 

June 10, 2019

CEDAW Committee

Human Rights Treaties Division, OHCHR

Palais Wilson

52, rue des Paquis

CH-1201 Geneva Switzerland

**Re: Supplementary information for the adoption of the list of issues on Pakistan and for the consideration of the Committee in its 75th session**

Dear Honourable Committee Members,

This letter intends to supplement the fifth periodic report of the Government of Pakistan (herein also referred to as the State Party), scheduled for pre-session review during the 75th session of the Committee on the Elimination of Discrimination Against Women (Committee). The Center for Reproductive Rights (the Center) and Shirkat Gah Women’s Resource Centre[[1]](#endnote-2) aim to support the Committee in its adoption of list of issues by reporting information concerning reproductive rights in Pakistan protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

In its last set of Concluding Observations, the Committee recommended that the State Party strengthen its efforts to reduce the rate of maternal mortality, ensure access to affordable contraceptive methods, review its abortion legislation and raise the minimum age of marriage for girls to 18.[[2]](#endnote-3) Although some progress has been made towards increasing access to reproductive health services since the Committee’s last review, several reproductive rights-related recommendations made previously by this Committee for Pakistan have yet to be addressed adequately. This letter will focus on three issues seriously affecting the reproductive health and rights of women and girls in Pakistan: (1) high prevalence of maternal mortality and morbidity; (2) lack of access to safe abortion and post-abortion care services; and (3) barriers to access to

reproductive health services for adolescents. This letter respectfully proposes questions to be addressed to the State Party by the Committee in its list of issues.

**I.**High Prevalence of Maternal Mortality and Morbidity (Articles 1, 12 & 16)

The CEDAW Committee has repeatedly reaffirmed state obligations arising from the right to survive pregnancy and childbirth,[[3]](#endnote-4) and has noted that it is “discriminatory for a State Party to refuse to provide legally for the performance of certain reproductive health services for women.”[[4]](#endnote-5)The CEDAW Committee has also found that persistently high maternal mortality rates violate states’ obligation to ensure non-discrimination in access to health care.[[5]](#endnote-6)

Pakistan’s maternal mortality ratio (MMR) as of 2015 is estimated to be 178 deaths per 100,000 live births,[[6]](#endnote-7) which is a decline from the MMR in 2007-08, which stood at 276 deaths per 100,000 live births.[[7]](#endnote-8) While the State Party’s efforts should be appreciated, the MMR is still unacceptably high. The World Bank has found that Pakistan remains among the top ten countries in the world accounting for the most maternal deaths, with 9,700 women dying of pregnancy-related causes in Pakistan every year.[[8]](#endnote-9)Thousands more face debilitating maternal morbidities due to non-availability of quality and affordable maternal healthcare. For example, it is estimated that 3000-5000 cases of fistula develop in Pakistan every year.[[9]](#endnote-10) These include cases of obstetric fistula, resulting from prolonged obstructed labor in the absence of skilled birth attendance, as well as iatrogenic fistula, which results from surgical negligence during a caesarian section or hysterectomy.[[10]](#endnote-11)

Furthermore, Pakistan’s data collection on maternal mortality may underestimate maternal mortality ratio as the health information systems have a number of shortcomings.[[11]](#endnote-12) For example, the District Health Information System (DHIS) does not incorporate data collected by Lady Health Workers, a cadre of health workers trained by the government to provide primary health services.[[12]](#endnote-13) The Demographic Health Surveys also have limitations as they rely on household censuses, but this source has various limitations, including underestimates of deaths and the need for a large sample size.[[13]](#endnote-14)

The State Party has introduced a series of health policies designed to improve maternal health, such as the Maternal, Newborn and Child Health (MNCH) Program of 2005, which focuses on improving accessibility of quality obstetric care services and strengthening existing district health systems.[[14]](#endnote-15) In addition, some provinces have adopted Health Sector Strategies, which also contain commitments pertaining to maternal healthcare.[[15]](#endnote-16) The implementation of these policies remains weak, however, as evidenced by the persistently high rates of maternal mortality. The section below will discuss barriers to implementation in more depth, including discrimination in accessibility to healthcare. Subsequent sections will discuss other challenges to reproductive health, specifically barriers to accessing safe abortions and adolescent sexual and reproductive health services.

