April 28, 2017

Committee on Economic, Social and Cultural Rights (CESCR)
Office of the High Commissioners for Human Rights
Geneva, Switzerland

RE: Supplementary information on Pakistan, scheduled for review by the CESCR during its 61st session in May-June 2017.

Dear Committee Members:

This shadow letter is intended to complement the periodic report submitted by the State of Pakistan for your consideration during the 61st session of the CESCR. The Pakistan Alliance for Postabortion Care (PAPAC), a coalition with more than 40 member organizations created in February 2010, aims to ensure access to quality postabortion care and related reproductive health services including family planning by sharing information, experiences and collaborating on strategic thinking and planning. This letter is intended to provide the Committee with an independent report on maternal mortality and abortion in Pakistan, particularly under Article 12 of the Covenant on Economic, Social, and Cultural Rights (the Covenant).

Under Article 12 of the Covenant, the government of Pakistan has a responsibility to take measures to reduce maternal mortality and increase access to health care services for women. Specifically, **article 12** protects the right to the highest attainable standard of physical and mental health for all people, including women's ability to obtain necessary reproductive health care services that include safe, legal abortion care. In its **General Comment 14**, the CESCR specifies that states must implement measures to "(i) improve child and maternal health, sexual and reproductive health care services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as resources necessary to act on that information."[1] Furthermore, in its most recent **General Comment 22** on the right to sexual and reproductive health under article 12 of the Covenant, this Committee has stated that the "right to sexual and reproductive health is an integral part of the right to health enshrined in article 12" and full enjoyment of this right is often limited by a number of legal, procedural, practical, and social

[1] Committee on Economic, Social and Cultural Rights (CESCR), *General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12)* (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies, at 90, par. 14, U.N. Doc. HRI/GEN/1/Rev.5 (2001).

barriers.[2] Specific to abortion, the General Comment notes that denial of abortion services often contributes to increased maternal mortality and morbidity, constituting a violation of the right to life or security, and sometimes amounting to torture or cruel, inhuman or degrading treatment.[3]

This Committee has underlined in **General Comment 14** the need for states parties to provide a full range of high-quality and affordable health care, including sexual and reproductive health services; the Committee has also emphasized states' obligation to reduce women's health risks and lower maternal mortality rates, including by removing all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health.[4] In General Comment 14, the Committee has also elaborated on principles of non-discrimination on the basis of gender, and equal treatment with respect to the right to health.[5]

Though the Committee has not yet issued Concluding Observations for Pakistan, this Committee has expressed in other countries' Concluding Observations a deep concern over the relationship between high rates of maternal mortality and illegal, unsafe abortions.[6] The Committee has made recommendations to states that they increase education on reproductive and sexual health, as well as implement programs to increase access to family planning services and contraception.[7]

The Committee on the Elimination of Discrimination against Women expressed concern about the "high maternal mortality rate in State party, women's lack of adequate access to family planning services, including contraceptives, restrictive abortion laws and the large number of women resorting to unsafe abortions, as well as the lack of adequate post-abortion care services."[8] and urged Pakistan to "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.[9] work on which has indeed moved forward. In addition, the Committee on the Rights of the Child has expressed concern about "reports of large numbers of teenage pregnancies terminated using unsafe and clandestine abortion procedures and lack of access to legal abortion, especially for unmarried girls"[10] and urged State party to "Review its legislation with a view to ensuring that children, including unmarried girls, have access to contraception, safe abortion and post-abortion care services."[11]

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[2] CESCR, *General Comment 22: The Right to Sexual and Reproductive Health (article 12 of the International Covenant on Economic, Social and Cultural Rights)* (May 2016), pars. 1-2.
[3] *Id.* at par. 12.
[4] *Id.*
[5] *Id.* at par. 18.
[6] *See e.g.,* **Cameroon,** 08/12/99, U.N. Doc. E/C.12/1/Add.40, par. 25; **Mauritius**, 31/05/94, U.N. Doc. E/C.12/1994/8, par. 15; **Mexico,** 08/12/99, U.N. Doc. E/C.12/1/Add.41, par. 29; **Nepal**, 24/09/2001, U.N. Doc. E/C.12/1/Add.66, par. 32.
[7] *See, e.g.,* **Bolivia,** 21/05/2001, U.N. Doc. E/C.12/1/Add.60, par. 43; **Mexico,** 08/12/99, U.N. Doc. E/C.12/1/Add.41, par. 43; **Nepal**, 24/09/2001, U.N. Doc. E/C.12/1/Add.66, pars. 33, 55; **Poland,** 16/06/98, U.N. Doc. E/C.12/1/Add.26, par. 12.
[8] CEDAW, *Concluding comments of the Committee on the Elimination of Discrimination Against Women*: *Pakistan*, par 31 (March, 2013).
[9] *Id*. at par. 32.
[10] CRC, *Concluding comments of the Committee on the Rights of the Child: Pakistan*, par. 51, (July, 2016).
[11] *Id*. at par 52.

