



June 7, 2011

The Committee on the Elimination of Discrimination against Women (CEDAW Committee)

Re: Supplementary information on Nepal scheduled for review by CEDAW during its 49th Session

Dear Committee Members:

This letter is intended to supplement the combined 4th and 5th periodic report of the government of Nepal, scheduled for review by this Committee during its 49th session. The Center for Reproductive Rights (the Center), Justice for All (J4A), and the Women's Reproductive Rights Program of the Centre for Agro-Ecology and Development (CAED), hope to further the work of the Committee by reporting information concerning the rights protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). **Beginning on page 20, the Center, J4A, and CAED respectfully suggest key questions to pose to the State Party during the session and offer for the Committee's consideration potential recommendations to include in the 2011 Concluding Observations to Nepal.**

During the CEDAW Committee's previous review of Nepal in 2004, the Committee expressed concern "at the status of women's health, particularly rural women."¹ The Committee also stated that it was "also concerned that women's health is adversely affected by factors such as early marriage and early pregnancy, inadequate family planning services and illiteracy, which is an obstacle to obtaining and effectively using health-related information."² The Committee recommended the State Party take the following steps:

** The University of Washington chapter of Law Students for Reproductive Justice contributed to the development of this report.

¹ Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: Nepal*, para. 212, U.N. Doc. CEDAW/C/NPL/CO/3 (2004).

² *Id.*

- Take further measures to improve the access of women, particularly rural women, to health-related services and information, including in regard to sexual and reproductive health, in an effort to reduce maternal mortality.³
- Adopt programs and policies to increase knowledge of and access to contraceptive methods, bearing in mind that family planning should be the responsibility of both partners.⁴
- Wide promotion of sex education, particularly targeting boys and girls, with special attention to the prevention and further control of sexually transmitted diseases and HIV/AIDS⁵

The Committee further requested the state party “conduct research on women's health and to provide sex-disaggregated data on access to health in its next report.”⁶

The state should be commended for its efforts over the past seven years to reduce its maternal mortality ratio (MMR), for which it has been globally recognized as making significant progress towards the fifth Millennium Development Goal.⁷ The Center, J4A, and CAED would also like to commend the State for the recent groundbreaking achievements of its judicial branch in the cases of *Lakshmi Dhikta v. Nepal* and *Prakash Mani Sharma v. Nepal*. The *Dhikta* case ordered the state to ensure that safe, legal abortion is affordable for all women, and the *Sharma* case ordered the government to address the high incidence of uterine prolapse. Similarly, the state should be commended for including an express protection of reproductive rights in the Interim Constitution. We hope that the new Constitution will preserve that constitutional protection of women’s reproductive rights.

While Nepal has made recent progress on women’s reproductive rights and health in its formal laws and in reducing its MMR, women and girls in Nepal cannot yet fully enjoy the fundamental rights to reproductive and sexual health protected by CEDAW and some of the recommendations made previously by this Committee remain unfulfilled. The first portion of this letter will highlight four areas around which the State must take further action to make the right to reproductive health services under CEDAW a reality: maternal mortality and morbidity, lack of access to safe abortion, unmet need for family planning, and a high incidence of uterine prolapse. The second part of this letter will discuss areas where women and girls, particularly adolescents, rural women, and poor women, in Nepal face discrimination in their enjoyment of the right to

³ *Id.* para. 213.

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ See GOVERNMENT OF NEPAL NATIONAL PLANNING COMMISSION & UNITED NATIONS COUNTRY TEAM NEPAL, NEPAL MILLENNIUM DEVELOPMENT GOALS PROGRESS REPORT 2010, at 48 (2010), *available at* <http://www.undp.org.np/pdf/MDG-Layout-Final.pdf> [hereinafter NEPAL MDG REPORT 2010]; WORLD HEALTH ORGANIZATION (WHO), TRENDS IN MATERNAL MORTALITY: 1990 TO 2008: ESTIMATES DEVELOPED BY WHO, UNICEF, UNFPA, & THE WORLD BANK 30 (2010), *available at* http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf [hereinafter WHO, TRENDS IN MATERNAL MORTALITY]; AJIT PRADHAN ET AL., NEPAL MATERNAL MORTALITY AND MORBIDITY STUDY 2008/2009, at 33 (2010) [hereinafter NEPAL MMMS].

health as guaranteed under CEDAW. As discussed above, the letter concludes with suggested questions and recommendations for the Committee's consideration.

I. The Right to Reproductive Health Services and Information (Arts. 12, 10(h), 14, 16).

Article 12(1) of CEDAW calls upon states parties to “take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure [...] access to health care services.”⁸ Article 12(2) further instructs states parties to “ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.”⁹ Article 10(h) requires that women have “access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.”¹⁰ Article 16 requires that states parties “take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and...ensure, on a basis of equality of men and women the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.”¹¹

CEDAW makes clear that the right to survive pregnancy and childbirth is a fundamental human right.¹² General Recommendation No. 24 requires states parties “to take appropriate ... measures to the *maximum extent* of their available resources to ensure that women realize their rights to health care.”¹³ It calls upon states parties to “implement a comprehensive national strategy to promote women's health throughout their lifespan. This will include interventions [...] [which will] ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services.”¹⁴

Nepal's own Interim Constitution, in line with CEDAW, affirms that “every woman shall have the right to reproductive health and other reproductive matters.”¹⁵ The Treaty Act of Nepal also effectively incorporates human rights treaty obligations into domestic law.¹⁶ Article 5(1) of the Treaty Act provides that “[i]n case of the provisions of a treaty, to which Nepal or Government of Nepal is a party ... [any] inconsistent provision of [a domestic] law shall be void for the purpose of that treaty, and the provisions of the treaty shall be enforceable as good as Nepalese

⁸ Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR (34th Sess.), Supp. No. 46, art. 12(1), U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].

⁹ *Id.* art. 12(2).

¹⁰ *Id.* art. 10(h).

¹¹ *Id.* art. 16(1)(e).

¹² *See, e.g.*, CEDAW Committee, *General Recommendation No. 24: Women and Health*, paras. 17, 27, U.N. Doc. A/54/38 (Feb. 5, 1999) [hereinafter CEDAW Committee, *General Recommendation No. 24*]; *see also* CEDAW Committee, *Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38 (1999); *Dominican Republic*, para. 337, U.N. Doc. A/53/38 (1998).

¹³ CEDAW Committee, *General Recommendation No. 24*, *supra* note 12, para. 17.

¹⁴ *Id.* para. 29.

¹⁵ INTERIM CONST. (2007) (Nepal), Part 3, 20 (2), *available at* http://www.worldstatesmen.org/Nepal_Interim_Constitution2007.pdf.

¹⁶ Nepal Treaty Act (1990), *available at* <http://www.unhcr.org/refworld/docid/3ae6b51724.html>.

laws.”¹⁷ Despite Nepal’s domestic and international commitments to women’s reproductive health and rights, these rights are not yet fully realizable for women in Nepal.

A. Maternal Mortality and Morbidity

Nepal’s MMR is estimated to have undergone a 56 percent decrease from 1990 to 2008.¹⁸ This steady decrease from 870 maternal deaths per 100,000 live births to 380¹⁹ is commendable, and demonstrates significant effort on Nepal’s part to actualize women’s rights to safe motherhood and childbirth.²⁰ While the positive trend is noteworthy, Nepal still has the third highest MMR outside of sub-Saharan Africa.²¹ In its report to this Committee, Nepal cited its MMR as 281.²² However, a report by the World Health Organization (WHO), United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA), and the World Bank states that the range of uncertainty for **Nepal’s MMR includes a lower estimate of 210 and an upper estimate of 650**,²³ demonstrating that the accurate MMR remains unclear and that it is likely much higher than the State’s estimate of 281. Such high MMRs indicate that many women in Nepal do not yet have adequate access to reproductive health services, quality nutrition, emergency obstetric care, or family planning.²⁴ High MMRs are also an indicator of underlying gender discrimination, as this Committee has emphasized.²⁵

Statistics on morbidity further demonstrate that pregnant women face serious health risks that are entirely preventable. If the ratio of injuries or disabilities that occur as a result of being pregnant or giving birth were calculated in the same way maternal mortality is calculated, according to a government study **Nepal’s maternal morbidity ratio would be 19,600 per 100,000 live births**; this number may even be an underestimate, since this figure accounts only for those women who

¹⁷ *Id.* art. 5.

¹⁸ WHO, TRENDS IN MATERNAL MORTALITY, *supra* note 7, at 30.

¹⁹ *Id.*

²⁰ NEPAL MMMS, *supra* note 7, at 33. After cataloguing the difficulties in calculating MMR and in comparing between different methods—and arguing that some calculations incorrectly suggest too-low an MMR and too-great a decline—the MMMS still concludes that “Overall the data over the last ten years suggest a decline in maternal mortality. Against a background of stagnating maternal mortality ratios worldwide and the recent political conflict this is a considerable achievement for Nepal. This decline has taken place despite low percentages of skilled attendance suggesting that other factors have contributed to this decline and stresses the importance of understanding the impact of other factors and not using SA as a proxy indicator of MMR.” *Id.* at 33 (while skilled attendance is still correlated to maternal survival and health, it is not the only factor implicated).

