



Justice for All (JFA)



CESCR Secretariat
Human Rights Treaties Division
Office of the High Commissioner for Human Rights (OHCHR)
Palais Wilson- 52, rue des Pâquis
CH-1201 Geneva, Switzerland

September 15, 2014

Re: Supplementary Information on Nepal, scheduled for review by the Committee on Economic, Social and Cultural Rights during its 53rd Session

Dear Committee Members:

The Center for Reproductive Rights (the Center), an international non-governmental organization with offices in Nepal, Colombia, Kenya, Switzerland, and the United States, Justice For All (J4A), and the Forum for Women, Law and Development (FWLD) have respectfully prepared this letter to further assist the Committee on Economic, Social, and Cultural Rights (the Committee) in its review of Nepal's third periodic report (State Party Report) on compliance with the International Covenant on Economic, Social and Cultural Rights (ICESCR) in its forthcoming 53rd session and for the adoption of Concluding Observations. This letter supplements the October 4, 2013, joint pre-session letter submitted by the Center together with its partners (annexed to this letter), and notes Nepal's obligations under ICESCR, particularly concerning **child marriage, access to reproductive health care services, and maternal mortality and morbidity**. As explained in this letter, these issues continue to adversely affect the lives of women in Nepal, violating their reproductive rights and infringing on their right to equality and the right to highest attainable standard of health guaranteed in ICESCR.¹

I. Issue Summary and Questions Raised in the List of Issues

Child marriage, lack of access to reproductive health care services including contraception and safe abortion, and maternal mortality and morbidity involve serious violations of women's reproductive rights. In addition to negatively impacting women's health, the denial of women's reproductive rights impedes the attainment of women's equality, which encompasses both formal and substantive equality based on appropriate recognition of certain differences between men and women, particularly in relation to their reproductive capacities, and further contributes to discrimination based on sex and gender. United Nations treaty monitoring bodies (U.N. TMBs) including the Committee, have made recommendations to Nepal emphasizing the importance of "strictly enforc[ing] the law prohibiting harmful practices . . . such as . . . marrying child brides,"² giving high priority to ensuring "physical and economic access to reproductive health care and contraceptives . . . , particularly in rural areas, and that specific measures be taken to enable women to give birth in the care of a trained health-care professionals"³ and to reducing maternal mortality.⁴

We welcome the Committee's inclusion of questions pertaining to child marriage, access to reproductive health care services including contraception and maternal mortality and

morbidity in the List of Issues (LOIs) to the Government of Nepal (the government).⁵ There is **strong evidence to show that ongoing measures to tackle these issues have been insufficient and the government needs to act more effectively to address the continuing violations of women’s rights** in Nepal. Despite legal prohibition,⁶ child marriage remains prevalent in Nepal,⁷ and is linked to high rates of physical and sexual violence,⁸ as well as adolescent pregnancy.⁹ UNICEF’s latest report on the global incidence of child marriage reveals that Nepal ranks 9th among countries with the highest rates of child marriage and over one third of women aged 20-24 years, who were married by age 15 have three or more children.¹⁰

Despite a recent decline in the overall maternal mortality ratio (MMR),¹¹ Nepal still has one of the highest maternal mortality ratios in Asia¹² and unsafe abortion is the third leading direct cause of maternal deaths.¹³ Further, maternal morbidity in the form of uterine prolapse is widely prevalent in Nepal.¹⁴ Although the government has taken some steps to provide treatment for uterine prolapse, including corrective surgery, there has been little focus on prevention.¹⁵ As a consequence, uterine prolapse has become the “most frequently reported cause of poor health among women of reproductive age,” affecting 10% of the female population.¹⁶

II. Child Marriage (Articles 3, 10(1), 12)

We welcome the Committee’s inclusion of the issue of child marriage in the LOIs and, specifically the **Committee’s request that the government “provide information on the steps taken to address the continued prevalence of harmful traditional practices [including] early marriage,”¹⁷ and “on the impact of measures taken, including . . . [preventing] forced marriage.”¹⁸**

As a signatory to the United Nations treaties on human rights, including ICESCR,¹⁹ and under the 2007 Interim Constitution of Nepal (Interim Constitution),²⁰ Nepal has an obligation to protect women and girls from child marriage and the continuum of harms resulting from the practice.²¹ The State Party Report recognizes that harmful practices such as child marriage violate women’s rights to be free from discrimination, exploitation, and violence.²² Moreover, the State Party Report expressly links adolescent pregnancy with early marriage and acknowledges that early marriage must be curtailed “to influence early childbearing.”²³

Since the pre-session letter was submitted in October 2013, Nepal has expressed political will to combat child marriage by co-sponsoring a Human Rights Council procedural resolution aimed at “strengthening efforts to prevent and eliminate child, early and forced marriage.”²⁴ Further, the government has adopted a five year National Plan of Action on the Holistic Development of Adolescents that aims to reduce the incidence of child marriage among adolescent girls between the ages of 15 and 19 from 28.8% to 22% by 2018.²⁵ In addition, the government is currently developing a National Strategy to End Child Marriage in Nepal.²⁶ While the government should be commended for its efforts, considering the alarming prevalence of child marriage in Nepal, it must take greater strides to combat this practice. According to the 2011 national census, approximately 75% of married women surveyed were married before age 20,²⁷ and more than 100,000 had been given away in marriage before the age of 10.²⁸ UNICEF’s latest report states that as of 2014, 15% of girls in Nepal are married by age 15, while 52% are married by age 18.²⁹ Globally, over 82 % of girls were married or in union before age 18 in comparison to 17.8% of boys, thereby illustrating that child

marriage continues to disproportionately impact females.³⁰ The prevalence of child marriage in Nepal varies by place of residence,³¹ level of education,³² household wealth status,³³ caste and ethnicity,³⁴ and development region.³⁵ According to the Nepal Adolescent and Youth Survey (NAYS), the majority of young women married before age 20 reported having married because of parental pressure and due to “traditional practices.”³⁶

