

UTERINE PROLAPSE AND MATERNAL MORBIDITY IN NEPAL: A HUMAN RIGHTS IMPERATIVE

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I. INTRODUCTION

In 2008, the Supreme Court of Nepal recognized what maternal health advocates in Nepal had known for decades:

the status of reproductive health of women in Nepal is in a serious state, and it is also clear that no plan has been made to address this problem. In the present context, there are approximately six hundred thousand women suffering from the problem of uterus prolapse and it is also evident that no preventive or remedial programs focusing on problems relating to reproductive health and uterus prolapse have been initiated.¹

The Supreme Court's proclamation in this case, *Prakash Mani Sharma v. Government of Nepal (Sharma)*, marked the first time that a legal body, international or national, has recognized explicitly that a high incidence of uterine prolapse may constitute a violation of human rights, including specifically women's reproductive rights. The Court held that "Article 20(2) of the Interim Constitution, 2063 prescribes reproductive health as a fundamental right and in the absence of proper protection of reproductive health, the problem of uterus prolapse has been far reaching and as such the said right can be deemed to have been violated."²

The Court's landmark decision in this case reflects a complex understanding of reproductive rights, and demonstrates

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1. *Prakash Mani Sharma v. Gov't of Nepal*, Writ No. 064 (2008) (SC) para. 48 (unofficial translation by National Judicial Academy).

2. *Id.* para. 50.

the potential of strong international and national reproductive rights frameworks to lead to legal recognition of the government's obligation to act where women are exposed to harm to their reproductive health. However, despite the strength of the case's legal foundations, the government of Nepal recently announced that rather than complying with the Court's order to address uterine prolapse, it would instead implement regressive measures, scaling back existing programs to treat uterine prolapse by thirty-three percent.³ Citing budget concerns, the government of Nepal reduced its 2010 goal of providing surgeries for women suffering from uterine prolapse from 12,000 women per year to 8,000 women.⁴

This Article aims to articulate a mandate for concrete involvement by human rights bodies calling for the government of Nepal to comply with its international legal obligations to take steps to prevent, detect, and treat uterine prolapse. As recognized by the Supreme Court of Nepal, the failure of States Parties to address high incidences of uterine prolapse violates multiple human rights. In light of the State Party's own recognition of this fact and the strong international framework establishing high incidences of maternal morbidity as a violation of human rights, human rights bodies have a strong mandate to urge that the government of Nepal begin to implement programs intended to address uterine prolapse. Part II of this Article will discuss the nature, scope, and incidence of uterine prolapse in Nepal, presenting the impact of this devastating condition on women's lives and health. Part III will analyze uterine prolapse under the human rights legal framework guaranteeing women the right to maternal health and the international legal commitments to the prevention of maternal morbidity. Part IV will discuss the *Sharma* case in depth, providing both an insight into the context in which the case was filed as well as measures that have been taken—and repealed in part—by the government of Nepal following the case. Part V will argue that, given the human rights implications of the nature, scope, and incidence of uterine prolapse and the Supreme Court of Nepal's reliance on human rights

3. Om Astha Rai, *Govt Lowers Uterine Prolapse Treatment Target*, REPUBLICA, Jan. 27, 2010, available at http://www.myrepublica.com/portal/index.php?action=news_details&news_id=14515.

4. *Id.*

law to give substance to newly recognized constitutional rights, human rights bodies have a significant role to play in supporting implementation of the decision. Part VI will conclude by articulating specific interventions that can be taken by human rights bodies to increase prevention of and accountability for violations of women's rights as a result of uterine prolapse.

II. NATURE, SCOPE, AND INCIDENCE OF UTERINE PROLAPSE IN NEPAL

Uterine prolapse, also known as genital prolapse and pelvic organ prolapse, is a debilitating condition that occurs where weakened pelvic muscles can no longer support the proper positioning of the pelvic organs, typically the vagina and uterus.⁵ In the later stages of prolapse, the uterus can protrude beyond the vaginal canal or the entire uterus may fall out of the vagina entirely.⁶ Uterine prolapse can lead to severe degrees of physical disability, including inability to work, difficulties walking or standing up, difficulties urinating or defecating, painful intercourse, increased social stigma, and economic deprivation.⁷ In some cases, uterine prolapse can be fatal if left untreated.⁸

According to a population-based survey carried out by the United Nations Population Fund (UNFPA)/World Health Organization and the Institute of Medicine at Tribhuvan University in 2006, more than 600,000 Nepali women suffer from some form of uterine prolapse.⁹ Of these women, nearly

5. Tiphaine Ravenel Bonetti et al., *Listening to "Felt Needs": Investigating Genital Prolapse in Western Nepal*, 12 REPROD. HEALTH MATTERS 166, 166 (2004), available at <http://www.advocacynet.org/modules/fck/upload/file/upa/bonetti%20et%20al%202004.pdf>.

