

Notes from the field: political norm change for abortion in Pakistan

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Abstract: *This commentary describes positive political norm change on abortion despite a restrictive abortion law. As we describe it, the approach in Pakistan has involved careful efforts to maintain government ownership, leadership, and accountability for safe abortion care and service delivery by Pakistani health authorities early and throughout, with technical support from civil society as requested. This commentary suggests that careful collaboration and mutual support by NGOs working on expanding access to abortion can have a lasting and efficient impact on improving political norms and government ownership over abortion care. In most restrictive settings, political norms may be extremely challenging to address due to the institutionalised nature of abortion stigma and resistance, and NGOs can spend many years of resources trying unsuccessfully to challenge and eliminate these barriers. The experience in Pakistan has been a nontraditional approach to political norm change, as it starts by centring the issue of unsafe abortion squarely within the authority and responsibility of the Pakistani government to avert maternal deaths, within the current legal parameters. Emphasis on the public health needs for safe abortion care and current government obligations in Pakistan, as we describe, has led to increased dialogue and discussion about the need for further reforms by government stakeholders who were previously less willing to meaningfully address this health topic. We believe this approach demonstrates significant promise for future progressive change, and we hope this information will be a valuable resource for others working in the field. DOI: 10.1080/26410397.2019.1586819*

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Laws governing sexual and reproductive health and decision-making, including access to information and services, are almost always subject to some form of political process prior to enactment. Whether through legislative debates, committee reviews, public comments, or expert opinions, elected officials are regularly called upon to voice their support or opposition for the existence and scope of such laws, effectively deciding who gets what, when and how when it comes to abortion care.¹

Continued reliance on colonial-era abortion laws through political inaction to amend these laws suggests political avoidance of the issue. Politicians

refrain from initiating or engaging in efforts to expand and modernise the provision of abortion care with an inevitable result – preventable maternal deaths and disability due to unsafe abortion persist, with a disproportionate and devastating impact on young women and marginalised communities.

Efforts to expand legal indications for abortion, or decriminalise the health service altogether, test the political tolerance of elected officials in countries where abortion access is restricted. These efforts may take decades, and often require a complicated and multi-pronged approach to improve and sustain political will, engage communities and mobilise their support, while ensuring health system readiness for such change.

This commentary provides a compelling example of how political norms in a restrictive

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legal setting for abortion may in fact be influenceable prior to any attempt at formal law change. Building the political will of key government stakeholders, we argue, to first address maternal mortality by improving safe abortion access within the parameters of the law, requires less reliance on formal political processes and the often highly stigmatised topic of abortion can instead be approached through a pragmatic and health-oriented process.

Ipas is a nongovernmental organisation (NGO) working globally to increase women's ability to exercise their sexual and reproductive rights and to reduce deaths and injuries from unsafe abortion. Ipas believes that every woman has the right to the highest attainable standard of health, to safe reproductive choices and to high-quality care.

With ongoing support from NGOs like Ipas, the public health crisis of unsafe abortion in Pakistan has led the government to directly address maternal deaths through a series of steps at the national and provincial/regional levels which improve key aspects of abortion care provision, such as who can provide the service, and what methods they should use to maximise safety. The term "uterine evacuation (UE)" has been used in Pakistan to emphasise the clinical nature of the service being provided, opening dialogue with government stakeholders and clinical advisors who may have otherwise avoided the topic. Ipas's work in Pakistan is described to demonstrate how some of the most harmful health impacts of longstanding restrictive abortion laws can in fact be mitigated through explicit political choices to prioritise and preserve *health* in the drafting and implementation of government policies and regulations. In Pakistan, this means the government is paving the way to safer abortion care in the country, within the parameters of otherwise restrictive abortion law.