The implications of child marriage for Nepalese women and girls are serious. There is clear evidence to show that child marriage is linked to a high prevalence of physical and sexual violence against married adolescent girls and adolescent pregnancy which carries a higher risk of maternal death and morbidity. The Nepal Demographic and Health Survey (NDHS) released in 2011 reveals that the unmet need for contraception is highest among married adolescent girls between ages 15-19³⁷ and only 17.6% of married adolescents have access to contraception.³⁸ Almost one quarter of Nepali women have given birth by age 18 and nearly half by age 20.³⁹ Accordingly, adolescent mothers in Nepal give birth to 81 out of every 1,000 children, which is the third highest rate in South Asia.⁴⁰ In almost 90% of cases where women have experienced sexual violence, the current husband is the perpetrator.⁴¹ NDHS links high rates of sexual violence to early marriage.⁴² Similarly, a new baseline study conducted by UNICEF in 15 districts reveals that 37% of currently married girls aged 15 to 19 from the Terai region have experienced sexual violence.⁴³

While the State Party Report notes that “various measures have been adopted to ensure strict enforcement of the legal provisions and directive orders [of the Supreme Court] for the protection of women and girls from such harmful practices,”⁴⁴ there are still gaps in the current law that contribute to the continuation of this practice with impunity. Under Nepalese law, child marriage is only voidable, not *void ab initio*⁴⁵ and the law does not offer any legal protection or entitlements to those who leave such marriages. Moreover, the penalties prescribed for marrying or causing a marriage of minors are too weak to be an effective deterrent.⁴⁶ In addition, despite repeated directive orders from the Supreme Court to the government for better enforcement of its laws,⁴⁷ the lack of implementation of existing legal provisions remains an issue and very few cases involving child marriage are prosecuted.⁴⁸ The low prosecution rate stands in stark contrast to the high incidence of child marriage reported in major studies.⁴⁹

In 2008, the Committee urged Nepal to “strictly enforce” existing laws prohibiting harmful practices that violate the rights of women and girls,” including child marriage,⁵⁰ and in 2014, the Human Rights Committee also noted as a “principal” matter of concern the “prevalence of harmful traditional practices such as child marriage” and urged Nepal to ensure “effective implementation” of domestic law in practice.⁵¹

III. Universal Access to Reproductive Health Care Services (Arts. 2(2), 3, 12(1))

We welcome the Committee’s inclusion of the issue of lack of access to contraceptives in the LOIs. The Committee requested clarification on “**which steps have been taken to ensure the provision of emergency obstetric care and universal access to sexual and reproductive health services, including contraceptives.**”⁵² Under ICESCR, the government has an obligation to provide universal access to reproductive health services to women in Nepal.⁵³ Further, the Interim Constitution⁵⁴ and the Supreme Court of Nepal, in landmark legal cases,⁵⁵ have recognized reproductive rights as fundamental rights, however, the government has yet to adequately implement programs and establish the infrastructure needed to ensure the fulfillment of these rights in practice.⁵⁶ The section below highlights the

need for additional steps to adequately ensure access to contraceptives information and services in Nepal.

The government has set a target to increase Nepal's contraceptive prevalence rate (CPR) to 67% by 2015 from 43.2% in 2013.⁵⁷ According to the State Party Report, the government has adopted a policy that prioritizes increasing the CPR "with an emphasis on promoting temporary methods of contraception aimed at reducing the share of permanent sterilization in overall family planning methods."⁵⁸

Despite these goals, women in Nepal continue to experience violations of their human rights as a result of the government's failure to address persistent barriers that limit their access to contraceptive information and services. Progress on contraceptive access has stalled in Nepal due to lack of funds and inadequate government attention.⁵⁹ In the National Planning Commission's Thirteenth Three-Year Plan, the government acknowledges the inadequate supply of essential medicines, lack of competence among health workers, difficulty in staffing healthcare facilities in remote areas, lack of repair and maintenance of physical facilities, and weak coordination among healthcare service providers as problems in the provision of health care services.⁶⁰ The government has also acknowledged a shortage of contraceptive methods and services due to limited training sites and service providers for long-acting contraceptive methods and a delay in the procurement of contraceptives and reproductive health supplies.⁶¹ A study of 20 districts in Nepal has found that female community health volunteers, who provide community-based health education and services in rural areas, with a special focus on maternal and child health and family planning lack sufficient supplies: 32% do not have any contraceptive pills, and 20% do not have condoms.⁶²

Although the vast majority of women in Nepal (86.7%) either prefer to delay the birth of their next child or do not desire additional children,⁶³ less than half of married women use any contraceptive method.⁶⁴ Nepal's CPR has stagnated in the past five years, and use of modern methods of contraception has shown a small decline (from 44% in 2006 to 43% in 2011).⁶⁵ Misinformation and lack of information inhibit women from accessing a full range of contraceptives in Nepal: 37% of women are not informed about the possible side effects of the contraceptive methods they use; 41% are not told what to do if they experience side effects; and 46% are not informed about other available methods.⁶⁶

The Committee has noted that health facilities, goods and services, including sexual and reproductive health services, must be accessible to everyone without discrimination.⁶⁷ Over a quarter of married Nepalese women (27%) have an unmet need for contraception.⁶⁸ The unmet need for contraception is highest among women ages 15-19 (41.5%) and 20-24 (36.8%),⁶⁹ rural women (28.1%), and those residing in Nepal's western region (34%).⁷⁰ Without access to contraceptives, women in Nepal are unable to control the timing, number, and spacing of their pregnancies, leading to increased risk of unintended pregnancies, which have a significant impact on women's equality, well-being, and their ability to pursue opportunities for education and employment.⁷¹

The government has committed to "ensur[ing] the adequate supply of items required for . . . emergency contraceptives and family planning."⁷² Yet, only 29% of Nepalese women have ever heard of emergency contraception⁷³ and a mere 0.1% have actually used it.⁷⁴ As a result, women are being denied an essential back-up contraceptive method in the event of unprotected intercourse, contraceptive failure and in cases of sexual violence involving rape.⁷⁵ The government's failure to ensure broad access to emergency contraception constitutes a violation of women's right to health, which includes the right to be free from

violence and other health risks.⁷⁶ Moreover, since it is only women who ever have a need for emergency contraception, to prevent an unplanned pregnancy, the failure to provide access to emergency contraception constitutes a violation of the right to substantive gender equality and freedom from discrimination based on sex.⁷⁷

IV. Maternal Mortality & Morbidity (Articles 10(2), 12)

We welcome the Committee's inclusion of maternal mortality and morbidity, including uterine prolapse, in the LOIs, and specifically the Committee's request that the government **“provide updated information on steps taken, and the impact measured, to address the high rates of . . . maternal mortality,”⁷⁸ and to clarify legislative measures taken to reduce the risk factors of uterine prolapse.⁷⁹**

