatment to emergency patients. The OPD conducts registration and examination of all other patients. Only two attendants are allowed with one patient. For better medical treatment of the patient, cooperate with the hospital staff. This is your hospital, keep it clean. [translation mine]" LRH, "Emergency" Official Website <http://www.lrh.gov.pk/index.php?option=com_content&view=article&id=8&Itemid=281>

attendants. A waiting room located near the entrance would make it easier for attendants to wait outside the facility.[110] Similar strategies may also be adopted by other health care facilities providing emergency services.

3.1.3. Disaster Management

A third function that HCPs perform, and which puts them at the centre of crises, is providing relief when disasters strike. The factors that lead to violence against them and healthcare facilities in such situations should be highlighted:

- A mass influx of patients means overcrowding.
- Overcrowding could result in a shortage of human and medical resources, thereby leading to stress and overwork, leaving little to no time for attending to patient queries.
- Overcrowding also leads to greater security risks, making it harder, if not impossible, to monitor people as they enter and exit.
- Disaster also means that medical professionals' own family or loved ones are may also be in danger, thereby adding to their anxiety and decreasing performance.
- There are likely to be large numbers of media representatives and curious onlookers.
- These statutes address disaster management and empower the work of the following authorities before, during and after a disaster.
- The National Disaster Management Act of 2010 (NDMA): Establishes the Provincial Disaster Management Authority (PDMA)[111] and empowers it to "coordinate response in event of a disaster".[112]
- The Civil Defence Act of 1952 (CDA): A Civil Defence Service constituted by the Provincial Government is headed by a controller in any area[113] for which such a service has been constituted.[114] *Razakars*[115] appointed to each service are obligated to "perform such functions as may be prescribed by the Government for the protection of life and property of the people in case natural calamities like flood, famine, fire accidents, and epidemics etc".[116]
- The KP Emergency Rescue Service Act of 2012 (ERSA): Establishes a Council to review and analyse statistics related to disasters.[117] It also requires that all members of other organizations and every member of the police force shall act in aid of Rescue 1122, thereby affording this service the operational lead in an emergency.[118]

The use of the term "disaster"[119] under various statutes applicable to KP means that there exist a variety of bodies with overlapping powers in disaster situations, thereby leading to confusion and inefficiency and in turn increasing staff exposure to risks.

110 See ICRC, Ensuring the Preparedness and Security of Health-Care Facilities in Armed Conflict and Other Emergencies, ICRC, July 2015
111 National Disaster Management Act, 2010, Section 15
112 National Disaster Management Act, 2010, Section 16(2)(f)
113 Civil Defence (Special Powers) Rules, 1951, Rule 3
114 West Pakistan Civil Defence Service Rules, 1966, Rule 2(c)
115 "Volunteers"
116 West Pakistan Civil Defence Service Rules, 1966, Rule 7(c)
117 KP Emergency Rescue Service Act, 2012, Section 7(2)(f)
118 KP Emergency Rescue Service Act, 2012, Section 17(1)
119 National Disaster Management Act, 2010, Section 2(c); The Civil Defence Act, 1952, Sections 1A(1) and (2); KP Emergency Rescue Service Act, 2012, Section 2(g)

3.1.3.1. Key Issues in the Legal Framework

The situation highlighted above, with multiple bodies exercising overlapping disaster-relief functions, arose because disaster-management laws were promulgated in response to different calamities, without addressing the issue in a holistic manner or incorporating the provisions of existing laws.

The resulting framework creates complexities for communication and coordination, which are key components of preparedness for health care facilities and first responders to prevent overcrowding. While Rescue 1122 has the operational lead, as mentioned previously, it is not operational across the province. It is impractical to expect local health facilities to make arrangements for different coordination mechanisms – the one used by Rescue 1122, if it arrives in a disaster situation, and another mechanism in case Rescue 1122 does not arrive.

Another serious concern is the lack of security for personnel responding to disaster situations. Among the three statutes, only ERSA stipulates that "the police acting-in-aid shall also provide personal security to the operational staff of Rescue 1122 at the time of an emergency."[120] Additionally, this provision provides protection only to the operational staff of Rescue 1122 and not to other first responders, such as those affiliated with other ambulance services. NDMA defines disaster as meaning "a catastrophe or a calamity in an affected area, arising from natural or man-made causes or by accident or fire, bomb blast, terrorist activities, militancy, annoyed or provoked mob which results in a substantial loss of life or human suffering or damage to, and destruction of, property both movable and immovable."[121] Thus, first responders are obligated to respond to catastrophes caused by terrorist activities, yet they are not afforded adequate personal security under the law. Such protection or security also is not expressly afforded to first responders by the army or police in their relevant legal texts.[122]

3.1.3.2. Recommendations relating to Disaster Management

The following are some general recommendations for a health care facility to consider while preparing a disaster management strategy, which should be done with consideration for measures to prevent violence against health care:

In addition to the measures related to communication, coordination, security and risk analysis already discussed, upgrading security should also be seriously considered, not just for the facility itself, but for all people going in and out. Periodic drills of contingency plans must be carried out because a person who knows what to do in a given situation is less likely to become anxious. For instance, the KP Medical Teaching Institutions Regulations require teaching hospitals to establish safety management procedures, and all employees and volunteers are required to actively participate in a fire drill. The handbook stipulates the colour code for each type of emergency – for instance, code blue for medical emergency or cardiac arrest, code green for gas or chemical spillage and code red for a fire emergency or bomb threat. The handbook also provides instructions to be followed in case of each code.[123] LRH,

120 KP Emergency Rescue Service Act, 2012, Section 17(4)
121 National Disaster Management Act, 2010, Section 2(b)
122 See Government of Pakistan, Ministry of Defence, Manual of Pakistan Military Law (Vol. I and II, 2nd edition 1987); see also the KP Police Act, 2017
123 Employee Handbook for KP Medical Teaching Institutions, "Safety and Security Measures: Life Safety Measures"

in its regulations, also requires that this handbook be given to each employee at the time of recruitment.[124]

Health care facilities also need to factor in the mass influx of people – including victims, authorized personnel, blood donors and other helpers and volunteers – in order to reasonably prevent and prepare for overcrowding and related risks.

The presence of media personnel and visits by various officials also need to be considered in planning. One option is to designate a location for media activity away from the emergency entrance, instruct the media in advance to remain in that location and provide a hospital spokesman to give periodic statements and updates. Moreover, the hospital Board could develop a media strategy[125] outlining the flow of relevant information from individual units in a facility to designated spokesperson, who then interacts with the media.[126] It may be noted that Pakistan Electronic Media Regulatory Authority (PEMRA), through a Code of Conduct issued in 2015, requires its licensees to ensure that "reporting of incidents of crime, accident, natural disaster or violence does not create hurdles in dispensation of the duties of … rescue agencies, hospitals, doctors, etc."[127] Therefore, media personnel are under an obligation not to obstruct health care services. Hospital management could also talk with officials about how visits obstruct health care services and devise strategies with those officials.

Extreme situations are also hard on HCPs. However, in their dealings with victims they must bear in mind medical ethics[128] and remember that these are human beings who are scared and vulnerable. Therefore, impartiality, compassion and, most of all, humanity must remain the only motivations. Moreover, if they appear in media, HCPs should "recognize the victims as dignified humans, not hopeless objects."[129]

Lastly, a typical issue that arises in disaster situations is the tension of access versus security; that is, whether law enforcement agencies (LEAs) should take the lead to first clear the site of further threats or give first responders access to the victims. While the interviews revealed that LEAs usually clear sites before giving access to first responders, who then have the operational lead, problems may arise with respect to the community perception of first responders. Witnessing first responders standing by while their loved ones or they themselves remain helpless may lead people to lose respect for health care services. Although it might be dangerous for rescuers to enter a site before it is cleared, they could seek to institute a strategy with the LEAs so that a safety zone is established and visibly injured people may be treated or transported to the hospitals while the rest of the site is cleared.

124 LRH Medical Teaching Institution Regulations, 2016, Regulation 2
125 KP Medical Teaching Institutions Reforms Act, 2015, Section 7(1)(a)
126 ICRC, Ensuring the Preparedness and Security of Health-Care Facilities in Armed Conflict and Other Emergencies, ICRC, July 2015, p. 33
127 Electronic Media (Programmes and Advertisements) Code of Conduct, 2015, Rule 8(4)
128 PMDC Code of Ethics of Practice for Medical and Dental Practitioners (Regulations)
129 The Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations in Disaster Relief, Rule 10 <http://www.ifrc.org/Global/Publications/disasters/code-of-conduct/code-english.pdf>

3.2. TRAINING OF HEALTH CARE PERSONNEL

Proper training of HCPs is crucial to minimize reactive violence, as discussed above. Moreover, this training should be multidimensional. It should not be limited only to triage protocols or to those HCPs who may be deployed in an accident and emergency unit. Rather, it is essential to train all HCPs for all situations, including everyday interactions within their professional functions.

3.2.1. Recommendations on Training Content

Several paths exist for developing and providing standardized training for HCPs. However, it is worthwhile to elaborate on the content of such training first. Interviews revealed that HCPs exhibit gaps in capacities in the following categories, which therefore require formal instruction:

a. Contemporary Challenges
b. Ethical Principles of Health Care
c. Legal Knowledge
d. Responding to Violence
e. Conflict Resolution

3.2.1.1. Contemporary Challenges

Professional training qualifies a person to practice a particular health care role. Graduate and post-graduate programs, as well as diplomas or specializations, cover all the technical training an HCP would require for registering. However, the curriculum should enable students to deal with situations that they are likely to face in their professional lives. Unfortunately, the security situation in Pakistan requires that HCPs be adequately trained in how to deal with crises, or even how to help colleagues through trauma they may face at the workplace. It is not sufficient to leave people on their own to tackle issues if and when they arise; contemporary realities should be reflected in professional training.