²¹ Outside of sub-Saharan Africa, the five highest MMR are Afghanistan (1400), the Lao People’s Democratic Republic (580), Nepal (380), Timor-Leste (370) and Bangladesh (340). WHO, TRENDS IN MATERNAL MORTALITY, *supra* note 7, at 1.

²² Government of Nepal, *Consideration of reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women: Combined fourth and fifth periodic reports of States parties: Nepal*, para. 14, tbl.1, U.N. Doc. CEDAW/C/NPL/4-5 (Nov. 9, 2010) [hereinafter Nepal Report before CEDAW].

²³ WHO, TRENDS IN MATERNAL MORTALITY, *supra* note 7, at 25.

²⁴ GOVERNMENT OF NEPAL, MINISTRY OF HEALTH AND POPULATION, POPULATION DIVISION, NEPAL DEMOGRAPHIC AND HEALTH SURVEY 2006, at 144 (2007), available at <http://www.measuredhs.com/pubs/pdf/FR191/FR191.pdf> [hereinafter NEPAL DHS 2006].

²⁵ See, e.g., CEDAW Committee, *General Recommendation No. 24*, *supra* note 12, paras. 17, 18, 19; CEDAW Committee, *Concluding Observations: Belize*, *supra* note 12, para. 56; *Dominican Republic*, *supra* note 12, para. 337.

were attended at emergency obstetric facilities.²⁶ One of those morbidities, **uterine prolapse, affected more than 600,000 women in Nepal in 2006.**²⁷ Globally, uterine prolapse is most common in women of post-reproductive age,²⁸ but in Nepal 51 percent of cases develop in women between the ages of 20 and 24.²⁹ This letter will more fully discuss uterine prolapse in section c below.

Under Articles 12(1), 12(2), 14, and 16 of this Convention, states are obligated to eliminate preventable maternal deaths and morbidity.³⁰ The Committee on Economic, Social and Cultural Rights (ESCR Committee) in 2007 urged Nepal to more highly prioritize reducing maternal mortality rates,³¹ to improve “physical and economic access to reproductive health care and contraceptives, particularly in rural areas,” and to take “specific measures...to enable women to give birth in the care of trained health-care professionals.”³²

Notwithstanding these treaty obligations and Nepal’s recent improvement in maternal mortality statistics, women in Nepal continue to face extremely high risks of maternal mortality and morbidity, in great part due to limited access to health care, malnutrition, unsafe abortion, and early marriage.

1. Limited Access to Reproductive Health Services and Low Prevalence of Skilled Birth Attendants

²⁶ A 2009 study found that the overall rate of major obstetric morbidities in the emergency obstetric care facilities of eight study districts in Nepal was 196 per 1,000 births. The major obstetric morbidities were prolonged labor, complications from abortion, hemorrhage, retained placenta, pre-eclampsia, eclampsia, ectopic pregnancy, sepsis, and ruptured uterus. NEPAL MMMS, *supra* note 7, at 129 (it is important to note, however, when comparing maternal mortality ratios with maternal morbidity in this sense that 196 represents total morbidities, not total women who were injured).

²⁷ UNITED NATIONS POPULATION FUND (UNFPA), BOOKLET ON UTERINE PROLAPSE 11 (2007), available at <http://nepal.unfpa.org/pdf/prolapse%20english%20book.pdf> [hereinafter UNFPA, BOOKLET ON UTERINE PROLAPSE].

²⁸ Tiphaine Ravenel Bonetti et al., *Listening to “Felt Needs”: Investigating Genital Prolapse in Western Nepal*, 12 REPROD. HEALTH MATTERS 166, 167 (2004) (72.4% of uterine prolapse (UP) cases in Nepal, unlike the global norm, are in pre-menopausal women.) [hereinafter Bonetti, *Genital Prolapse in Western Nepal*].

²⁹ Center for Agro-Ecology and Development, Uterine Prolapse Study Report, Nepal (2006), p. 23, <http://www.advocacy.net/modules/fck/upload/file/upa/CAED%20Uterine%20Prolapse%20Study%20Report.doc> [hereinafter Uterine Prolapse Study Report] (“[c] omparing the duration by age groups...51% [suffered from UP] from 20-24 years [of age].” This data reinforces the indication of early onset, as a high number of women of ages 20-65 have been found suffering from UP for 10-20 years. The mean time of UP suffering was found to be 11 years”).

³⁰ See generally CEDAW Committee, *General Recommendation No. 24*, *supra* note 12. General Recommendation No. 24 stresses that “it is the duty of states parties to ensure women’s right to safe motherhood...” and explains that such an obligation arises not just from the right to health but under other articles of the Convention (CEDAW, *supra* note 8), including arts. 10, 10(h), 11, 14(2)(b), 14(2)(b)(h), 16(1)(e) and 16(2) (para. 28). CEDAW Committee, *General Recommendation No. 24*, *supra* note 12, para. 27. See also CEDAW Committee, *Concluding Observations: Belize*, *supra* note 12, para. 56; *Nepal*, paras. 212, 13, U.N. Doc CEDAW/C/NPL/CO/3 (2004); *Nigeria*, paras. 336, 337, U.N. Doc. CEDAW/C/NGA/CO/6 (2008).

³¹ Committee on Economic, Social and Cultural Rights (ESCR Committee), *Concluding Observations: Nepal*, para. 45, U.N. Doc. E/C.12/NPL/CO/2 (2008).

³² *Id.* para. 46.

This Committee has emphasized the importance of skilled birth attendants in ensuring safe pregnancy and childbirth,³³ and Article 12(2) of CEDAW requires states to provide free maternal health services where necessary.³⁴ In response to that mandate, Nepal has introduced a number of maternal healthcare initiatives, including the Safe Delivery Incentives Program.³⁵ After a study confirmed that transportation costs were a major barrier to the utilization of delivery services at health facilities, the Program was developed to provide cash payments to mothers who deliver their babies at facilities, and to reward birth attendants for the deliveries they assist.³⁶ However, access to delivery services, especially emergency obstetric care, still remains a significant issue. A government study revealed that **less than 19 percent of births took place with skilled birth attendants present.**³⁷ **Within the poorest quintile, only 4.8 percent of births took place with a skilled birth attendant.**³⁸ Eighty-one percent of Nepali women deliver at home as opposed to in hospitals.³⁹ Thus, it is clear that while the government is taking steps to increase utilization of delivery services, more work is to be done if Nepal is to make safe delivery care possible for the majority of its women.

Lack of access to health and emergency obstetrics services contribute to maternal mortality, as this Committee has noted.⁴⁰ The ESCR Committee has expressed concern about the fact that an overall inadequacy of health services in Nepal places women especially at risk, which results in Nepal's "alarmingly high rates" of maternal mortality.⁴¹ Failure to provide the majority of Nepal's women with access to healthcare services not only deprives them of their human right to reproductive health⁴² but also signifies a failure to ensure access to healthcare on a basis of equality between men and women, as required by Article 12.

2. *Malnutrition Causes Poor Maternal Health Outcomes*

This Committee has emphasized that proper nutrition is essential for women to be able to realize their right to health under Article 12.⁴³ Nutrition is part of overall health, but it is especially crucial in ensuring that women are healthy during pregnancy and the post-partum period.⁴⁴ A

³³ See, e.g., CEDAW Committee, *Concluding Observations: Turkey*, para. 38, U.N. Doc. CEDAW/C/TUR/4-5 (2005); *Gambia*, para. 34, U.N. Doc. CEDAW/C/GMB/1-3 (2005); *Congo*, para. 175 U.N. Doc. A/58/38 (2003); *Nigeria*, *supra* note 30, para. 337; *Equatorial Guinea*, para. 205, U.N. Doc. A/59/38 (2004).

³⁴ CEDAW, *supra* note 8, art. 12(1).

³⁵ TIMOTHY POWELL-JACKSON ET AL., GOVERNMENT OF NEPAL, SUPPORT FOR THE SAFE MOTHERHOOD PROGRAM, EVALUATION OF THE SAFE DELIVERY INCENTIVE PROGRAMME, FINAL REPORT OF THE EVALUATION (2008), available at http://www.safemotherhood.org.np/pdf/106Final_SDIP_Evaluation_Report.pdf.

³⁶ Tim Ensor & Sophie Witter, *Proposed Revisions to the SDIP – Strengthening a Major National Initiative for Safe Motherhood in Nepal* 6 (2008). Another problem with this scheme is that it does not provide the cash payment for women delivering a third or subsequent child. Nepal Report before CEDAW, *supra* note 22, para. 159.

³⁷ NEPAL DHS 2006, *supra* note 24, at 144.

³⁸ *Id.*

³⁹ *Id.* at 141.

⁴⁰ See, e.g., CEDAW Committee, *Concluding Observations: Malawi*, paras. 31, 32, U.N. Doc. CEDAW/C/MWI/CO (2006); *Nigeria* (2008), *supra* note 30, paras. 336, 37.

⁴¹ ESCR Committee, *Concluding Observations: Nepal* (2008), *supra* note 31, paras. 25, 26.

⁴² This right is also protected by Nepal's Constitution. INTERIM CONST., *supra* note 15, Part 3, 20 (2).

⁴³ CEDAW Committee, *General Recommendation No. 24*, *supra* note 12, para. 7.