At Ipas we believe that no lasting change in addressing restrictive abortion laws can be achieved without some indication from the government that it is ready and willing to open this issue to the political process. In some cases, this may mean starting with health system level policies, to assess and better soften the ground for future law reform efforts. Policy-focused efforts by Ipas and similar organisations in Pakistan have recently resulted in positive statements made by some champion policy makers and influencers. These statements refer to finding flexibility within the current abortion law, particularly for the protection of service providers who are willing to offer safe abortion services. Such statements not

only create opportunities for immediate changes within the current health system policies, but also contribute towards broader political norm change, creating advocacy tools, opening up opportunities for moving the conversation forward with key stakeholders, and ultimately increasing the appetite for broader legal changes that can catalyze major shifts in access.

It is our hope that the government will be encouraged by the progress made thus far, and that it will continue along its current path to better meet the health needs and human rights of women and girls in the country. Below, we describe the key elements used to generate and sustain political support thus far.

Background

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. 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 health care providers means that women often resort to clandestine and unsafe procedures that result in death or adverse health consequences.² One study found that in 2012 there were a reported 2.2 million abortions performed in Pakistan, with more than 85% of women accessing services through untrained providers or quacks, resulting in almost 7,00,000 life-threatening complications each year due to the use of outdated and unsafe methods.³

High levels of unmet need for contraception and low levels of contraception use leave many women at risk for unintended pregnancy.⁴ 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%.⁵

Partnering with the government – using evidence-based policy initiatives to highlight the need for safe abortion care

During Ipas's experience in Pakistan, we have found that the key to making progress on a politically sensitive and stigmatised issue like abortion is

desensitising others to the topic through continuous conversations with a broad range of stakeholders. While the Ministry of National Health Services, Regulations and Coordination (MoNHSR&C) and lawmakers are ultimately in control of the laws and policies governing access to safe abortion, the advocacy efforts of professional associations and societies, such as the Society of Obstetricians and Gynecologists of Pakistan (SOGP) and Midwifery Association of Pakistan (MAP), play a vital role to encourage progressive policies. Their opinions, public statements, and advocacy initiatives are an influencing force on the policy actions by Ministry and departmental officials. Ipas and other key partners have played a key role in mobilising professional associations to advance the advocacy work with the Ministry. As an example, we worked with senior officials and members of SOGP through professional conferences to educate members about existing abortion laws, conduct values clarification trainings and build consensus on the importance of access to safe abortion to reduce maternal mortality. A result of this work was a statement released by SOGP on the importance of using safe methods for UE, and the need for incorporating these in the training curriculums for medical, nursing and midwifery students.

Under Prime Minister Yousuf Raza Gilani's administration, the national Ministry of Health in Pakistan was devolved in June 2011 to increase provincial autonomy in Pakistan.⁶ In 2013, Prime Minister Mir Hazar Khan Khoso's caretaker government reinstated the ministry as the Ministry of National Health Services, Regulations and Coordination in May 2013, mainly to perform a regulatory, accreditation and coordination role. The devolution necessitated a strategic shift for abortion-related policy initiatives. Since the provincial health departments were now responsible for policy-making and implementation, Ipas with other partners initially focused attention on Punjab, as being the province with the highest population. In July 2012, Ipas hosted key provincial stakeholders to discuss the impact of unsafe abortion on women and girls, and identify a common solution for mitigating this impact, primarily by advocating for the use of the latest World Health Organization (WHO) endorsed UE technologies.⁷ Ipas used local evidence from the national studies conducted by Population Council in 2002 and 2012–13 to discuss induced abortions in Pakistan, focusing on complications and deaths due to unsafe approaches and practices, untrained mid-

level providers and the negative health impact of using the outdated method of dilation and curettage (D&C) which had been the most widely used method (59%) for UE services in the country.⁸ The solution we presented was to recommend the use of Manual Vacuum Aspiration (MVA) which has been proven to be a safe, effective UE method and is recommended by the WHO.