3.2.1.2. Ethical Principles of Health Care

Interviews with contacts exposed a glaring omission in formal training of HCPs: ethical principles. As seen in Section 2 above, disregard of these principles is a strong contributor to violence against health care. However, when a person has not been taught something, it is unreasonable to expect them to act in a certain way. Formal instruction is necessary, as relying on a person's "innate goodness" is neither sufficient nor reasonable. Moreover, principles such as humanity, confidentiality, impartiality, consent-based treatment and ethical communication ease tough situations and make it easier for HCPs to decide how to act in the situations they face at the workplace.

Medical ethics, as derived from the Hippocratic Oath and Avicenna's Canon of Medicine, are codified in a Code of Ethics for Medical and Dental Practitioners (the Code) issued by the Pakistan Medical and Dental Council (PMDC). The Code requires[130] that physicians observe the principles of the Declaration of Geneva:

I solemnly pledge to consecrate my life to the **service of humanity**;
I will give to my teachers the respect and gratitude that is their due;

130 PMDC Code of Ethics of Practice for Medical and Dental Practitioners (Regulations), Regulation 5

> I will practice my profession with conscience and dignity;
> The **health of my patient** will be my first consideration;
> I will **respect the secrets that are confided in me**, even after the patient has died;
> I will **maintain** by all the means in my power, **the honour and the noble traditions of the medical profession**;
> My colleagues will be my sisters and brothers;
> I will **not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient**;
> I will maintain the **utmost respect for human life**;
> I will **not use my medical knowledge to violate human rights** and civil liberties, even under threat…[131] [emphasis added]

The Code itself is very comprehensive and sets forth numerous ethical principles to be observed by physicians. Some of these principles, listed below for better understanding, state that a physician shall:[132]

- Maintain the highest standards of professional conduct.
- Actively participate in continuous medical education.
- Not permit motives of profit to influence the free and independent exercise of professional judgement on behalf of patients.
- Be dedicated to providing competent medical services in full technical and moral independence, with compassion and respect for human dignity.
- Respect the rights of patients, colleagues and of other health professionals.
- Safeguard patient confidences.
- Preserve absolute confidentiality on all he knows about his patient even after the patient has died.
- Give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care.
- Promote the education of the public on health issues and their rights to quality care;
- never forget that the health and the lives of those entrusted to his care depend on his skill and attention.[133]
- Not refuse treatment to a patient, unless he deems it necessary that he himself should not treat a particular patient or is not qualified to do so.[134]
- Provide quality patient care that is timely, compassionate and respects human privacy and dignity, is non-discriminating and does not exploit vulnerable situations.[135]
- Bear in mind the obligation of preserving life and to not discriminate on the basis of age, sex, gender, class, race, ethnicity, national origin, religion, sexual orientation, disability, health conditions, marital discord, domestic or parental status, criminal record, or any other applicable bias as proscribed by law, and ensure that personal beliefs do not prejudice patient care.

131 World Medical Association, Declaration of Geneva <https://www.wma.net/policies-post/wma-declaration-of-geneva/>
132 See PMDC Code of Ethics of Practice for Medical and Dental Practitioners (Regulations), Regulations 3, 4, 9(2), 9(4), 11, 22, 27, 30
133 PMDC Code of Ethics of Practice for Medical and Dental Practitioners (Regulations), Regulation 9(2)(c)
134 PMDC Code of Ethics of Practice for Medical and Dental Practitioners (Regulations), Regulation 9(4)
135 Gross negligence in respect of professional duties may justify suspension or removal from the Register.

- Give patients (and, provided the patient agrees, family members) information (about their illness) in a way that they can understand.
- Encourage patients to ask questions, as they do not always fully understand the information and advice given to them by doctors. These should be answered carefully in non-technical terms, with or without information leaflets. The aim is to promote understanding and to encourage compliance with recommended therapy.
- Keep a note of such explanation. If it is felt that the patient still does not understand, it may be advisable to ask the patient's permission to speak to a relative.[136]
- Truthfully provide information to patients to enable informed choices on their part as well as to inform them about their situation.
- Strive to create a "true impression" in the mind of the patient. To this end, the physicians shall present information in such a way that it can be understood and applied.

The principles also state the following:

- A doctor is not obligated to hand over the medical records of a patient without the concerned patient's consent. Furthermore, the State has no right to demand that any information be handed over by the doctor concerning any patient. Information on communicable diseases may be an exception to this principle. The doctor has a right to consult his legal counsel in any circumstance.
- When appearing as a witness before a competent Court, the doctor has no option but to disclose confidential information upon an express order of the Court that overrules the confidentiality or directs the witness to supply the required information.

Nevertheless, the Code is applicable to only medical and dental practitioners registered with the PMDC, not all HCPs. LRH, for instance, requires appending a Code of Conduct to the Employees Handbook given to each employee at the time of their appointment to the hospital.[137] With regard to patients' rights, the Employees Handbook for teaching hospitals directs only that "patient confidentiality" be maintained and provides that, "it is strictly prohibited to discuss any patient with anyone except members of the treatment team. Anyone breaching patient confidentiality will receive immediate disciplinary action, which may include termination of employment." Therefore, a more comprehensive code is necessary for all HCPs.

3.2.1.3. Responding to Violence

Another aspect of mandatory training should be on responding to violence. Violence may take various forms, and HCPs need training to respond properly to it.

One form of violence is heated arguments with patients or attendants. The Code enunciates that "where differences have arisen between the doctor and the patient or the patient's relatives, there is much to be gained and rarely anything to be lost by the expression of regret by the doctor."[138] Doctors, however, refrain from apologizing, fearing that it would amount to an admission that creates liability for them. But such a fear is not necessarily well-founded. Any determination of guilt or liability

136 PMDC Code of Ethics of Practice for Medical and Dental Practitioners (Regulations), Regulation 22
137 LRH Medical Teaching Institution Regulations, 2016, Regulation 2
138 PMDC Code of Ethics of Practice for Medical and Dental Practitioners (Regulations), Regulation 41

would rest on facts and evidence, not on an expression of regret for having acted discourteously. Moreover, criminal law creates certain exemptions for medical professionals for unintended harm caused by acts done in good faith for the benefit of a patient, even without consent in certain cases,.[139] Therefore, HCPs should be trained to identify signs of potential aggression and respond in a more appropriate way, instead of indulging in arguments with patients or their attendants.

Other types of violence have the potential to cause physical or psychological harm to HCPs or other patients, or to damage health care facilities. HCPs should have training in how to remain calm, think rationally and respond in a way that would prevent, or at the very least, mitigate harm, instead of panicking or responding in ways that would further escalate the situation. Additionally, efficient evacuation plans must be developed, routinely practiced and made known to all concerned in case of extreme, pre-meditated acts of violence.

3.2.1.4. Conflict Resolution

Resolving matters peacefully is at the cornerstone of any relationship, including between doctors and patients, who essentially have a fiduciary relationship[140] based on trust.[141] As mentioned above, ethical practices need to be actively inculcated in doctors, with an emphasis on how showing regret will not harm them. The essence of a fiduciary relationship is understanding that a patient is scared and worried and dealing with them in a manner befitting a person of superior knowledge and training. This trust may diminish if HCPs are allowed to complain about patients or attendants. Moreover, it would be hard to create a functional mechanism for complaints at health care facilities, as patients or attendants cannot be brought within the scope of hospital disciplinary procedures. Other, more amicable avenues for resolution must therefore be followed in the interest of protecting HCPs and creating a climate of mutual respect.

While simultaneously addressing other factors that instigate violence against health care, HCPs could also receive training in amicable resolution of minor disputes, such as misunderstandings related to gaps in communication. Moreover, legislation could be drafted mandating arbitration as the first recourse for forms of violence such as disrupting services, interfering with or obstructing services, or causing commotions that adversely affect other patients.[142] However, where situations cross a certain threshold of violence, putting HCPs or others in physical danger, harming them, or causing damage or loss to medical equipment, then legislation could also provide for criminal prosecution.[143]

That said, regardless of the nature of violence and its resolution, all incidents must be reported to a competent authority and data collected on such instances for future analysis and action.[144]

3.2.1.5. Knowledge about Rights and Responsibilities

It is also essential for HCPs to have legal knowledge. They must be aware of how they are required to

139 Pakistan Penal Code, 1860, Sections 88-92
140 PMDC Code of Ethics of Practice for Medical and Dental Practitioners (Regulations), Regulation 21
141 PMDC Code of Ethics of Practice for Medical and Dental Practitioners (Regulations), Regulation 15
142 See Section 5 of this Report
143 See Section 5 of this Report
144 See Section 4.1. of this Report

act in a given situation and what they may expect from others.[145] Legal knowledge empowers individuals, making them aware of their rights and their responsibilities. As "ignorance of the law is no defence", those providing critical and often life-saving services need to be aware of the legal parameters binding them. Lack of legal knowledge may expose them to litigation, as they might unknowingly violate an obligation or infringe upon another person's rights. Knowing their own rights would also protect them.

Moreover, HCPs need to be encouraged to use the legal recourses presently available, at least against acts of pre-meditated violence such as abduction or armed assault, with the understanding that the criminal justice system is both deterrent and reformative. Granted, criminal proceedings may often require HCPs to invest time and resources they can scarcely afford, but gross atrocities should not be swept under the carpet. A victim's fear or reluctance further emboldens perpetrators and puts the society at a greater risk. In this case, it may result in increased violence against health care.