⁴⁴ NEPAL DHS 2006, *supra* note 24, at 185; see also Vulimi Ramalingaswami et al., UNICEF, The Progress of Nations 1996, Nutrition, *Commentary: The Asian enigma*, <http://www.unicef.org/pon96/nuenigma.htm> (last visited May 25, 2011) [hereinafter Ramalingaswami et al., *Commentary: The Asian enigma*].

2008-2009 study found that **of women in Nepal who died of maternal causes, 34 percent suffered from anemia and 21 percent were malnourished.**⁴⁵ One of the root causes of anemia is poor nutrition; thus, poor nutrition is strongly correlated to higher risks of maternal mortality and morbidity, including uterine prolapse, discussed below. Gender-based discrimination in access to food and nutrition within the home can be one reason that women of reproductive age, more so than men, suffer from malnutrition and anemia.⁴⁶ In its report to the CEDAW Committee, Nepal noted that malnutrition is the “root cause of almost all health problems,”⁴⁷ but conceded that anemia and malnutrition have “yet to be adequately addressed.”⁴⁸ As such, to ensure women’s survival during pregnancy and childbirth, Nepal must take steps towards providing pregnant women and women of reproductive age with the resources to attain a healthy, adequate diet, including confronting gender-related discrimination in nutrition at home.

3. Uterine Prolapse

Uterine prolapse is a devastating and preventable women’s health condition that has become a major public health problem in Nepal.⁴⁹ **It is the most frequent type of maternal disability, affecting at least 10 percent of all Nepali women, and up to 45 percent of women in some parts of the country.**⁵⁰ It is extremely problematic not just because of its symptoms and its prevalence but because of the fact that younger Nepali women are at high risk of uterine prolapse,⁵¹ even though, globally, it is usually found in women of post-reproductive age.⁵² **In 2007, the UNFPA found that 600,000 women in Nepal suffered from uterine prolapse.**⁵³ **That is more than the number of people in Nepal suffering from malaria, tuberculosis, and HIV/AIDS combined.**⁵⁴ Up to 51 percent of uterine prolapse cases in Nepal occur in women between twenty and twenty-four years old.⁵⁵ This early onset of uterine prolapse may be a result of early and too-frequent childbearing.⁵⁶ Researchers opine that the overall prevalence of uterine

⁴⁵ NEPAL MMMS, *supra* note 7, at 148.

⁴⁶ *Id.* at 24-25. A report published by UNICEF has noted that gender-based discrimination in access to food, nutrition, and healthcare can predispose girls and women to risks of maternal morbidity and mortality. Ramalingaswami et al., *Commentary: The Asian enigma*, *supra* note 44.

⁴⁷ Nepal Report before CEDAW, *supra* note 22, para. 164.

⁴⁸ *Id.*

⁴⁹ Nicole Farkouh, *Reframing Maternal Health In Nepal*, POL’Y MATTERS J. 33, 33 (2009).

⁵⁰ INSTITUTE OF MEDICINE, TRIBHUVAN UNIVERSITY, STATUS OF REPRODUCTIVE MORBIDITIES IN NEPAL 71 (2006), available at

<http://www.advocacynet.org/modules/fck/upload/file/upa/Status%20of%20Reproductive%20Morbidity%20in%20Nepal.pdf> [hereinafter TRIBHUVAN UNIVERSITY, STATUS OF REPRODUCTIVE MORBIDITIES IN NEPAL].

⁵¹ *Id.* at 76.

⁵² Bonetti, *Genital Prolapse in Western Nepal*, *supra* note 28, at 167; see also WOMEN’S REPRODUCTIVE RIGHTS PROGRAM, CENTER FOR AGRO-ECOLOGY AND DEVELOPMENT, UNHEEDED ANALOGIES: A STUDY OF UTERINE PROLAPSE PREVALENCE AND ITS CAUSES IN SIRAHA AND SAPTARI DISTRICTS, NEPAL 40 (2007), available at <http://wrrpnepal.org/uploads/doc/46Unheeded%20Agonies-UP%20Survey%20Report.pdf>.

⁵³ UNFPA, BOOKLET ON UTERINE PROLAPSE, *supra* note 27, at 11.

⁵⁴ Farkouh, *Reframing Maternal Health In Nepal*, *supra* note 49, at 35.

⁵⁵ Uterine Prolapse Study Report, *supra* note 29, at 23.

⁵⁶ Early age at first childbirth, and having many births, are factors that are correlated to uterine prolapse. 65.16% of women with uterine prolapse were first pregnant when they were in their teens. SAFE MOTHERHOOD NETWORK FOUNDATION, BEYOND BEIJING COMM., & TRIBHUVAN UNIV. TEACHING HOSP., PREVALENCE OF UTERINE PROLAPSE AMONGST GYNECOLOGY OPD PATIENTS IN TRIBHUVAN UNIVERSITY TEACHING HOSPITAL IN NEPAL AND ITS SOCIO-CULTURAL DETERMINANTS 21 (2010) [hereinafter UTERINE PROLAPSE AMONGST GYNECOLOGY OPD PATIENTS].

prolapse in Nepal may also be caused by malnutrition, unattended or unskilled delivery, insufficient recovery time after delivery, and heavy manual labor, especially shortly after giving birth.⁵⁷ Uterine prolapse is extremely stigmatizing for women in Nepal, and knowledge of how to prevent it, and how to reduce its severity or stop early-stage prolapse from escalating, is not widespread.⁵⁸

The Supreme Court of Nepal's decision in *Prakash Mani Sharma v. Gov't of Nepal* (2008) acknowledged that uterine prolapse in Nepal is a human rights violation. The Supreme Court held that the widespread nature of uterine prolapse implicated women's fundamental right to reproductive health under Article 20(2) of Nepal's Interim Constitution and under international human rights law.⁵⁹ The Court stated that "[u]nfortunately, no laws till date in relation to reproductive health has been enacted and implemented and neither has it been defined in any law and nor any prescribed procedure has been prescribed for the enjoyment of this right. [...] [I]n order for people to realize this right, efforts should be made towards the formulation of policies (including formulation of laws), drafting of plans, its subsequent implementation, extension and evaluation"⁶⁰ and further found that, "neither has the Ministry of Health made reproductive health as its focal point nor has the Ministry of Women, Children and Social Welfare made any effort towards addressing the matter...."⁶¹ The Supreme Court issued a directive order that the Prime Minister and the Office of the Council of Ministers consult with "health related experts and representatives of the society and [] draft a Bill and submit it before the Legislature-Parliament as soon as possible."⁶² Likewise, it ordered the Ministry of Women, Children and Social Welfare and Ministry of Population and Health "to prepare special work plans and to provide free consultation, treatment, health services and facilities"⁶³ to women with uterine prolapse, and to "set up various health centers and to initiate effective programs with the aim of raising public awareness on problems relating to reproductive health of women and the problem of uterus prolapse."⁶⁴

"85% of prolapse occurred in cases among respondents who had given birth for more than three times. What is more shocking is that even after having prolapse, the women in 29 cases had up to 6 pregnancies thereafter." *Id.* at 22.

⁵⁷ NEPAL MMMS, *supra* note 7, at 27; *see also* Bonetti, *Genital Prolapse in Western Nepal*, *supra* note 28, at 167; UTERINE PROLAPSE AMONGST GYNECOLOGY OPD PATIENTS, *supra* note 56, at 23-24 ("[a]fter delivery, 45% [of UP cases] had rested for 7-14 days while 30% of the respondents had post-partum rest for 15-30 days.... Generally, after delivery the mother should rest for at least six weeks for the uterus to develop and three months for all the pelvic ligaments and organs to function normally again. Within this period of rest, she should not lift heavy weights and be given proper nutrition"); Barbara Earth & Sabitri Sthapit, *Uterine Prolapse in Rural Nepal: Gender and Human Rights Implications, A Mandate for Development*, 4 CULTURE, HEALTH, & SEXUALITY 281, 283 (2002) (on how harmful delivery practices can cause uterine prolapse).

⁵⁸ Uterine Prolapse Study Report, *supra* note 29, at 9 (on lack of knowledge about treatment and prevention), 16 (on stigmatization of UP); Nicole Farkouh, *Nepal's Silent Tragedy: Perspectives on Uterine Prolapse* (poster), available at www.jdcpartnerships.com/PDFs/UP%20Poster.pdf.

⁵⁹ *Prakash Mani Sharma v. Gov't of Nepal*, Writ No. 064 (2008) (SC) (unofficial translation by National Judicial Academy)) (on file with the Center for Reproductive Rights).

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.* para. 48.

Of 600,000 women with uterine prolapse in 2009, 200,000 needed surgery immediately.⁶⁵ Despite the Supreme Court’s order that the state provide “free consultation, treatment, health services, and facilities to the aggrieved women,” Nepal has not implemented large-scale treatment programs but has in fact scaled back its interventions for uterine prolapse. While the state should be commended for the corrective surgeries it has performed, it has not performed enough to meet women’s need. Further, **in 2010 it reduced its 2009 target of providing 12,000 women with surgeries per year—the target it cited to this Committee⁶⁶—to a new target of 8,000 women per year, representing a reduction of one-third—and has also reduced travel stipends for women with uterine prolapse who are seeking treatment.**⁶⁷ These are **retrogressive measures** that automatically put Nepal in violation of its obligations under international law.