Under ICESCR, Nepal has an immediate obligation to guarantee women's right to health and to ensure special protection of pregnant women in the pre- and post-natal period.⁸⁰ Additionally, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) has expressed concern over these issues in Nepal, including specifically the “challenges in accessing delivery services, especially emergency obstetric care [and] poor nutrition, which is strongly correlated with higher risks of maternal mortality and morbidity.”⁸¹

The State Party Report acknowledges that the Interim Constitution safeguards the right to health as a fundamental right which is “intrinsic to the dignity of human being”⁸² and states that reducing maternal and child mortality rates is a “higher priority.”⁸³ The government also explains that its Safe Motherhood Programme includes a provision for antenatal care services to prevent “adverse pregnancy outcomes.”⁸⁴ Nonetheless, the government fails to explicitly recognize that maternal mortality is an issue affecting a woman's right to reproductive health, which is guaranteed as a fundamental right under Article 20(2) of the Interim Constitution.⁸⁵

According to the World Health Organization (WHO), as of 2013, the MMR in Nepal was 170.⁸⁶ Despite an overall reduction in maternal mortality there are large disparities in MMR across geographic location, age, and ethnicity in Nepal.⁸⁷ For example, MMR is much higher in remote and rural districts where health service access is more limited than in urban areas.⁸⁸ This is often because women do not receive adequate care and support during childbirth.⁸⁹ Additionally, MMR is much higher for socially marginalized women who are more likely to experience discrimination, such as Muslim and Dalit women.⁹⁰ Similarly, age is another contributing factor to increased MMR. A major study indicates that MMR is lowest for women in their twenties and is much higher for women under age 20 and women between ages 30-34.⁹¹ The MMR dramatically increases to 962 per 100,000 live births for women aged 35 and older.⁹²

The government initiated the Safe Delivery Incentive Programme (SDIP) in 2005, under which it started offering cash payments to offset a woman's cost of travel to deliver in a health facility.⁹³ The SDIP program is inadequate⁹⁴ as many women are still unaware of or denied SDIP assistance due to lack of knowledge of the programme.⁹⁵ For example, it has been reported that at Lumbini Zonal Hospital in Butwal-11 district, a mere 45 out of 7,172 women—less than one percent—giving birth in the hospital received the incentive in 2013.⁹⁶ While the government should be commended for taking positive steps to promote women's use of health services, the government must be urged to direct its attention to issues arising

from the lack of institutional preparedness to provide quality care. Reports of the failure of health officials to provide delivery services,⁹⁷ lack of necessary infrastructure to support the provision of critical maternal health services,⁹⁸ unavailability of life saving drugs such as misoprostol in 36 Mountainous and Hilly districts,⁹⁹ and corruption undermining the distribution of cash payments under SDIP¹⁰⁰ are rife in the media. It has also been reported that women from distant villages have to bear additional travel costs as they arrive in the district headquarters ahead of childbirth.¹⁰¹

As noted earlier in the letter, unsafe abortion accounts for almost one third of all maternal deaths in Nepal. The Committee has recognized safe abortion services as falling within the sexual and reproductive health services that women are guaranteed.¹⁰² The provision of maternal health services is a core, non-derogable obligation of states parties.¹⁰³ Article 12 of ICESCR guarantees the “highest attainable standard of physical and mental health,”¹⁰⁴ which the Committee has said creates an obligation to ensure access to safe abortion services.¹⁰⁵ Additionally, access to legal, safe abortion services is intricately related to gender equality and its denial constitutes gender-based discrimination, as only women have the need to access such services.¹⁰⁶ Women have the right to determine if and when they will have children, and Nepal, as a party to ICESCR, has a duty to offer sexual and reproductive health services, which include abortion services.¹⁰⁷ In 2011, the CEDAW Committee noted that it was “deeply concerned” about Nepal’s “high rate of unsafe abortion, in particular for women living in poverty, women from rural villages and women from marginalized communities within urban areas, in spite of the legalization of abortion in 2002.”¹⁰⁸

According to the State Party Report, some 300,000 women have utilized safe abortion services.¹⁰⁹ Yet more than a decade after the legalization of abortion on broad grounds, only 38% of women ages 15-49 are aware that abortion is legal,¹¹⁰ with rural, uneducated, and poor women being the least likely to know under what circumstances abortion is legal.¹¹¹ Adolescents generally face particular barriers to safe abortion services; for example, studies show that girls are likely to be unaware of which health professionals can provide safe and legal abortion services.¹¹² Nearly one in two (48%) women who have had an abortion said that they paid more than 1,500 Nepalese Rupees for the abortion,¹¹³ which is a significant amount for women with little or no independent income. The cost of obtaining an abortion is a barrier, as women in Nepal are often dependent on their families or husbands to finance their health care expenses.¹¹⁴

The legal provisions on abortion are found in the Chapter on Homicide of the *Muluki Ain* (Country Code), implicitly identifying abortion as a crime akin to murder.¹¹⁵ As a general rule, abortion is a criminal offence and can be resorted to only under certain conditions permitted by law.¹¹⁶ In 2009, in the case of *Lakshmi and Others v. Government of Nepal*, the Supreme Court ruled that the right to abortion is a fundamental right under the Interim Constitution and issued a directive order to the government to introduce a comprehensive abortion law in line with international human rights law.¹¹⁷ Recently, the National Women Commission led the submission of a draft Safe Abortion Services Bill to the Ministry of Health and Population¹¹⁸ which has promised to review the draft and submit it to the legislature.¹¹⁹

As noted in the pre-session letter, maternal morbidity, particularly uterine prolapse,¹²⁰ is widely prevalent in Nepal.¹²¹ Since this Committee’s last review of Nepal, in 2011, the CEDAW Committee has expressed concern over the high incidence of uterine prolapse despite government efforts to offer corrective surgery.¹²² There is a high correlation between

uterine prolapse and child marriage,¹²³ gender inequality,¹²⁴ and early¹²⁵ and closely spaced pregnancies.¹²⁶ For example, one study shows that the mean age of women undergoing uterine prolapse surgery was 28, with the women having previously given birth to 3.5 children.¹²⁷ Other factors include lack of access to skilled health workers during labor, and returning to work prior to full recovery from childbirth.¹²⁸ Another study indicates that nearly 95% of women undergoing uterine prolapse surgery had given birth at home and 92% of births were attended by a traditional birth attendant, relatives or friends.¹²⁹ Additionally, during the neo-natal period, a time of resting period for mothers, 12% of women worked on the farms and 27% carried heavy loads.¹³⁰

