CENTER FOR REPRODUCTIVE RIGHTS

April 11, 2007

The Committee on Economic, Social and Cultural Rights

Re: Supplementary information on Nepal
Scheduled for review by the Committee on Economic, Social and Cultural Rights
during its 38th Session

Dear Committee Members:

The Center for Reproductive Rights, an independent, non-governmental organization, intends to submit a letter to supplement the second periodic report of the government of Nepal to the Committee on Economic, Social, and Cultural Rights, which is scheduled to be reviewed during the Committee's 38th Session. We hope that the Committee's review will cover several areas of concern related to the status of the reproductive health and rights of women and adolescents in Nepal. This letter is intended to provide a summary of the issues of greatest concern, as well as a list of questions that we hope the Committee will raise with the official delegation from Nepal.

Because reproductive rights are fundamental to women's health and equality, States parties' commitment to ensuring them should receive serious attention. Furthermore, reproductive health and rights receive broad protection under the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12(1) recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[1] In interpreting the right to health, this Committee, in General Comment 14, has explicitly defined this right to "include the right to control one's health and body, including sexual and reproductive freedoms."[2] Articles 2(2) and 3 guarantee all persons the rights set forth in the ICESCR without discrimination, specifically as to "sex, social origin or other status."[3] The Committee has characterized the duty to prevent discrimination in access to health care as a "core obligation" of the state.[4]

The Committee has further asserted that States parties are required to take "measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, emergency obstetric services and access to information, as well as to resources necessary to act on that information."[5] General Comment 14 also specifically states that "[t]he realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health."[6]

Concluding Observations issued to the government of Nepal in 2001 included specific recommendations to improve the status of women's reproductive health. The Committee urged the State party to take action to address the problems of clandestine abortions, unwanted pregnancies, and the high rate of maternal mortality. Specifically, the Committee recommended that the State party reinforce reproductive and sexual health programs, particularly in rural areas, and allow abortion to save the life of the woman or when the pregnancy is the result of rape or incest.[7] The 2002 amendment to the *Muluki Ain* (National Code), which decriminalized abortion on broad grounds, is the most noteworthy legislative and policy change related to women's health that has occurred since the last time Nepal reported to this Committee.

The government of Nepal's second periodic report discusses efforts made to reduce maternal mortality and morbidity rates and to expand coverage of family planning[8] and reproductive health services for adolescents,[9] including counseling and reproductive health education.[10] In addition, the report discusses ambitious programs outlined in the Ninth and Tenth Plans and the National Human Rights Action Plan.[11]

Nevertheless, the government's failure to fully comply with the Convention is evidenced by the reality of women's lives in Nepal. Nepal continues to have one of the highest maternal mortality rates in the world. Although abortion is now legally permitted on broad grounds, the demand for safe services remains unfulfilled. Consequently, unsafe abortion remains a leading cause of death and morbidity among pregnant women in Nepal and disproportionately impacts low-income women and those living in rural areas. In addition, most women do not have the ability to control their fertility due to a lack of access to modern contraceptives and related information. As a result, the number of unplanned and unwanted pregnancies is high. Finally, another cause for concern is the decade-long conflict which has led to a massive destruction of health infrastructure, disruption of normal life, and internal displacement. The true impact of the conflict remains to be officially documented and assessed.

We would like to take this opportunity to bring the Committee's attention to some issues of concern, which directly affect the reproductive health and lives of women in Nepal:

Women's Reproductive Health Rights (Articles 10, 12, and 15(1)(b) of the ICESCR)

> Article 12 guarantees the right of all persons to enjoy the highest attainable standard of physical and mental health. The Committee defines "reproductive health" to include "the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning services that will, for example, enable women to go safely through pregnancy and childbirth."[12] The right to health also contains entitlements, which include "the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health."[13]

In its past Concluding Observations, CESCR has expressed concern over women's inability to access reproductive health services[14] and has criticized states parties' inadequate policies and programs.[15] The Committee has noted that a state's failure to ensure access to reproductive health care for women constitutes discrimination in that it deprives them of their ability to fully enjoy their economic, social and cultural rights on an equal basis with men.[16] Three issues of concern that directly implicate women's reproductive rights as recognized through Articles 12, 10 and 15 (1)(b) of the Convention include the high rates of maternal mortality, unsafe abortion, and lack of access to contraception.

1. Maternal Mortality

Article 10 of the Convention grants special protection to pregnant women before and after delivery, as well as to adolescents and children. The Nepalese government's report does not explicitly and fully convey the catastrophic nature of maternal mortality or the devastating impact of the decade-long conflict on maternal health. The official report states that there has been "significant improvement in the maternal mortality rates in Nepal," and that they have decreased from 850 deaths per 100,000 births in 1990 to 415 in 2002.[17] However, according to the Millennium Development Goals Progress Report from 2005, the data on maternal mortality in Nepal is potentially flawed due to misclassification and under-reporting.[18] In fact, Nepal's health information system is not equipped to determine the real magnitude of this problem due to inadequate record-keeping.[19]

