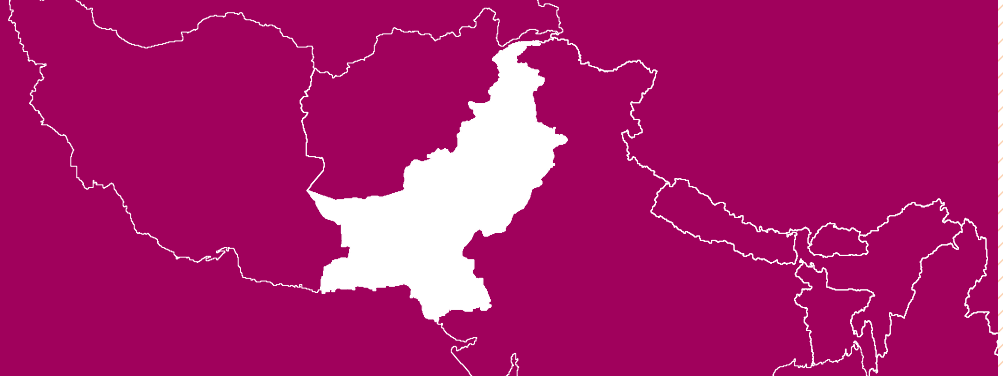
PAKISTAN

PAC-FP COUNTRY BRIEF



Postabortion care (PAC) provides a comprehensive approach to preventing morbidity and mortality caused by abortion complications (PAC Consortium, 2014). As per the U.S. Agency for International Development (USAID) PAC model, a critical component of PAC is providing access to family planning (FP) counseling and services. Providing these services helps meet the reproductive intentions of women who most clearly demonstrate an unmet need for FP, reduces unintended pregnancies, and prevents repeat abortions, thus reducing maternal deaths (Curtis, Huber, and Moss-Knight, 2010). The information below highlights the Islamic Republic of Pakistan's investment in providing PAC and FP services to women in need.

POLICIES, LEADERSHIP, AND GOVERNANCE

The Islamic Republic of Pakistan's national policy on family planning (FP) and reproductive health (RH) is outlined in a number of documents, including the 2001 National Health Policy, the revised National Health Policy—Zero Draft (2009), and the National Population Policy (2010). In 2011, the Ministry of Health (MOH) and the Ministry of Population Welfare (MOPW) devolved responsibilities to the provincial level, where policies can more specifically target and address FP and RH needs. Policy examples include the Punjab Population Policy (2017), the Sindh Population Policy (2016), and the Punjab and Sindh Health Sector Strategies 2012–2020 (2012).

In 2009, Pakistan's MOH and MOPW committed to institutionalizing postabortion care (PAC) in the country's national guidelines, protocols, and policies. In 2010, the government included PAC in its National Health and Population Policies (Sathar et al, 2013). Specific guidelines discussing PAC include the Service Delivery Standards and Guidelines for High-Quality Safe Uterine Evacuation and Postabortion Care (2015) and the Woman-Centered Postabortion Care: Reference Manual (2015). Following the dissolution of Pakistan's MOH and MOPW in 2011, the government decentralized PAC and similar policies to the provinces. This decentralization caused delays in PAC implementation and delivery. Currently, only the Punjab Essential Package on Health Services includes PAC.

Legal Status on Abortion

Pakistan allows abortions only in the early stages of pregnancy and only to save the woman's life or to provide lifesaving treatment (Azmat et al, 2012; Women on Waves, 2016).

PAC TRAINING AND STANDARDS

In Pakistan, the majority of PAC training has remained at the top of the healthcare pyramid: doctors receive training at public teaching hospitals and district headquarter hospitals in Punjab and Sindh provinces (Sathar et al, 2013). In 2015, the government introduced the Woman–Centered Postabortion Care Reference Manual, a national standard approved by the Ministry of National Health Services Regulation and Coordination. All provinces and teaching institutions received this document for training doctors and mid-level providers (including midwives) in PAC service delivery.

The government, with technical support from Ipas, disseminates annual RH clinical updates based on the World Health Organization's technical guidance to each province and institution. However, there are also province-specific policies and guidelines, including ones concerning PAC.