**Disparities in access to maternal healthcare and intersectional discrimination.** A deeper review of the persistently high maternal mortality ratio reveals severe disparities in access to maternal healthcare. Quality obstetric care services are beyond the reach of low-income women. A study of over 1000 cases of maternal death across the country found that an overwhelming majority of women and girls who died during pregnancy and childbirth were poor.[[16]](#endnote-17) The study concluded that “accessibility of health services was a big hindrance to obtaining medical care.”[[17]](#endnote-18) The Pakistan Demographic and Health Survey 2017-18 (PDHS 2017-18) noted that wealth and educational status is “highly related to whether delivery is assisted by a skilled provider and whether birth is delivered in a health facility.”[[18]](#endnote-19) It also found disparities in access to maternal healthcare between urban and rural women: while 84% of births to urban mothers were assisted by a skilled provider, only 63% of rural women were supported by a skilled provider.[[19]](#endnote-20)

**Inadequate budget for health services.** Although most victims of maternal mortality and morbidity are poor women, government health services remain woefully under-funded.The health system in Pakistan continues to suffer from a lack of investment by the government. Pakistan’s expenditure in healthcare stands at 1.12% of the GDP, which is well below the World Health Organization recommendation of 6%.[[20]](#endnote-21) Although government hospitals and basic health units exist at the district level to provide secondary and primary healthcare services, most expenditure in healthcare in Pakistan is out of pocket, and in spite of the public health infrastructure, a majority of Pakistan’s population relies on private healthcare facilities and providers.[[21]](#endnote-22) In its last set of Concluding Observations, the CEDAW Committee expressed concern regarding the “inadequate budget allocated to the health sector, in particular with regard to sexual and reproductive healthcare services, especially in rural remote areas.”[[22]](#endnote-23)

**Need for implementation of court orders to address fistula.** A constitutional petition filed in 2015 before a Provincial High Court on behalf of a woman who developed obstetric fistula requested that the government of Sindh province be directed to implement policies pertaining to obstetric care services in order to prevent the incidence of obstetric fistula.[[23]](#endnote-24) The petition, in the case of *Dr. Shershah Syed & Another v. Province of Sindh & Others* (C.P. 4243 of 2015), also requested that the government of Sindh be directed to ensure access to affordable fistula repair surgery. During the pendency of the petition, the Sindh Government disclosed that more than 50% of the sanctioned posts for gynecologists in government hospitals in Sindh were vacant, indicating that comprehensive obstetric care was not available in a large number of government health facilities.[[24]](#endnote-25) In 2019, the High Court of Sindh passed an order directing the Sindh government to establish four fistula repair centers across Sindh to increase access to fistula repair surgery and recruit gynecologists to fill vacancies in government hospitals across Sindh to increase availability of comprehensive obstetric care.[[25]](#endnote-26) The order is yet to be fully implemented. A compliance report from the Sindh Government detailing the measures it has taken to comply with the orders of the High Court was due in May 2019; the report has not yet been submitted.

**Attacks on Lady Health Workers*.*** The Lady Health Worker program, which was implemented in 1994 by the Ministry of Health continues to provide primary healthcare services, including contraceptive services, through community health workers.[[26]](#endnote-27) Pakistan should be commended for the success of its Lady Health Worker (LHW) program, which has shown to be effective in improving maternal and child health.[[27]](#endnote-28) External reviews of the program confirm that populations served by LHWs have substantially better indicators than those that are not.[[28]](#endnote-29) However, the government has not guaranteed sufficient protections for the LHWs, which limits the potential of the program to influence access to reproductive health services even more significantly. In many areas, LHWs are vulnerable to sexual harassment and physical violence, and several have been killed while performing their duty.[[29]](#endnote-30) The threats to LHWs intensified after militant groups began to target them in their campaign to disrupt polio vaccination drives.[[30]](#endnote-31) Further, a proper service structure, granting wage and benefits protections, for LHWs is yet to be implemented, and LHWs report long delays in payment of their wages.[[31]](#endnote-32)

**Barriers to Contraception Information and Services.** In spite of the policies and programs pertaining to the obstetric care, contraceptive prevalence rates in Pakistan remain low. This leads to high rates of unintended pregnancy, which contributes to the high MMR.[[32]](#endnote-33) According to a 2012 study, nearly half of all pregnancies in Pakistan were unintended.[[33]](#endnote-34) It is highly concerning that the use of contraceptive methods has remained stagnant over the past 5 years.[[34]](#endnote-35) The CEDAW Committee has recognized that lack of access to contraceptives contributes to maternal mortality by denying women the ability to prevent unwanted pregnancies and by exposing them to the risk of pregnancy complications as well as unsafe abortion complications.[[35]](#endnote-36)