NGO estimates of maternal death are significantly higher than the government's data. For example, the UNFPA cites the maternal mortality rate in Nepal as 740 per 100,000 live births, the second highest in Asia after Afghanistan,[20] while the Population Reference Bureau places the rate at 830/100,000.[21] According to the World Disasters Report, every year, 5000 to 6000 mothers die in childbirth (one woman every 90 minutes), making Nepal one of the most dangerous places in the world to give birth.[22] A global review of 49 developing countries by reproductive health experts ranked Nepal 47th in all areas of neo-natal and maternal health services.[23] That adolescents are at particular risk is demonstrated by the fact that young women ages 15 to 19 account for more than 20 percent of all maternal deaths. [24] At the current rate, the Millennium Development Goal of reducing maternal mortality by 75 percent from 1990—to 134 deaths per 100,000 by 2015[25]—is a considerable challenge.

The principal contributors to maternal mortality are inaccessibility to emergency obstetric services, including unsafe delivery and postnatal complications; unsafe abortion; early marriage; short birth intervals; and poor maternal nutrition and health.[26] High maternal mortality rates are also caused by delays in seeking medical assistance, delays in accessing proper care, and delays in care at health facilities.[27]

Approximately 70 percent of the country's maternal mortality deaths are attributable to obstetric causes, the majority of which are manageable and preventable.[28] Nepal's Second Long Term Health Plan aims to increase the percentage of deliveries by trained health personnel to 95 percent by 2017.[29] Nonetheless, the current reality is that more than 80 percent of deliveries take place in the home; most of these are attended by family members or neighbors. Only 11 percent of deliveries are attended by skilled staff (doctors, nurses, and auxiliary nurse midwives).[30] According to the United Nations, of the 900,000 women pregnant in Nepal every year, 129,000 develop life-threatening complications requiring emergency obstetric services.[31] However, only one in twenty women with pregnancy complications receives emergency care.[32] Even those who are able to access obstetric services may not survive, as safe blood is in short supply.[33]

There are large discrepancies in access to health care based on geography, as most doctors and public sector facilities are concentrated in large cities such as Katmandu.[34] Of the 75 districts in Nepal, only 25 have comprehensive Emergency Obstetric Care facilities. In addition, the majority of private health centers are located in more developed regions of the country. The two least developed regions in the country have no private health facilities at all.[35] The majority of households are more than a 45 minute walk from the nearest paved road. In poor communities, many women hesitate to visit health facilities for fear of dying along the way.[36] In fact, a woman in an urban area is six times more likely to deliver a child at a health facility than a woman from a rural area.[37] Health services and personnel remain extremely limited due to the government's failure to invest in rural health facilities[38]—the doctor to patient ratio is approximately 1 to 15,000.[39] According to the World Health Organization, evidence suggests that there is a strong correlation between the number and quality of health care workers and maternal survival.[40]

A small percentage of women in Nepal (14 percent) attend the recommended four pre-natal visits. On average, only one in seven adolescents receives any pre-natal care.[41] Without access to a trained professional, women often suffer from protracted labor and consequences from a retained placenta and may die as a result of bleeding or post-partum hemorrhage.[42] Every year, nearly 3,000 women bleed to death after giving birth.[43] Post-natal care is also uncommon, especially for poor and rural women; 97 percent of mothers delivering outside a health facility do not receive a postnatal checkup. Furthermore, less than one in five mothers receives care within the first two days after giving birth.[44]

For most women, maternal care is prohibitively expensive. The average hospital delivery and surgery cost the equivalent of US$70 and US$150 respectively.[45] According to the government's Demographic and Health Survey, two out of three women in Nepal consider the cost of treatment to be a significant problem.[46] In its past Concluding Observations, the CESCR has demonstrated concern over the high price of treatment for patients.[47] The government has recently begun a cost-

sharing program whereby pregnant women can receive cash to cover travel to a district hospital or primary healthcare center. However, these payments are not large enough to cover the expenses incurred for pre- and post-natal care.[48] The government has not established pricing guidelines for life-saving interventions in response to complications.[49] Consequently, financial constraints frequently come between women and life-saving health care.

Nepal's decade-long Maoist insurgency has further exacerbated the maternal health crisis. While the government of Nepal has not yet conducted a study to determine the impact of the conflict on women's health, the World Disasters Report states that it has increased the time it takes for a woman to seek and receive essential maternal care by ten percent.[50] In 2005 and 2006, 80 percent of Nepal was under the control of Maoists. These groups often required advanced written permission to move from remote, rural areas under their control to district capitals containing medical facilities (under government control).[51] Consequently, the delay pregnant women experienced on their way to the hospital because of roadblocks, security checkpoints, strikes, and ambushes often proved deadly.[52] Moreover, due to the conflict, health facilities have been left vacant or unsupervised, and insurgents have reportedly looted medicines from pharmacies and supplies from porters.[53] In effect, the conflict has destroyed much of Nepal's limited health network and infrastructure.[54] Many qualified doctors and nurses have refused to work in rural areas out of fear.[55]

The CESCR has consistently expressed concern to States parties about the high rates of maternal mortality,[56] which the Committee views as a violation of the right to health. Linking high maternal mortality rates to inadequate health[57] and family planning services,[58] the Committee has recommended that States parties take measures to address the problem,[59] including the review of health policies[60] and implementation of programs that increase women's access to comprehensive reproductive health care and information.[61] The Committee has also expressed concern about particularly high rates of maternal mortality among rural,[62] poor, uneducated, and indigenous women;[63] it has asked States parties to ensure that these populations have equal access to health care.[64] In this instance, it is important for the Committee to recognize the Nepalese government's failure to fully implement its policies and programs on maternal health and to generate the necessary political and financial will to support them.