6. CTR. FOR AGRO-ECOLOGY & DEV., NEPAL, UTERINE PROLAPSE STUDY REPORT 6 [hereinafter UTERINE PROLAPSE STUDY REPORT], available at <http://www.advocacynet.org/modules/fck/upload/file/upa/CAED%20Uterine%20Prolapse%20Study%20Report.doc>.

7. Nicole Farkouh, *Reframing Maternal Health in Nepal*, POL'Y MATTERS J., Spring 2009, at 33, 33.

8. The Advocacy Project, *Challenge*, <http://www.advocacynet.org/page/upachallenge> (last visited May 19, 2010).

9. UNITED NATIONS POPULATION FUND, BOOKLET ON UTERINE PROLAPSE 11 (2007) [hereinafter BOOKLET ON UTERINE PROLAPSE], available at <http://nepal.unfpa.org/pdf/prolapse%20english%20book.pdf>; see also Bishnu Kumari, *Fallen Wombs, Broken Lives: Responding to Uterine Prolapse in Nepal*, UNITED NATIONS POPULATION FUND, Aug. 3, 2009, <http://www.unfpa.org/public/News/pid/3282>.

200,000 are in immediate need of surgery.¹⁰ What makes the incidence of uterine prolapse particularly distinct in Nepal is that unlike in other countries where uterine prolapse is predominantly seen in women of postmenopausal age and unrelated to childbirth, younger Nepali women are also vulnerable to uterine prolapse.¹¹ Globally, uterine prolapse is a condition that impacts only 2–20% of women of reproductive age worldwide, and typically is found in women of post-reproductive age.¹² In Nepal, however, studies have estimated that as many as 51% of uterine prolapse cases first occur in women between the ages of twenty and twenty-four years old.¹³ Fourteen percent of uterine prolapse cases occur before the age of twenty, and another 44% of cases occur before thirty.¹⁴ In some districts, the incidence of uterine prolapse among women of reproductive age is even higher – in Doti, for example, a far-western district in Nepal, 23.5% of women reported uterine prolapse occurring before the age of twenty.¹⁵ Uterine prolapse occurs after the first delivery for 30.4% of women who have the condition,¹⁶ and after the second delivery for 62%.¹⁷ The high incidence of uterine prolapse in young women is unique to Nepal, and indicative of a failure of the government to address what is essentially a preventable or treatable condition. Women who suffer from uterine prolapse are denied a healthy and dignified existence.

A. Causes of Uterine Prolapse

When uterine prolapse occurs in women of reproductive age, it is typically a product of poverty, entrenched gender discrimination, and inadequate health care services. In Nepal, uterine prolapse usually occurs as a result of excessive physi-

10. Kumari, *supra* note 9.

11. INST. OF MED. TRIBHUVAN UNIV., A REPROD. MORBIDITY REPORT ON CLINIC-BASED SURVEY: STATUS OF REPROD. MORBIDITIES IN NEPAL 76 (2006) [hereinafter REPRODUCTIVE MORBIDITY], available at http://www.advocacynet.org/modules/fck/upload/file/upa/Status%20of%20Reproductive%20Morbidity%20in%20Nepal_august%202006_UN.doc.

12. Bonetti et al., *supra* note 5, at 166–67.

13. UTERINE PROLAPSE STUDY REPORT, *supra* note 6, at 23.

14. REPRODUCTIVE MORBIDITY, *supra* note 11, at 74–75.

15. *Id.* at 24.

16. *Id.* at 74.