Early-stage prevention and rehabilitative measures are far more affordable and scalable to rural villages and mountainous zones than is surgery, which is the treatment for late-stage prolapse.⁶⁸ Since uterine prolapse is preventable and treatable, surgery only becomes necessary once those early stage interventions do not occur, and after women suffer for years if not decades from increasingly severe uterine prolapse.⁶⁹ However, the state does not yet have a comprehensive plan for implementing preventive and early-stage strategies to combat uterine prolapse, such as lack of access to family planning, uterine prolapse-awareness and prevention training in already-existing Safe Motherhood programs.⁷⁰ The state should also address indirect factors, such as malnutrition, the use of skilled birth attendants, and the uneven division of labor between men and women,⁷¹ and the social, cultural, and economic factors that cause women to have to return to manual labor shortly after giving birth, if it is to be able to decrease incidences of uterine prolapse and thus comply with the Supreme Court’s decision and with this Convention.

Women’s right to health under this Convention means that it is the state’s “duty” to “ensure women’s right to safe motherhood.”⁷² While uterine prolapse is a form of morbidity and not mortality, it is a chronic, debilitating, stigmatizing, and painful condition. Motherhood is therefore not “safe” when women face such a high risk of suffering from uterine prolapse. In order to comply with Article 12 of this Convention, the state should prioritize the problem and

⁶⁵ Bishnu Kumari, UNFPA, *Fallen Wombs, Broken Lives: Responding to Uterine Prolapse in Nepal* (Aug. 3, 2009), <http://www.unfpa.org/public/News/pid/3282>.

⁶⁶ Nepal Report before CEDAW, para. 53, *supra* note 22.

⁶⁷ Om Astha Rai, *Government lowers uterine prolapse treatment target*, REPÚBLICA (Jan. 27, 2010), http://www.myrepublica.com/portal/index.php?action=news_details&news_id=14515 [hereinafter Rai, *Government lowers UP treatment target*].

⁶⁸ The treatment for late-stage prolapse is a hysterectomy, which costs between \$200 to \$300 and requires access to a surgical operating room, surgeons, and/or a mobile surgical camp to reach rural and mountainous zones. Meanwhile, the treatment for Stage II prolapse is a pessary ring, which in Nepal costs between 3 and 5 dollars -- a prohibitive cost for many women, but still far more affordable -- and scalable for small villages and rural, mountainous zones -- than surgical operating rooms are. Meanwhile, if Stage I prolapse is identified, it can be treated—and arrested—with only exercises, which require only instructions and human resources. With proper exercises, early UP can thus be arrested. With adequate knowledge about preventive measures—such as nutrition and rest after childbirth—UP can be prevented entirely. Farkouh, *Reframing Maternal Health In Nepal*, *supra* note 49, at 35.

⁶⁹ Uterine Prolapse Study Report, *supra* note 29, at 23 (“... a high number of women of ages 20-65 have been found suffering from UP for 10-20 years. The mean time of UP suffering was found to be 11 years.”).

⁷⁰ *Id.*; Farkouh, *Reframing Maternal Health In Nepal*, *supra* note 49, at 35.

⁷¹ *Id.*; see also Rai, *Government lowers uterine prolapse treatment target*, *supra* note 67.

⁷² CEDAW Committee, *General Recommendation No. 24*, *supra* note 12, para. 27.

take immediate aggressive steps towards preventing and treating it. The lack of a national prevention and rehabilitation plan or component within the existing maternal health schemes, such as the Maternal and Neonatal Health scheme and the Maternity Incentive, evinces a failure to protect women's rights under this Convention. Further, lowering its targets and limiting the number of women who receive emergency surgery for uterine prolapse is a backward step, which runs counter to international human rights norms.⁷³ Regressive measures are especially unacceptable when it comes to states' obligations to realize and enforce the right to health.⁷⁴ Without taking immediate and effective steps to combat and treat uterine prolapse, women's rights to life, health, and dignity on an equal basis with men—as guaranteed by CEDAW—will not be realized.

B. High Rates of Unsafe Abortion Persist in Spite of 2002 Legalization

Nepal should be commended for formally recognizing that women's ability to realize their highest attainable standard of health requires access to legal, safe abortion, and for legalizing abortion in 2002.⁷⁵ Previously, abortion in Nepal was a crime, and women were imprisoned for undergoing abortions. This Committee had expressed concern about Nepal's criminalization of abortion, and urged Nepal to change the criminal law and to make safe abortion services available.⁷⁶ While Nepal has, importantly, complied with that first obligation by decriminalizing abortion, it has not yet made access to safe abortion services available for most women in Nepal, especially poor and rural women.

Abortion services are provided by the government through the Comprehensive Abortion Care program (CAC), which began providing services in March of 2004.⁷⁷ In fiscal year 2005/2006, according to Nepal's report to this Committee, the CAC program trained 83 doctors and brought the total number of clinics to 191.⁷⁸ The 2009 Maternal Mortality and Morbidity Study by the Government of Nepal, DFID (UK), and USAID reports that abortion services are available in all

⁷³ According to the ESCR Committee, “any deliberately retrogressive measures . . . would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources.” ESCR Committee, *General Comment No. 3: The nature of States parties obligations (Art. 2, par. 1)*, para. 9, U.N. Doc. E/1991/23 (1990).

⁷⁴ While retrogressive measures can, in theory, occasionally be “justified” (*see id.*), “there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible.” ESCR Committee, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, para. 32, U.N. Doc. E/C.12/2000/4 (2000).

⁷⁵ Abortion was legalized in March 2002 under the 11th amendment to the Country Code and received royal assent in September 2002. The amendment legalized abortion on the following grounds: 1) upon request for pregnancies of up to 12 weeks, with voluntary consent of the woman; 2) when pregnancy of up to 18 weeks results from rape or incest; and 3) when, at any time during the pregnancy, the life or physical or mental health of the pregnant woman is at risk, or if there is a risk of fetal impairment, with the woman's consent and the recommendation of an authorized medical practitioner. In December 2003, the procedural order was endorsed, giving force to the law through enabling implementation. *Muluki Ain 2020* [National Code 1963].

⁷⁶ CEDAW Committee, *Concluding Observations: Nepal*, paras. 147, 148 U.N. Doc A/54/38 (1999).

⁷⁷ GOVERNMENT OF NEPAL, MINISTRY OF HEALTH AND POPULATION ET AL., UNSAFE ABORTION: NEPAL COUNTRY PROFILE 3 (JULY 2006), available at http://www.crehpa.org.np/download/unsafe_abortion_nepal_country_profile_2006.pdf [UNSAFE ABORTION: NEPAL].

⁷⁸ Nepal Report before CEDAW, *supra* note 22, para. 157.

of Nepal's 75 districts.⁷⁹ Nepal should be commended for the fact that CAC facilities have been found by this study to provide safe, high-quality care, with low complication rates reflecting "good provider training and adherence to procedure protocols."⁸⁰ However, medical abortion is not officially available in Nepal,⁸¹ and quality care at CACs is not accessible to the whole population. Poor women, women from rural villages, and from marginalized communities within urban areas, are still likely to seek abortion from unauthorized providers, which endangers their health⁸² and puts their lives at risk.

Unsafe, clandestine abortion procedures were very common prior to the legalization of abortion in Nepal,⁸³ and accounted for up to 61 percent of obstetric admissions to hospitals.⁸⁴ After legalization, there has been a small but persistent annual decline in the percent of obstetric complications caused by unsafe abortions.⁸⁵ However, unsafe abortion practices continue. Unsafe abortions are most likely to occur when women do not have awareness about the new law, or lack access to safe, affordable abortion services.⁸⁶ Some of the unsafe abortion techniques that continue to be used in Nepal since the law changed in 2002 include "insertion of sticks, insertion of sharp metal objects, insertion of...herbs, and oral intake of unknown medicines."⁸⁷ Of those methods, insertion of sticks and orally taking unknown medicines are the most common clandestine methods still in use in Nepal.⁸⁸ Even after legalization, **unsafe abortions persist as a cause of maternal death—up to 27 percent of maternal deaths according to one NGO estimate.**⁸⁹ This percentage of maternal deaths caused by unsafe abortions is higher than in Asia generally, where the figure is 12 percent, and is higher than the global average of 13 percent.⁹⁰

Women of all income levels do not have adequate access to safe abortion in Nepal, but low-income women especially lack access to the service and those abortions they do undergo are more likely to cause complications.⁹¹ One reason poor women have less access to abortion is the prohibitively high cost. Fees for abortion at CAC facilities range between Rs. 800 and Rs. 2,000

⁷⁹ NEPAL MMMS, *supra* note 7, at 3.

⁸⁰ *Id.* at 23.

⁸¹ UNSAFE ABORTION: NEPAL, *supra* note 77, at 15.

⁸² *Id.* at 25.

⁸³ *Id.* at 22.

⁸⁴ NEPAL MMMS, *supra* note 7, at 22.

⁸⁵ *Id.*

⁸⁶ UNSAFE ABORTION: NEPAL, *supra* note 77, at 36.

⁸⁷ *Id.* at 25.