2. Unsafe abortion adversely impacts women's health and leads to high maternal mortality and morbidity

The government's report to the Committee fails to make any mention of the continuing problem of unsafe abortion. In its Concluding Observations to Nepal in 2001, this Committee expressed deep concern over the relationship between high rates of maternal mortality and illegal, unsafe, and clandestine abortions.[65] By some estimates, complications from unsafe abortion account for 20 percent of

maternal deaths in health facilities in Nepal—not to mention those who never make it to a hospital.[66]

In 2002, in response to a bold demand by women's rights activists and health advocates, the Nepalese government legalized abortion on the following grounds: a) upon request for pregnancies of up to 12 weeks, with the voluntary consent of the woman; b) when the pregnancy (of up to 18 weeks) results from rape or incest; and c) 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 women's consent and the recommendation of an authorized medical practitioner.[67] However, a recent study conducted by the Center for Research on Health, Environment and Population Activities (CRHEPA), in collaboration with the Family Health Division, Ministry of Health, and the World Health Organization (hereinafter referred to as the "Country Profile"), reveals that despite the decriminalization of abortion and the subsequent introduction of the Safe Pregnancy Order, access to safe abortion services remains inadequate.[68] A leading survey at the Maternal Hospital in Katmandu between April 2005 and April 2006 (cited in the Country Profile) shows that a quarter of women seeking health care for abortion related complications had initially sought an abortion from an unskilled provider; 14 percent had used unapproved drugs sold by pharmacists or medicine shops; and 19 percent had used herbs or other unidentified substances to induce an abortion.[69] Women most at risk of dying or suffering complications from unsafe abortion include the following: low-income women; women located in remote areas; women in vulnerable circumstances such as refugee women and internally displaced women; and, adolescents, particularly those who are not married.[70]

Cost is a significant obstacle for low-income women seeking safe abortion services. The cost of a legal abortion in a public hospital is inconsistent and prohibitive, ranging from Rs. 900 to Rs. 2000.[71] These prices do not include essential medicines,[72] an additional burden to women and their families. Abortion fees in private clinics and nursing homes are reportedly three to four times higher.[73] While official provisions for subsidized or even free services for low-income women have been enacted, not one of the more than 2000 women interviewed by CREHPA had benefited from this provision.[74] The government's failure to regulate the cost of abortion services and make them affordable has led to a denial of access to safe services, often resulting in forced pregnancies that intensify the health and economic burden on women.

Legal abortion services are highly irregular, causing unnecessary delays in obtaining safe services. Of the13 government hospitals providing legal abortions, only nine offer services every day of the week while the remaining four provide services only two days per week.[75] Consequently, women who decide to terminate their pregnancy within the first twelve weeks often end up crossing the legal limit for abortion upon request by the time they actually come into contact with a provider. According to the Country Profile, one tenth of clients are turned

away from the Maternity Hospital in Katmandu for crossing the 12 week limit for abortion on request.[76] Ensuring the timeliness of abortion services is essential for the protection of women's health since the risks associated with abortion increase exponentially with the delay in access to services. The unequal distribution of services also creates unnecessary delays, and those living in rural and remote areas suffer the most. Most government approved facilities are confined to urban areas and are available in only 68 of the country's 75 districts.[77]

Furthermore, the Country Profile shows that women have been suffering due to the unavailability of competent abortion providers. For example, doctors at government facilities are often not trained or authorized to perform termination procedures beyond 12 weeks, which are legally permissible when the pregnancy is the result of rape or incest.[78]

Another major impediment to women accessing safe abortions is their lack of information about the law and government-approved clinics. A survey conducted in 2004, and cited in the Country Profile, shows that as few as 20 percent of married women were aware that abortion had been legalized and fewer than half of the respondents knew their hospitals or NGO health institutions provided abortion services.[79] Moreover, widespread misconceptions about abortion prevent women from accessing legal services. Fear and social stigma contribute significantly to a woman's decision about where to terminate a pregnancy. Due to their age and social factors including lack of education, high illiteracy rates, and early marriage,[80] adolescents are particularly susceptible to misinformation and suffer from lack of information about abortion.

Considering the harmful impact of unsafe and traditional abortion procedures on women's health and the pressing need to expand access to safe abortion services, it is unwise for the government not to approve medical abortion as a method for early termination of pregnancy. The government's failure to approve medical abortion through the Safe Pregnancy Termination Procedural Order 2004—which lists the approved methods and includes those such as manual vacuum aspiration (MVA) and dilation and curettage (D&C)—constitutes a denial of the right to enjoy the benefits of scientific progress.