17. Farkouh, *supra* note 7, at 33 (citing Samita Pradhan, UNHEEDED AGONIES: A STUDY IN UTERINE PROLAPSE PREVALENCE AND ITS CAUSES IN SIRAHA AND SAPTARI DISTRICTS (2007)).

cal labor during and immediately after pregnancy, a lack of skilled attendants during delivery, frequent and numerous pregnancies, early childbirth, and/or a lack of nutritious food during maternity.¹⁸

1. Lack of Adequate and Appropriate Health Care

Uterine prolapse is likely to occur when the muscular floor and ligaments of the pelvis are damaged.¹⁹ Pelvic floor damage can occur where there is “overstretching of the perineum, obstructed labor, delivery of a large infant, delay in episiotomy, and/or imperfect repair of perineal injuries.”²⁰ In Nepal, where 81% of women deliver at home and only 23.4% of women deliver with the assistance of a trained birth attendant,²¹ women are particularly vulnerable to these risk factors. For example, a study done by Tribhuvan University’s Institute of Medicine found that *dais*, traditional birth attendants, do not employ episiotomies, leading to undue stretching of the pelvic floor if the second stage of labor is prolonged.²² When such damage happens, the uterus is supported only by the ligaments.²³ If subjected to excessive weight or pressure, these ligaments will tear.²⁴ This pressure can result from a range of improper delivery techniques, including many that are frequently employed by untrained birthing attendants in Nepal, such as: bearing down by the pregnant woman before the cervix is dilated; inappropriate pressing on the belly to deliver the infant; the vaginal extraction of the infant; delivery in a squatting position; or forced vomiting to expel the placenta.²⁵

18. Barbara Bodner-Adler et al., *Risk Factors for Uterine Prolapse in Nepal*, 18 INT’L. UROGYNECOLOGY J. 1343, 1343 (2007); see also Bonetti et al., *supra* note 5, at 167.

19. Barbara Earth & Sabitri Sthapit, *Uterine Prolapse in Rural Nepal: Gender and Human Rights Implications. A Mandate for Development*, 4 CULTURE, HEALTH & SEXUALITY 281, 283 (2002).

20. *Id.*

21. NEPAL MINISTRY OF HEALTH AND POPULATION, DEMOGRAPHIC AND HEALTH SURVEY 2006 20 (2006), available at <http://www.measuredhs.com/pubs/pdf/FR191/FR191.pdf>.

22. REPRODUCTIVE MORBIDITY, *supra* note 11, at 24.

23. Earth & Sthapit, *supra* note 19, at 283.

24. *Id.*

25. *Id.*

2. *Societal Norms Leading Women To Work During and Soon After Pregnancy*

Pressure causing tension on the pelvic ligaments also commonly occurs among Nepali women as a result of excessive physical labor throughout and following pregnancy.²⁶ Particularly in rural areas, where 86% of the population lives, women do significantly more work than men in preparing seedlings, transplanting, weeding, applying fertilizer, irrigating, and harvesting.²⁷ Research also shows that women do most of the work in collecting fodder, making animal food, cleaning animal sheds, and feeding animals.²⁸ Women are almost exclusively responsible for household activities, such as grinding and polishing rice, cooking, cleaning, washing, caring for children, fetching water, and collecting fuel wood.²⁹ Studies show that in rural Nepal, a woman's work burden is 12-22% greater than a man's.³⁰ Women typically do not alter their workload during pregnancy; in fact, there is a common belief that work during pregnancy makes delivery easier, leading women to keep working until immediately before labor.³¹

Although reproductive organs require at least six weeks of rest to heal post-delivery, many ethnic communities traditionally observe significantly shorter resting periods, ranging from one month for Newar women to one week for Tamang women.³² Women's premature return to household or agricultural labor may also be prompted by financial constraints on the woman's family,³³ particularly in poor, rural families where the burden of work is too substantial for women to be able to abstain from household and farm labor.³⁴ A United Nations study found that, on average, more than 14% of women in Nepal are engaging in heavy labor within a week of child-

26. *Id.* at 288.

27. *Id.*

28. *Id.*

29. *Id.*

30. *Id.* at 287.

31. *Id.* at 288.

32. *Id.* at 289-90.

33. *See id.* at 290.