It first must be recognized that existing penal laws do criminalize certain acts with the aim of protecting every individual, regardless of their professional affiliation. Many of the acts included in the definition of violence – such as assault,[146] hurt,[147] extortion,[148] abduction[149] – are already criminalized and penalized by criminal statutes, and yet HCPs refrain from pursuing legal recourse, instead accepting violence as part of the job. The law also affords specific protections to HCPs, as noted previously, for acts done in good faith for a patient's benefit.[150]

Moreover, penal laws afford certain protections to public servants by criminalizing certain acts when committed against such persons – for instance, intimidating a public servant to take a certain action or not perform job duties is a criminal offence.[151] And although grave or sudden provocation may offer a mitigating circumstance in cases of assault or use of criminal force, this does not apply when the provocation was caused as consequence of a public servant exercising his lawful powers.[152] Another example of an offence is assault or use of criminal force against a public servant in the performance of his official duties, to prevent or deter him from the performance of his duties, or as a consequence of anything a public servant does in the lawful discharge of his official duties.[153]

Certain acts committed against public servants constitute an act of terrorism, as legislated in the Anti-Terrorism Act of 1997. A threat or act constitutes terrorism[154] when it is perpetrated for the purpose of creating a sense of fear in the society[155] or advancing a religious, sectarian, or ethnic cause[156] and

145 See the PMDC Code of Ethics of Practice for Medical and Dental Practitioners (Regulations)
146 Pakistan Penal Code, 1860, Section 351
147 Pakistan Penal Code, 1860, Section 337
148 Pakistan Penal Code, 1860, Section 383
149 Pakistan Penal Code, 1860, Section 362
150 See Section 3.2.1.3 of this Report; see also Pakistan Penal Code, 1860, Sections 88-92
151 Pakistan Penal Code, 1869, Section 189; see also AIR 1916 Madras 408: "the prosecution must prove: that there was a real threat held by the accused; the threat was of giving physical injury; to the public servant or someone put on his behalf; for the purpose to induce said public servant to do any act or to forbear or delay to do any act connected with the exercise of public duties."
152 Pakistan Penal Code, 1860, Section 352
153 Pakistan Penal Code, 1860, Section 353
154 Anti-Terrorism Act, 1997, Section 6(1)
155 Anti-Terrorism Act, 1997, Section 6(1)(b)
156 Anti-Terrorism Act, 1997, Section 6(1)(c)

involves serious[157] coercion or intimidation,[158] extortion,[159] or serious violence against a public servant.[160] Furthermore, if such an act involves the use of firearms, explosives, or any other weapon, then even without the purpose of advancing any ideology it amounts to terrorism.[161] The prosecution of these acts falls within the jurisdiction of Anti-Terrorism Courts.[162]

HCPs employed in the government sector are public servants,[163] and therefore the above-mentioned acts are criminal offences when committed against them. HCPs in both the public and private sector have legal recourse in the form of ordinary criminal courts, while HCPs in the public sector also have recourse to anti-terrorism courts given their status as public servants.

Moreover, an act may fall under the definition of terrorism if it involves grievous damage to property, including hospitals,[164] for the purpose of creating a sense of fear or insecurity in society, etc.[165]

3.2.2. Recommendations on Delivering and Streamlining Training

In order to streamline the training of HCPs regarding the issues highlighted above – contemporary challenges, medical ethics, responding to violence, conflict resolution and legal awareness – various authorities are empowered to take appropriate steps and devise courses. For instance:
The Pakistan Medical and Dental Council Ordinance of 1962 (the Ordinance) establishes and empowers the PMDC to regulate the medical and dental profession, education and institutions.[166] Similarly, the Pharmacy Act of 1967 establishes and empowers the Central Pharmacy Council to "approve the courses of study and practical training in pharmacy."[167] The Pakistan Nursing Council established under its Act of 1973 performs similar functions for nursing education,[168] and the Faculty of Paramedical and Allied Health Sciences has a similar function with regard to paramedics pursuant to its constituting Act of 2016.

The 1985 Rules of Business of the KP Government authorize the Health Department to undertake measures for "medical education including medical schools and colleges, and institution for dentistry"[169] and for "regulation of medical and other professional qualification and standards"[170] for

157 Serious is defined as meaning "dangerous to life or property" in The Anti-Terrorism Act of 1997, Section 2(w); "Disruption and interference with duties of public servant, no doubt was caused by accused and a minor simple injury was also caused by him to public servant, but such an act of violence against a public servant would not attract the definition of 'terrorism' …being not a 'serious' interference, 'serious' disruption, 'serious' coercion or intimidation…" in Muhammad Sharif v. the State, 2005 PCrLJ 941
158 Anti-Terrorism Act, 1997, Section 6(2)(m)
159 Anti-Terrorism Act, 1997, Section 6(2)(k)
160 Anti-Terrorism Act, 1997, Section 6(2)(n)
161 Anti-Terrorism Act, 1997, Section 6(3)
162 Anti-Terrorism Act, 1997, Section 12; However, where the act is not "serious", the anti-terrorism courts were held to not have jurisdiction – see Raj Muhammad v. Judge, Anti-Terrorism Court, PLD 2003 Lahore 588
163 See Dr. Ghous Ali Shah v. the State, 1987 PCrLJ 1370 (where the petitioner was a doctor in government service and referred to as a public servant); see also the KP Medical Teaching Institutions Reforms Act, 2015, Section 21, wherein all employees of medical teaching institutions are deemed to be "public servants" covered by Section 21 of the Pakistan Penal Code, 1860; see also the KP Emergency Rescue Service Act, 2012, Section 22.
164 Anti-Terrorism Act, 1997, Section 6(2)(c)
165 Anti-Terrorism Act, 1997, Section 6(1)(b) and (c)
166 Pakistan Medical and Dental Council Ordinance, 1962, Section 6
167 Pharmacy Act, 1967, Section 17
168 Pakistan Nursing Council Act, 1973 Section 16
169 KP Government Rules of Business, 1983; Schedule II, Health Department, item no. 18
170 KP Government Rules of Business, 1983; Schedule II, Health Department, item no. 12

which assistance may be sought from its policy advisory division, the Health Sector Reforms Unit (HSRU).[171]

Finally, all medical teaching institutions are established "to undertake all functions required for … medical education and training and research …"[172] Each such institution is required to have an Academic Council, headed by the dean, to "prescribe and set principles and standards for teaching, research, training, student admissions, curriculum development, scholarly activity, to ensure and inculcate the highest ethical standards."[173] The Act also requires a nursing director to be appointed at all teaching hospitals to perform various functions, one of which is training nurses."[174]

The Khyber Medical University (KMU), one of the universities formed under the Khyber Pakhtunkhwa Universities Act of 2012, is empowered to "provide for education and scholarship in such branches of knowledge as it may deem fit, and to make provision for … the application, advancement and dissemination of knowledge in such manner as it may deem fit."[175] KMU can "prescribe courses of studies to be conducted by it, colleges and institutions."[176] The university's Academic Council is authorized to make regulations for "the courses of study for degrees, diplomas and certificates of the University"[177] and for the "conduct of examinations."[178] These functions are also recognized by the 2016 KMU Statutes.[179]

In light of the above-mentioned statutes, following options exist for training HCPs:

i. Teaching institutions themselves could introduce short certification courses as part of post-graduate or graduate medical/dental degrees. Several medical institutes are affiliated with KMU,[180] so courses accepted by KMU could be conducted across KP.
ii. Until that time, the Academic Council of KMU could include at least one compulsory question on medical ethics in medical examinations.
iii. The Faculty of Paramedical and Allied Health Sciences could create a certification course for paramedics.
iv. The Health Department could issue a notification making such certifications compulsory to apply for in-house hospital jobs. Notifications are legally binding.
v. The PMDC expects medical and dental practitioners to inculcate ethical values in students through instruction and role modelling,[181] in pursuance of which senior practitioners could supervise their juniors at teaching hospitals to ensure proper application of ethics.
vi. The regulatory bodies concerned, such as the PMDC, Pharmacy Council and the Pakistan Nursing Council, could also consider including training in the aforementioned matters as a compulsory module in their syllabi.

171 KP Health Department, "Health Sector Reforms Unit" <http://www.healthkp.gov.pk/index.php/904-2/>
172 KP Medical Teaching Institutions Reforms Act, 2015, Section 4(a)
173 KP Medical Teaching Institutions Reforms Act, 2015, Section 9(3)
174 KP Medical Teaching Institutions Reforms Act, 2015, Section 14(7)
175 Khyber Pakhtunkhwa Universities Act, 2012, Section 6(i)
176 Khyber Pakhtunkhwa Universities Act, 2012, Section 6(ii)
177 Khyber Pakhtunkhwa Universities Act, 2012, Section 29(1)(a)
178 Khyber Pakhtunkhwa Universities Act, 2012, Section 29(1)(e)
179 Khyber Medical University Establishment of Faculties, Teaching Departments, Constituent Institutions, Constituent Colleges and Other Academic Divisions Statutes, 2016
180 KP Medical Teaching Institutions Reforms Act, 2015, Section 9(1)
181 PMDC Code of Ethics of Practice for Medical and Dental Practitioners (Regulations), Regulation 11(g)

Whether achieved through certification courses, examination or compulsory curriculum modules, it is recommended that those studying to join the health care profession in any capacity receive training in all five topics previously discussed.[182]

3.3. THE KP HEALTH CARE COMMISSION

The KP Health Care Commission (the Commission), as established under the KP Health Care Commission Act of 2015 to take over the functions of the Health Regulatory Authority, is empowered to inspect health care facilities within the province when issuing or renewing the facility's license or on receipt of a complaint.[183] Upon such inspection, the Commission has two checklists for health care facilities: one related to "hospital minimum standards"[184] and the other related to "clinics minimum standards".[185]

It is interesting to note that most of the recommendations proposed in Sections 3.1 and 3.2 are included in the "hospital minimum checklist", such as:

- establishing effective internal communication in hospitals, as an internal communication system connecting all units of the hospital enables a continuous flow of communication and immediate reporting of any incident;
- risk and quality management;
- access to health services – entrances and passageways are kept clear at all times, and a nurse on duty gives patients a general orientation to the department to which they have been admitted;
- guidance and advice is provided to the patients at the registration counter;
- doctors, qualified nurses and appropriate support staff are on site 24 hours a day;
- patients' relatives and carers are included in the (treatment) assessment by providing them information whenever possible;
- relatives are kept informed of the client's/patient's condition, with the consent of the client/patient where possible; patients and their families are fully informed about the client's/patient's health status, including the clinical facts about their condition, unless they explicitly request not to be informed.
- fire safety and emergency preparedness measures; and
- a staff member is responsible for checking and recording facilities and equipment availability daily and after each use.