STRENGTHENING SERVICE DELIVERY

Since 2012, Ipas has worked with international and local partners (including the World Health Organization in Punjab and the Pakistan Nursing Council) to integrate PAC and PAC technologies into the midwifery training curriculum (Awan,

2014). Nongovernment organizations have further advocated for use of misoprostol as a key tool for PAC and lobbied for its inclusion in mid-level training curricula. As a result, the Punjab government included misoprostol and manual vacuum aspiration as part of the essential drug and equipment list for PAC. Similarly, the Drug Regulation Authority of Pakistan also included misoprostol for PAC in the National Essential Medicine List in 2016.

The U.S. Agency for International Development (USAID) is also an important partner to Pakistan in strengthening the country's contraceptive distribution system. Financially, USAID provided Pakistan with more than $147 million to strengthen the national supply chain. It also supported a web-based training for local supply chain managers on the utilization of data for contraceptive use monitoring, with an emphasis on the lower levels of the health system (FP2020, 2014).

More than 12,000 community midwives have been trained and deployed to provide maternal, newborn, and child health services—including misoprostol for PAC—to rural populations. An additional 52 community midwife tutors have been trained in misoprostol for PAC.

BARRIERS TO PAC

Women in Pakistan face multiple barriers to accessing PAC and FP services, including primarily service costs and mobility constraints. Through much of the country, women are financially dependent on their husbands and must seek their approval before visiting a service provider (Sathar et al, 2013; Sathar et al, 2013). As a result, women are unable to seek PAC services without consulting with their husbands.

Additionally, upon reaching PAC health facilities, women often face stigma from providers. Inadequately trained personnel and a lack of equipment—especially manual vacuum aspiration kits—hinder the provision of comprehensive PAC in facilities at all levels of the system. Furthermore, lack of privacy and poor organization in healthcare facilities compound barriers to PAC.

FINANCING MECHANISMS

The federal government is implementing a national health insurance plan. While health insurance does not include coverage for PAC services, contraceptive services—including postabortion FP—are available for free in public sector facilities.

In 2012–2013, Pakistan committed $197.7 million to ensure universal access to contraceptives, in line with the country's FP2020 commitments. In 2015–16, the Punjab government procured 10 million misoprostol tablets for PAC and 5,000 manual vacuum aspirators for distribution to primary, secondary, and tertiary health facilities. Sindh province has developed a FP-focused cost implementation plan that includes postabortion FP; the Punjab cost implementation plan is under approval.

PAKISTAN		Year	Source
Demographic/background indicators			
Country population	197,015,955	2018	World Bank[1]
Total fertility rate	3.5	2016	
Maternal mortality per 100,000 live births	178	2015	UNICEF[2]
Age at first birth	22.8	2017–18	Demographic and Health Survey, 2017–18
Newborn mortality per 1,000 live births	42		
Infant mortality per 1,000 live births	62		
Under-five child mortality per 1,000 live births	74		
Facility-based deliveries	66.0%		
Proportion of women who received antenatal care from a skilled provider	86.0%		
Proportion of women who received a postnatal check within two days of delivery	62.0%		
Abortion and FP-related indicators			
Number of abortions	2,250,000	2012	Guttmacher Institute, 2015
Abortions per 1,000 women	50		
Number of women treated for abortion complications	623,000		
Number of unintended pregnancies	4,723,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Proportion of unintended pregnancies that end in abortion	54%	2012	Guttmacher Institute, 2015
Number of unintended pregnancies averted due to use of modern contraceptive methods	3,687,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of unsafe abortions averted due to use of modern contraceptive methods	1,475,000		
Number of maternal deaths averted due to use of modern contraceptive methods	3,500		
Modern method contraceptive prevalence rate, all women of reproductive age (WRA)	20.8%		
Knowledge of FP, all WRA	99%	2017–18	Demographic and Health Survey, 2017–18
Contraceptive use by type		2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Long-acting and permanent methods			
Sterilization (female)	33.2%		
Sterilization (male)	1.1%		
Intrauterine device	8.8%		
Implant	0.0%		
Short-acting methods			
Injection (intramuscular and subcutaneous)	10.7%		
Pill	6.1%		
Condom (male)	33.6%		
Condom (female)	0.0%		
Other modern methods (e.g., cycle beads, and lactational amenorrhea method)	6.5%		
Unmet need for FP[3] (2018)	17.0%	2017–18	Demographic and Health Survey, 2017–18
Percentage of all women who received FP information during their last visit with a health service provider	40.6%		

[1] https://databank.worldbank.org/data/reports.aspx?source=2&country=PAK
[2] https://data.unicef.org/wp-content/uploads/country_profiles/Pakistan/country%20profile_PAK.pdf
[3] Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report either not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.

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