Ipas's focus during such meetings and conversations has been on maternal death and negative health impacts associated with unsafe abortion and its burden on health systems, guiding stakeholders to look beyond pregnancy termination and the socio-political stigma it invokes. Our approach has been to position ourselves as partners with the government and policymakers, who are ultimately accountable for protecting the health of women. We do this by providing the evidence and technical resources they need to make informed decisions about how to make UE as safe, and woman-centred as possible, in accordance with WHO-recommended technologies. These efforts ultimately led the Punjab government to establish the Punjab Reproductive Health Technology Assessment Committee (PRHTAC) in December 2012⁷ to assess the feasibility of integrating WHO-recommended technologies in the Essential Package of Primary Health services, and medicine and equipment lists. The PRHTAC model is unique in that this is a government committee in the provincial health department, but includes members from other non-state actors such as UN agencies, donors, and NGOs (like Ipas) who participate as technical assistance partners.

Members of PRHTAC were receptive to the evidence provided for safe UE technology and understood the impact of unsafe service provision. This led the Committee to include misoprostol and MVA in the Essential Package of Health Services and essential lists as the reproductive health technology of choice for providing safe UE and post-abortion care (PAC) in February 2013.⁷ These policy changes necessitated effective programmatic interventions for capacity building, particularly with mid-level providers (midwives and lady health visitors*) in use of misoprostol and MVA for UE/PAC

*Lady Health Workers is a cadre of female health care workers in Pakistan, who act as a link between the communities and the health facilities. Their work includes disseminating information and educational material on health, family planning and sanitation, administering immunization campaigns, etc.

and bringing about commodity sustainability and service availability, all of which was primarily led by NGOs. Social marketing organisations like DKT International and Greenstar Social Marketing (an affiliate of Population Services International) played a pivotal role in creating an effective supply chain. Efforts by Ipas to educate providers, public health facility leaders/administrators and continued work with the Department of Health in Punjab, primarily through PRHTAC, led to significant improvement in sustainable commodity availability. By 2015, the Department of Health in Punjab had procured 10 million misoprostol pills from the government's budget.⁹

Task shifting to increase access

Health system policies requiring the administration of these technologies strictly through Ob-gyns or physicians alone meant that access was still limited. Increased availability and accessibility of services could only be realised by “task shifting”. “Task shifting” can be a highly political topic where mid-level/less specialised providers are trained and delegated to perform certain tasks. The need to address this barrier despite the political sensitivities was clear, and supported by international health authorities like the WHO, which recommends that safe abortion be provided by a range of trained health care professionals, including nurses and midwives.¹⁰

Navigating such an initiative in Pakistan required careful consideration of the higher-level service providers from whom tasks are being delegated, necessitating conversations around the need, benefits (both to the service providers involved and to the public in accessing health services) and viability of carrying out the task shifting. Ipas worked with the Pakistan Nursing Council for the inclusion of misoprostol in the midwifery curriculum and, given the non-surgical and less-skilled nature of the technology, they agreed and endorsed the inclusion of misoprostol in September 2013.¹¹ More effort was needed with MVA, given the surgical nature of the technology and the need for additional skills with the provider. Ipas worked with the Society of Obstetricians & Gynecologists of Pakistan to build consensus and support around the need for mid-level providers to be trained in MVA. The efforts resulted in a position statement being released by them in February

2015 supporting the training of mid-level providers in UE/PAC technologies. This made it easier to secure support from the Pakistan Nursing Council, and in December 2015, MVA was included in the midwifery curriculum.¹² Ipas and partners continued advocacy for expanding the provider base, particularly the non-allopathic (complementary) healthcare providers that are often preferred by women in rural and urban/peri-urban slums for reproductive health service provision. However, limited success was observed when it came to training and authorisation of these non-allopathic providers (homeopaths). While the National Council of Homeopaths endorsed the inclusion of MVA in the curriculum and homeopaths' training in October 2017, progress was stalled at the MoNHSR&C level, citing lack of any recent evidence that UE/PAC services are being provided by homeopaths. Research studies are needed to collect evidence on the scale of service provision for UE and PAC by this cadre to convince policy officials of the need for training and authorisation.