In accordance with its Act of 2015 and the Rules made thereunder in 2016,[186] the Commission is empowered to investigate allegations of medical negligence, maladministration, malpractice, or failure in the provision of health care services and to take appropriate action.

Regardless of the comprehensive nature of the legislation governing the Commission, it is still developing its capacity to fully discharge its mandate. It is not yet functional in the entire province, owing to a variety of reasons such as insufficient human resources, and therefore the implementation of these provisions is not ideal.

182 See Section 3.2.1 of this Report
183 KP Health Care Commission Act, 2015, Section 14(2)
184 Hospital Minimum Standards Checklist <http://kp.gov.pk/uploads/2016/03/Hospital_Minimum_Standard_Check_List.pdf>
185 Clinics Minimum Standards Checklist <http://kp.gov.pk/uploads/2016/03/Clinics_Minimum_Standard_Check_List.pdf>
186 KP Healthcare Commission Regulations, 2016 (Complaint Management and Patients' Rights) Regulation 47

The Commission, in addition to enforcing and monitoring minimum standards of patient and health care safety as well as evaluating performance against prescribed standards, also has support functions, such as:[187]

- holding seminars, conferences and meetings to raise awareness about providing high quality private healthcare services; and
- playing a technical, advisory, educative and disciplinary role to support registered and licensed health care establishments in improving the quality of services.

The Regulations of 2016 need to be updated to include these support functions and put them into action so that health care facilities can provide quality services with government assistance, thereby addressing issues of substandard care or inefficient services.

187 KP Health Care Commission Act, 2015, Section 6

4. PREVENTING VIOLENCE AGAINST HEALTH CARE: A COLLECTIVE RESPONSIBILITY

Assessing and describing the factors that lead to violence against health care is not meant to justify such acts but rather to prevent them in the future. Other measures may be taken to combat this issue, supported by legal awareness and contributions from various authorities. This section seeks to provide an oversight of what those positive actions could be.

4.1. SAFETY OF HEALTH CARE PERSONNEL

Two factors that could lead to policies for improving HCPs' safety are data collection and a reporting mechanism. Both of these are discussed below.

4.1.1. Data Collection

HCPs tend to trivialize the violence they face in the performance of their duties, which may in itself be a sign of helplessness. This attitude causes a variety of problems. Not only is emotional well-being of the victim at stake, but the society ceases to perceive violence as the problem that it is, which in turn potentially increases the risk of committing violence. Trivializing violence weakens the humanitarian advocacy against phenomena that start to be viewed as acceptable by both the victim and the society, despite the physical and/or psychological harm they cause. There is an urgent need to recognize the occurrence of violent acts that interfere with the constitutional rights to life, human dignity and health, in order to address such acts and protect human beings.

Violence against health care may be prevented by drafting and implementing policies or legislation on the matter. Sound and effective policies cannot emerge unless policy-makers are aware of the nature of the problem to be tackled. Policy-makers need to know about the persistent issue of violence, which health care sectors are most affected and the contexts for violence. Given the vital role of data, a mechanism must be instituted to collect it.

RECOMMENDATIONS

The KP Health Care Commission (the Commission), in exercising its power to "enforce minimum standards of patient and health staff safety in public and private sectors",[188] may make regulations for data collection and reporting,[189] as they would not be inconsistent with the parent law, the KP Health Care Commission Act of 2015.

Health care facilities themselves are an appropriate avenue for data collection. Through regulations, the Commission could require that each health care facility, whether public or private, nominate[190] a person to record instances of violence and submit periodic reports (ideally twice a month) to the relevant hospital director for review. For instance, all government teaching hospitals in KP are required to have a Hospital Director responsible for "all non-clinical functions"[191] and for the "maintenance and development of all ancillary services including…security services [emphasis

188 KP Health Care Commission Act, 2015, Section 6(2)(c)
189 KP Health Care Commission Act, 2015, Section 31
190 For instance the KP Medical Teaching Institutions Reforms Act, 2015, Section 7(1)(c-i)
191 KP Medical Teaching Institutions Reforms Act, 2015, Section 14(a)

added]."[192] Similarly placed people may be identified at all health care facilities and tasked to perform this function by the Board of Governors concerned.[193] The same data could then be submitted quarterly to the Commission.

The Comission would need to develop a uniform data collection template for every health care facility to use. It would be practical to categorize the various forms of violence to allow appropriate responses for each form to be planned. For instance:

Category A	Abusive language; minor scuffle
Category B	Verbal threat to life/property/family; obstruction of emergency vehicle leading to interference with health care services
Category C	Acts that cause damage to property; damage to medical equipment
Category D	Threat or actual use of criminal force; armed interference in performance of duties; armed assault; theft of medical equipment or medical transport
Category E	Threat or actual use of explosive device

192 KP Medical Teaching Institutions Reforms Act, 2015, Section 14(d)

193 A Board of Governors is constituted for each medical teaching institution to administer and manage its affairs, and to that effect it is responsible for the institution's policy-making. See the KP Medical Teaching Institutions Reforms Act, 2015, Section 5 and 7(1)(b)

Following is a proposed template for the data collection form:[194]

Category of Violence *e.g. Category C*	**Form of Violence** (very briefly) *e.g. damage to medical equipment*	
Name of Victim _	**Designation of Victim** *e.g. Nurse, EMT, Ambulance Driver*	
Institution ID # *of the person who reports the incident (if provided with any sort of identification number)*		
Informant *If someone other than the victim*	**Date of Report** *dd/mm/yyyy*	**Time of Report** *0000hr*
Site of Occurrence	*e.g. emergency unit*	
Date of Occurrence	*dd/mm/yyyy*	
Time of Occurrence	*0000hr*	
Perpetrator	*e.g. patient, attendant*	
Witness(es)	*This need not be for evidentiary purposes but merely to ensure the veracity of reports.*	
How was the incident responded to? *e.g.: the institution took a specific step such as engaged law enforcement agencies; or the HCP themselves resolved it amiably; or other persons intervened*		
Description of Incident: *State in simple words the fact that constitutes the act of violence, specifying the details that allow to identify if they affected people, units, means of transport or the health activities. When it comes to people, write down their positions and names, if applicable.*		
Signed & Dated by Informant _ dd/mm/yyyy	**Signed & Dated by Duly Authorized Person** _ dd/mm/yyyy	

Such categories provide comprehensive actionable data without naming a perpetrator. This maintains the trust between HCPs and patients while also giving a complete picture.

4.1.2. Reporting Mechanism

Once data has been collected and submitted twice a month to the hospital director (or a similarly placed person at all other health care facilities) and then quarterly to the Commission, it must be analysed and proper action taken in response. An appropriate initial response would be for each

194 Ministry of Health and Social Protection, Colombia, Medical Mission Handbook (Republic of Colombia, 2013)

health care service to adopt a policy to address the type of violence it primarily faces and protect the HCPs who are the victims of such violence. Another crucial purpose this data would serve is to force an appropriate authority to take action to ensure the safety of patients and health staff.

The Commission, with the mandate to "perform such functions and exercise such powers as may be required to ensure the safety of patient and health staff",[195] is the correct forum for taking action in response to the data collected and analysed. It therefore should adopt data-collection regulations mandating health care facilities to submit data to it and the authorities to take appropriate actions for each category of violence. Such measures may involve passive security measures instituted by health care facilities themselves or active security measures externally provided to a facility in severe cases.

Moreover, the Commission shall also "perform any function assigned to it by the Government from time to time."[196] Therefore, the KP Government, through the Health Department if required, could make rules to give effect to the provisions of this Act[197] quoted above.

4.2. PSYCHOLOGICAL AND PSYCHOSOCIAL SUPPORT

It is important to understand that mental health is just as vital as physical health. HCPs who witness or experience trauma, or assist others through such situations, may themselves require help. Emergency doctors, nurses and first responders, for instance, might be exposed to horrifying scenes on a daily basis. Moreover, HCPs may experience anxiety because of personal hardships or an unhealthy work environment that exposes them to violence.

Even so, HCPs show up to help others in their time of need, whether because of an innate drive to do so or owing to societal pressures.[198] An interviewee narrating feelings of caught in the midst of a bomb-scare said, "I could not run, I knew they would laugh at me because I am a doctor and a Pakhtoon."

Statistically, it is hard to know how many HCPs suffer from anxiety, as there are no figures nor guidelines from the regulatory authorities concerned, such as the PMDC and the Pakistan Nursing Council.[199] According to WHO, "occupational health should aim at the promotion and maintenance of the highest degree of physical, mental and social well-being of all workers in all occupations ….".[200] Under the PMDC Code of Ethics, practitioners are expected to "ensure continuation of practice only when in normal physical and mental health."[201] People usually do not ask for help where mental health is concerned, out of fear of stigma, so HCPs should be trained to look for signs of stress in their colleagues. Every health care facility should encourage routine group sessions, for instance, in order to promote quality health services, which depend on the health of those who provide such services.