Recognizing uterine prolapse as a human rights issue with implications for women's fundamental rights under the Interim Constitution, the Supreme Court in *Prakash Mani Sharma and Others v. Government of Nepal*,¹³¹ ordered the government to increase public awareness about women's reproductive rights, implement policies to address the high prevalence of uterine prolapse and draft a reproductive health bill.¹³² The government's efforts to prevent uterine prolapse, however, have been inadequate—due, in part, to its primary focus on providing subsidies for corrective treatment—leading to additional health and financial complications for many women.¹³³ Mobile camps that receive government subsidies for performing uterine prolapse surgeries are criticized for causing greater health risks due to the high number of surgeries performed daily and the lack of post-operative follow-up services.¹³⁴ Moreover, health facilities are still unable to meet the demand for corrective surgeries, and many women are forced to travel to India to undergo surgery.¹³⁵ Taking cognizance of the irregularities reported in the performance of uterine prolapse surgeries, in May 2014, the government adopted the Procedural Guidelines on Prevention and Treatment of Women's Uterine Prolapse.¹³⁶ The impact of these guidelines remains to be seen and will need to be assessed.

V. Recommended Questions

In light of the above, we respectfully request the Committee to raise the following questions with the government during its review:

1. What steps have been taken by the government to enforce the minimum legal of marriage and prosecute perpetrators of child marriage in accordance with the law? What steps are being taken to identify and address shortcomings in the law and ensure access to effective legal remedies and additional support for girls and women married as children?
2. What steps have been taken by the government to ensure universal access to quality reproductive health information and services, including contraceptive information and services, maternal health care, and safe abortion services, especially for adolescents girls and socio-economically marginalized women and girls in rural and remote areas?
3. What steps have been taken by the government to protect women and girls from sexual and other forms of physical and emotional violence, both within and outside marriage, and to provide access to emergency contraception in addition to other services including counselling and legal redress?

4. What steps have been taken by the government to address disparities in maternal mortality based on factors such as age, geographic location and socio-economic status?
5. What steps have been taken by the government to enact comprehensive abortion legislation in line with the Supreme Court's decision in *Lakshmi and Others v. Government of Nepal*? What measures have been taken to eliminate cost barriers that limit women's access to safe abortion services?
6. What steps have been taken by the government to prevent the incidence of uterine prolapse and to provide quality treatment to those who require corrective surgery?

VI. Suggested Concluding Observations

We respectfully submit the following recommendations for the Committee to consider incorporating into the Concluding Observations for Nepal:

1. Take immediate and concrete steps to enforce the legal minimum age of marriage, including by punishing perpetrators of child marriage, raising awareness about the minimum legal ages of marriage and consequences for violating the law and ensuring access to legal remedies.
2. Review the existing legal provisions on child marriage and identify areas for legal reform to ensure substantive equality within marriage and the adequate protection and fulfilment of the full range of rights under the Covenant.
3. Take concrete steps to ensure universal access to reproductive health information and services, including contraceptive information and services, maternal health care, and safe abortion services, especially for socio-economically marginalized women and girls including adolescents and young married girls.
4. Ensure effective implementation of laws and policies aimed at preventing and punishing physical and sexual violence against women within and outside marriage, including counselling and legal remedies, and in recognition of the specific risk of unplanned pregnancy faced by women and girls, ensure timely access to emergency contraception.
5. Take concrete steps to address disparities in maternal mortality by ensuring that maternal health services of high quality are available to all women and by addressing structural and other barriers that undermine the effective implementation of government schemes.
6. Take steps to implement the Supreme Court's 2009 decision in *Lakshmi and Others v. Government of Nepal*, by enacting a comprehensive law on safe abortion services in line with human rights standards, as mandated by the Supreme Court, and eliminating cost barriers to safe abortion services.
7. Take concrete steps to prevent and address the high prevalence of uterine prolapse by effectively implementing the recently adopted procedural guidelines on prevention and treatment of uterine prolapse.

Sincerely,



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¹ Articles 2(2) and 3 guarantee all persons, without discrimination, the rights set forth in ICESCR equally between men and women. In addition, article 10(1) requires that marriage “be entered into with the free consent of the intending spouses.” Under Article 10(2), pregnant women and mothers are entitled to “[s]pecial protection” “during a reasonable period before and after childbirth.” Article 10(3) states that “special measures of protection and assistance should be taken on behalf of all children”, including adolescent girls. Under Article 12, women have the right “to the enjoyment of the highest attainable standard of physical and mental health.” International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, arts. 2(2), 3, 10(1)-(3), 12, G.A. Res.2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976) [hereinafter ICESCR].

² Committee on Economic, Social and Cultural Rights (ESCR Committee), *Concluding Observations: Nepal*, para. 34, U.N. Doc. E/C.12/NPL/CO/2 (2008).

³ ESCR Committee, *Concluding Observations: Nepal*, para. 46, U.N. Doc. E/C.12/NPL/CO/2 (2008).

⁴ ESCR Committee, *Concluding Observations: Nepal*, para. 45, U.N. Doc. E/C.12/NPL/CO/2 (2008).

⁵ ESCR Committee, *List of issues in relation to the third periodic report of Nepal*, paras. 13, 15, 25, 26, 27, U.N. Doc. E/C.12/NPL/Q/3 (Dec. 18, 2013) [hereinafter ESCR Committee, *List of Issues* (2013)].

⁶ Legal age of marriage in Nepal is 18 years, with guardian’s consent for both parties and 20 years, without guardian’s consent for both parties. Muluki Ain [Country Code], part 4, ch. 17 on marriage, no. 2 (1963) (Nepal) [hereinafter Muluki Ain (Nepal)].

⁷ UNICEF, THE STATE OF THE WORLD’S CHILDREN 2014 IN NUMBERS 81 (2014), *available at* http://www.unicef.org/sowc2014/numbers/documents/english/SOWC2014_In Numbers_28 Jan.pdf.

⁸ POPULATION COUNCIL, HIGHLIGHTS FROM THE UNICEF ADOLESCENT DEVELOPMENT AND PARTICIPATION BASELINE STUDY, NEPAL 9 (2014) [hereinafter UNICEF BASELINE STUDY]; GOVERNMENT OF NEPAL, MINISTRY OF HEALTH AND POPULATION, POPULATION DIVISION, NEPAL DEMOGRAPHIC AND HEALTH SURVEY 2011 236-39 (2012) [hereinafter NDHS 2011].