This Committee has consistently expressed concern about the impact of unsafe and illegal abortion on women's health and, during the last reporting session, went as far as to ask the government of Nepal to decriminalize abortion when a pregnancy is life-threatening or results from rape or incest. The experience of Nepal has shown that while the legalization of abortion is an important step towards saving women's lives and protecting their health, it is by no means sufficient. The government has a pursuant obligation to take all possible practical measures to ensure the meaningful implementation of its laws and policies in a timely and effective manner.

On February 22, 2007, the Center for Reproductive Rights, in collaboration with the Forum for Women, Law and Development and other petitioners, filed a case before the Supreme Court of Nepal calling on the government to guarantee the protection of women's rights by taking immediate steps to ensure practical access to safe and affordable abortion services for all women who need them.[81]

3. Access to Contraception

This Committee has commented consistently on the need for access to contraception and family planning information and services[82] and has framed lack of such access as a violation of the right to health.[83] In its 2001 Concluding Observations to Nepal, CESCR urged the State party to reinforce reproductive and sexual health programs, in particular in rural areas.[84] In 1998, the Committee pointed out how low contraceptive prevalence rates contribute to unsafe abortions and resultant maternal deaths.[85] According to the United Nations Development Programme, effective family planning can reduce maternal mortality by up to 30 percent.[86] Article 15(1)(b) of the Convention grants all persons the right to benefit from the advances of scientific research and its applications. This provision should be interpreted as requiring governments to ensure that women are able to enjoy the benefits of current research and advances in the reproductive health field through access to a full range of the most effective and safest contraceptive methods.

Despite decades of family planning programs by the government—most notably in cooperation with the Family Planning Association of Nepal—contraceptive availability remains limited. There is a significant gap between the demand for contraception (67 percent)[87] and those using any method of contraception (39 percent). Even fewer women (35 percent) use a modern method of contraception.[88] Contraception prevalence rates for young, married women are even lower: only nine percent of married women age 15 to 19 and 20 percent of married women age 20 to 24 use a modern method of contraception.[89] Furthermore, those using modern contraception tend to gravitate towards permanent or semi-permanent methods, an indication of the unavailability of a full range of options in Nepal. For example, fifteen percent of currently married women use female sterilization; eight percent use injectables; two percent use the pill; and less than one percent use implants, the IUD, foam or jelly.[90] Only six per cent of women rely on male sterilization and three per cent on male condom use for fertility control.[91] These figures suggest that the burden of family planning is borne primarily by women. More specifically, the low rate of condom use by married men is particularly troubling since it is the only method that offers protection against sexually transmissible infections such as HIV/AIDS.

Due to higher incomes, better education, and wider availability of contraception in towns and cities, urban women are more likely to use family planning methods than rural women.[92] This is another striking example of the inequitable access to health services experienced by rural women.

The Committee has made recommendations to States parties that they increase access to information on contraception[93] through the implementation of educational programs.[94] However, in Nepal, only three quarters of married women between 15 and 49 years of age are aware of any family planning method.[95] Furthermore, a recent poll shows that of women using a form of contraception, less than half were informed about possible side effects or problems with contraception; only one out of three were informed about what steps to take if they experienced side effects; and less than 30 percent were informed about other contraception options.[96]

Many women could avoid unwanted pregnancies with use of emergency contraception (EC), a safe and effective means of preventing pregnancy following unprotected sex, especially when a pregnancy results from a stigmatizing event such as rape or incest. However, EC is not widely available, as it cannot be obtained from public clinics or hospitals.[97] This situation persists despite the fact that the World Health Organization considers EC to be a safe, convenient and effective method of modern contraception,[98] and it has been safely used on the global market for several decades.[99] Women in more than 140 countries can buy emergency contraception (with a prescription), and it is available over the counter in 44 countries.[100]

In order to protect their health, it is critical that adolescents be able to access contraceptive methods and information. Adolescents are particularly vulnerable in Nepal, where studies show that early initiation of sexual activity has become increasingly common, and 40 percent of adolescent girls are already mothers.[101] Child marriage is a leading cause of early pregnancy; surveys of 20 to 24 year old married women indicate the median age of first marriage to be less than 17 years.[102] NGO studies reveal that only 19 percent of adolescents are aware of possible complications resulting from pregnancy,[103] and 40 percent of adolescents have no knowledge of any type of sexual activity. [104] Only 52 percent of girls ages 15 to19 had heard of HIV/AIDS; of those adolescents, fewer than half believe there is a way to avoid infection.[105] Adolescents' limited access to condoms and general information about reproductive and sexual health has become an enormous risk factor for their health and well-being.

We would like to request that the Committee consider addressing the following questions to the Nepalese government, pursuant to its obligations under ICESCR Article 12, 10 and 15(b) and CESCR General Comment 14:

1. How does the government propose to significantly reduce the maternal mortality rate in the near future? Has the government examined why the policies and programs introduced so far have not led to a significant decline? What has the government done to assess the impact of the conflict on maternal death and morbidity and to determine its implications for current policies and programs?