195 KP Health Care Commission Act, 2015, Section 6(1)
196 KP Health Care Commission Act, 2015, Section 6(2)(q)
197 KP Health Care Commission Act, 2015, Section 32
198 See Svetlana Stankovic, "'I Cried Every Day at Work': Mental Health Among Doctors is Still Taboo", The Guardian (4 July 2017) <https://www.theguardian.com/commentisfree/2017/jul/04/mental-health-among-doctors-still-a-taboo-in-a-high-performing-profession>
199 Amin A. Muhammad Gadit, "Mental Illness among Doctors: How Serious Can This Be?", Journal of Pakistan Medical Association, May 2009, Vol. 59, p. 5
200 Muhammad Hanif Shiwani, "Health of Doctors: A Cause of Concern", Journal of Pakistak Medical Association, April 2009, Vol. 59, p. 4
201 PMDC Code of Ethics of Practice for Medical and Dental Practitioners, Regulation 11(i)

The purpose of KP's health laws is to ensure "quality health care services",[202] a precondition for which is the emotional well-being of HCPs.[203]

4.3. PROTECTION AND RESPECT FOR HEALTH CARE SERVICES

Using a uniform sign and creating public awareness of the sign is another factor in generating respect and enhancing the protection of health care services

4.3.1. Assignment and Use of a Symbol

Entities the world over use signs to proclaim their identity. The medical profession has its own signs and symbols – for instance, the caduceus, which is most commonly used in the US and consists of two snakes entwined around a rod with wings at the top.

The Geneva Conventions of 1949 authorize medical personnel, units and transport to use the red cross, red crescent, red lion and sun, or red crystal.[204] These emblems have two functions: protective and indicative. Protective use is displaying the emblem on medical units, transport or HCPs' attire for their protection during an armed conflict. The emblems are used for their indicative function primarily in peacetime, to signify an affiliation with the Red Cross and Red Crescent Movement. Any use of these emblems that is not mandated by law "is considered to be improper."[205] It is important to clarify that the emblems themselves do not afford protection, rather they are a visible manifestation of a protection that already exists under law.

Pakistan, being party to the Geneva Conventions, prohibited unauthorized use or exhibition of the emblems and the designations "Red Cross", "Red Crescent", "Red Lion and Sun" or "Sun", through the Geneva Conventions Implementing Act of 1936.[206] The law provides that the red cross emblem may be used with the written permission of the Pakistan Red Crescent Society (PRCS) in peacetime to identify vehicles used as ambulances or to mark the position of aid stations set up exclusively for giving free medical treatment to wounded or sick people.[207] Contravention of this provision is an offence punishable by a fine of 50 rupees.[208]

The Act of 1936 is very restrictive in its scope. Though the title states that it implements the Geneva Conventions, in fact it regulates only one provision of the Conventions,[209] that is, Article 53 of GC I. Moreover, the 50-rupee fine is merely nominal or symbolic rather than deterrent or repressive of misuse. The Act was last amended in 1963. Perhaps it is appropriate for the federal legislature to seek an amendment to incorporate the numerous legal protections afforded under the Conventions and to amend the penalty. This would protect entities in Pakistan that use these emblems with PRCS

202 See ICRC, "Helping the Helpers – Why Does Psychosocial Support Matter?" (1 December 2015) <https://www.icrc.org/en/document/helping-helpers-why-does-psychosocial-support-matter>; see also "Helping the Helpers – Community-Based Psychosocial Support" <https://mhpss.net/?get=58/1354772532-Mod06CommBasedPSSSupport-HelpingtheHelpers.pdf>
203 See the KP Health Care Commission Act, 2015, Preamble; KP Medical Teaching Institutions Reforms Act, 2015, Preamble
204 Arts. 36, 38-44, 53, 54 of GC I; Arts. 39, 41, 43-45 of GC II; Arts. 18, 20-22 of GC IV; ICRC Customary Law Study, Rules 30, 59, 60; see also the three Protocols Additional to the Geneva Conventions of 1949
205 ICRC, 'Domestic Normative Framework for the Protection of Health Care' Report of the Brussels Workshop 29-31 January 2014 (May 2015) [21]
206 Geneva Convention Implementing Act, 1936, Section 2
207 Geneva Convention Implementing Act, 1936, Section 2 proviso
208 Geneva Convention Implementing Act, 1936, Section 4
209 Geneva Convention Implementing Act, 1936, Preamble

approval and would ensure proper use of the emblems, restoring respect for ambulances and increasing confidence in their protective value.

Therefore, an appropriate symbol[210] could be designed to signal the protection that health care facilities, HCPs and ambulances or other medical transport enjoy. The use of a uniform symbol, replacing a flood of emblems used by different entities, would ensure that there is no confusion in the general public as to this protection. For the meantime, at least, the various ambulance services in Pakistan, including KP, could apply to the PRCS for permission to display the red cross.[211]

4.3.2. Respect for Health Care Services

Respect for health care services may be enhanced by spreading awareness among the HCPs of their rights and responsibilities, as well as making patients aware of theirs. Moreover, awareness campaigns at the community level could help the general public realize the importance of the services HCPs and health care facilities provide, in order to promote mutual respect among the service providers and the beneficiaries.

To this end, as discussed in Section 3.2.1.2, HCPs should be encouraged to abide by the PMDC Code of Ethics. For those HCPs who do not fall under the jurisdiction of PMDC, a similar Code could be adopted and disseminated among all personnel concerned. Specialized training in ethics also would greatly assist the cause. When HCPs establish a culture of confidentiality and impartiality and refuse to afford preferential treatment to anyone, matters may greatly improve.

One issue that may have harmed the image of the health care profession are strikes by HCPs.[212] The Supreme Court of Pakistan has ruled the services of all health institutions essential under definition in the West Pakistan Essential Services (Maintenance) Act of 1958, "which prohibits the employees, subject to the provisions of the Act,[213] to absent themselves from work." The respondents (hospital authorities) had terminated the services of hospital employees for not reporting to duty and remaining on strike despite public notices and warnings, and the Apex Court held that the dismissal was in accordance with the law.[214] In the same vein, the Peshawar High Court, in 2010, directed the Government of KP to include "health services" within the meaning of "essential services" applicable to health institutions including those that are "administrative, curative, rehabilitative, preventive, promotive and supportive, partially or fully funded from the general exchequer who are under direct or indirect control of Government." In pursuance of this judicial directive, the KP government issued a notification on 12 June 2012. The same holding was reiterated by the Peshawar High Court in a 2016 judgment.[215] HCPs must adhere to and respect these pronouncements and notifications[216] in order to garner respect for their profession and themselves.

210 For instance, medical missions in Colombia are empowered to use a specially created emblem. See Ministry of Health and Social Protection, Colombia, Medical Mission Handbook (Republic of Colombia, 2013), pp. 19-22.
211 Although the PRCS itself uses the red crescent, the Act of 1936 empowers it to authorize the use of the red cross to ambulances; see the Geneva Convention Implementing Act, 1936, Section 2 proviso.
212 "YDA Strike Partially Hits Government Hospitals in Peshawar", The Express Tribune (24 May 2017 <https://tribune.com.pk/story/1417461/yda-strike-partially-hits-govt-hospitals/>; "11 Dead as Young Doctors Association Strike Continues", The News (3 July 2012) <https://www.thenews.com.pk/archive/print/623469-11-dead-as-young-doctors-association-strike-continues>
213 West Pakistan Essential Services (Maintenance) Act, 1958, Sections 4 and 5
214 Shakeel Akhtar v. MS Mental Hospital, 2000 SCMR 71
215 Dr. Iftikhar Ahmad v. Government of KP, PLD 2016 Peshawar 212, para. 43
216 Ashfaq Yusufzai, "KP Declares Healthcare an Essential Service", Dawn (9 February 2016) <https://www.dawn.com/news/1238360>

This is not to imply that a person does not have rights to assembly,[217] association[218] and speech, which are fundamental rights "granted under the Constitution and such rights [are] to be liberally construed unless and until restrictions were placed on rational grounds related to public welfare."[219] As per the Supreme Court of Pakistan, HCPs do have a right to form an association under Article 17 of the Constitution and an inalienable right to be treated in accordance with the law,[220] as "the dignity of their person and profession is protected by law."[221] However, their profession deals with human life, and bearing that in mind:

> They should always resort to legal means to ventilate their feelings and should avoid jeopardizing medical facilities provided to innocent persons by the Government. They should … [not] create such an atmosphere which leads to endangering lives of innocent people in the medical institutions. It is not denied that if they were demanding for betterment of their service structure, there is a method for the same and the authorities are enjoined to tackle the problem in a peaceful and congenial atmosphere.[222]

Thus, the exercise of one person's rights must not adversely affect the rights of another, and conflicts should be resolved peacefully so that neither party suffers.

That said, patients, attendants and the public at large also need to be aware of their responsibilities. For instance, under the non-obstante clause embodied in S. 29(2), a medical certificate or prescription or advice is valid only if obtained from a duly registered medical or dental practitioner.[223] Therefore, patients need to make the effort to consult a qualified practitioner instead of unqualified people. Under its Sehat Sahulat programme, the KP government seeks to aid the poor and the needy, for which purpose 105 health care facilities across the province provide free medical care to card holders.[224] To date, 35,032 persons have benefitted from this programme.[225] Such initiatives leave little excuse for consulting unqualified people for treatment because they are "less expensive".

Under the PMDC Code of Ethics, patients have certain duties, which they should be made aware of and encouraged to adhere to:

- Patients share with physicians the responsibility for their own health care. Therefore, patients are expected to follow treatment and prescription from their physicians.[226]
- Patients should respect the privacy of practitioners, call them only in dire emergency and restrict themselves to medical or dental problems and not use the call to seek other information.[227]

Furthermore, ambulances must be respected. Non-obstruction of ambulances and emergency vehicles must be ingrained in the general public. It is a violation of law and punishable with a traffic

217 Constitution of the Islamic Republic of Pakistan, 1973, Art. 16
218 Constitution of the Islamic Republic of Pakistan, 1973, Art. 17
219 Dr. Yasmin Rashid v. Chief Secretary, Government of Punjab, 2004 PLC(C.S) 668
220 Constitution of the Islamic Republic of Pakistan, 1973, Art. 4
221 Government of NWFP v. Dr. Husain Ahmad Haroon, 2003 SCMR 104
222 Government of NWFP v. Dr. Husain Ahmad Haroon, 2003 SCMR 104
223 Pakistan Medical and Dental Council Ordinance, 1962, Section 29(2)
224 Sehat Sahulat programme, "Find a Hospital" <http://jimmartzall.com/ssv7/find-a-hospital.php>
225 Sehat Sahulat programme, "Hospital-Wise Treatment Detail Report" <http://103.205.176.75:8088/apex/f?p=101:48:15378953777797002?
226 PMDC Code of Ethics of Practice for Medical and Dental Practitioners (Regulations), Regulation 12
227 PMDC Code of Ethics of Practice for Medical and Dental Practitioners (Regulations), Regulation 14

challan[228], which often is not imposed, a practice that needs to change. Traffic wardens need to be trained to fine offenders and to endeavour to get emergency vehicles through traffic without delays. Additionally, it is a police officer's duty to "cause awareness among the public regarding traffic laws",[229] therefore the police should instruct the public. An equally bad and prevalent practice is making fake calls for emergency services. A shocking 70% of the calls Rescue 1122 receives are fake, even though fake calls are prohibited under ERSA,[230] and a violation of this law constitutes an offence punishable with imprisonment and/or a fine.[231] The public needs to be made aware of the adverse effects such behaviour has on the provision of emergency services to those who genuinely need them.