The Punjab province has developed standards and guidelines for the provision of high quality, safe abortion and post-abortion care services. This province represents approximately 60% of the population of Pakistan, and there is promising political will to replicate these standards and guidelines in the remaining provinces. We request that the Committee praise the government for this progress on development of standards and guidelines for the provision of safe abortion services. Another strategic step is that postpartum and postabortion family planning Task Force, led by Department of health in each province is created to strengthen synergies and addressing high FP-unmet needs in Pakistan.

In its current report to this Committee, the government has reported on specific health worker programs that support maternal health and family planning trainings, as well as private sector efforts to improve maternal and child health. We wish to supplement the government's report by commenting on the positive steps that the government of Pakistan has taken to alleviate maternal mortality due to unsafe abortion and identify areas where the government should take further measures to fulfill women's right to health under the Covenant.

The Legal Framework for Abortion

The abortion law in Pakistan provides for legal abortion in cases of threat to health and in early pregnancy for "necessary treatment." The phrase necessary treatment is not clearly defined or widely understood, and safe and legal abortion care is not widely accessible. High levels of unmet need for contraception and low levels of contraception use leave many women at risk for unintended pregnancy.[12] Without access to safe abortion, many women and girls who experience unintended pregnancy risk their health and lives by resorting to unsafe abortion. Unsafe abortion accounts for at least 6% of maternal mortality in Pakistan, and this might be an underestimate given the sub regional average of 13%.[13]

Post-Karachi Declaration Progress made:

Unsafe abortions increase the likelihood of complications that require medical attention. Training medical personnel in how to properly treat these complications (postabortion care or PAC) is key to reducing deaths and injuries from unsafe abortion procedures. In 2009, the Ministry of Health and the Ministry of Population Welfare of Pakistan sought to implement postabortion care (PAC) guidelines nationally as part of the Karachi Declaration, the aim of which was to scale up best practices for maternal, newborn and child health, and family planning to achieve the Millennium Development Goals. PAC was included in the draft of the National Health and Population Policies in 2010, but, per a 2013 Guttmacher report, "since the Ministry of Health and Population Welfare were abolished in 2011, each province is now expected to develop its own population and health policy. This process of decentralization has caused some delays in the implementation of PAC policies through all the provinces.[14] However, there have been many important advances we would like to highlight. Punjab Province has taken the lead in many initiatives, including creating the Punjab RH Technology Assessment Committee (PRTHAC) in 2013 which advocated for

[12] National Institute of Population Studies (NIPS) and Macro International, *Pakistan Demographic and Health Survey 2006–07*, Islamabad, Pakistan: NIPS and Macro International, 2008.
[13] World Health Organization (WHO), *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008*, sixth ed., Geneva: WHO, 2011.
[14] Zathar S et al., Postabortion Care in Pakistan, In Brief, New York: Guttmacher Institute, 2013, No. 4.

government-included misoprostol and MVA in provincial essential lists and Essential Package of Health Services (EPHS) in 2013. Following in its suite, Sindh government has also created Sindh RH Technology Assessment Committee (SRHTAC) in 2016. Similarly, Postpartum and Postabortion FP task forces have been notified in each province under lead of Department of Health.

The government of Pakistan has shown commitment towards eliminating maternal mortality due to unsafe abortion. Service delivery standards and guidelines for high quality uterine evacuation and postabortion care have moved forward in Punjab Province with movement to replicate these S&Gs in other provinces in coming years. In addition, the Pakistan Nursing Council extended authorization to midwives to provide care with misoprostol and MVA, misoprostol has been included for PAC in National Essential Medicine List (NEML) and the Ministry of National Health Services Regulation and Coordination (MoNHSR&C) has endorsed a Reference manual for Women-centered PAC as the standard document for all PAC-trainings including doctors and midlevel providers. The recent research report on FP Landscape by Population Council indicates a large, untapped private sector that has prompted provincial governments to consider partnership with private players. These are all positive steps the government of Pakistan has taken to protect and fulfill women's right to health. However, much more needs to be done as women continue to experience barriers accessing otherwise legal services.

Joining hands with Government and partners, PAPAC is playing a key role in promoting enabling policy environment, and scaling up Quality and Task shifting in PAC and postabortion family planning. There is strong need to link all these positive steps towards reaching out to young and adolescent girls for fulfilling their RH needs and rights, and with FP2020 movement already started in Pakistan.

We urge this Committee to remind the government of its obligation under the Covenant to make health services more readily available to women in the country, and to remove barriers that keep women from accessing lifesaving health services.