34. *See* Bodner-Adler et al., *supra* note 18, at 1344.

birth.³⁵ For women in rural areas, even returning to cooking too soon after delivery increases the chances of uterine prolapse, as kitchens tend to be primitive and poorly ventilated, causing chronic and severe coughing, which adds additional pressure to the pelvic ligaments.³⁶

3. *Vulnerability to Uterine Prolapse Due to Women's Inability to Access Family Planning and Safe Abortion*

Women are particularly vulnerable to uterine prolapse as a result of an inability to control their fertility and a lack of access to safe abortion. One study found that "rapid succession of pregnancies preclude[s] proper postnatal rehabilitation" and leads to a "tendency to develop prolapse."³⁷ Women who are unable to access family planning services and supplies are also at an increased risk for uterine prolapse. Repeated pregnancies and childbirth strain the pelvic floor and ligaments, particularly among adolescents whose bodies are not yet developed to support childbirth.³⁸ In Nepal, less than half of married women of reproductive age use any family planning methods. Additionally, 26% of rural women want to time or space their pregnancies, but have an unmet need for family planning.³⁹ One-fifth of women deliver their second baby within two years of the delivery of their previous child.⁴⁰ According to the UNFPA, "[t]he unmet need for family planning in Nepal is higher among women with low income and living in the most remote areas."⁴¹

Unwanted pregnancies also expose women to uterine prolapse when women are unable to access safe abortion and

35. Sushma Amatya, *Fallen Womb: The Hardest Burden for a Woman to Bear*, XLIII U.N. Chron. 2006, available at <http://www.un.org/Pubs/chronicle/2006/issue3/0306p53.htm>.

36. See Earth & Sthapit, *supra* note 19, at 283.

37. REPRODUCTIVE MORBIDITY, *supra* note 11, at 24.

38. THE ADVOCACY PROJECT, UTERUS DAMAGE CONDEMNS WOMEN TO SICKNESS AND STIGMA IN RURAL NEPAL (Aug. 2, 2007) [hereinafter ADVOCACY PROJECT, UTERUS DAMAGE], available at <http://www.advocacynet.org/resource/967>; see also UTERINE PROLAPSE STUDY REPORT, *supra* note 6, ¶ 7.2.2.

39. UNFPA, Nepal Key Indicators, <http://nepal.unfpa.org/en/statistics/> (last visited Mar. 10, 2010).

40. *Id.* (placing percentage of women with their "Most Recent Births Occurring less than 24 Months After Prior Birth" at 22%).

41. UNFPA, Factsheet: Family Planning—Fighting Poverty and Empowering Women (July 7, 2009), available at <http://nepal.unfpa.org/en/news/news.php?ID=67>.

ultimately resort to unsafe abortion.⁴² Approximately 16% of pregnancies in Nepal are unwanted, leading in some cases to abortion.⁴³ Although abortion was legalized in 2002, studies show that three-fourths of all abortions are still performed in clandestine and informal settings⁴⁴ and up to 25% of maternal deaths are still caused by unsafe abortion.⁴⁵ Uterine prolapse is among the dangerous complications that can occur as a result of unsafe abortion.⁴⁶

4. *Gender Inequality as an Underlying Determinant of Vulnerability to Uterine Prolapse*

Gender inequality is an internationally recognized underlying determinant of women's maternal health.⁴⁷ For example, the lack of access to adequate and nutritious food for females in Nepal increases their risk for uterine prolapse.⁴⁸ Malnutrition is a dominant risk factor in Nepal, in large part because it leads to low maternal weight.⁴⁹ Traditional practices often contribute to women's malnutrition and subsequent vulnerability to uterine prolapse. For example, one non-governmental organization worker stated, "In Western Nepal, people believe women should eat only oil and rice for eleven days af-

42. See BOOKLET ON UTERINE PROLAPSE, *supra* note 9, at 20 (including "[u]nsafe abortions" on list of "Reasons for Uterine Prolapse"); see also UTERINE PROLAPSE STUDY REPORT, *supra* note 6, at 15 (noting association between uterine prolapse and abortion, particularly induced abortions); SAFE MOTHERHOOD NETWORK FOUND., BEYOND BEIJING COMM., & TRIBHUVAN UNIV. TEACHING HOSP., PREVALENCE OF UTERINE PROLAPSE AMONGST GYNECOLOGY OPD PATIENTS IN TRIBHUVAN UNIVERSITY TEACHING HOSPITAL IN NEPAL AND ITS SOCIO-CULTURAL DETERMINANTS 7 [hereinafter PROLAPSE AND ITS SOCIO-CULTURAL DETERMINANTS], (2010), available at <http://arrow.org.my/publications/ICPD+15Country&ThematicCaseStudies/Nepal.pdf>.

43. See UNFPA, Nepal Key Indicators, <http://nepal.unfpa.org/en/statistics/> (last visited Mar. 26, 2010); International Planned Parenthood Foundation, *Abortion*, <http://www.ippfsar.org/en/What-we-do/Strategic+plan/abortionnepal.htm> (last visited Mar. 26, 2010).