With regard to ambulances getting stuck in protests, guidance may be sought from jurisprudence, as the Peshawar High Court has observed that a balance must be struck between the fundamental rights of both sides – specifically, protestors' rights to assembly[232] and speech[233] in blocking a road in protest and transporters' rights to trade[234] and life[235] in being able to use that road without obstruction.[236] In health care settings where a patient in an ambulance has a right to life, while protestors have rights of assembly and speech, a balance has to be struck and an ambulance allowed unimpeded passage. The traffic police need to devise strategies for this purpose, such as providing prior information on alternate routes to ambulance services or exempting them from obeying traffic lights or the speed limit.[237] Interviews highlighted the KP Traffic Police's commendable public awareness campaign for an ambulance's right to pass, along with other messages under consideration, such as the proper use of lanes and the need to keep the emergency lane or the hard shoulder empty. Similarly, there must be efforts to establish effective communication and coordination links with ambulance services to give them real-time directions for avoiding certain routes or to fast-track them through check-points.

Another issue that deserves mention is the procedure when an injured person is brought to an emergency unit:

- The law categorically requires the provision of immediate medical aid to an injured person, prior to any medicolegal formalities.[238]
- It also provides that police officers shall not interfere with or interrupt the treatment of an injured person at the hospital, except with written permission of the person in charge at the hospital. However, the person in charge may give such permission only if it is necessary for an investigation to be conducted in the hospital while the injured person is under treatment.[239]
- Furthermore, an injured person may not be taken to the police station before he has been treated, which the police officer is legally bound to ensure.[240]

228 A challan is a ticket given for a traffic violation; see Provincial Motor Vehicles Ordinance, 1965, Twelfth Schedule, Part I (Moving Violations) at Serial No. 7; see also Traffic Warden, "Traffic Violations: Moving Vehicles" official website <http://ptpkp.gov.pk/index.php?page=6>
229 KP Police Act, 2017, Section 4(2)(d)
230 KP Emergency Rescue Services Act, 2012, Section 26
231 The KP Emergency Rescue Services Act, 2012, Section 27
232 Constitution of the Islamic Republic of Pakistan, 1973, Art. 16
233 Constitution of the Islamic Republic of Pakistan, 1973, Art. 19
234 Constitution of the Islamic Republic of Pakistan, 1973, Art. 18
235 Constitution of the Islamic Republic of Pakistan, 1973, Art. 9
236 See Haji Lal Muhammad v. Federation of Pakistan, PLD 2014 Peshawar 199
237 The Provincial Motor Vehicles Ordinance of 1965, Chapter VII, Section 96(2)(e) empowers the provincial government to make rules for exempting emergency vehicles (including ambulances) from obeying the provisions of chapter VII
238 KP Injured Persons and Emergency (Medical Aid) Act, 2014, Section 3
239 KP Injured Persons and Emergency (Medical Aid) Act, 2014, Section 4
240 KP Injured Persons and Emergency (Medical Aid) Act, 2014, Section 8

- People who bring an injured person to the hospital are safeguarded against harassment from the authorities. Such a person is to be treated with due respect and acknowledgement of their selfless act and shall be allowed to leave the hospital after submitting their personal and contact details. However, they will be allowed to drop off a copy of NIC[241] within three days if they are not carrying it with them. Conversely, such a person is liable for causing any injury to the injured person.[242]

The prioritization of health care above legal procedures is a critical aspect of respect for health care services. It reduces the chances of agitation among attendants and protects people who, in performance of their civic duty, help an injured person. Therefore, it is the responsibility of medicolegal officers and the designated police officials at public hospitals to respect these provisions. It is worth mentioning that contravening this act is an offence punishable with imprisonment and/or a fine.[243] Additionally, where the offender is a doctor, the Court may also direct the PMDC to cancel their registration,[244] or the doctor may be liable to disciplinary action at government instruction. The latter is also applicable where the offender is a police officer or any other official.[245]

Consideration of and adherence to all these rules, among others, are essential to generate and enhance respect for health care services. With greater respect comes safety and security for both the service providers and beneficiaries. However, the authorities also need to play their role in effectively implementing the existing laws, as weak implementation is a major factor in fostering disrespect of the system among the public and practitioners.

241 National Identity Card
242 KP Injured Persons and Emergency (Medical Aid) Act, 2014, Section 9
243 KP Injured Persons and Emergency (Medical Aid) Act, 2014, Section 11
244 KP Injured Persons and Emergency (Medical Aid) Act, 2014, Section 11, second proviso
245 The KP Injured Persons and Emergency (Medical Aid) Act, 2014, S. 13

5. PREVENTING AND ADDRESSING VIOLENCE AGAINST HEALTH CARE: THE NEED FOR COMPREHENSIVE LEGISLATION

The foregoing discussion has highlighted the need for adopting legislation that would address all aspects of violence against health care and provide comprehensive protection to the medical profession. As seen in this report, the existing laws are insufficient in many ways:

- Where legal protections exist, they are either scattered among various laws or do not protect all categories of HCPs, for instance:
  - Rescuers are to be protected by the police while they manage emergencies, but other categories, in particular volunteers for various private ambulance services, remain outside such protection;
  - HCPs at government hospitals are protected as public servants and may bring criminal proceedings if they are forcefully obstructed from performing their duties, but HCPs who are not public servants cannot seek this remedy;
  - Forceful obstruction is not the only form of violence that could hinder the performance of their duties. Demands for preferential treatment may also create hurdles.
- Existing laws provide recourse to criminal litigation alone – a process most HCPs are reluctant to initiate.
- Some laws also create duplication in offences, thereby complicating an already complex criminal justice system:
  - The Pakistan Penal Code of 1860 and the Anti-Terrorism Act of 1997 criminalize the same act when committed against public servants, with the former giving jurisdiction to ordinary criminal courts, while the latter provides jurisdiction to anti-terrorism courts.
  - Such complexities further discourage HCPs from seeking legal recourse.
- Adherence to certain principles of medical ethics is instrumental in preventing violence against healthcare, yet no law exists that obligates their observance by all categories of HCPs and in all health care settings, for instance:
  - The PMDC Code of Ethics only addresses registered medical and dental practitioners;
  - A Code of Ethics for Unani, Ayurvedic or Homeopathic practitioners must be obeyed by these practitioners,[246] and where they fail to do so it would amount to misconduct,[247] however, the existence of the Code itself is dubious.
- No mechanism exists for collecting data on incidents of violence or for monitoring violence, so any reforms, whether legal or strategic, may still prove to be deficient.
- No legally mandated, uniform sign exists for signalling the protection of health facilities, health care transport and HCPs.

Recommendations for Strengthened Legislation on Preventing Violence against Health Care

Any legislation for the prevention of violence against health care should at the very least include the following:

i. Appropriate definitions for the operation of the proposed law. Where such definitions are present

246 Unani, Ayurvedic and Homeopathic Practitioners Act, 1965, Section 2(cccc)
247 Unani, Ayurvedic and Homeopathic Practitioners Act, 1965, Section 33(4)

in other laws, they could be utilized or referred to:

a. Arbitration

"means a process by which parties submit a dispute to the decision of a neutral person or persons appointed by mutual consent or under a statutory provision."[248]

b. Award

"means an arbitration award."[249]

c. Damage

As the proposed law should penalize "damage" to medical transport, medical supplies and health care facilities, an appropriate definition is required. Inspiration may be taken from, "'damage' was done to property, whether movable or immovable, whether partially or totally, without taking possession of the property."[250]

d. Health Care Facilities

"means a hospital, diagnostic centre, blood bank, medical clinic, nursing home, maternity home, dental clinic, homeopathy clinic, Tibb clinic, acupuncture, physiotherapy clinic, medical camp or any other premises or conveyance that is wholly or partly used for providing healthcare services in public and private sectors."[251]

e. Health Care

"Prevention, diagnosis, treatment or control of diseases, injuries or disabilities, as well as measures to safeguard the health of mothers and young children. The term encompasses all activities that ensure, or provide support for, access for the wounded and sick to these health-care services, including searching for, collecting or transporting the wounded and sick, or the management of health-care facilities."[252]

f. Health Care Personnel

"means all persons, paid or unpaid, working in healthcare settings and involved in providing healthcare services who may potentially be exposed to infectious materials, including, but not limited to, persons involved directly or indirectly in the provision of healthcare services, persons performing administrative tasks, persons involved in operation or transportation of medical services, and volunteers [proposed]."

g. Medical Supplies

"As regards the expression 'medical equipment or medical supplies', this should be interpreted broadly. It includes any equipment and supplies necessary for medical care – particularly surgical equipment – but also heavier equipment (for example, the equipment for an operating theatre or even an entire field hospital), or even, quite simply, medicines themselves."[253]

h. Medical Transport

"Medical transports include ambulances, medical … aircraft – whether civilian or military –

248 Draft Bill for Alternate Dispute Resolution Act, 2016, a bill introduced in the National Assembly of Pakistan on 18 November 2016 <http://www.na.gov.pk/uploads/documents/1479464263_627.pdf>

249 Arbitration Act, 1940

250 See Muhammad Hanif v. The State, PLD 2003 Peshawar 164, wherein the High Court differentiated between "damage to property" and "forcibly taking away property out of possession of owner".