⁸⁸ *Id.*

⁸⁹ WOMEN'S HEALTH AND RIGHTS ADVOCACY PARTNERSHIP (WHRAP), ADVOCATING ACCOUNTABILITY: STATUS REPORT ON MATERNAL HEALTH AND YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN SOUTH ASIA 55 (2010), *available at*

http://www.arrow.org.my/images/publications/research/Advocating_Accountability/chap_3_nepal.pdf [hereinafter WHRAP, ADVANCING ACCOUNTABILITY].

⁹⁰ WHO, UNSAFE ABORTION: GLOBAL AND REGIONAL ESTIMATES OF THE INCIDENCE OF UNSAFE ABORTION AND ASSOCIATED MORTALITY IN 2003, at 13 (2007), *available at*

http://whqlibdoc.who.int/publications/2007/9789241596121_eng.pdf [hereinafter WHO, UNSAFE ABORTION].

⁹¹ Women in the lowest three wealth quintiles reported abortions at a rate of 1.7 percent; women in the highest quintile accessed abortions at a rate of 6.6 percent. Women in the lowest quintile reported complications associated with the abortion or miscarriage in 76.3 percent of cases, compared with 44.0 percent in the highest quintile. NEPAL DHS 2006, *supra* note 24, at 153.

(USD 11.33 – US\$ 28.33), with the median fee of Rs. 1,175 (USD 16.44).⁹² These prices exclude the cost of medicines, including antibiotic prophylaxis, which range from Rs. 60 (USD 0.83) and Rs. 80 (USD 1.11).⁹³ Since 30.8 percent of people in Nepal live below the poverty line, which is Rs. 7,696 (US \$107) per year, or about 29 cents (US) per day,⁹⁴ it is clear that **Comprehensive Abortion Care facilities are not affordable for Nepal’s poor.** While high costs clearly impede women’s ability to obtain abortion services, Nepal did not address that issue in its current report to this Committee. This Committee has identified “high fees for health care services...”⁹⁵ as a barrier to women’s health care. Thus, Nepal must take steps to make abortion services affordable for all in order to comply with CEDAW, as its Supreme Court has also required in the *Lakshmi Dhikta* decision, discussed below.

This Committee has also emphasized that great distances from health services and lack of convenient and affordable public transport⁹⁶ also impede women’s ability to realize their right to health. Those barriers to abortion services are present in Nepal and compound the economic barriers discussed above. Eighty-six percent of the population,⁹⁷ and almost ninety-six percent of the country’s poor,⁹⁸ live in rural areas. However, most CAC services are available in urban areas and district headquarters; thus, rural women are less likely to know about or have access to CAC services.⁹⁹ **Because they have less access to safe services, women in rural locations are far more likely to have complications from abortion as compared to urban women.**¹⁰⁰ Abortion services that are available in rural areas are less likely to be safe,¹⁰¹ and because of Nepal’s difficult geographic terrain and limited road infrastructure, rural women cannot easily access CAC services in urban centers.¹⁰²

Moreover, while abortion has been legal since 2002, many women are not aware that it is legal, and are not aware of where and under what conditions they can access services.¹⁰³ **Only about half of the CAC clients interviewed in a 2009 study were aware that abortion had been legalized.**¹⁰⁴ Lack of awareness of abortion’s legal status is most prevalent in rural areas: 44 percent of rural CAC clients were aware of the legal status of abortions, compared with 55

⁹² GOVERNMENT OF NEPAL, MINISTRY OF HEALTH AND POPULATION & CENTER FOR RESEARCH ON ENVIRONMENT HEALTH AND POPULATION ACTIVITIES (CREHPA), NEPAL, NEPAL COMPREHENSIVE ABORTION CARE (CAC): NATIONAL FACILITY-BASED ABORTION STUDY 20 (2006), available at http://www.creha.org.np/download/summary_report_december_2006.pdf [hereinafter NEPAL COMPREHENSIVE ABORTION CARE].

⁹³ UNSAFE ABORTION: NEPAL, *supra* note 77, at 39.

⁹⁴ GOVERNMENT OF NEPAL, MINISTRY OF FINANCE, ECONOMIC SURVEY: FISCAL YEAR 2009/10, at 94 (2010), available at <http://www.mof.gov.np/publication/budget/2010/pdf/chapter7.pdf>.

⁹⁵ CEDAW Committee, *General Recommendation No. 24*, *supra* note 12, para. 21.

⁹⁶ *Id.*

⁹⁷ NEPAL DHS, *supra* note 24, at 3 (stating that 14% of the population now lives in urban areas—thus, 100 % minus 14 % equals 86—but that Nepal remains “predominantly rural”).

⁹⁸ NEPAL MDG REPORT 2010, *supra* note 7, at 13.

⁹⁹ UNSAFE ABORTION: NEPAL, *supra* note 77, at 36.

¹⁰⁰ NEPAL DHS 2006, *supra* note 24, at 153 (rural women have a 60.8% chance of experiencing complications as a result of abortion, compared with 46.3% of urban women).

¹⁰¹ UNSAFE ABORTION: NEPAL, *supra* note 77, at 20.

¹⁰² *Id.* at 39.

¹⁰³ NEPAL COMPREHENSIVE ABORTION CARE, *supra* note 92, at 13.

¹⁰⁴ *Id.* at 11.

percent in urban populations, and **only 30 percent of CAC clients in the Far-western region were aware that abortion was legal on any grounds.**¹⁰⁵

Overall, these data show that there is a problematic contradiction between the law – now almost 10 years old—allowing abortion, and the facts on the ground showing lack of access to safe abortion. Lack of access, as this Committee has understood, results in women’s unnecessary deaths and serious health complications.¹⁰⁶ The Nepal Supreme Court acknowledged this problem in the 2009 case of *Lakshmi Dhikta v. Nepal*, brought by a low-income woman who could not afford an abortion due to prohibitive fees.¹⁰⁷ The Court’s decision in *Dhikta* is to be commended for emphasizing that women’s right to safe and legal abortion under the Nepal Constitution and under international human rights law requires that abortion be accessible, not just formally legal.¹⁰⁸ The *Dhikta* Court decision has explicitly laid out steps for the state to take to make this right a concrete reality by enacting a comprehensive law on abortion and to separate abortion law from the criminal code entirely.¹⁰⁹ The Court has also asked the government to take all necessary measures to ensure stronger safeguards for women’s privacy, promote access to safe services for all women, and disseminate information about safe abortion services to health service providers and the public.¹¹⁰ As a result of the *Dhikta* decision, a draft abortion law will soon be presented before Parliament.

In the past, this Committee has urged states to implement Supreme Court decisions,¹¹¹ and to address unsafe abortion,¹¹² including in cases where, despite legalization, high rates of unsafe abortion persist.¹¹³ This Committee expressed concern about unsafe abortion in Nepal in 1999,¹¹⁴ and in 2004, this Committee urged the state to take further steps to improve women’s access–

¹⁰⁵ *Id.*

¹⁰⁶ CEDAW Committee, *Concluding Observations: Nepal* (1999), *supra* note 76, para. 147.

¹⁰⁷ Lakshmi Devi Dhikta, a woman from an extremely poor household in the far-western region of Nepal, already had five children when she became pregnant for the sixth time. She and her husband knew that having another child would be financially strenuous and would take a significant toll on Lakshmi’s health, so they requested an abortion at a government hospital. There, they were told that there would be a fee of 1,130 Rupees for an abortion. The Dhiktas did not have enough money to pay this fee and Lakshmi had no choice but to continue with the unwanted pregnancy. Center for Reproductive Rights, *Lakshmi Dhikta v. Government of Nepal*, Writ No. 0757, Jestha, 2066, at 1 (2011) (quoting from the decision), *available at* [http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Lakshmi_Dihkta_decision%20\(April%202011\).pdf](http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Lakshmi_Dihkta_decision%20(April%202011).pdf).

¹⁰⁸ *Lakshmi Dhikta v. Government of Nepal*, Writ No. 0757, Jestha, 2066 (2009) (Supreme Court of Nepal).

¹⁰⁹ The “legal provisions for abortion currently reside in the chapter on life in the National Code (Muluki Ain). Punishments for crimes against human life such as murder are also found in this section, implicitly identifying abortion as a crime akin to murder. In its decision, the Court makes it clear that a woman’s reproductive capacity cannot be used against her, and can in no way be grounds to punish her...the Court states that legal provisions on abortion must be contained in a separate law and disassociated from discussion of murder.” *Id.* at 1.

¹¹⁰ *Id.* at 2.

¹¹¹ CEDAW Committee, *Concluding Observations: India*, para. 61, U.N. Doc. CEDAW/C/2000/1/CRP.3/Add.4/Rev.1 (2000).

¹¹² CEDAW Committee, *Concluding Observations: Nepal* (1999), *supra* note 76, para. 148. *See also* CEDAW Committee, *Concluding Observations: Poland*, paras. 24, 25, U.N. Doc. CEDAW/C/POL/CO/6 (2007); *Namibia*, para. 24, U.N. Doc. CEDAW/C/NAM/CO/3 (2007).

¹¹³ CEDAW Committee, *Concluding Observations: Mexico*, paras. 32, 33, U.N. Doc. CEDAW/C/MEX/CO/6 (2006).