2. What does the government propose to do next to ensure access to safe and affordable abortion services for women who need them? What mechanisms have been established to monitor the effective implementation of the current legal and policy provisions on abortion, especially to ensure that women are not turned away from public hospitals due to their inability to pay for services and to prevent the exploitation of women by illegal and unskilled providers?

3. How does the government propose to increase the contraceptive prevalence rate for modern methods among adolescent and adult women and make emergency contraception available to those who need it?

There remains a significant gap between the provisions contained in the ICESCR and the reality of women's reproductive health and lives in Nepal. We appreciate the active interest the Committee has taken in the reproductive and sexual health and rights of women and the strong Concluding Observations and Recommendations the Committee has issued to governments in the past, stressing the need for governments to take steps to ensure the realization of these rights.

We hope that this information is useful during the Committee's review of the Nepalese government's report on its compliance with the ICESCR. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Very truly yours,

Melissa Upreti
Senior Legal Adviser
International Legal Program

[1] International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 3 (*entered into force* Jan. 3, 1976), art. 12(1) [hereinafter Economic, Social and Cultural Rights Covenant].
[2] Committee on Economic, Social and Cultural Rights, Gen. Comment 14, *The Right to the Highest Attainable Standard of Health*, para. 8, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter CESCR Gen. Comment 14].
[3] Economic, Social, and Cultural Rights Covenant, *supra* note 1, at art. 2(2).
[4] CESCR Gen. Comment 14, *supra* note 2, at para. 19.
[5] *Id*. at para. 14.

[6] *Id.* at para. 21.
[7] *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Nepal*, 26th Sess., 44th to 46th mtg., para. 55 U.N. Doc. E/C.12/1/Add.66 (2001) [hereinafter *Concluding Observations of CESCR: Nepal*].
[8] *Second periodic reports submitted by States parties under articles 16 and 17 of the Covenant, Nepal,* Committee on Economic, Social, and Cultural Rights (CESCR Committee), para. 75, U.N. Doc. E/C.12/NPL/2 [hereinafter Nepal Report].
[9] *Id*. at para. 229.
[10] *Id*. at para. 232.
[11] *Id*. at paras. 76, 229, 232.
[12] CESCR Gen. Comment 14, *supra* note 2, at para. 12.
[13] *Id.* at para. 8.
[14] CENTER FOR REPRODUCTIVE RIGHTS & UNIVERSITY OF TORONTO PROGRAMME OF REPRODUCTIVE AND SEXUAL HEALTH LAW, BRINGING RIGHTS TO BEAR: AN ANALYSIS OF THE WORK OF UN TREATY MONITORING BODIES ON REPRODUCTIVE AND SEXUAL RIGHTS 117 (2002) [hereinafter BRINGING RIGHTS TO BEAR]. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g,* **Armenia**, 08/12/99, U.N. Doc. E/C.12/1/A dd.39, ¶ 15; **Bolivia**, 21/05/2001, U.N. Doc. E/C.12/1/Add.60, ¶ 23; **Georgia**, 12/05/2000, U.N. Doc. E/C.12/1/Add.42, ¶ 18; **Mali**, 21/12/94, U.N. Doc. E/C.12/1994/17, ¶ 13; **Mongolia**, 01/09/2000, U.N. Doc. E/C.12/1/Add.47, ¶ 15; **Panama**, 24/09/2001, U.N. Doc. E/C.12/1/Add.64, ¶ 20; **Poland**, 16/06/98, U.N. Doc. E/C.12/1/Add.26, ¶ 12; **Senegal**, 31/08/2001, U.N. Doc. E/C.12/1/Add.62, ¶ 26.
[15] *Id.* This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g,*, **Cameroon**, 08/12/99, U.N. Doc. E/C.12/1/A dd.40, ¶ 25; **Gambia**, 31/05/94, U.N. Doc. E/C.12/1994/9, ¶ 16; **Honduras**, 21/05/2001, U.N. Doc. E/C.12/1/Add.57, ¶ 27; **Poland**, 16/06/98, U.N. Doc. E/C.12/1/Add.26, ¶ 12.
[16] *Id.* This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.,* **Dominican Republic**, 12/12/97, U.N. Doc. E/C.12/1/Add.16, ¶ 15; **Dominican Republic**, 06/12/96, U.N. Doc. E/C.12/1/Add.6, ¶ 22.
[17] Nepal Report, *supra* note 8, at para. 75.
[18] HMG NEPAL, UNITED NATIONS DEVELOPMENT PROGRAMME, NEPAL MILLENNIUM DEVELOPMENT GOALS PROGRESS REPORT 43 (2005).
[19] INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES, WORLD DISASTERS REPORT 106 (2006).
[20] UNFPA, STATE OF THE WORLD POPULATION REPORT 95 (2006), *available at* http://www.unfpa.org/swp/2006.
[21] IRINnews, *Nepal: Focus on maternal mortality* (February 9, 2007), *available at* http://www.irinnews.org/print.asp?ReportID=46346.
[22] WORLD DISASTERS REPORT, *supra* note 19, at 94.
[23] *Id.* at 104.
[24] FAMILY HEALTH DIVISION, DEPARTMENT OF HEALTH SERVICES, MINISTRY OF HEALTH, GOVERNMENT OF NEPAL, NATIONAL ADOLESCENT HEALTH AND DEVELOPMENT STRATEGY, Annex II, at 16 (2000).
[25] NEPAL MILLENNIUM DEVELOPMENT GOALS PROGRESS REPORT, *supra* note 18, at 43.
[26] Nepalnews, Maternal Mortality: Killing Mother (November 20, 2003), *at* http://www.nepalnews.com.np/contents/englishweekly/spotlight/2003/nov/nov14/coverstory.htm
[27] IRINnews, *supra* note 21.
[28] WORLD DISASTERS REPORT, *supra* note 19, at 95.
[29] WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES—SOUTH ASIA 123 (Center for Reproductive Rights ed., 2004) [hereinafter WOMEN OF THE WORLD SOUTH ASIA].
[30] NEPAL MILLENNIUM DEVELOPMENT GOALS PROGRESS REPORT, *supra* note 18, at 2005.
[31] WORLD DISASTERS REPORT, *supra* note 19, at 99.
[32] *Id.*
[33] *Id.* at 100.
[34] NEPAL MILLENNIUM DEVELOPMENT GOALS PROGRESS REPORT, *supra* note 18, at 46.
[35] WOMEN OF THE WORLD SOUTH ASIA, *supra* note 29, at 125.
[36] WORLD DISASTERS REPORT, *supra* note 19, at 98.