251 KP Health Care Commission Act, 2015

252 ICRC, Health Care in Danger: Violent Incidents Affecting the Delivery of Health Care, April 2015, p. 4 <https://www.icrc.org/eng/assets/files/publications/icrc-002-4237.pdf> ; see also the KP Medical Teaching Institutions Reforms Act, 2015, Section 2(k)

253 Yves Sandoz, Christophe Swinarski and Bruno Zimmermann (eds.), ICRC Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949, ICRC, Geneva, 1987, Commentary to Art. 8(f)

and means of transport conveying the wounded and sick, health-care personnel and medical supplies or equipment. The term includes all vehicles used for health-care purposes, even if not assigned exclusively to medical transportation … such as private cars used to transport the wounded and sick to a health care facility, transport vehicles for medical supplies, and people-carriers transporting medical staff (e.g. for local vaccinations or to work in mobile clinics)."[254]

i. Emergency Vehicle

"means a motor vehicle, private or public, used solely for ambulance purposes or to relieve distress [proposed]"[255]

ii. Ambulance

"means a vehicle designed for the carriage of sick, wounded or invalid persons or animals"[256]

i. Obstruction

As the proposed law should penalize "obstruction" to the work of an HCP, whether at a health care facility or acts performed beyond the premises in professional capacity, the definition should be comprehensive. It may be noted that the HCiD definition of violence includes "forceful obstruction".[257] However, it should be defined regardless of whether it is treated separately from "violence" or as a category of it.

j. Violence

"Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, [or medical transport or health care facility] which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."[258]

k. Volunteer

"any person who has been appointed, at his own request, as an unpaid member to act in aid of health care personnel in the performance of any health care services [proposed]."[259]

ii. Any offences and penalties created by the proposed law should protect the entire spectrum of health care services. It should therefore create distinct offences against HCPs, medical supplies, medical transport and health care facilities, with appropriate penalties.

a. Regarding Health Care Personnel
   i. Obstruction (once defined in the proposed law, it may be penalized)
   ii. Violence (defined as proposed above and then appropriately penalized)

b. Regarding Medical Transport
   i. Obstruction (once defined in the proposed law, it may be penalized)
   ii. Theft (may refer to definitions in the Pakistan Penal Code)
   iii. Damage (once defined in the proposed law, it may be penalized)

254 See ICRC, Health Care in Danger: Violent Incidents Affecting the Delivery of Health Care, ICRC, April 2015, p. 4 <https://www.icrc.org/eng/assets/files/publications/icrc-002-4237.pdf>
255 Provincial Motor Vehicles Ordinance, 1965
256 Provincial Motor Vehicles Ordinance, 1965
257 See ICRC, Health Care in Danger: Violent Incidents Affecting the Delivery of Health Care, ICRC, April 2015, p. 4 <https://www.icrc.org/eng/assets/files/publications/icrc-002-4237.pdf>
258 See WHO, "Health Topics: Violence" <http://www.who.int/topics/violence/en/>
259 West Pakistan Defence Service Rules, 1966

c. Regarding Health Care Facilities
    i. Damage (once defined in the proposed law, may then be penalized)
    ii. Theft (may refer to definitions in the Pakistan Penal Code)
    iii. Robbery (may refer to definitions in the Pakistan Penal Code)
    iv. Dacoity (may refer to definitions in the Pakistan Penal Code)

iii. Proposed Legal Recourse:

Identify the appropriate legal forums for recourse and make arbitration mandatory in less-severe cases in order to settle disputes without resorting to criminal litigation. In contrast to the adversarial judicial system, arbitration offers a quick, simple and – if the parties accept – peaceful means of resolution.

a. Referral to Arbitration before Legal Proceedings
    i. Arbitrator: There must be a provision outlining the appointment of an arbitrator, whether by a court or by agreement of the parties themselves.
    ii. Award of Fine: An arbitrator should have the power to settle a dispute up to a certain severity and to impose a fine up to a certain limit. Moreover, the provision should specify the maximum period an arbitrator may take in reaching a decision. For instance, a bill in the National Assembly gives an arbitrator 60 days for this purpose.[260]

b. Criminal Proceedings

Where the offence is too grievous for the penalties that may be imposed by an arbitrator, it may be tried in criminal court. In other cases, where recourse to arbitration is a possibility, the award would still need to be submitted to a court of competent jurisdiction to pronounce judgment.

iv. Proposed Mechanism for Monitoring Violence against Health Care:

As detailed in Section 4.1 of the report, a mechanism should be established to collect and report data on violence against health care. Such a provision should include these aspects:

a. Form of Data Collection
b. Duty to Collect Data
c. Duty to Report Incident
d. Quarterly Review of Data
e. Power to Take Action

v. Responsibilities of Health Care Personnel:

In accordance with and taking inspiration from the PMDC Code of Ethics, the following ethical conduct should be recognized by the proposed law and made obligatory upon all HCPs, thereby addressing some of the main causes of violence and assisting in preventing violence. The legislation could also include disciplinary action for violating these principles. All health care facilities are required to have a complaints management system under the Complaint

260 Draft Bill for Alternate Dispute Resolution Act, 2016, a bill introduced in the National Assembly of Pakistan on 18 November 2016 <http://www.na.gov.pk/uploads/documents/1479464263_627.pdf>

Management and Patient's Rights Regulations of 2016,[261] and the Health Care Commission could include in this sytem`s mandate dealing with the violation of these principles:[262]

a. maintaining the highest standards of ethical conduct
b. respect for the rights of patients
c. safeguarding patient confidentiality
d. emergency care as a humanitarian duty[263] – i.e., not refusing to give medical treatment
e. non-discrimination among patients
f. furnishing complete information to a patient

vi. Protective Symbol:

As mentioned in Section 4.3.1 of the report, a uniform symbol could be designed for adoption by the entire health sector. While designating a symbol, the law would also need to stipulate its purpose, proper use, who may use it and under what circumstances, and what constitutes improper use. It should also penalize improper use. Therefore, the following subsections may be considered:

a. Proper Use of Symbol
b. Duty to Display Symbol
c. Penalty for Improper Use

As much as there is a need for legislation to prevent and prohibit violence against health care, it is only a first step. In order to be effective, any legislation must be followed up with strict implementation. The authorities need to play their role to ensure adherence to such a law and to put proper mechanisms in place.

261 Complaint Management and Patient's Rights Regulations, 2016, Regulation 44

262 Under Regulation 47, a complaint, at present, may address these issues:
- Medical negligence;
- Maladministration;
- Malpractice; and
- Failure in provision of health care services in accordance with the Health Care Commission Act of 2015 or the 2016 Regulations,.

263 "A physician shall … give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care." PMDC Code of Ethics of Practice for Medical and Dental Practitioners (Regulations), Regulation 4

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ANNEX I

HCID THEMATIC AREAS INDEX

This document enumerates the statutes relevant for the health sector in the context of Khyber Pakhtunkhwa. This is a comprehensive list of the statutes relied upon for the report, categorizing them into thematic areas for issues pertaining to Health Care in Danger and providing extracts to explain the context in which they are relevant.

Serial #	Relevant Legislation [Federal (F) / Provincial (P)]	Summary / Relevancy
1. RIGHTS & RESPONSIBILITIES OF HEALTH CARE PERSONNEL		
1	Pakistan Medical and Dental Council Ordinance, 1962 (F)	The Ordinance as amended in 2012, U/S[264] 3 reconstitutes the Pakistan Medical and Dental Council (PMDC) to regulate the recognition of institutions providing training in modern scientific medicine and dentistry, as well as for the registration of medical and dental practitioners. It also stipulates certain rules relevant to: • practitioners' privileges • patient-related matters • practitioners' responsibilities • removal of practitioners from the register
2	PMDC Code of Ethics for Medical and Dental Practitioners (Regulations)	Originally approved by the PMDC in 1968, these Regulations have been revised a few times, with the latest revision repealing the 2002 Code. Providing guiding principles for registered medical and dental practitioners, these regulations may be broadly divided into the following categories: • practitioners' duties • expectations for practitioners • prohibitions and ethical standards • practitioners' rights • professional fees • patients' rights • patients' duties • consent • exposure to liability
3	Unani, Ayurvedic and Homeopathic Practitioners Act, 1965 (F)	The Act aims to regulate traditional means of medicine and the registration of their practitioners by the establishing a Council for Tibb and a Council for Homeopathy. Under the Act, these traditional means include Unani, Ayurvedic and Homeopathic. It also stipulates certain obligations for these practitioners.

264 Under section

4	Unani, Ayurvedic and Homeopathic System of Medicine Rules, 1980	Clarifying certain provisions in the Act, 1965, these rules provide the procedure for registration of practitioners of traditional medicine and their entitlement to receive a certificate verifying their registration.
5	KP Tuberculosis Notification Act, 2016 (P)	This Act was promulgated for the establishment and effective management of the KP Tuberculosis Control Program (Provincial Program) in pursuance of the National Tuberculosis Control Program. Certain provisions of the Act enumerate the duties of registered medical practitioners and those in charge of private clinics and hospitals and other health care personnel.
6	KP Protection of Breast-Feeding and Child Nutrition Act, 2015 (P)	The Act establishes rules to ensure safe and adequate nutrition for infants and toddlers by promoting and protecting breastfeeding. It prohibits certain practices among health workers that discourage breastfeeding and imposes obligations on them to encourage breastfeeding.
7	KP Health Care Commission Act, 2015 (P) accompanied by Conduct of Business Regulations	This Act establishes the KP Health Care Commission to regulate health care services and promote and improve patient safety and the provision of quality health care services in both the public and private sectors. The accompanying regulations provide for: • registering and licensing health care establishments and personnel • complaint management and patients' rights • inspection of health care establishments
8	KP Medical Relief Endowment Fund Act, 2004 (P)	The Act was promulgated to create an endowment fund for providing medical relief and treatment to the poor and those who qualify as *Mustahiq e Zakat*.
9	West Pakistan Essential Services (Maintenance) Act, 1958 (P)	An Act to provide for the maintenance of certain essential services, including health services.