In its last set of Concluding Observations, the Committee expressed “concern about the high mortality rate” as well as “women’s lack of adequate access to family planning services.”[[36]](#endnote-37) The Committee recommended that the State Party “improve women’s access to health-care facilities and medical assistance by trained personnel, especially in rural and remote areas, and ensure access to affordable contraceptive methods throughout the country.”[[37]](#endnote-38) General Recommendation 24 obligates states “to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care,”[[38]](#endnote-39) and links high maternal mortality and morbidity rates with a failure to do so.[[39]](#endnote-40) It is encouraging that the State Party’s report references a number of policies and programs initiated in order to address maternal health.[[40]](#endnote-41) However, the report does not contain an assessment of these programs and the State Party should provide more information on the measures it has taken to ensure that policies and programs have an impact on accessibility and availability of reproductive health services.

**II.** Barriers To Accessing Safe Abortion Services (Articles 1, 12, 16)

The CEDAW Committee has found that restrictive abortion laws violate a range of human rights, including the right to non-discrimination in health-care (Article 12) and in all matters related to marriage and family relations (Article 16), and has recognized the connection between restrictive abortion laws, high rates of unsafe abortion and maternal mortality.[[41]](#endnote-42) The CEDAW Committee has also recognized that at a minimum, abortion must be legal when a woman’s life or health is at risk, in cases of rape and incest, and in cases of severe or fatal fetal impairment.[[42]](#endnote-43)

Restrictive abortion laws in Pakistan deny women their right to access safe abortion services. Abortion is criminalized under Pakistan’s Penal Code unless it is to save the life of the woman or provide “necessary treatment” to a woman before the organs of the fetus have been formed.[[43]](#endnote-44) The law does not define “necessary treatment” creating ambiguity for the providers and women about when abortion is not criminalized. Once the organs have been formed, abortion is permitted only to save the life of the pregnant woman.[[44]](#endnote-45) Aside from these two exceptions, abortion remains criminalized, and women undergoing abortions as well as service providers are liable to criminal penalties.[[45]](#endnote-46) Although the government has taken some positive policy measures to promote safe abortion services, these policies are in the form of guidelines to service providers that are not legally binding and do not contain provisions regarding monitoring and accountability.[[46]](#endnote-47) The ambiguity in the law therefore persists, creating confusion and insecurity among service providers and leading to the denial of abortion services.[[47]](#endnote-48)

Despite the narrow legal grounds for abortion, there were an estimated 2.2 million abortions in 2012, the last year for which figures are available, and the abortion rate was 50 abortions per 1000 women aged 15-29, which is one of the highest abortion rates in the world.[[48]](#endnote-49) A majority of abortions in Pakistan are clandestine, which place the health and lives of women at risk.[[49]](#endnote-50) In 2012, an estimated 623,000 women were treated for post-abortion complications, the vast majority of which were performed by unqualified providers or involved traditional methods.[[50]](#endnote-51) According to a 2012 study, a majority of women treated for post-abortion complications obtained care in a private facility,[[51]](#endnote-52) suggesting that low-income women unable to afford treatment in private facilities were less likely to receive post-abortion care.

In its 2013 Concluding Observations, the Committee recommended that Pakistan “review its abortion legislation with a view to expanding the grounds under which abortion is permitted, for example, cases of rape and incest, and prepare guidelines on post-abortion care to ensure that women have access to this type of service…”[[52]](#endnote-53) Despite these recommendations, law reform has not occurred on abortion itself and the criminalization of abortion and persistent ambiguity and very limited exceptions in the law continue to violate women’s and girls’ rights.