⁹ NDHS 2011, *supra* note 8, 67 (2012).

¹⁰ UNICEF, ENDING CHILD MARRIAGE: PROGRESS AND PROSPECTS (2014), *available at* [unicef.org/au/downloads/publications/Child_Marriage_Data_Brochure_July_2014.aspx](http://www.unicef.org/au/downloads/publications/Child_Marriage_Data_Brochure_July_2014.aspx) [hereinafter UNICEF, ENDING CHILD MARRIAGE].

¹¹ World Health Org. (“WHO”), TRENDS IN MATERNAL MORTALITY: 1990-2013. ESTIMATES BY WHO, UNICEF, UNITED NATIONS POPULATION FUND (UNFPA), THE WORLD BANK AND THE UNITED NATIONS POPULATION DIVISION 26 (2014), *available at* <http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/> [hereinafter WHO, TRENDS IN MATERNAL MORTALITY].

¹² *Id.* at 36-43.

¹³ AJIT PRADHAN ET AL., NEPAL MATERNAL MORTALITY AND MORBIDITY STUDY (MMS) 9 (2009) [hereinafter NEPAL MMS].

¹⁴ NDHS 2011, *supra* note 8, 143.

¹⁵ Messerschmidt L, *Uterine Prolapse in Nepal: The Rural Health Development Project’s Response*, *Journ. of Nepal Public Health Association* 37-39 (Nov. 2009) [hereinafter Messerschmidt L, *Uterine Prolapse in Nepal* (2009)].

¹⁶ NDHS 2011, *supra* note 8, 143.

¹⁷ ESCR Committee, *List of Issues* (2013), *supra* note 5, at para. 13.

¹⁸ *Id.* para. 15.

¹⁹ Article 3 of ICESCR recognizes the “equal right of men and women to the enjoyment of all economic, social and cultural rights.” In addition, article 10(1) of ICESCR requires that marriage be entered into “with the free consent of the intending spouses.” ICESCR, *supra* note 1, arts. 3, 10(1). The Committee’s General Comments to ICESCR acknowledge that child marriage is a harmful traditional practice that affects girls’ health. ESCR Committee, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at para. 22, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*]. As the Committee recognized in General Comments 3 and 9, state parties must give effect to the rights recognized in ICESCR “by all appropriate means” within the particularities of that State’s legal and administrative systems. ESCR Committee, *General Comment No. 3: The nature of States parties’ obligations (Art. 2, para. 1)*, (5th Sess., 1990), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at paras. 47-50, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008); ESCR Committee, *General Comment No. 9: The domestic application of the covenant*, para. 1, U.N. Doc. E/C.12/1998/24 (1998). Further, the Committee recognized that state parties must take steps to eliminate “prejudices, customary and all other practices that perpetuate the notion of inferiority or superiority of either of the sexes, and stereotyped roles for men and women.” ESCR Committee, *General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights (Art. 3)*, (34th Sess., 2005), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at paras. 18-19, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008).

²⁰ Article 13 of the 2007 Interim Constitution provides that all persons, including children “shall [not] be denied the equal protection of the law,” and Article 22 guarantee children “the right against physical, mental or any other form of exploitation.” In addition, Article 20 of the 2007 Interim Constitution guarantees protection from discrimination and violence and provides every woman “the right to reproductive health and reproduction.” NEPAL (INTERIM) CONST., arts. 13, 20(1)-(3), 22(3).

²¹ See ICESCR, *supra* note 1, arts. 3, 10(1); Convention on the Rights of the Child, *adopted* Nov. 20, 1989, arts. 3, 4, 7, 12, 14, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990); Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, art. 1, 3, 5, 12, 16, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981).

²² Government of Nepal, *Implementation of the International Covenant on Economic, Social and Cultural Rights: 3rd Periodic Report*, para. 55, U.N. Doc. E/C.12/NPL/3 (2012) [hereinafter State Party Report (2012)].

²³ *Id.* at para. 116.

²⁴ Human Rights Committee, *Report of the Human Rights Council on its twenty-fourth session*, para. 195, U.N. Doc. A/HRC/24/2 (2014).

²⁵ GOVERNMENT OF NEPAL, NATIONAL PLANNING COMMISSION, NATIONAL PLAN OF ACTION ON THE HOLISTIC DEVELOPMENT OF ADOLESCENTS (2013/14-2017/18) 14 (2013).

²⁶ MINISTRY OF WOMEN, CHILDREN AND SOCIAL WELFARE, STAKEHOLDERS’ INTERACTION ON NATIONAL STRATEGY TO END CHILD MARRIAGE IN NEPAL (2014).

²⁷ GOVERNMENT OF NEPAL, NATIONAL PLANNING COMMISSION SECRETARIAT, CENTRAL BUREAU OF STATISTICS, NATIONAL POPULATION AND HOUSING CENSUS 2011 131 (2012), *available at* cbs.gov.np/wp-content/uploads/2012/11/National%20Report.pdf [hereinafter NATIONAL POPULATION AND HOUSING CENSUS 2011].

²⁸ *Id.* at 131.

²⁹ UNICEF, ENDING CHILD MARRIAGE, *supra* note 10, at 2. The Government’s 2011 census showed that 58.2% of married women in Nepal were between 15-19 years old at the time of their first marriage, with 16.3% of girls reporting being married by age 15. NATIONAL POPULATION AND HOUSING CENSUS 2011, *supra* note 27, at 131.

³⁰ UNICEF, ENDING CHILD MARRIAGE, *supra* note 10, at 1.

³¹ According to UNFPA, 42.9% of women residing in rural areas were married before reaching the age of 18 in comparison to 26.9% of those residing in urban areas. UNFPA, MARRYING TOO YOUNG: END CHILD MARRIAGE 73 (2012), *available at* <http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/MarryingTooYoung.pdf> [hereinafter UNFPA, MARRYING TOO YOUNG].

³² Women between ages 25 and 49 years with a school-leaving certificate and higher education marry five years later (21.8 years) than those with no education (16.6 years). NDHS 2011, *supra* note 8, at 68.