Improving quality of care

Making commodities available and increasing the provider base is a significant step in expanding access. However, equal attention needed to be paid to the quality of services being provided and how the providers were treating women. Ipas and partner organisations tackled these aspects of quality in two key ways. The first was a programmatic intervention by implementing Ipas's global Values Clarification and Attitude Transformation (VCAT) training model¹³ with all levels of service providers and health facility officials. These trainings are a powerful tool that help individuals come to the realisation that no matter what their beliefs are about abortion, no woman should suffer the loss of life because of lack of access and that, as providers, their professional responsibility trumps their personal values. The second was a policy initiative where Ipas worked with members of PRHTAC and the Pakistan Alliance for Post-Abortion Care (PAPAC), a cross-regional coalition of stakeholders from government departments, NGOs, UN entities and others collaborating to reduce unsafe abortions, to develop Service Delivery Standards and Guidelines for High-Quality Safe Uterine Evacuation and Post-abortion Care. These guidelines were endorsed by the Department of Health, Punjab in

April 2015 and were widely disseminated for implementation at public health facilities. The document served as both a job aid and guide to provide a quality control measure for the facilities where services are being provided.¹⁴

Scaling up and replicating success

Evidence of the success of these policy initiatives and programmatic interventions meant that the approach could be replicated in other provinces. Ipas and partners moved efforts to Sindh, the second most populous province. A similar approach with the Department of Health in Sindh led to the formation of Sindh Reproductive Health Technologies Assessment Committee (SRHTAC) in May 2016. The support demonstrated by the Punjab government made it more acceptable for the Sindh provincial government to recognise the importance of safe abortion access and the need for investment of resources in achieving this goal. SRHTAC led the adoption and implementation of Standards and Guidelines (which were previously approved/endorsed by Punjab's department of health) in health facilities in Sindh.

In 2013, when the national level ministry was reinstated and re-named Ministry of National Health Services, Regulations and Coordination (MoNHSR&C), the new opportunity this presented to increase the impact of the policy work necessitated a shift in focus of the policy strategy from a provincial level to also include the national level. Ipas and partners advocated with the MoNHSR&C for endorsement of a woman-centred PAC manual as the national standard document for trainings in September 2015. Advocacy with the Drug Regulatory Authority of Pakistan (DRAP) resulted in the inclusion of misoprostol in National Essential Medicine List (NEML) in May 2016 for UE/PAC. To further scale up efforts at the national level, Ipas and partners used Punjab approved guidelines as a starting point and national level guidelines were developed, approved and endorsed by the Director-General, MoNHSR&C in March 2018.¹⁵ This has provided an opportunity for various organisations working in abortion and post-abortion care to take these standards and guidelines and implement them in new provinces/regions. Given that the implementation of these standards and guidelines is still the responsibility of the provincial governments, work remains to be done to institutionalise them in the health departments in new provinces and facilities therein.

Spotlighting the national public health realities in a global human rights arena

In 2017, during the periodic review of progress made by the government of Pakistan under the International Covenant on Civil and Political Rights, Ipas sponsored one of our partners (a local medical provider), Dr Sadiya Ahsan, to speak in Geneva to the United Nations Human Rights Committee about the stigma and barriers faced by Pakistani women and girls when accessing safe abortion. This direct testimony provided Committee members with an on-the-ground account of the challenges related to abortion care and service delivery, which the government had referenced but not elaborated on in its State Party report. The testimony of this health care provider led the Committee to issue concluding observations that called on the government of Pakistan to make improvements towards both policy and health systems strengthening, with the goal of reducing stigma and increasing access to safe abortion care. The statement also made special mention of adolescents and disadvantaged women and girls in rural areas to highlight the important needs of these otherwise marginalised populations. In December 2017, The Ministry of Human Rights in Pakistan formally requested that the Ministry of National Health Services, Regulations and Coordination address this specific obligation coming out of the reporting session.¹⁶ The Human Rights Committee's concluding observations, in this way, helped accelerate the process of national-level standards and guidelines being endorsed by the Ministry in March 2018.