III. barriers to adolescents’ access to sexual and reproductive health services (articles 1, 10, 12 & 16)

The Committee has recognized that adolescent pregnancy is linked to high rates of maternal mortality – particularly when girls are subjected to child, early and forced marriages – noting that complications from pregnancy are the leading cause of death for adolescent girls aged 15-19 in developing countries.[[53]](#endnote-54) Treaty monitoring bodies have also called on governments to guarantee the rights of adolescents to health, life, education and non-discrimination by ensuring that health systems are able to meet the sexual and reproductive health needs of adolescents, and by providing them comprehensive sexuality education that is scientifically accurate and objective, age appropriate, and free of prejudice and discrimination.[[54]](#endnote-55)

The 2017-18 PDHS notes that “[t]eenage mothers are more likely to experience adverse pregnancy outcomes and be constrained in their ability to pursue educational opportunities than young women who delay childbearing.”[[55]](#endnote-56) The promotion of adolescent sexual health and reproductive rights in Pakistan is challenging due to a prohibitive legal and cultural environment, which creates circumstances where “there is little acknowledgment that adolescents have sex, whether consensual or coerced, before marriage and many believe that exposure to sexuality education will incite unwanted behavior.”[[56]](#endnote-57) Despite the high incidence of child marriage in Pakistan, “there is also little acknowledgement that married adolescents need to be proactively prepared to meet their [sexual and reproductive health needs] and promote their well-being.”[[57]](#endnote-58)

The persistence of child marriage in Pakistan poses a grave risk to the reproductive health and rights of girls. Child marriage is linked to a continuum of reproductive and sexual harms for girls, as it severely compromises their sexual and reproductive health and autonomy. Twenty one percent of girls in Pakistan are married by the time they reach the age of 18[[58]](#endnote-59) and Pakistan ranks sixth in the world in terms of the highest absolute numbers of child marriage.[[59]](#endnote-60) The Child Marriage Restraint Act 1929, (CMRA) which is applicable in most provinces of Pakistan, does not entirely prohibit child marriages as it permits the marriage of girls above the age of 16, while setting 18 as the minimum age of marriage for boys.[[60]](#endnote-61) The only province in Pakistan with independent legislation on child marriage is Sindh, which passed the Sindh Child Marriage Restraint Act (SCMRA) in 2013.[[61]](#endnote-62) The SCMRA sets a uniform age minimum age as 18 for both boys and girls. The implementation of the law is severely hampered, however, by the absence of support mechanisms for girls who wish to leave child marriages.[[62]](#endnote-63) There is a severe shortage of child protection institutes and shelters for girls as well as an absence of effective legal aid and psycho-social counseling.[[63]](#endnote-64)

The Committee has expressed concern about the “persistence of child and forced marriages and at the fact that the minimum age of marriage for girls is 16” in Pakistan.[[64]](#endnote-65) It has recommended the State Party to “raise the minimum age of marriage for girls to 18.”[[65]](#endnote-66) However, the federal CMRA, which is applicable in most parts of Pakistan, remains unamended. Recently, in a positive development, the Senate passed a bill amending the CMRA to increase the minimum age of marriage for girls to 18.[[66]](#endnote-67) The bill cannot become law, however, until it passes in the National Assembly, where it has already faced considerable opposition.[[67]](#endnote-68)

Proposed List of Issues

We respectfully request that the Committee raise the following issues with the delegation representing the Government of Pakistan during its pre-session review:

1. What steps have been taken by the State Party to improve maternal health, particularly for adolescents and poor women since the last periodic review?
   * 1. What measures have been taken by the State Party to address high rates of maternal mortality and morbidity by ensuring the implementation of policies pertaining to basic and comprehensive care, including addressing disparities in health care such as barriers faced by rural women?
     2. What measures have been taken by the State Party to ensure that government health facilities are properly staffed and equipped to provide quality obstetric care and that women, particularly from low-income and rural backgrounds, have access to affordable and quality healthcare facilities for their reproductive health needs?
     3. What measures are being taken by the State Party to ensure implementation of the orders of the Sindh High Court in *Dr. Shershah Syed & Another v. Province of Sindh & Others* (C.P. 4243 of 2015), directing the Government of Sindh to establish four fistula repair centers and to fill vacancies in positions of gynecologists in government hospitals. Has the government submitted its report to the Court as directed, and what are the contents of this report?
     4. What measures are being taken by the State Party to ensure that Lady Health Workers are paid regularly, are guaranteed work protections through a recognized service structure and are protected against physical and sexual harassment and violence?
2. What measures have been taken by the State Party to ensure access to safe abortion services? What measures have been taken by the State Party to provide clarity on the legal exception to abortion to save a woman’s life and in the course of “necessary treatment” and address barriers from criminalization?
3. What steps have been taken by the State Party to ensure dignified treatment and timely access to post-abortion care for women suffering complications from unsafe abortions?
4. What measures have been taken by the State Party to remove barriers to adolescents’ access to sexual and reproductive health services? Specifically:
   * 1. What measures are being taken to provide adolescents comprehensive sexuality education?
     2. What measures are being taken to address social and cultural taboos that prevent adolescents from accessing sexual and reproductive health services?
     3. What measures are being taken by the State Party to end impunity for child marriage and ensure the availability of support and protection mechanisms for girls who are victims of child marriage?