- ³³ Women between ages 25 and 49 years from the highest wealth quintile marry two years later (19 years) than those from lower wealth quintiles (17 years). NDHS 2011, *supra* note 8, at 68.
- ³⁴ The proportion of women between ages 20 and 24 years who have married before 20 years of age is highest among the more disadvantaged non-Dalit Terai caste groups (85%) and Dalits (76%) in comparison to upper caste groups (57%) and relatively advantaged Janajatis (42%). GOVERNMENT OF NEPAL MINISTRY OF HEALTH AND POPULATION, POPULATION DIVISION, NEPAL ADOLESCENT AND YOUTH SURVEY (NAYS) 49 (2012) [hereinafter GOVT. OF NEPAL, NAYS].
- ³⁵ The prevalence of child marriage in the mid-western region of Nepal is the highest (53%) followed by the Far-Western region (48%), Central region (40%), Western region (36%) and Eastern region (34%). UNFPA, *MARRYING TOO YOUNG*, *supra* note 31, at 25.
- ³⁶ GOVT. OF NEPAL, NAYS *supra* note 34, at 49-50.
- ³⁷ NDHS 2011, *supra* note 8, at 105.
- ³⁸ *Id.* at 104.
- ³⁹ *Id.* at 75.
- ⁴⁰ UNFPA, *STATE OF THE WORLD POPULATION: MOTHERHOOD IN CHILDHOOD* 103 (2013).
- ⁴¹ NDHS 2011, *supra* note 8, at 238.
- ⁴² *Id.* at 239.
- ⁴³ UNICEF BASELINE STUDY, *supra* note 8, at 9.
- ⁴⁴ State Party Report (2012), *supra* note 22, at para. 54.
- ⁴⁵ The law permits any party to the child marriage to void such marriage upon turning age 18 *only if* the couple does not have any children at the time of dissolution and they have up to three months to pursue legal action to void a child marriage upon turning 18 years. *Muluki Ain* (Nepal), *supra* note 6, at part 4, ch. 17 on marriage, no. 2(9), *read together with* no. 11 (1963). 36.1% of currently married women between the ages of 15-19 had given birth to at least one child. NDHS, *supra* note 8, at 79.
- ⁴⁶ If the marriage is contracted contrary to this provision, the principal offenders having attained majority, out of those committing the offense, shall be liable to the following punishment: (1) Where the marriage of a girl below 10 years of age is contracted or procured, punishment of imprisonment for a term from six months to three years and a fine of one thousand to ten thousand rupees; (2) Where the marriage of a girl over 10 years and below 14 years of age is contracted or procured, punishment of imprisonment for a term from three months to one year and a fine of up to five thousand rupees; (3) Where the marriage of a woman over 14 years and below 18 years of age is contracted or procured, punishment of imprisonment for a term not exceeding six months or a fine of up to ten thousand rupees or both; (4) Where the marriage of a woman or man below 20 years of age is contracted or procured, punishment of imprisonment for a term not exceeding six months or a fine of up to ten thousand rupees or both. *Muluki Ain* (Nepal), *supra* note 6, at part 4, ch. 17 on marriage, no. 2 (1-4).
- ⁴⁷ *Sapana Pradhan & Others v. Prime Minister & Council of Ministers & Others*, decision no. 7659, N.K.P. 2063, Vol. 3 at 289 para. 24 (2006) and *Rama Panta Kharel & Others v. Government of Nepal*, Writ no. WS-128/2063 B.S. (2007) in CENTER FOR REPRODUCTIVE RIGHTS (CRR), FORUM FOR WOMEN, LAW AND DEVELOPMENT (FWLD) and NATIONAL WOMEN COMMISSION (NWC), *A COMPILATION OF SUPREME COURT DECISIONS ON REPRODUCTIVE RIGHTS* 69 (2013).
- ⁴⁸ A review of the Supreme Court's Annual Reports shows that only 13 cases on child marriage were filed in the District Courts of Nepal in 2012, and only 30 in 2013. In the Appellate Courts there were only six cases filed in 2012, and only 15 cases filed in 2013. While there were seven cases filed in the Supreme Court in 2012, there was only one case filed in 2013. SUPREME COURT OF NEPAL, ANNUAL REPORT 2068/69, 88, 107, 156 (2012); SUPREME COURT OF NEPAL, ANNUAL REPORT 2069/70, 79, 95, 144 (2013).
- ⁴⁹ UNICEF, *ENDING CHILD MARRIAGE* *supra* note 10, at 5.
- ⁵⁰ ESCR Committee, *Concluding Observations: Nepal*, para. 34, U.N. Doc. E/C.12/NPL/CO/2 (2008).
- ⁵¹ Human Rights Committee, *Concluding Observations: Nepal*, para. 8, U.N. Doc. CCPR/C/NPL/CO/2 (2014).
- ⁵² ESCR Committee, *List of Issues* (2013), *supra* note 5, at para. 25.
- ⁵³ Article 12(1) of ICESCR recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Articles 2(2) and 3 guarantee all persons, without discrimination, the rights set forth in the Covenant equally between men and women. ICESCR, *supra* note 1, arts. 2(2), 3, 12(1). General Comment 14 defines the right to health to include control over one's sexual and reproductive freedom, and guarantees the right of access to contraceptive information and services, pre- and post-natal care, and emergency obstetric services—helping to ensure safe pregnancy and childbirth. ESCR Committee, *Gen. Comment No. 14*, *supra* note 19, at paras. 8, 14.
- ⁵⁴ NEPAL (INTERIM) CONST. art. 20(2).