¹¹⁴ CEDAW Committee, *Concluding Observations: Nepal* (1999), *supra* note 76, para. 148.

especially rural women—to “health-related services and information, including in regard to sexual and reproductive health, in an effort to reduce maternal mortality.”¹¹⁵ The Supreme Court’s order in the *Dhikta* case aligns with those recommendations. To comply with CEDAW, Nepal should adopt the draft abortion law as well as take the measures necessary to implement the other elements of the *Dhikta* decision: namely, scale up its campaign to educate the public on the legalization of abortion, and increase access to safe services.

C. Unmet Need for Contraception

This Committee makes clear that women’s human rights to health, life, self-determination, and to found a family require adequate access to family planning products, technologies, and services.¹¹⁶ Contraception, including emergency contraception, is on the WHO’s list of essential medicines.¹¹⁷ States are thus obligated to provide adequate contraceptives as well as emergency contraception. This Committee has specifically urged Nepal to “increase knowledge of and access to contraceptive methods,”¹¹⁸ and has also noted that family planning duties should not disproportionately burden women, but should “be the responsibility of both partners.”¹¹⁹

Nepal’s population still lacks sufficient access to family planning, and while emergency contraception is ostensibly available,¹²⁰ awareness of it is extremely low. Rural women, adolescents, and poor women have the highest unmet needs for contraception.¹²¹ Since unwanted or mistimed pregnancies may result in women seeking unsafe abortion, it is thus especially concerning that the population most vulnerable to complications from unsafe abortion—adolescents¹²² – is also the population most at risk for unwanted pregnancy.¹²³ Data is lacking on unmarried women, and statistics show that when couples do use contraception, women still bear a disproportionate burden as compared to men.¹²⁴ Further, the fact that female sterilization

¹¹⁵ *Id.* paras. 212, 213.

¹¹⁶ Under this Convention’s Articles 10, 12, and 16, states are obligated to ensure that women and girls have access to a full range of contraceptive choices and to information about those options. In General Recommendation 21, this Committee reiterated that inadequate access to contraceptives contravenes women’s right to “decide freely and responsibly on the number and spacing” of children; and that “women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services.” CEDAW, *supra* note 8, arts. 10, 12, 16; Committee, *General Recommendation No. 21: Equality in Marriage and Family Relations*, paras. 1, 22, U.N. Doc. A/49/38 (1994).

¹¹⁷ WHO, MODEL LIST OF ESSENTIAL MEDICINES (16TH ED., UPDATED) 23 (March 2009), *available at* http://www.who.int/selection_medicines/committees/expert/17/sixteenth_adult_list_en.pdf. The 750 micrograms dose of levonorgestrel (in sec.18.3.1, p. 23) is the EC regimen.

¹¹⁸ CEDAW Committee, *Concluding Observations: Nepal* (2004), *supra* note 1, para. 213.

¹¹⁹ *Id.* paras. 212, 213.

¹²⁰ International Consortium for Emergency Contraception (ICEC), *EC Status and Availability: Nepal*, <http://www.cecinfo.org/database/pill/countrieDisplay.php?viewall=1&countdist=Nepal&print=1>.

¹²¹ *See infra* notes 127, 128, 170; *see also supra* note, 56, and surrounding text.

¹²² Adolescents are also particularly vulnerable to complications from unsafe abortion, NEPAL DHS 2006, *supra* note 24, at 6.

¹²³ Adolescents have the highest unmet need for contraception. *Id.* at 117. Adolescents have higher risk of maternal death and morbidities than adult women, and are most likely to suffer from too-close birth spacing, which also increases their risk of maternal death. NEPAL MMMS, *supra* note 7, at 18. (A lack of adequate, available, appropriate contraception – or a lack of decision-making power within the context of child marriage – may result in these young women and girls being unable to appropriately space their pregnancies.)

¹²⁴ *See infra* notes 129, 130, 131, and accompanying text.

and injectables are the most common forms of contraception suggests that women and couples may not have adequate access to or information about the full spectrum of modern contraceptive methods.¹²⁵

While the Nepal Demographic and Health Survey (DHS) reports that unmet need for contraception has declined over the past ten years,¹²⁶ the U.N. Country Office for Nepal calculates that unmet need has in fact been stagnant during that time.¹²⁷ Other indicators suggest that stagnation is most likely; the **contraceptive prevalence rate, which is 45 percent, has increased by less than one percent since 2005.**¹²⁸ In addition to this relatively low and stagnant rate of contraceptive use, there are significant disparities by age, region, and wealth level in access to and use of contraceptives.

1. Low usage of non-permanent methods and methods that do not disproportionately burden women

In its 2010 report, Nepal indicated that 44 percent of married women use a modern form of contraception. Within this 44 percent, the most popular methods are female sterilization (18 percent of all women, or 41 percent of women who use contraception) and injectables (10 percent of all women, or 23 percent of all women who use contraception).¹²⁹ Women with more education are more likely to use condoms as opposed to female sterilization, whereas women with less education are more likely to have undergone sterilization.¹³⁰ That correlation suggests that invasive, permanent or semi-permanent methods such as sterilization may be employed as opposed to less permanent methods (such as condoms) due to lower levels of education about the full range of contraceptives. According to the Nepal DHS, “female sterilization in Nepal [occurs] early in women’s reproductive lives. The median age at sterilization [...] is 27 years, and has not changed much over the last ten years.”¹³¹ The prevalence of female sterilization also reveals that **women bear an asymmetrical burden as compared to men in family planning and birth spacing**, despite this Committee’s instructions to the state in 2004.¹³² Only 6 percent of women are able to rely on male sterilization and 4.8 percent rely on condoms as their form of family planning.¹³³ Low condom use combined with a low rate of male sterilization shows that women face almost the exclusive burden of family planning as compared to men. Because condom use is the only modern method of family planning that also offers protection against sexually

¹²⁵ See *infra* note 129 and accompanying text.

¹²⁶ NEPAL DHS 2006, *supra* note 24, at 118.

¹²⁷ NEPAL MDG REPORT 2010, *supra* note 7, at 51.

¹²⁸ *Id.*

¹²⁹ NEPAL DHS 2006, *supra* note 24, at 80 (the DHS calculates that 44.2% of all women use a modern form of contraception, 18.0% of all women use sterilization, and 10.1% use injectables. We calculate, based on these numbers, that 40.7% of women using modern form of contraception are using sterilization (since 18 is 40.7% of 44.2) and 22.8% of women that use a modern form of contraception use injectables (since 10.1 is 22.8% of 44.2)).

¹³⁰ *Id.* at 81 (“[c] ontraceptive use is higher among women with little or no education primarily because a sizeable proportion of these women use sterilization. The most popular method among women who have completed SLC or higher education is condoms (16 percent), whereas the most popular method among women who have no education is female sterilization (23 percent) followed by injectables (10 percent)”).

¹³¹ *Id.* at 84.

¹³² CEDAW Committee, *Concluding Observations: Nepal* (2004), *supra* note 1, para. 213.

¹³³ NEPAL DHS 2006, *supra* note 24, at 81.

transmitted infections, such low condom use also puts women at risk for STIs, jeopardizing their right to health.

In its report to this Committee, Nepal acknowledges that female sterilization and injections are the “most popular” modern methods of contraception,¹³⁴ but did not discuss any programs undertaken to improve use of less permanent methods of contraception or of methods that do not put the burden entirely on women such as male sterilization and condoms. The state did not mention efforts to expand family planning education to men, nor did it provide information as to the extent to which community health volunteers have received training to disseminate information on family planning. There are **female community health volunteers who report never having received training on family planning, or not having received refresher training in years.**¹³⁵

2. Access to and information about emergency contraception is limited

Emergency contraception is an essential medicine intended as a back-up contraceptive method in the event of unprotected intercourse or contraceptive failure.¹³⁶ As such, treaty-monitoring bodies, including the CEDAW Committee, have recognized emergency contraception fills a unique role in the range of modern contraceptive methods and is particularly valuable for victims of sexual violence, adolescents, and other marginalized groups who may face greater barriers in accessing other contraceptive methods.¹³⁷ Repeatedly, this Committee has urged states parties to make emergency contraception available.¹³⁸

However, women in Nepal lack information about and access to emergency contraception. **Only 7 percent of Nepali women have ever heard of emergency contraception;¹³⁹ and only 0.1 percent of Nepalese women, as of 2006, had ever used emergency contraception.**¹⁴⁰

Emergency contraception is not widely available in government health facilities or hospitals because the government does not procure it.¹⁴¹ While emergency contraception is available in private pharmacies, an official from Nepal’s Family Health Division suggested that women who purchase emergency contraceptives are being financially exploited as the price is marked up significantly.¹⁴² Female community health volunteers also shared in interviews that they are not provided with information about emergency contraception or with emergency contraception pills themselves.¹⁴³

¹³⁴ Nepal Report before CEDAW, *supra* note 22, para. 147.

¹³⁵ Interview with female community health volunteers, in Lalitput, Nepal (Mar. 2011).

¹³⁶ WHO, Media Centre, Emergency contraception, FactSheet No. 244, Oct. 2005, <http://www.who.int/mediacentre/factsheets/fs244/en/index.html>.

¹³⁷ UNFPA, Where next for Family Planning? (Dec. 2009), <http://www.unfpa.org/public/News/pid/4557> (last visited June 1, 2011).

¹³⁸ CEDAW Committee, *Concluding Observations: Mexico*, paras. 32, 33, U.N. Doc CEDAW/C/MEX/CO/6 (Aug. 25, 2006).