If you have any questions on the information submitted herein, please contact Payal Shah, Acting Regional Director for Asia, Center for Reproductive Rights at pshah@reprorights.org and Sara Malkani, Advocacy Adviser Asia, Center for Reproductive Rights at smalkani@reprorights.org. Thank you for your consideration.

Respectfully submitted,

Center for Reproductive Rights

Shirkat Gah Women’s Resource Centre

1. The Center for Reproductive Rights is a global legal advocacy organization with offices in Nepal, Colombia, Kenya, Switzerland and the United States using the power of law to advance reproductive rights as fundamental rights around the world. Shirkat Gah Women’s Resource Centre is a women’s rights organization based in Pakistan with the mission to advocate and mobilize for gender equality and social justice. [↑](#endnote-ref-2)
2. Committee on the Elimination of Discrimination against Women (CEDAW), *Concluding*

   *Observations: Pakistan*, paras. 32, 38, CEDAW/C/PAK/CO/4 (2013) [hereinafter CEDAW Committee, *Concluding Observations: Pakistan* (2013)]. [↑](#endnote-ref-3)
3. *See e.g.* CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), U.N. Doc. HRI/GEN/1/Rev.9 (Vol II)(2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*]; Alyne da Silva Pimentel Teixeira v Brazil, CEDAW Committee, Comm’n No. 17/2008 U.N. Doc CEDAW/C/49/D/17/2008 (2011). [↑](#endnote-ref-4)
4. CEDAW Committee, *Gen. Recommendation No. 24, supra* note 3, para. 11. [↑](#endnote-ref-5)
5. *See* CEDAW Committee, *Concluding Observations: India*, para. 30, UN Doc. CEDAW/C/IND/CO/4-5 (2014). [↑](#endnote-ref-6)
6. World Bank, Maternal mortality ratio (modeled estimate, per 100,000 live births)(2015), *available at* https://data.worldbank.org/indicator/sh.sta.mmrt. [↑](#endnote-ref-7)
7. National Institute of Population Studies, Pakistan: Demographic and Health Survey 2006-07 177 (2008) [hereinafter PDHS 2006-07]. [↑](#endnote-ref-8)
8. World Bank, *Number of maternal deaths* (2015), *available at* https://data.worldbank.org/indicator/SH.MMR.DTHS?name\_desc=true. [↑](#endnote-ref-9)
9. *Victims of Obstetric Fistula Continue to Suffer in Silence*, The News, May 24, 2018*, available at* https://www.thenews.com.pk/print/320649-victims-of-obstetric-fistula-continue-to-suffer-in-silence. [↑](#endnote-ref-10)
10. *Id.* [↑](#endnote-ref-11)
11. Jasmin Anwar et al., *Under-estimation of maternal and perinatal mortality revealed by an enhanced surveillance system: enumerating all births and deaths in Pakistan*, 18 BMC Public Health 428 (2018), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5880001/. [↑](#endnote-ref-12)
12. Jasmin Anwar et al., *Under-estimation of maternal and perinatal mortality revealed by an enhanced surveillance system: enumerating all births and deaths in Pakistan*, 18 BMC Public Health 428 (2018), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5880001/. [↑](#endnote-ref-13)
13. *Id.* [↑](#endnote-ref-14)
14. Planning Commission, Government of Pakistan, Pakistan Millennium Development Goals Report 2013(2013), *available at* http://www.undp.org/content/dam/pakistan/docs/MDGs/MDG2013Report/UNDP-Report13.pdf. [↑](#endnote-ref-15)
15. *See e.g.* Government of Punjab, Punjab Health Sector Strategy 2012-20; Government of Sindh, Sindh Health Sector Strategy 2012-20. [↑](#endnote-ref-16)
16. Paiman & USAID, Deaths of Women of Reproductive Age, 6 (2010). [↑](#endnote-ref-17)
17. *Id.* at 15. [↑](#endnote-ref-18)
18. National Institute of Population Studies, Pakistan: Demographic and Health Survey 2017-18 20 (2019) [hereinafter PDHS 2017-18]. [↑](#endnote-ref-19)
19. *Id.* [↑](#endnote-ref-20)