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- ⁵⁵ Lakshmi and Others v. Government of Nepal, Decision No. 8464, N.K.P. 2067, (Vol. 9) at 1551 (2009); Prakashmani Sharma and Others v. Government of Nepal, Decision No. 8001, N.K.P. 2065 (Vol. 8) at 956 (2008).
- ⁵⁶ GOVERNMENT OF NEPAL, NATIONAL PLANNING COMMISSION, THIRTEENTH YEAR PLAN (2014/15-2016/17) 143 (2014), *available at* <http://www.npc.gov.np/new/uploadedFiles/allFiles/13th-Plan.pdf> [hereinafter GOVT. OF NEPAL, THIRTEENTH YEAR PLAN (2014/15-2016-17)].
- ⁵⁷ MILLENNIUM DEVELOPMENT GOALS (MDG), NEEDS ASSESSMENT FOR NEPAL 2013 49 (2013). The contraceptive prevalence rate, or CPR, is measured as the percentage of married women ages 15-49 using any method of contraception.
- ⁵⁸ State Party Report (2012), *supra* note 22, at para. 114.
- ⁵⁹ NDHS 2011, *supra* note 8, at 93.
- ⁶⁰ GOVT. OF NEPAL, THIRTEENTH YEAR PLAN (2014/15-2016-17), *supra* note 56, at 143.
- ⁶¹ GOVERNMENT OF NEPAL, MINISTRY OF HEALTH AND POPULATION, DEPARTMENT OF HEALTH SERVICES, ANNUAL REPORT 2067/68 (2010/2011) 58 (2012).
- ⁶² USAID, NEW ERA, AND GOVERNMENT OF NEPAL, MINISTRY OF HEALTH AND POPULATION, AN ANALYTICAL REPORT ON FEMALE COMMUNITY HEALTH VOLUNTEERS OF SELECTED DISTRICTS OF NEPAL xvii (2008).
- ⁶³ NDHS 2011, at *supra* note 8, 86-87.
- ⁶⁴ *Id.* at 95.
- ⁶⁵ *Id.* at 97, 104. Alarming, this decline is occurring at a time when experts are predicting growth in demand for contraceptives due to an increasing number of women of reproductive age and the number of women who want smaller families.
- ⁶⁶ *Id.* at 101.
- ⁶⁷ ESCR Committee, *Gen. Comment No. 14: supra* note 19, at para. 12(b).
- ⁶⁸ NDHS 2011, *supra* note 8, at 104.
- ⁶⁹ *Id.*
- ⁷⁰ *Id.*
- ⁷¹ See UNFPA, STATE OF THE WORLD POPULATION 2012, BY CHOICE, NOT BY CHANCE: FAMILY PLANNING, HUMAN RIGHTS AND DEVELOPMENT 1, 73-76 (2012).
- ⁷² GOVERNMENT OF NEPAL, NATIONAL PLANNING COMMISSION, THREE-YEAR INTERIM PLAN (2007/8-2010/11) 286 (2007) *available at* http://www.npc.gov.np/new/uploadedFiles/allFiles/11tyip_eng.pdf.
- ⁷³ NDHS 2011, *supra* note 8, at 94.
- ⁷⁴ International Consortium on Emergency Contraception, *Knowledge and Ever Use of Emergency Contraception in Asia, Demographic and Health Survey Data*, *available at* <http://www.cecinfo.org/custom-content/uploads/2012/12/Emergency-Contraception-in-Asia-Updated-11-27-2012.pdf>.
- ⁷⁵ WHO, MEDIA CENTRE, EMERGENCY CONTRACEPTION, FACT SHEET NO. 244 (2005), *available at* <http://www.who.int/mediacentre/factsheets/fs244/en/index.html>.
- ⁷⁶ ESCR Committee, *Gen. Comment No. 14, supra* note 19, at paras. 21, 35.
- ⁷⁷ CEDAW Committee, *Concluding Observations: Nepal*, para. 32(g), U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011).
- ⁷⁸ ESCR Committee, *List of Issues* (2013), *supra* note 5, at para. 25.
- ⁷⁹ *Id.* para. 26.
- ⁸⁰ ICESCR, *supra* note 1, arts. 10, 12; ESCR Committee, *Gen. Comment No. 14, supra* note 19, at para. 22; ESCR Committee, *Concluding Observations: Nepal*, para. 25, U.N. Doc. E/C.12/NPL/CO/2 (2008).
- ⁸¹ CEDAW Committee, *Concluding Observations: Nepal*, para. 31, U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011).
- ⁸² State Party Report (2012), *supra* note 22, at para. 102.
- ⁸³ *Id.* para. 102.
- ⁸⁴ *Id.* para. 115.
- ⁸⁵ *Id.* paras. 114-20.
- ⁸⁶ WHO, MAPPING ABORTION POLICIES PROGRAMS AND SERVICES IN THE SOUTH EAST ASIA REGION 4 (2013).
- ⁸⁷ Nepal MMS, *supra* note 13, at 6; see UNICEF, NEPAL MILLENNIUM DEVELOPMENT GOALS PROGRESS REPORT 2013 46 (2013).
- ⁸⁸ Unable to travel far distances, women in rural areas greatly depend on skilled birth attendants. Studies indicate, however, that only 32% of births in rural regions (compared with 73% in urban areas) are assisted by a skilled birth attendant. See NDHS, *supra* note 8, at 126-27.
- ⁸⁹ See *Id.* at 129.
- ⁹⁰ Dalit women face real barriers to prenatal care due to the caste-based discrimination among health service providers. Janardan Thapa, *The Other Side of the Coin: Disparities in Achievement of Health Related*

Millennium Development Goals (MDGs) in Nepal, Himilayan Journ. Of Sociology and Anthropology, 76, 78-80 (2012).

⁹¹ Nepal MMS, *supra* note 13, at 6.

⁹² *Id.*

⁹³ State Party Report (2012), *supra* note 22, at para. 105.

⁹⁴ Between 2009 and 2011, the NDHS indicated that 39.8 percent of mothers paid cash to the health facility during delivery. NDHS 2011, *supra* note 8, at 128-29.

⁹⁵ See *Post-natal women unaware of government incentive*, KATHMANDU POST (Nepali Daily), Feb. 16, 2014, <http://www.ekantipur.com/the-kathmandu-post/2014/02/15/news/post-natal-women-unaware-of-government-incentive/259332.html>.

⁹⁶ *See Id.*

⁹⁷ Though 24 hour delivery service centers have been established in 21 health services in Bajura district, no health officials are present/or found in 16 centers beyond the normal duty times (generally 10 am to 5 pm). Prakash Singh, *24 hours maternity services exist in name only: doctors are not available*, ANNAPURNA POST (Nepali Daily), Dec. 27, 2013, at 5.

⁹⁸ For instance, in Baitadi district hospital, delivery and abortion services are affected due to lack of water. Khagendra Awasthi, *No water in the hospital*, KANTIPUR (Nepali Daily), May 20, 2014.

⁹⁹ Deepa Dahal, *Women at risk due to lack of pill for safe delivery*; ANNAPURNA POST (Nepali Daily), June 22, 2014 at 1.

¹⁰⁰ Raju Adhikari, *Hospital's share in delivery incentives*, NAGARIK (Nepali Daily), July 13, 2014, at 3.

¹⁰¹ Narhari Sapkota, *Months to be spent in hotel for delivery*, NAGARIK (Nepali Daily), August 28, 2013, at 5.