2. HEALTH GOVERNANCE LAWS		
10	KP Health Foundation Act, 2016 (P)	An Act to establish the KP Health Foundation for promoting and enabling innovative health care delivery models to achieve the government's policy objectives through public-private partnerships.
11	KP Regularization of Lady Health Workers Program and Employees (Regularization and Standardization) Act, 2014 (P)	This Act provides for the recruitment of lady health workers. It seeks to bring the federal program to the provincial level. To this end, after the Eighteenth Amendment to the Constitution in 2010, the federal program called National Program for Family Planning and Primary Health Care became the Lady Health Workers Program.
12	Pharmacy Act, 1967 (F)	The Act provides for the creation of a Pharmacy Council of Pakistan at the federal level and provincial pharmacy councils for each of the provinces, responsible for registering pharmacists.
13	Pakistan Nursing Council Act, 1973 (F)	The Act establishes the Pakistan Nursing Council. The Council is responsible for maintaining a registry of people qualified to serve as nurses, midwives, health visitors and nursing aids. It is also responsible for recognizing institutions providing training in these areas that are established and recognized by the federal government or a provincial government.
14	KP Faculty of Paramedical and Allied Health Sciences Act, 2016 (P)	This Act reconstituted and reorganized KP Faculty of Paramedical and Allied Health Sciences. Among other things, the Faculty is responsible for registering successful candidates after receiving diplomas or certificates issued by the Faculty and for handling the registry renewal process, which is required of paramedics every five years.
15	KP Medical Transplantation Regulatory Authority Act, 2014 (P)	The Act provides for the creation of the KP Medical Transplantation Regulatory Authority, responsible for regulating, monitoring and controlling transplantation of human organs and overseeing the various committees constituted under the Act.
16	KP Food Safety Authority Act, 2014 (P)	The Act provides for the establishment of a Food Safety and Halal Food Authority for food safety and standards in KP.

3. PREVENTIVE HEALTH CARE		
17	West Pakistan Epidemic Diseases Act, 1958 (F)	The Act consolidates the law relating to prevention of the spread of dangerous epidemic diseases. It empowers every provincial government to take measures and prescribe such temporary regulations as may be necessary for controlling the spread of any epidemic disease.
18	West Pakistan Vaccination Ordinance, 1958 (P)	The Act provides for the vaccination of children under 16 years of age and other unprotected people with a number of vaccinations for preventable diseases, such as tuberculosis, hepatitis B, polio, chickenpox, smallpox, rubella, tetanus, influenza, measles, etc. It obligates a vaccination officer to ensure that every person within his jurisdiction is vaccinated and to take appropriate steps in pursuance thereof.
19	KP Blood Transfusion Safety Authority Act, 2016 (P)	The Act creates a KP Blood Transfusion Authority responsible for adopting a uniform policy regarding all aspects of safe blood transfusion. The Authority also is responsible for registering and licensing blood banks and regional blood centres.
20	KP Preventive Health Act, 2009 (P)	The Act provides that before a marriage is solemnized the following safeguards must be taken: • A Nikah Registrar shall obtain test results of premarital screening of spouses for thalassemia and hepatitis C. • The Nikah Registrar shall keep and maintain these records for a period of at least two years from the date of solemnizing of the marriage.
4. TRAINING OF HEALTH CARE PERSONNEL		
21	Khyber Pakhtunkhwa Universities Act, 2012 (P)	An Act to reconstitute and reorganize the universities established or to be established in the public sector by the government of KP.

22	Khyber Medical University Statutes, 2016	Promulgated under the authority of S. 28 of the KP Universities Act, 2012, these statutes regulate a variety of matters related to KMU: • Annual reports; • University Fees and other miscellaneous charges; • Establishment of faculties, teaching departments, constituent institutions, constituent colleges and other academic divisions.
23	The KP Medical Teaching Institutions Reforms Act, 2015 (P)	This Act enables the establishment and regulation of medical teaching institutions and their affiliated hospitals. It also applies to medical teaching institutions created prior to its promulgation.
24	The KP Province Medical Teaching Institutions Interim Rules, 2015 (KP MTI Rules)	Under Rule 7(g), all medical teaching institutions shall strive to provide the highest quality facilities in terms of space, fixtures, equipment, personnel, and laboratory and imaging facilities to give the best possible environment for patient care, both private and general patients. This responsibility rests with the medical and hospital directors of the affiliated teaching hospitals, the board of each institution and all committees formed under the Act. Under Rule 7(h), the consultants are responsible for the most efficient and effective use of these facilities.
25	LRH Medical Teaching Institution Regulations, 2016	Promulgated in accordance with the KP Medical Teaching Institutions Reforms Act, 2015.
5. RESPECT FOR EMBLEMS		
26	Geneva Convention Implementing Act, 1936 (F)	Under the Act, it is prohibited to make unauthorized use or exhibition of the red cross, red crescent, or red lion and sun emblems. However, the red cross may be used with the permission of the Pakistan Red Crescent Society in time of peace to identify vehicles used as ambulances or to mark the position of aid stations set up exclusively for giving free medical treatment to wounded or sick people.

6. PROTECTION OF HEALTH CARE SERVICES		
27	KP Sensitive and Vulnerable Establishments and Places (Security) Act, 2015	Any establishment, including a hospital, which has been declared vulnerable by the Special Advisory Committee under this Act, is required to make appropriate and sufficient security arrangements. For this purpose, the head of district police may issue security guidelines to such establishments.
28	Pakistan Penal Code, 1860 (F)	The PPC is a penal law, stipulating offences and their punishments. However, it creates general exceptions for health care personnel from criminal liability for acts done in good faith and for the benefit of the patient.
29	Anti-Terrorism Act, 1997	Creates the offence of terrorism, including certain categories of the offence when committed against public servants, which includes HCPs employed in the government sector.
7. EMERGENCY SERVICES		
7.1. Emergency Care at Hospitals		
30	KP Injured Persons and Emergency (Medical Aid) Act, 2014 (P)	This Act provides for immediate emergency care to injured patients on a priority basis in order to save their lives and to protect their health. U/S 8, medical aid and treatment shall be given to injured persons before they are taken to a police station, if required. Section 9 creates a safeguard against harassment for people who bring injured people to the hospital.
7.2. Emergency Rescue Services and Disaster Management		
31	Civil Defence Act, 1952 (F)	The Act empowers the federal government to make such rules as may be expedient for securing the civil defence of Pakistan. Civil defence includes remedial measures during calamity or disaster in peace time.
32	Civil Defence (Special Powers) Rules, 1951 (F)	Under these rules, the federal government or the provincial government are empowered within their jurisdictions to constitute a body for the civil defence of any area, known as Civil Defence Services, and a controller to be appointed as head of these services.
33	West Pakistan Civil Defence Service Rule, 1966 (F)	A Civil Defence Service shall include casualty service comprising first aid posts, the ambulance service and first aid party service. This rule also allows for the appointment of paid or unpaid Razakars to these services.

34	National Disaster Management Authority Act, 2010 (F)	This Act establishes national, provincial and district disaster management authorities to provide for an effective disaster management system that includes: • preparedness • response • recovery and rehabilitation • reconstruction
35	KP Emergency Rescue Service Act, 2012 (P)	This Act provides for the establishment of Rescue 1122. It deals with all matters related to rescue operations, such as preparedness, training, emergency response, rescue and emergency medical treatment, non-obstruction of emergency services and criminalization of such obstruction.
7.3. Functioning of Emergency Services		
36	KP Industrial Relations Act 2010 (P)	The Act seeks to formulate the law relating to forming trade unions and regulating and improving relations between employers and employees. U/S 1(3)(h) the Act does not apply to employees of an establishment or institution that provides emergency services on a non-commercial basis. It does apply to those providing emergency services on a commercial basis. For hospitals and ambulance services considered "public utility services" as enumerated in the appended Schedule, U/S 45 the provincial government is empowered to prohibit a strike or lockout at any time before or after it commences.
7.4. Exemptions for Ambulances		
37	Provincial Motor Vehicles Ordinance, 1965 (F)	Emergency vehicles (including ambulances) and vehicles used solely to transport corpses may operate without permit from the Provincial Transport Authority.
38	KP Motor Vehicles Rules, 1969 (P)	Under Rule 43, motor ambulances used solely to transport dead bodies or sick or injured people are exempt from paying registration fees.

39	KP Motor Vehicles Taxation Rules, 1959 (P)	Exempts ambulances from paying taxes.
40	National Highways Safety Ordinance, 2000 (F)	Exempts ambulances on emergency run from obeying traffic signs.
8. RIGHTS AND RESPONSIBILITIES OF PATIENTS		
41	Pakistan Medical and Dental Council Ordinance, 1962	This section lists statutes (federal or provincial) and subordinate legislation that provide for the rights and duties of patients. These have been mentioned above in relation to various themes and are compiled here for convenience. It should also be noted that express rights or duties are found within each of the mentioned sources. However, where practitioners have certain responsibilities towards the patients, the latter would then have corresponding rights, even if not explicitly stated.
42	PMDC Code of Ethics of Practice for Medical and Dental Practitioners	
43	Complaint Management and Patient's Rights Regulations, 2016	
44	KP Medical Relief Endowment Fund Act, 2004	
45	KP Medical Transplantation Regulatory Authority Act, 2014	
46	West Pakistan Vaccination Ordinance, 1958	
47	KP Injured Persons and Emergency (Medical Aid) Act, 2014	

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