20. Asma Ghani, *Less than half of health budget used*, Express Tribune, Apr. 27, 2018, available at https://tribune.com.pk/story/1696195/1-less-half-health-budget-used/. [↑](#endnote-ref-21)
21. World Bank, Out of Pocket Expenditure (% of current expenditure) *available at* https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS [↑](#endnote-ref-22)
22. CEDAW Committee, *Concluding Observations: Pakistan* (2013) *supra* note 1. [↑](#endnote-ref-23)
23. *Shershah Syed & Others v. Province of Sindh & Another*, C.P. 4243 of 2015 (copy of petition is available on file with the Center). [↑](#endnote-ref-24)
24. Copy of order of Sindh High Court dated December 18 2018 is available on file with the Center for Reproductive Rights; *see also* *SHC voices concern over 95 vacant posts of Gynecologists*, Express Tribune, December 19 2018 *available at* https://www.thenews.com.pk/print/407675-shc-voices-concern-over-95-vacant-posts-of-gynaecologists [↑](#endnote-ref-25)
25. Copy of order of Sindh High Court dated February 19 2019 is available on file with the Center for Reproductive Rights; see also *SHC Directs Health Department To Prevent Incidence of Obstetric Fistula*, The News, March 5, 2019, available at https://www.thenews.com.pk/print/439783-shc-directs-health-department-to-prevent-incidence-of-obstetric-fistula [↑](#endnote-ref-26)
26. *See* Nina Zhu et al., Lady Health Workers in Pakistan: Improving access to health care for rural women and families 3 (2014), available at https://cdn2.sph.harvard.edu/wp-content/uploads/sites/32/2014/09/HSPH-Pakistan5.pdf. [↑](#endnote-ref-27)
27. *Id*. at 5. [↑](#endnote-ref-28)
28. *Id.* [↑](#endnote-ref-29)
29. Public Services International, *Time to end attacks on Lady Health Workers in Pakistan*, World-PSI.org, Feb. 2, 2017 *available at* http://www.world-psi.org/en/time-end-attacks-lady-health-workers-pakistan. [↑](#endnote-ref-30)
30. Hafsa Adil, *The Plight of Pakistan’s Lady Health Workers*, Al-Jazeera, April 10, 2018, https://www.aljazeera.com/indepth/features/plight-pakistan-lady-health-workers-180410085710330.html. [↑](#endnote-ref-31)
31. *Id.* [↑](#endnote-ref-32)
32. *See e.g.* World Health Organization (WHO), The World Health Report 2005: Make Every Mother and Child Count, 48-50 (2005) *available at* https://www.who.int/whr/2005/whr2005\_en.pdf?ua=1. [↑](#endnote-ref-33)
33. Sathar et. al. *Induced Abortions and Unintended Pregnancies in Pakistan*, Studies in Family Planning, 471-491, 483 (2014). [↑](#endnote-ref-34)
34. PDHS 2017-18, *supra* note 18 at 20. [↑](#endnote-ref-35)
35. CEDAW Committee, *Concluding Observations: Pakistan*, para. 41, U.N. Doc. CEDAW/C/PAK/CO/3 (2007). [↑](#endnote-ref-36)
36. CEDAW Committee, *Concluding Observations: Pakistan* (2013), *supra* note 2 at para. 31. [↑](#endnote-ref-37)
37. *Id.* [↑](#endnote-ref-38)
38. CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 3 at para 17. [↑](#endnote-ref-39)
39. CEDAW Committee, *Concluding Observations: Bolivia*, para.43 U.N. Doc CEDAW/C/BOL/CO/4 (2008). [↑](#endnote-ref-40)
40. CEDAW, *Fifth Periodic Report Submitted by Pakistan under Article 18 of the Convention*, paras. 153-164, CEDAW/C/PAK/5 (2018). [↑](#endnote-ref-41)
41. See e.g. L.C. v. Peru, CEDAW Committee, Commc’n No. 22/2009, para. 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011). [↑](#endnote-ref-42)
42. *Id.*  [↑](#endnote-ref-43)
43. Pakistan Penal Code of 1860, s. 338. [↑](#endnote-ref-44)
44. Pakistan Penal Code of 1860, s. 338-B [↑](#endnote-ref-45)
45. Pakistan Penal Code of 1860, s. 338-A, 338-B. [↑](#endnote-ref-46)
46. *See* Government of Punjab, Service Delivery Standards and Guidelines for High Quality Safe Uterine Evacuation and Post-Abortion Care (April 2015).