Barriers to Safe Abortion in Pakistan

<u>Ignorance of the law and stigma</u>

Abortion is legal in Pakistan to save the life of the woman or to provide necessary treatment. The abortion law, however, does not address cases of rape, incest, and fetal abnormalities. Abortion-related stigma, the narrow legal grounds for abortion, and the lack of understanding or clarity in interpreting and implementing the law by both women and healthcare providers means that women often resort to clandestine and unsafe abortion procedures that result in death or adverse health consequences. Although policy commitments and training the health work force are important steps, they are not enough to change the underlying economic, social, and cultural factors, including stigma, that lead women to seek abortion in unsafe conditions. Without attitudes grounded in respect for women, providers may refuse to provide care or provide substandard care. Abortion like other public health concerns that are related to sex, gender and sexuality, has engendered stigma and discrimination against those advocating for, seeking and providing services. As a result, different stakeholders with personal values, beliefs and biases, influence and sometimes obstruct safe uterine evacuation/PAC service. It is in this context that one study found

that in 2012 there were a reported 2.2 million abortions, performed in Pakistan, of which more than 85% women accessed untrained service providers or quacks and resorted to life threatening complications (almost 700,000 each year) due to use of outdated and unsafe approaches and methods.[15]

Many factors become the barrier when a woman with postabortion complications needs treatment at a health facility. These barriers include costs, availability, distance and level of family support. However, financial barrier is the most significant of all being faced by the women and families.[16] One of the real issues is whether women themselves take their symptoms seriously and whether their health is given value by their family. Usually women seek care only when complications have become more serious. Women usually ignore their mild or moderate symptoms and avoid seeking care due to financial pressure and household responsibilities. There is a sharp contrast in the desperation seen in women at the time of seeking abortion that is not seen for seeking care for post-abortion complications. At the time of abortion, they consider health as one of the main reasons for having an abortion but this is not seen as a priority at the time of complications. Service providers also said that when women ignore or delay seeking treatment, the complications become more serious and women end up spending a lot more money on their treatment.

Unmet Contraceptive Need

Out of a total of approximately 9 million pregnancies in Pakistan in 2012, 4.2 million (46 percent) are unintended. Of these 4.2 million unintended pregnancies, 54 percent end in induced abortions. An additional 34 percent of unintended pregnancies result in an estimated 1.4 million unplanned births. These abortions carry huge costs as witnessed by the large numbers of women who have postabortion complications and obtain treatment, as well as those who need but do not get treatment. Further, the unplanned births impose their own economic, social, and health costs on families, especially mothers.[17] "Reproductive health and rights of girls and women and their agency to claim them is inter-linked with their social status as well as other developmental issues such as food insecurity poverty, lack of education and opportunities for economic and social growth." Hence the need to take an inter-sectoral approach towards SRHR with inclusion of Women Development Department, Social Welfare Department and other social security plans for women to prevent unsafe abortion and remove barriers to safe abortion. Hospital based data mentions that postabortion family planning is a missed opportunity which needs to be addressed at all levels of health care delivery system both in public and private sector to reduce number of unwanted pregnancies.

We request that the Committee praise the State of Pakistan for its role in working to address maternal mortality due to unsafe abortion and improve women's access to safe uterine evacuation/postabortion technologies.

We request this Committee pose the following questions to the State of Pakistan during the 61st Session of the CESCR:

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[15] Sathar, Z., Singh, S., Rashida, G., Shah, Z. and Niazi, R. (2014), Induced Abortions and Unintended Pregnancies in Pakistan. Studies in Family Planning, 45: 471–491. doi:10.1111/j.1728-4465.2014.00004

[16] Zathar S et al., Postabortion Care in Pakistan, In Brief, New York: Guttmacher Institute, 2013, No. 4.

[17] Sathar, Z., Singh, S., Rashida, G., Shah, Z. and Niazi, R. (2014), Induced Abortions and Unintended Pregnancies in Pakistan. Studies in Family Planning, 45: 471–491. doi:10.1111/j.1728-4465.2014.00004

1. What further steps will the State take to ensure that maternal mortality due to unsafe abortion is reduced?

2. What is being done to ensure that safe abortion is accessible to women, especially poor and young women?

3. What measures will be taken to reduce ignorance of the abortion law and stigmatization of abortion? What is being done to ensure that health care personnel and other stakeholders are aware of the abortion law?

4. How will the State ensure that young women and poor women do not experience additional barriers in accessing reproductive health services, including family planning services and safe abortion care?

While the rights guaranteed under the Covenant are not yet a full reality for all women in Pakistan, we hope that the CESCR will recognize the measures taken by the Government of Pakistan to ensure women's access to health care services under article 12 of the Covenant. We also wish to acknowledge the gaps that still exist between the government's action and its duties under the treaty. We hope that this information is useful during the Committee's review of the Pakistan government's compliance with the Covenant.

Very Sincerely,

Ms. Nabila Malick
Chairperson
PAPAC Secretariat (Rahnuma-FPAP)
On behalf
Pakistan Alliance for post Abortion Care (PAPAC) Pakistan Steering Committee

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3	Dr. Ghulam Shabbir	Ipas
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