Moving forward

Providing access to safe abortion without immediate follow up with post-abortion family planning (PAFP) services does not address women's need for comprehensive reproductive healthcare. Policy initiatives are needed and are being undertaken to help women minimise the risk of future unplanned/unwanted pregnancies through PAFP, enabling them to be in control of their reproductive lives.¹⁷

Given that contraception is primarily under the purview of Population Welfare Departments and UE services are provided by facilities managed by Departments of Health in the public sector, integration of the services between the two is imperative to ensure women are also provided with an opportunity to access a contraceptive method of

their choice. A post-abortion family planning policy with accompanying guidelines needs to be developed and incorporated into the broader family planning policy.

Other top priorities include strengthening budgetary commitments from provincial health departments for procurement of essential commodities, integration of PAC/PAFP indicators in the department of health information systems and wider dissemination of information about the correct interpretation of the current abortion law led by the Ministry. With the commitment of donors, NGOs, and champions in the government, we are confident that Pakistan will continue on the path of progress.

Conclusion

Abortion remains a politically charged issue in Pakistan. However, the efforts of numerous organisations over the last decade have resulted in

regular conversations within the health authorities and among government stakeholders about the impact of unsafe abortion on the health and lives of Pakistani women and girls. Public health officials no longer think they must find a private corner and whisper when talking about abortion care. The work that has been done by the SRHR community has reduced stigma at the governmental and institutional levels. We now frequently hear from organisations that have never worked on abortion-related issues, asking us how we can find synergies between our work and theirs.

We hope that the successful political norm changes described in the context of Pakistan can be adapted and replicated in other settings where institutionalised stigma, in law and in practice, means that women and girls have limited access to life-saving abortion and post-abortion services. Increasing access globally will help reduce preventable maternal deaths and disabilities.

References

1. Lasswell H. Politics: who gets what, when, how. London: Whittlesey House; 1936.
2. Pakistan Alliance for Post Abortion Care. (2017). *Shadow letter to the committee on economic, social and cultural rights (CESCR)*.
3. Sathar ZS. Induced abortions and unintended pregnancies in Pakistan. *Stud Fam Plann*. 2014;45:471–491.
4. National Institute of Population Studies (NIPS) and Macro International. Pakistan demographic and health survey 2006–7. Islamabad: NIPS and Macro International; 2008.
5. World Health Organization (WHO). Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. Geneva: WHO; 2011.
6. Dawn. (2011, June 28). *Cabinet approves devolution of seven ministries*. Dawn: <https://www.dawn.com/news/640139>.
7. Shabbir G, Samandari G, Pearson E, et al. A coordinated approach to policy change and programmatic integration of safe uterine evacuation and post abortion care services in Punjab province, Pakistan. Chapel Hill: Ipas; 2015.
8. Vlassoff M, Singh S, Suárezand G, et al. Postabortion care in Pakistan. New York: Guttmacher Institute; 2013.
9. Sarwar S, Shabbir G. Commodity sustainability – policy and Budgeting; Pakistan experience. 20. Bangkok: Ipas; 2016, January 23; Retrieved September 26, 2018.
10. World Health Organization (WHO). Health worker roles in providing safe abortion care and post-abortion contraception. Geneva: WHO; 2015.
11. Ipas Pakistan. Uterine evacuation with misoprostol. Chapel Hill: Ipas; 2013.
12. Pakistan Nursing Council. Community midwifery curriculum. Islamabad: Pakistan Nursing Council; 2015.
13. Turner K, Pearson E, George A, et al. Values clarification workshops to improve abortion knowledge, attitudes and intentions: a pre-post assessment in 12 countries. *Reprod Health*. 2018.
14. Government of Punjab, Pakistan. (2015, April). Service delivery standards and guidelines for high quality safe uterine evacuation and postabortion care. Punjab, Pakistan.
15. Ministry of National Health Services, Regulation and Coordination. National service delivery standards and guidelines for high quality safe uterine evacuation and post abortion care. Islamabad: Government of Pakistan; 2018.
16. Ministry of Human Rights. UN concluding observations on human rights convention. Islamabad: Government of Pakistan; 2017, Dec 6.
17. High Impact Practices in Family Planning (HIP). Family planning high impact practices list. Washington, DC: USAID; 2018.