[37] MINISTRY OF HEALTH, DEPARTMENT OF HEALTH SERVICES, FAMILY HEALTH DIVISION, NEPAL DEMOGRAPHIC AND HEALTH SURVEY 147 (2001).
[38] IRINnews, *supra* note 21.
[39] WOMEN OF THE WORLD SOUTH ASIA, *supra* note 29, at 125.
[40] World Health Organization, *Human Resources for Health, at* http://www.who.int/whosis/whostat2006NumberOfHealthWorkers.pdf.
[41] NEPAL MILLENNIUM DEVELOPMENT GOALS PROGRESS REPORT, *supra* note 18, at 44.
[42] IRINnews, *supra* note 21.
[43] WORLD DISASTERS REPORT, *supra* note 19, at 107-8.
[44] NEPAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 37, at 153.
[45] WORLD DISASTERS REPORT, *supra* note 19, at 110.
[46] NEPAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 37, at 168.
[47] BRINGING RIGHTS TO BEAR, *supra* note 14, at 99. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g,* **Azerbaijan**, 22/12/97, U.N. Doc. E/C.12/1/Add.20, ¶ 37; **Finland**, 01/12/2000, U.N. Doc. E/C.12/1/Add.52, ¶ 31; **Italy**, 23/05/2000, U.N. Doc. E/C.12/1/Add.43, ¶ 31; **Russian Federation**, 20/05/97, U.N. Doc. E/C.12/1/Add.13, ¶ 28; **Sudan**, 01/09/2000, U.N. Doc. E/C.12/1/Add.48, ¶ 27.
[48] WORLD DISASTERS REPORT, *supra* note 19, at 109. The cash payments vary depending on where a woman lives. Women traveling from the mountains receive the equivalent of US$20, women from the hill regions receive US$15, and women from the terai receive US$7. *Id.*
[49] NEPAL MILLENNIUM DEVELOPMENT GOALS PROGRESS REPORT, *supra* note 18, at 46.
[50] *Id.* at 47.
[51] WORLD DISASTERS REPORT, *supra* note 19, at 97.
[52] NEPAL MILLENNIUM DEVELOPMENT GOALS PROGRESS REPORT, *supra* note 18, at 47; IRINnews, *supra* note 21; WORLD DISASTERS REPORT, *supra* note 19, at 97.
[53] NEPAL MILLENNIUM DEVELOPMENT GOALS PROGRESS REPORT, *supra* note 18, at 47.
[54] Nepalnews, *supra* note 26.
[55] WORLD DISASTERS REPORT, *supra* note 19, at 100-1.
[56] BRINGING RIGHTS TO BEAR, *supra* note 14, at 118. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.,* **Argentina**, 08/12/99, U.N. Doc. E/C.12/1/Add.38, ¶ 24; **Bolivia**, 21/05/2001, U.N. Doc. E/C.12/1/Add.60, ¶ 23; **Cameroon**, 08/12/99, U.N. Doc. E/C.12/1/Add.40, ¶ 25; **Dominican Republic**, 12/12/97, U.N. Doc. E/C.12/1/Add.16, ¶ 15; **Dominican Republic**, 06/12/96, U.N. Doc. E/C.12/1/Add.6, ¶ 22; **Gambia**, 31/05/94, U.N. Doc. E/C.12/1994/9, ¶ 16; **Mali**, 21/12/94, U.N. Doc. E/C.12/1994/17, ¶ 13; **Mexico**, 08/12/99, U.N. Doc. E/C.12/1/Add.41, ¶ 29; **Mongolia**, 01/09/2000, U.N. Doc. E/C.12/1/Add.47, ¶ 15; **Morocco**, 01/12/2000, U.N. Doc. E/C.12/1/Add.55, ¶ 29; **Nepal**, 24/09/2001, U.N. Doc. E/C.12/1/Add.66, ¶ 32; **Panama**, 24/09/2001, U.N. Doc. E/C.12/1/Add.64, ¶ 20; **Paraguay**, 28/05/96, U.N. Doc. E/C.12/1/Add.1, ¶ 16; **Peru**, 16/05/97, U.N. Doc. E/C.12/Add.1/14, ¶ 16; **Senegal**, 24/09/2001, U.N. Doc . E/C.12/1/Add.62, ¶ 26; **Solomon Islands**, 14/05/99, U.N. Doc. E/C.12/1/Add.33, ¶ 22.
[57] *Id.* This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.,* **Bolivia**, 21/05/2001, U.N. Doc. E/C.12/1/Add.60, ¶ 23; **Cameroon**, 08/12/99, U.N. Doc. E/C.12/1/Add.40, ¶ 25; **Gambia**, 31/05/94, U.N. Doc. E/C.12/1994/9, ¶ 16; **Mali**, 21/12/94, U.N. Doc. E/C.12/1994/17, ¶ 13; **Peru**, 16/05/97, U.N. Doc. E/C.12/Add.1/14, ¶ 16.
[58] *Id.* This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.,* **Cameroon**, 08/12/99, U.N. Doc. E/C.12/1/Add.40, ¶ 25; **Panama**, 24/09/2001, U.N. Doc. E/C.12/1/Add.64, ¶ 37; **Paraguay**, 28/05/96, U.N. Doc. E/C.12/1/Add.1, ¶ 16.
[59] *Id.* This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.,* **Bolivia**, 21/05/2001, U.N. Doc. E/C.12/1/Add.60, ¶ 23; **Mexico**, 08/12/99, U.N. Doc. E/C.12/1/Add.41, ¶ 43; **Morocco**, 01/12/2000, U.N. Doc. E/C.12/1/Add.55, ¶ 53; **Nepal**, 24/09/2001, U.N. Doc. E/C.12/1/Add.66, ¶ 32; **Panama**, 24/09/2001, U.N. Doc. E/C.12/1/Add.64, ¶ 37; **Senegal**, 24/09/2001, U.N. Doc. E/C.12/1/Add.62, ¶ 47.
[60] *Id.* This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.,* **Argentina**, 08/12/99, U.N. Doc. E/C.12/1/Add.38, ¶ 38; **Cameroon**, 08/12/99, U.N. Doc. E/C.12/1/Add.40, ¶ 45.