44. CTR. FOR RESEARCH ON ENV'T HEALTH & POPULATION ACTIVITIES ET AL., UNSAFE ABORTION: NEPAL COUNTRY PROFILE 2 (2006), available at http://www.creha.org.np/download/unsafe_abortion_nepal_country_profile_2006.pdf.

45. *Unsafe Abortion Cause of 1/4 Maternal Deaths in Nepal*, CHINA DAILY, Feb. 4, 2009, http://www.chinadaily.com.cn/world/2009-02/04/content_7445030.htm.

46. See BOOKLET ON UTERINE PROLAPSE, *supra* note 9, at 20.

47. Paul Hunt & Judith Bueno DeMesquita, REDUCING MATERNAL MORTALITY: THE CONTRIBUTION OF THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH, 5 (2007), available at <http://www.unfpa.org/publications/detail.cfm?ID=356>.

48. See *id.*

49. Bodner-Adler et al., *supra* note 18, at 1345.

ter giving birth, while in Eastern Nepal, for nine days after delivery, women eat only a mixture of ginger and jaggary."⁵⁰ Similarly, studies show that early marriage and early child bearing increases women's risk factors for uterine prolapse. In one study, 61% of women with uterine prolapse had given birth to their first child at less than nineteen years of age, and almost all of the women in the study area were married before the age of twenty.⁵¹

B. Impact of Uterine Prolapse and Inaccessibility of Care

Several studies document the tragic impact that uterine prolapse has on the quality of life of women who suffer from the condition.⁵² Women who experience uterine prolapse are often unable to work, find sex painful or physically impossible, and may be unable to control the secretion of fluids from their bodies.⁵³ Women with uterine prolapse face immense social stigma and are often considered impure, leading to social ostracization.⁵⁴ Further, many women report that if they decline sex due to pain or are unable to engage in sex altogether, they experience violence and marital rape from their husbands, and their husbands often threaten to take new wives or abandon them.⁵⁵ When women are divorced by their husbands as a result of uterine prolapse, returning to their parents' home is often not an option, leading women to resort to working as domestic servants, sometimes even in the home of their former husband and his new wife.⁵⁶ Women's diminished productivity as a result of uterine prolapse further impacts the way women with uterine prolapse are treated by members of their household, including exposure to domestic violence by their spouses or in-laws.⁵⁷ Given studies that show that 82% of women reported experiencing reduced family in-

50. Farkouh, *supra* note 7, at 34.

51. UTERINE PROLAPSE STUDY REPORT, *supra* note 6, at 31.

52. *Id.* at 16.

53. Farkouh, *supra* note 7, at 33.

54. UTERINE PROLAPSE STUDY REPORT, *supra* note 6, at 16.

55. See Earth & Sthapit, *supra* note 19, at 291; UTERINE PROLAPSE STUDY REPORT, *supra* note 6, at 16.

56. ADVOCACY PROJECT, UTERUS DAMAGE, *supra* note 38; see also PROLAPSE AND ITS SOCIO-CULTURAL DETERMINANTS, *supra* note 42 at 19.

57. Farkouh, *supra* note 7, at 36; Bonetti et al., *supra* note 5, at 172.

come as a result of uterine prolapse, the implications of uterine prolapse for women's physical integrity and quality of life can be quite significant.⁵⁸

Although uterine prolapse is a treatable condition, women experience barriers to care for a host of reasons.⁵⁹ A recent study of women who sought treatment for uterine prolapse in Tribhuvan University Teaching Hospital reveals that 46.97% waited for fifteen to thirty years before seeking treatment in a hospital.⁶⁰ In early stages of prolapse, the condition can be managed either through pelvic floor strengthening exercises or with the use of a rubber ring called a pessary, which holds up the uterus and prevents any further descent.⁶¹ In more advanced stages, particularly where the uterus has descended entirely from the body, women require surgical interventions, often times including the removal of the uterus altogether.⁶² Women face significant barriers to accessing care for uterine prolapse, including a lack of awareness about the treatability of the condition, lack of control over when to seek medical treatment or to see a doctor, as well as inability to pay for medical expenses or transportation costs to health facilities.⁶³ Even when women know where to seek treatment and have the means to access it, they hesitate due to fear of divorce or abandonment; isolation, shame, and sensitivity surrounding genital issues; traditional beliefs that hysterectomies will lead to weakness; and lack of emotional support.⁶⁴ Finally, for the reasons listed above, many women face obstacles in receiving necessary follow-up care, particularly as needed in the case of pessary rings, which require periodic replacement by a medical practitioner and maintenance to avoid infection.⁶⁵