Résumé

Ainsi que nous le décrivons, le Pakistan a déployé des efforts attentifs pour maintenir l'appropriation, le leadership et la redevabilité de la prestation de soins et services d'avortement sûrs par les autorités sanitaires pakistanaises dès le début et tout au long du processus, avec l'appui technique de la société civile, comme demandé. Ce commentaire suggère que la collaboration soigneuse et le soutien mutuel des ONG qui s'emploient à élargir l'accès à l'avortement peuvent avoir un effet durable et efficace sur l'amélioration des normes politiques et de l'appropriation par le Gouvernement des soins en cas d'avortement. Dans la plupart des environnements restrictifs, il peut se révéler très difficile d'aborder les normes politiques, en raison de la nature institutionnalisée de la stigmatisation de l'avortement et de la résistance à cette pratique; les ONG dépensent parfois beaucoup d'années de ressources en tentant sans succès de lever et d'éliminer ces barrières. L'expérience au Pakistan a appliqué une approche non traditionnelle du changement des normes politiques puisqu'elle commence par axer la question de l'avortement à risque directement sur l'autorité et la responsabilité du Gouvernement pakistanais d'éviter les décès maternels, dans le cadre des paramètres juridiques actuels. Comme nous le montrons, l'accent sur les besoins de santé publique en matière de soins d'avortement sans risque et les obligations gouvernementales actuelles au Pakistan ont conduit des acteurs gouvernementaux qui étaient auparavant moins désireux d'aborder véritablement ce thème de santé à élargir le dialogue et la discussion sur la nécessité de nouvelles réformes. Nous pensons que cette approche est prometteuse pour de futurs changements progressifs et nous espérons que cette information sera une ressource valable pour d'autres qui travaillent sur le terrain.

Resumen

Como lo describimos, el enfoque en Pakistán ha implicado cuidadosos esfuerzos por mantener apropiación, liderazgo y responsabilidad del gobierno con relación a la prestación de servicios de aborto seguro por autoridades sanitarias paquistaníes en las etapas iniciales y a lo largo del proceso, con apoyo técnico de la sociedad civil según solicitado. Este comentario sugiere que una colaboración cuidadosa y apoyo mutuo de las ONG que trabajan para ampliar el acceso a los servicios de aborto pueden tener un impacto duradero y eficiente en mejorar las normas políticas y la apropiación de los servicios de aborto por parte del gobierno. En los entornos más restrictivos, podría ser increíblemente difícil abordar las normas políticas debido a la naturaleza institucionalizada del estigma y la resistencia relacionados con el aborto, y las ONG pueden dedicar muchos años de recursos para intentar en vano cuestionar y eliminar estas barreras. La experiencia en Pakistán ha sido un enfoque poco tradicional para cambiar las normas políticas, ya que éste comienza centrando el tema del aborto inseguro directamente dentro de la autoridad y responsabilidad del gobierno paquistaní para evitar muertes maternas, dentro de los parámetros legislativos actuales. El énfasis en las necesidades de salud pública con relación a los servicios de aborto seguro y las obligaciones actuales del gobierno de Pakistán, según las describimos, ha propiciado más diálogo y discusión sobre la necesidad de mayores reformas por las partes interesadas del gobierno, que anteriormente estaban menos dispuestas a tratar este tema de salud de manera más significativa. Creemos que este enfoque demuestra considerable promesa para futuros cambios progresistas y esperamos que esta información sea un recurso valioso para otras personas que trabajan en este campo.