[61] *Id.* This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.,* **Bolivia**, 21/05/2001, U.N. Doc. E/C.12/1/Add.60, ¶ 43; **Cameroon**, 08/12/99, U.N. Doc. E/C.12/1/Add.40, ¶ 45; **Mexico**, 08/12/99, U.N. Doc. E/C.12/1/Add.41, ¶ 43; **Nepal**, 24/09/2001, U.N. Doc. E/C.12/1/Add.66, ¶ 32; **Panama**, 24/09/2001, U.N. Doc. E/C.12/1/Add.64, ¶ 37; **Paraguay**, 28/05/96, U.N. Doc. E/C.12/1/Add.1, ¶ 16; **Senegal**, 24/09/2001, U.N. Doc. E/C.12/1/Add.62, ¶ 47.
[62] *Id.* at 119. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.,* **Nepal**, 24/09/2001, U.N. Doc. E/C.12/1/Add.66, ¶ 32; **Paraguay**, 28/05/96, U.N. Doc. E/C.12/1/Add.1, ¶ 16.
[63] *Id.* This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.,* **Peru**, 16/05/97, U.N. Doc. E/C.12/Add.1/14, ¶ 16.
[64] *Id*. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.,* **Paraguay**, 28/05/96, U.N. Doc. E/C.12/1/Add.1, ¶ 28; **Peru**, 16/05/97, U.N. Doc. E/C.12/Add.1/14, ¶ 36.
[65] *Concluding Observations of CESCR: Nepal*, *supra* note 7, at para. 33.
[66] WORLD DISASTERS REPORT, *supra* note 19, at 107-8.
[67] WOMEN OF THE WORLD SOUTH ASIA, *supra* note 29, at 131.
[68] GOVERNMENT OF NEPAL MINISTRY OF HEALTH AND POPULATION, WORLD HEALTH ORGANIZATION, AND CENTRE FOR RESEARCH ON ENVIRONMENT HEALTH AND POPULATION ACTIVITIES, UNSAFE ABORTION: NEPAL COUNTRY PROFILE (2006).
[69] *Id.* at 25.
[70] WORLD HEALTH ORGANIZATION (WHO), SAFE ABORTION: TECHNICAL AND POLICY GUIDELINES FOR HEALTH SYSTEMS 14 (1992).
[71] UNSAFE ABORTION: NEPAL COUNTRY PROFILE, *supra* note 68, at 39.
[72] *Id.*
[73] *Id.* at 40.
[74] *Id.*
[75] *Id.*
[76] *Id.*
[77] *Id.* at 39, 45.
[78] *Id.* at 56.
[79] *Id.* at 37-8.
[80] *Id.* at 36.
[81] Laxmi Dhikta v. Government of Nepal. For more information, *see* http://www.reproductiverights.org/ww_asia_nepal.html.
[82] BRINGING RIGHTS TO BEAR, *supra* note 14, at 131. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.*, **Armenia**, 08/12/99, U.N. Doc. E/C.12/1/Add.39, ¶ 15; **Cameroon**, 08/12/99, U.N. Doc. E/C.12/1/Add.40, ¶ 25; **Dominican Republic**, 12/12/97, U.N. Doc. E/C.12/1/Add.16, ¶ 15; **Dominican Republic**, 06/12/96, U.N. Doc. E/C.12/1/Add.6, ¶ 22; **Honduras**, 21/05/2001, U.N. Doc. E/C.12/1/A dd.57, ¶ 27; **Paraguay**, 28/05/96, U.N. Doc. E/C.12/1/A dd.1, ¶ 16; **Poland**, 16/06/98, U.N. Doc. E/C.12/1/Add.26, ¶ 12; **Saint Vincent and the Grenadines**, 02/12/97, U.N. Doc. E/C.12/1/Add.21, ¶ 12.
[83] *Id.* This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See* **Cameroon**, 08/12/99, U.N. Doc. E/C.12/1/A dd.40, ¶ 25; **Paraguay**, 28/05/96, U.N. Doc. E/C.12/1/Add.1, ¶ 16.
[84] *Concluding Observations of CESCR: Nepal*, *supra* note 7, at para. 33.
[85] *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Poland*, 18th Sess., 10th to 12th mtg., para. 12, U.N. Doc. E/C.12/1/Add.26 (1998).
[86] NEPAL MILLENNIUM DEVELOPMENT GOALS PROGRESS REPORT, *supra* note 18, at 49.
[87] *Id.* at 44.
[88] STATE OF THE WORLD POPULATION REPORT, *supra* note 20, at 95.
[89] NEPAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 37, at 70.
[90] *Id.* at 71.
[91] *Id.*
[92] *Id.*