Without access to treatment by trained providers, women are forced to resort to crude methods of self-treatment. Doc-

58. Farkouh, *supra* note 7, at 36.

59. Bodner-Adler et al., *supra* note 18, at 1345.

60. PROLAPSE AND ITS SOCIO-CULTURAL DETERMINANTS, *supra* note 42, at 17.

61. UTERINE PROLAPSE STUDY REPORT, *supra* note 6, at 7.

62. *Id.*

63. Earth & Sthapit, *supra* note 19, at 291; PROLAPSE AND ITS SOCIO-CULTURAL DETERMINANTS, *supra* note 42, at 18.

64. See Bonetti et al., *supra* note 5, at 167; Earth & Sthapit, *supra* note 19, at 291; Farkouh, *supra* note 7, at 34; PROLAPSE AND ITS SOCIO-CULTURAL DETERMINANTS, *supra* note 42, at 11, 16-18.

65. Earth & Sthapit, *supra* note 19, at 291.

tors report that to prevent their uteri from descending women will insert other available items into their vaginas, including “glass bangles, wads of cloth, and balls,”⁶⁶ or attempt to reduce their food intake to minimize abdominal pressure, which often leads to malnourishment.⁶⁷ One non-governmental organization worker stated that, “[o]ne woman in our working area tried to remove her uterus herself, saying she would rather die than live with the pain of this condition.”⁶⁸

III. UTERINE PROLAPSE AS A HUMAN RIGHTS VIOLATION

Uterine prolapse, particularly among younger women, is a pregnancy-related condition that debilitates women and is recognized as a form of maternal morbidity.⁶⁹ Under international law, high incidences of maternal morbidity in a country is indicative of violations of a host of human rights obligations, including the right to health, the right to life, and the right to nondiscrimination. This section applies the human rights framework to the issue of uterine prolapse to provide a broad understanding of the key obligations to address these violations borne by States Parties to human rights treaties.

Under the 1994 International Conference on Population and Development Programme of Action (ICPD), governments agreed that “all countries should reduce mortality and morbidity and seek to make primary health care, including reproductive health care, available universally by the end of the current decade”⁷⁰ and aimed “[t]o prevent unwanted pregnancies and reduce the incidence of high-risk pregnancies and morbidity and mortality.”⁷¹ Under the ICPD, governments recognized that “[t]he age at which women begin or stop child-bearing, the interval between each birth, the total number of lifetime pregnancies and the socio-cultural and eco-

66. Farkouh, *supra* note 7, at 34.

67. *Id.*

68. *Id.* (internal quotations omitted).

69. U.K. All Party Parliamentary Group on Population, Dev. & Reprod. Health, BETTER OFF DEAD? 10 (May 2009), available at <http://www.appg-popdevrh.org.uk/Publications/publications.html#otherpubs> (follow “APPG Hearings Report ‘Better Off Dead?’ on maternal morbidity”).

70. Int’l Conf. on Population & Dev., Sept. 5–13, 1994, *Report of the International Conference on Population and Development*, ¶ 8.5, U.N. Doc. A/Conf.171/13 (Oct. 18, 1994).

71. *Id.* ¶ 7.14(b).

conomic circumstances in which women live all influence maternal morbidity and mortality."⁷² Parties to the ICPD, including Nepal, committed that "all countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem"⁷³ and agreed that

[t]he underlying causes of maternal morbidity and mortality should be identified, and attention should be given to the development of strategies to overcome them and for adequate evaluation and monitoring mechanisms to assess the progress being made in reducing maternal mortality and morbidity and to enhance the effectiveness of ongoing programmes.⁷⁴

Since the ICPD, treaty-monitoring bodies have specifically recognized both high incidences of maternal morbidity⁷⁵ and lack of information on maternal morbidity as a violation of human rights.⁷⁶

Most recently, the United Nations Human Rights Council has adopted a landmark resolution on *Preventable Mortality and Morbidity and Human Rights*, which acknowledges "that a human rights analysis of preventable maternal mortality and morbidity and the integration of a human rights perspective in international and national responses to maternal mortality and morbidity could contribute positively to the common goal of reducing this rate."⁷⁷ The resolution, co-sponsored by Nepal, states that:

72. *Id.* ¶ 8.19.