¹³⁹ NEPAL DHS 2006, *supra* note 24, at 75.

¹⁴⁰ International Consortium on Emergency Contraception (ICEC), *Knowledge and Ever Use of Emergency Contraception in Asia, Demographic and Health Survey Data* (one page)).

¹⁴¹ Interview with officials, Family Health Division, Ministry of Health, in Kathmandu, Nepal (Mar. 2011).

¹⁴² *Id.*

¹⁴³ Interview with female community health volunteers, in Lalitput, Nepal (Mar. 2011).

II. The Right to Non-Discrimination (Articles 1, 2, 5, 12, 14, and 16)

The CEDAW Committee has recognized that the right to health should be upheld without discrimination based on either biological, societal,¹⁴⁴ or geographic factors. CEDAW is violated, therefore, when adolescent, poor, or rural women face disproportionate risks of maternal mortality and morbidity or disproportionate barriers to family planning information, services, and supplies. Furthermore, Article 16 prohibits child marriage.¹⁴⁵ The CEDAW Committee has repeatedly articulated that where early marriage persists, girls and young women experience negative effects on the enjoyment of their human rights, including the right to health.¹⁴⁶ In Nepal, reproductive health data for girls and young women entered into early marriage clearly demonstrate how this practice violates their right to equal enjoyment of the right to health.

A. Early Marriage Endangers Girls' and Adolescents' Health

Giving birth at too young an age puts girls and adolescents at high risk of maternal death and morbidity, as this Committee, other treaty monitoring bodies (TMBs), the WHO, and the UNFPA have repeatedly emphasized.¹⁴⁷ Early pregnancy, when it does not cause death, takes a toll on young women's bodies and leads to, among other things, an alarming prevalence of uterine prolapse.¹⁴⁸ The risk of maternal death worldwide is twice as high for adolescents than for women in their twenties.¹⁴⁹ In Nepal, **adolescents under 20 have almost three times as high a risk of maternal death as do women in their early twenties.**¹⁵⁰ Further, lower levels of education are correlated to higher rates of maternal death.¹⁵¹ Since early marriage causes girls in Nepal to leave the formal education system, their resultant lower level of education may also heighten their risk for maternal death.

While the legal age of marriage for women in Nepal is 18, the practice of early marriage persists and contributes to Nepal's high rates of maternal mortality and morbidity.¹⁵² 60 percent of

¹⁴⁴ CEDAW Committee, *General Recommendation No. 24*, *supra* note 12, para. 6.

¹⁴⁵ *Id.* art. 16(2).

¹⁴⁶ *See, e.g.*, CEDAW Committee, *Concluding Observations: Gambia*, para. 40, U.N. Doc. A/60/38 (2005); *Hungary*, para. 334, U.N. Doc. A/57/38 (2002); *Peru*, para. 489, U.N. Doc. A/57/38 (2002); *Serbia*, para. 36, U.N. Doc. CEDAW/C/SCG/CO/1 (2007).

¹⁴⁷ WHO, THE WORLD HEALTH REPORT 2005: MAKE EVERY MOTHER AND CHILD COUNT 4 (2005), *available at* http://www.who.int/whr/2005/whr2005_en.pdf; UNFPA, STATE OF THE WORLD POPULATION 2004: THE CAIRO CONSENSUS AT TEN: POPULATION, REPRODUCTIVE HEALTH AND THE GLOBAL EFFORT TO END POVERTY 76 (2004), *available at* www.unfpa.org/swp/2004/pdf/en_swp04.pdf [hereinafter UNFPA, STATE OF THE WORLD POPULATION 2004]; CEDAW Committee, *Concluding Observations: Nepal* (2004), *supra* note 1, paras. 212, 213; Committee on the Rights of the Child, *General Comment No. 4: Adolescent Health*, para. 20, U.N. Doc. CRC/GC/2003/4 (2003). (“[e]arly...pregnancy [is a] significant factor in health problems related to sexual and reproductive health”).

¹⁴⁸ Early marriage leads to increased life-long fertility rates as well as increased risks of obstetric complications, such as prolapse. NEPAL MMMS, *supra* note 7, at 18. A Tribhuvan University study found high rates of uterine prolapse in young mothers. *See* TRIBHUVAN UNIVERSITY, STATUS OF REPRODUCTIVE MORBIDITIES IN NEPAL, *supra* note 50, at 74-75 (since early marriage is related to increased overall fertility, and since having multiple births is strongly correlated to incidences of UP, early marriage is thus clearly implicated in high rates of UP overall).

¹⁴⁹ UNFPA, STATE OF THE WORLD POPULATION, *supra* note 147, at 26.

¹⁵⁰ Under 20 years of age, MMR is 297. In the 20-24 age group, MMR is 119. NEPAL MMMS, *supra* note 7, at 119.

¹⁵¹ *Id.* at 121 (illiterate women with no schooling accounted for 41% of maternal deaths, whereas women with the highest level of education accounted for 3%).

¹⁵² NEPAL DHS 2006, *supra* note 24, at 102; NEPAL MMMS, *supra* note 7, at 18.

women marry by age 18 in Nepal,¹⁵³ and **41 percent of 19-year-olds have already had a child or are pregnant.**¹⁵⁴ Nepal has the second highest rate of adolescent childbearing in South Asia, due in part to the prevalence of early marriage.¹⁵⁵ **Girls and young women between the ages of 15 to 19 represent more than 20 percent of all maternal deaths in Nepal.**¹⁵⁶

Article 5 of CEDAW obliges states parties to “take all appropriate measures to modify the social and cultural patterns of conduct of men and women...” that perpetuate discrimination and harm to women,¹⁵⁷ and Article 16(2) states that the marriage of children “shall have no legal effect.”¹⁵⁸ This Committee has expressed concern about high rates of teen pregnancies, especially in rural areas,¹⁵⁹ and in 2004 this Committee urged Nepal to enforce its marriage laws which ban the practice of child marriage, and to take measures to reduce its occurrence since it is both discriminatory and leads to adverse health effects on girls and young women, who, as a result of early marriage, experience early pregnancy.¹⁶⁰ Other TMBs, including the ESCR Committee and the Committee on the Rights of the Child, have similarly expressed concern about the persistence of child marriage in Nepal.¹⁶¹ The continued prevalence of early marriage in spite of its illegality indicates that strict enforcement of the law is needed to actually prevent the practice from occurring and thus lower maternal mortality and morbidity rates.

B. Discrimination in Fulfillment of the Right to Maternal Health Services and Abortion for Rural Women

Reproductive health services are especially unavailable for rural women. Eighty-six percent of Nepal’s population lives outside of urban areas¹⁶² and **the majority of women do not have easy access to maternal health care services, especially emergency obstetric care.** Only 35 of

¹⁵³ NEPAL DHS 2006, *supra* note 24, at 102.

¹⁵⁴ NEPAL MDG REPORT 2010, *supra* note 7, at 51.

¹⁵⁵ NEPAL MMMS, *supra* note 7, at 18. *See also* U.N. ECON. & SOC. COMM’N FOR ASIA & THE PACIFIC, ADOLESCENT REPRODUCTIVE HEALTH IN THE ASIAN AND PACIFIC REGION, *in* ASIAN POPULATION STUDIES SERIES NO. 156 (2001)), available at <http://www.unescap.org/esid/psis/population/popseries/apss156/> (that 2001 survey used 1996 data, the latest year for which this data was available. In 1996, 51.6 percent of women between the ages of 20 and 24 had a child by age 20).

¹⁵⁶ In 2000, girls in this age group represented about 20% of all maternal deaths. FAMILY HEALTH DIVISION, DEPARTMENT OF HEALTH SERVICES, MINISTRY OF HEALTH, GOVERNMENT OF NEPAL, NATIONAL ADOLESCENT HEALTH AND DEVELOPMENT STRATEGY, Annex II, at 15 -16 (2000) (they made up the same proportion in 2006). NEPAL DHS 2006, *supra* note 24, at 133 (in a sample of 39 deaths, adolescents aged 15-19 accounted for 8 of them, equaling 20.5%).

¹⁵⁷ CEDAW, *supra* note 8, art. 5(a).

¹⁵⁸ *Id.* art. 16(2); CEDAW Committee, *General Recommendation No. 21: Equality in Marriage and Family Relations*, para. 16, U.N. Doc. A/49/38 (1994).

¹⁵⁹ *See, e.g.*, CEDAW Committee, *Concluding Observations: Ecuador*, paras. 38, 39, 41, U.N. Doc. CEDAW/C/ECU/CO/7 (2008).

¹⁶⁰ CEDAW Committee, *Concluding Observations: Nepal* (2004), *supra* note 1, paras. 208, 209, 212.

¹⁶¹ ESCR Committee, *Concluding Observations: Nepal* (2008), *supra* note 31, para. 15; Committee on the Rights of the Child, *Concluding Observations, Nepal*, paras. 65, 66, U.N. Doc. CRC/C/15/Add.261 (2005).

¹⁶² NEPAL DHS 2006, *supra* note 24, at 3 (stating that 14% of the population now live in urban areas (thus, 100 percent minus 14 percent equals 86) but that Nepal remains “predominantly rural”).