¹⁰² See ESCR Committee, *Concluding Observations: Nicaragua*, para. 27, U.N. Doc. E/C.12/NIC/CO/4 (2008); *Philippines*, para. 31, U.N. Doc. E/C.12/PHL/CO/4 (2008); *Dominican Republic*, para. 28, U.N. Doc. E/C.12/DOM/CO/3 (2010); *Armenia*, para. 19, U.N. Doc. E/C.12/1/Add.39 (1999); *Azerbaijan*, paras. 30, 56, U.N. Doc. E/C.12/1/Add.104 (2004).

¹⁰³ ESCR Committee, *Gen. Comment No. 14*, *supra* note 19, at paras. 43, 44(a).

¹⁰⁴ ICESCR, *supra* note 1, art. 12(1).

¹⁰⁵ See, e.g., ESCR, *Concluding Observations: The Philippines*, para. 31, U.N. Doc. E/C.12/PHL/CO/4 (2008).

¹⁰⁶ ICESCR, *supra* note 1, arts. 2, 3, 12; ESCR Committee, *General Comment No. 20: Non-discrimination in economic, social and cultural rights*, para. 7, U.N. Doc. E/C.12/GC/20 (2009).

¹⁰⁷ ESCR Committee, *Gen. Comment No. 14*, *supra* note 19, at para. 12.

¹⁰⁸ CEDAW Committee, *Concluding Observations: Nepal*, para. 31, U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011).

¹⁰⁹ State Party Report (2012), *supra* note 22, at para. 280.

¹¹⁰ NDHS 2011, *supra* note 8, at 137.

¹¹¹ *Id.*

¹¹² GOVT. OF NEPAL, NAYS, *supra* note 34, at 185.

¹¹³ NDHS 2011, *supra* note 8, at 143.

¹¹⁴ GOVERNMENT OF NEPAL, MINISTRY OF HEALTH AND POPULATION, WITH SUPPORT FROM NEPAL HEALTH SECTOR SUPPORT PROGRAMME, VOICES FROM THE COMMUNITY: ACCESS TO HEALTH SERVICES 7 (2012).

¹¹⁵ *Muluki Ain* (Nepal), *supra* note 6, at part 4, ch. 10 on Homicide, nos. 28-33.

¹¹⁶ *Id.* at part 4, ch. 10 on Homicide, no. 28.

¹¹⁷ Lakshmi and Others v. Government of Nepal, Decision No. 8464, N.K.P. 2067, (Vol. 9) at 1551.

¹¹⁸ This draft was developed under the leadership of the NWC in coordination with various NGOs, INGOs and UN agencies, including the Center.

¹¹⁹ The draft was officially submitted by NWC to Ministry of Health and Population on April 28, 2014.

¹²⁰ Uterine Prolapse is a debilitating and painful condition where the pelvic organs abnormally descend from their position in the pelvis. The symptoms severely decrease a woman's quality of life and cause social embarrassment. See Chhetry DB, et.al, *Impact Evaluation of Uterine Prolapse Surgery in Nepalese Women*, JOURNAL OF NEPAL HEALTH RESEARCH COUNCIL 10(21) 167 (May 2012) [hereinafter Chhetry DB et al., *Impact Evaluation of Uterine Prolapse Surgery in Nepalese Women*].

¹²¹ Approximately 10% of the population suffers from uterine prolapse, and the condition is the "most frequently reported cause of poor health among women of reproductive age and postmenopausal women. NDHS 2011, *supra* note 8, at 143.

¹²² CEDAW Committee, *Concluding Observations: Nepal*, para. 31, U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011).

¹²³ UNFPA, *Fallen Wombs, Broken Lives: Responding to Uterine Prolapse in Nepal* (2009), available at: <http://www.unfpa.org/public/home/news/pid/3282#sthash.5GaE0g7W.dpuf>; see also Magally Zelaya and Ian Bickis, *Nepalese women suffer stigma and pain of fallen wombs*, THE GUARDIAN, May 7, 2014,

<http://www.theguardian.com/global-development/2014/may/07/nepalese-women-stigma-fallen-wombs-prolapsed-uterus>.

¹²⁴ Prakashmani Sharma and Others v. Government of Nepal, Decision No. 8001, N.K.P. 2065, para. 37 (Vol. 8) (2008).

¹²⁵ Messerschmidt L, *Uterine Prolapse in Nepal* (2009), *supra* note 15, at 34.

¹²⁶ Chhetry DB et al., *Impact Evaluation of Uterine Prolapse Surgery in Nepalese Women*, *supra* note 120, at 171.

¹²⁷ *Id.* at 168.

¹²⁸ Messerschmidt L, *Uterine Prolapse in Nepal* (2009), *supra* note 15, at 37-38.

¹²⁹ Chhetry DB et al., *Impact Evaluation of Uterine Prolapse Surgery in Nepalese Women*, *supra* note 120, at 169.

¹³⁰ *Id.* at 169.

¹³¹ Prakashmani Sharma and Others v. Government of Nepal, Decision No. 8001, N.K.P. 2065 (Vol. 8) (2008).

¹³² *Id.*

¹³³ See Kalendra Sejuwal, *Uterine Prolapse victims stuck knee deep in debt*, REPUBLICA, April 25, 2014, http://www.myrepublica.com/portal/index.php?action=news_details&news_id=73517. For example, at a free health camp organized by Sushma Koirala Memorial Trust at Mehalkuna Hospital, 70 percent of women had to obtain further treatment due to health complications resulting from corrective surgery.

¹³⁴ Moreover, reports indicate that health camps are performing operations on patients who do not require corrective surgery. *Uterine prolapse: Experts scorn health camp surgeries*, KATHMANDU POST (Nepali Daily), Sept. 14, 2011, <http://www.ekantipur.com/the-kathmandu-post/2011/09/14/nation/uterine-prolapse-experts-scorn-health-camp-surgeries/226306.html>.

¹³⁵ See Kalendra Sejuwal, *Uterine Prolapse victims stuck knee deep in debt*, REPUBLICA, April 25, 2014, http://www.myrepublica.com/portal/index.php?action=news_details&news_id=73517; *Uterine prolapse: Experts scorn health camp surgeries*, KATHMANDU POST (Nepali Daily), Sept. 14, 2011, <http://www.ekantipur.com/the-kathmandu-post/2011/09/14/nation/uterine-prolapse-experts-scorn-health-camp-surgeries/226306.html>.

¹³⁶ Kalendra Sejuwal, *Uterine Surgery camps closed in villages*, NAGARIK (Nepali Daily), May 5, 2014, <http://nagariknews.com/feature-article/story/17404/17404.html#sthash.TifsVnWE.dpuf>.