    Government of Pakistan, National Service Delivery Standards and Guidelines for High Quality Safe Uterine Evacuation and Post-Abortion Care, (March 2018). [↑](#endnote-ref-47)
47. Diaa Hadid, *Why the abortion rate in Pakistan is one of the highest*, NPR, Nov. 28 2018 *available at* https://www.npr.org/sections/goatsandsoda/2018/11/28/661763318/why-the-abortion-rate-in-pakistan-is-one-of-the-worlds-highest [↑](#endnote-ref-48)
48. Sathar et. al. *Induced Abortions and Unintended Pregnancies in Pakistan*, Studies in Family Planning, 471-491, 471 (2014). [↑](#endnote-ref-49)
49. Guttmacher Institute, Factsheet: Unintended Pregnancy and Induced Abortion in Pakistan (2015) *available at* https://www.guttmacher.org/sites/default/files/factsheet/fb-pakistan.pdf [↑](#endnote-ref-50)
50. Sathar et. al. *Induced Abortions and Unintended Pregnancies in Pakistan*, Studies in Family Planning, 471-491, 481 (2014). [↑](#endnote-ref-51)
51. *Id.* [↑](#endnote-ref-52)
52. CEDAW Committee, *Pakistan: Concluding Observations* (2013), *supra* note 2 at para. 31. [↑](#endnote-ref-53)
53. CEDAW Committee & CRC Committee, *Joint Gen. Recommendation No. 31 & Gen. Comment No. 18 on harmful practices*, paras. 21, 22, U.N. Doc. CEDAW/C/GC/31-CRC/C/GC/18 (2014). [↑](#endnote-ref-54)
54. CEDAW Committee, Concluding Observations: Italy, para. 35 U.N. Doc. CEDAW/C/ITA/CO/7 (2017); *Nigeria*, para 34 U.N. Doc. CEDAW/C/NGA/CO/7-8 (2017); *Ireland* para. 39 U.N. Doc. CEDAW/C/IRL/CO/6-7 (2017). [↑](#endnote-ref-55)
55. 2017-18 PDHS *supra* note 18 at 16. [↑](#endnote-ref-56)
56. Chandra-Mouli et. al., *Building Support for Adolescent Sexuality and Reproductive Health Education and Responding to Resistance in Conservative Contexts: Cases from Pakistan,* GLOBAL HEALTH: SCIENCE AND PRACTICE, 1-2 (2018). [↑](#endnote-ref-57)
57. *Id.* [↑](#endnote-ref-58)
58. Girls Not Brides, Where Does It Happen, available at https://www.girlsnotbrides.org/child-marriage/pakistan/ [↑](#endnote-ref-59)
59. UNICEF, State of the World’s Children, 152 (2016) *available at* https://www.unicef.org/publications/index\_91711.html [↑](#endnote-ref-60)
60. Child Marriage Restraint Act 1929. [↑](#endnote-ref-61)
61. Sindh Child Marriage Restraint Act 2013. [↑](#endnote-ref-62)
62. Center for Reproductive Rights, Ending Impunity for Child Marriage in Pakistan: Normative and Implementation Gaps, 33-34 (2018) *available at* https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/64785006\_ending\_impunity\_for\_child\_marriage\_pakistan\_2018\_print-edit-web.pdf [↑](#endnote-ref-63)
63. *Id.* [↑](#endnote-ref-64)
64. CEDAW Committee, *Concluding Observations: Pakistan* (2013) *supra* note 2 at para. 37 (2013) [↑](#endnote-ref-65)
65. *Id.* at para. 38 [↑](#endnote-ref-66)
66. Javed Hussain, *Senate Sees Off Religious Parties’ Opposition To Pass Bill Against Child Marriage*, DAWN, April 29, 2019 available at https://www.dawn.com/news/1479198 [↑](#endnote-ref-67)
67. Amir Wasim, *Bill Against Child Marriage Divides Parties in NA*, DAWN, May 1, 2019 available at https://www.dawn.com/news/1479444 [↑](#endnote-ref-68)