Nepal's 75 districts have comprehensive emergency obstetric care facilities.¹⁶³ Most rural households are more than a 45-minute walk away from a drivable road.¹⁶⁴

With limited access to healthcare, rural women also disproportionately suffer from the effects of unsafe abortions. When women seek abortions from untrained providers or in poorly equipped facilities, which they are more likely to do when they lack access to safe services, these unsafe, clandestine abortions can result in death or morbidity.¹⁶⁵ While the government calculates that unsafe abortions contribute to only 3.5 percent of maternal deaths,¹⁶⁶ as noted previously, some nongovernmental organization reports place the figure as high as 27 percent.¹⁶⁷ These figures are concerning, since Nepal legalized abortion in 2002, but the higher estimate of maternal deaths attributable to unsafe abortion exceeds the global average of 13 percent.¹⁶⁸ Lack of access to safe abortion can be an “indirect” cause of maternal death for women who are unable to obtain safe abortion services when a pregnancy threatens their health.¹⁶⁹

C. Discrimination in Fulfillment of the Right to Family Planning for Adolescent, Rural, and Poor Women

Adolescents aged 15 to 19 have the highest unmet need for contraception of all women in Nepal.¹⁷⁰ **In this age group, only 29.6 percent of the demand for contraception is satisfied,**¹⁷¹ and 41 percent of all 19-year-olds have had at least one child.¹⁷² The fact that large numbers of women begin childbearing in their teens in Nepal may be attributable not just to early marriage, discussed above, but also to the lack of adequate access to desired contraception once adolescents are married. Since adolescents face a much higher risk of maternal death than adults do, access to contraception for this age group should be a serious priority for the state. The younger a woman is in Nepal, the more likely she will be having too-closely spaced births—defined as births that are less than 24 months apart—which increases the likelihood of maternal death and morbidity.¹⁷³ Early and too-frequent childbearing in Nepal are also leading causes of

¹⁶³ NEPAL MMMS, *supra* note 7, at 14 (35 districts have comprehensive EOC).

¹⁶⁴ INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES, WORLD DISASTERS REPORT: FOCUS ON NEGLECTED CRISES 98 (2006), *available at* <http://allafrica.com/download/resource/main/main/idatcs/00011069:a5e3eaa1c2bbc35210bb7b704773dc43.pdf>.

¹⁶⁵ *See, e.g.*, CEDAW Committee, *Concluding Observations: Argentina*, para. 380, U.N. Doc. A/59/38 (2004); *Azerbaijan*, para. 73, U.N. Doc. A/53/38 (1998); *Venezuela*, para. 31, U.N. Doc. CEDAW/C/VEN/CO/6 (2006); *Burkina Faso*, para. 35, U.N. Doc. A/60/38 (2005); *Burundi*, para. 61, U.N. Doc. A/56/38 (2001); *Cape Verde*, para. 29, U.N. Doc. CEDAW/C/CPV/CO/6 (2006); *Chile*, para. 228, U.N. Doc. A/54/38 (1999); *Chile*, para. 19, U.N. Doc. CEDAW/C/CHI/CO/4 (2006); *Colombia*, para. 22 U.N. Doc. CEDAW/C/COL/CO/6 (2007); *Dominican Republic*, para. 337, U.N. Doc. A/53/38 (1998); *Eritrea*, para. 22, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); *Georgia*, para. 111, U.N. Doc. A/54/38 (1999); *Ghana*, para. 31, U.N. Doc. CEDAW/C/GHA/CO/5 (2006); *Lebanon*, para. 35, U.N. Doc. A/60/38 (2005); *Malawi*, para. 31, U.N. Doc. CEDAW/C/MWI/CO (2006); *Mali*, para. 33, U.N. Doc. CEDAW/C/MLI/CO/5 (2006).

¹⁶⁶ NEPAL MMMS, *supra* note 7, at 104.

¹⁶⁷ WHRAP, ADVANCING ACCOUNTABILITY, *supra* note 89, at 55.

¹⁶⁸ Unsafe abortion accounts for 13% of maternal deaths globally. WHO, UNSAFE ABORTION, *supra* note 90, at 13.

¹⁶⁹ NEPAL MMMS, *supra* note 7, at 109-110.

¹⁷⁰ NEPAL DHS 2006, *supra* note 24, at 117.

¹⁷¹ *Id.*

¹⁷² NEPAL MDG REPORT 2010, *supra* note 7, at 51 (41% of 19 year olds are pregnant or have a child).

¹⁷³ NEPAL DHS 2006, *supra* note 24, at 70.

uterine prolapse.¹⁷⁴ As discussed above, uterine prolapse is a painful, potentially fatal problem that usually occurs in older women, but in Nepal it is prevalent in young women as well, in large part caused by early, too-frequent, too-closely-spaced pregnancies.

Age disparities in need for contraception also exist for women older than adolescents. In the 20 to 24 age group, 48.2 percent of demand is satisfied, as compared to 64.4 percent for women between 25 and 29, and almost 75 percent for women over 30.¹⁷⁵ These age disparities indicate that more work is to be done in providing access to needed contraceptive methods, services and information for younger women and couples.

As is the case regarding access to abortion and to maternal health services in general, rural women in Nepal are most likely to lack access to family planning.¹⁷⁶ In 2004, the CEDAW Committee expressed particular concern about rural women in Nepal's inadequate access to family planning as well as illiteracy, which is "an obstacle to obtaining and effectively using health-related information."¹⁷⁷ Despite this Committee's instructions, rural women still have significantly less access to family planning than do urban women.¹⁷⁸ Inequitable access to family planning services for rural women violates CEDAW's Article 14, which specifies that states must take special steps to provide rural women with access to adequate health care and family planning services.¹⁷⁹

Poorer women are far less likely than wealthier women to be able to meet their contraceptive needs. In the lowest wealth quintile, only 50.7 percent of demand for contraception is satisfied, as compared to 75.9 percent in the wealthiest quintile.¹⁸⁰ It is likely that within these cohorts, the other trends are present and exaggerated. For example, poor adolescents living in rural areas are likely to have access to family planning services that is so limited as to be nonexistent.

III. CONCLUSION: SUGGESTED QUESTIONS AND RECOMMENDATIONS

We respectfully request that this Committee pose the following questions to the delegation representing the government of Nepal during its 49th Session.

1. High rates of maternal death persist, which are most severe for rural, adolescent, and poor women. What steps have been taken by the government to improve maternal health for those populations? What is the state doing to address some of the leading causes of maternal death and morbidity such as early marriage, malnutrition, and anemia?
2. Despite the 2002 legalization of abortion and the 2009 *Lakshmi Dhikta* order by the Supreme Court, access to safe abortion remains out of reach for most women in Nepal, especially poor, rural, and adolescent women. What steps have been taken by the

¹⁷⁴ See NEPAL MMMS, *supra* note 7, at 18.

¹⁷⁵ NEPAL DHS 2006, *supra* note 24, at 117.

¹⁷⁶ *Id.* (75.2 percent of need is met for urban women, while 64.3 percent of need is met for rural women).

¹⁷⁷ CEDAW Committee, *Concluding Observations: Nepal* (2004), *supra* note 1, para. 212.

¹⁷⁸ NEPAL DHS 2006, *supra* note 24, at 117.

¹⁷⁹ CEDAW, *supra* note 8, arts. 14(1), 14(2)(b).

¹⁸⁰ NEPAL DHS 2006, *supra* note 24, at 117.

government to enact a comprehensive abortion law guaranteeing access to abortion to all women, regardless of economic status, as it has been instructed by the Supreme Court? What steps has the government taken to raise public awareness about safe and legal abortion in line with the Supreme Court's decision?

3. What steps have been taken by the government to establish universal access to a full range of contraceptives, including emergency contraception, and to reduce the unmet need for contraceptives, especially that of adolescents?
4. How does the government plan to meet the current demand for corrective surgeries for women suffering from uterine prolapse, especially in light of the cutbacks in targets and transportation fees?
5. Does the state have a national comprehensive plan for increasing knowledge about uterine prolapse, and its prevention and early-stage treatment? How does the state plan to incorporate uterine prolapse awareness, prevention, and treatment activity into its already-existing community health programs?

The Center, J4A, and CAED further respectfully submit the following recommendations for the Committee to consider incorporating into the concluding observations for Nepal.

1. Take steps to immediately implement the *Lakshmi Dhikta* decision by disseminating information about the decision, passing a comprehensive abortion law, and improving access to abortion services throughout the country.
2. Prioritize ensuring access to a full range of maternal health services, including antenatal, postnatal, and emergency obstetric care, particularly for poor women, rural women, and adolescent girls.
3. Take adequate steps to address prevention, detection, and treatment of forms of maternal morbidity, including uterine prolapse. Given the extreme frequency of uterine prolapse in Nepal, the state party should specifically address the need for preventative measures as well ensure sufficient allocation of funds to meet the demand for corrective surgeries.
4. Address unmet need for contraception by prioritizing universal access to the full range of contraceptive methods, information, and services, including emergency contraception, with a particular focus on rural women, poor women, and adolescent girls.
5. Address discriminatory practices against women and girls that jeopardize their reproductive health. The state party should also prioritize addressing malnutrition amongst women and girls, both as a form of gender discrimination and as a means to ensure survival of women during pregnancy and childbirth. Similarly, the state party should eliminate child marriage through proper implementation of the legal ban on child marriage.

Sincerely,



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