[93] BRINGING RIGHTS TO BEAR, *supra* note 14, at 131. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.,* **Armenia**, 08/12/99, U.N. Doc. E/C.12/1/Add.39, ¶ 15; **Panama**, 24/09/2001, U.N. Doc. E/C.12/1/Add.64, ¶ 37; **Ukraine**, 31/08/2001, U.N. Doc. E/C.12/1/Add.65, ¶ 31.
[94] *Id.* This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.,* **Bolivia**, 21/05/2001, U.N. Doc. E/C.12/1/Add.60, ¶ 43; **Cameroon**, 08/12/99, U.N. Doc. E/C.12/1/Add.40, ¶ 45; **Honduras**, 21/05/2001, U.N. Doc. E/C.12/1/Add.57, ¶ 48; **Poland**, 16/06/98, U.N. Doc. E/C.12/1/Add.26, ¶ 20; **Ukraine** , 31/08/2001, U.N. Doc. E/C.12/1/A dd.65, ¶ 31.
[95] NEPAL MILLENNIUM DEVELOPMENT GOALS PROGRESS REPORT, *supra* note 18, at 44.
[96] NEPAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 37, at 88.
[97] International Consortium for Emergency Contraception, *EC Status and Availability: Nepal*, *at* http://www.cecinfo.org/database/pill/countrieDisplay.php?viewall=1&countdist=Nepal.
[98] World Health Organization (WHO), Emergency Contraception, A Guide For Service Delivery 7, WHO/FRH/FPP/98.19 (1998).
[99] *Certain Combined Oral Contraceptives for Use as Postcoital Emergency Contraception,* 62 Fed. Reg. 8609, 8610 (1997).
[100] International Consortium for Emergency Contraception, Welcome to ICEC: International Consortium for Emergency Contraception, *at* http://www.cecinfo.org/. In 1995, WHO added the combined estrogen-progestin (Yuzpe) regimen to its *Model List of Essential Drugs*, and in 1997, WHO included the levonorgestrel-only EC regimen in this list. ELISA WELLS & MICHELE BURNS, CONSORTIUM FOR EMERGENCY CONTRACEPTION (ICEC), EXPANDING GLOBAL ACCESS TO EMERGENCY CONTRACEPTION: A COLLABORATIVE APPROACH TO MEETING WOMEN'S NEEDS 6 (2000), *at* http://www.cecinfo.org/files/Expaning-Global-Access-to%20EC.rtf.
[101] NEPAL MILLENNIUM DEVELOPMENT GOALS PROGRESS REPORT, *supra* note 18, at 6.
[102] UNSAFE ABORTION: NEPAL COUNTRY PROFILE, *supra* note 68, at 39.
[103] WOMEN'S REHABILITATION CENTRE, NEPALI RURAL ADOLESCENT GIRLS SPEAK OF THEIR REPRODUCTIVE HEALTH CONCERNS 38 (2000).
[104] COMMUNICATION AND ADVOCACY STRATEGIES: ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH 7 (2000).
[105] NEPAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 37, at 197.