73. *Id.* ¶ 8.21.

74. *Id.* ¶ 8.22.

75. U.N. Convention on the Elimination of All Forms of Discrimination Against Women [CEDAW], Comm. on the Elimination of Discrimination Against Women, *Concluding Comments of the Committee on the Elimination of Discrimination Against Women: India*, ¶¶ 40–41, U.N. Doc. CEDAW/C/IND/CO/3 (Feb. 2, 2007); CEDAW, Comm. on the Elimination of Discrimination Against Women, *Concluding Comments of the Committee on the Elimination of Discrimination Against Women: Cambodia*, ¶¶ 29–30, U.N. Doc. CEDAW/C/KHM/CO/3 (Jan. 25, 2006) ("The Committee recommends that the obstacles to accessing obstetric services be monitored and removed and that . . . a strategic plan to reduce maternal mortality and morbidity be put in place through which quality prenatal, post-natal and emergency obstetric services are progressively distributed in all provinces.").

76. *See, e.g.*, CEDAW, Comm. on the Elimination of Discrimination Against Women, *Concluding Comments of the Committee on the Elimination of Discrimination Against Women: Georgia*, ¶ 29–30, U.N. Doc. CEDAW/C/GEO/CO/3 (Aug. 25, 2006).

77. U.N. Hum. Rights Comm., Res. 11/3, at 2, U.N. Doc. A/HRC/11/L.16/Rev.1 (June 16, 2009).

most instances of maternal mortality and morbidity are preventable, and that preventable maternal mortality and morbidity is a health, development and human rights challenge that also requires the effective promotion and protection of the human rights of women and girls, in particular their rights to life, to be equal in dignity, to education, to be free to seek, receive and impart information, to enjoy the benefits of scientific progress, to freedom from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health.⁷⁸

Understanding uterine prolapse as a maternal morbidity issue is key to situating uterine prolapse as a human rights issue. Human rights bodies, treaties, and consensus documents have established several relevant standards applicable for proper protection from maternal morbidity. This section argues that if met, many of the standards and legal guarantees established to prevent maternal mortality and morbidity could be tailored to allow States Parties to prevent, detect, and treat uterine prolapse as required by international and constitutional law.

A. Right to Health

Under Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR), which Nepal acceded to in 1991,⁷⁹ States Parties must “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”⁸⁰ The United Nations Committee on Economic, Social, and Cultural Rights (CESCR) stated in General Comment No. 14 on the right to health that “[e]very human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity,”⁸¹ and

78. *Id.* ¶ 2.

79. OFFICE OF THE U.N. HIGH COMM’R FOR HUMAN RIGHTS, STATUS OF RATIFICATION: INT’L COVENANT ON ECON., SOC. & CULTURAL RIGHTS (2004), <http://www2.ohchr.org/english/law/cescr-ratify.htm>.

80. Int’l Covenant on Econ., Soc. & Cultural Rights, G.A. Res. 2200A (XXI), art. 12(1) (Dec. 16, 1966) [hereinafter ICESCR], available at <http://www2.ohchr.org/english/law/pdf/cescr.pdf>.

81. U.N. Comm. on Econ., Soc. & Cultural Rights [CESCR], *General Comment No. 14*, ¶ 1, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR, *General Comment No. 14*], avail-

States Parties have an “obligation to take steps . . . towards the full realization of article 12.”⁸² The right to health, as articulated in the ICESCR, and as interpreted by the CESCR and the Special Rapporteur on the Right to Health requires States Parties to take steps towards realizing specific freedoms and entitlements under Article 12.⁸³ Of particular relevance to the incidence of uterine prolapse is the obligation to provide maternal, sexual, and reproductive health services and the obligation to ensure the underlying determinants of health.

It is important to note that insufficient or regressive measures curtailing access to treatment for uterine prolapse cannot be justified under human rights law by the government’s claim of resource constraints. The right to reproductive and maternal health is recognized as a “core obligation,”⁸⁴ meaning that the freedoms and entitlements guaranteed by this right are not subject to progressive realization. Rather, “a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable.”⁸⁵ The CESCR has established that “[t]he adoption of any retrogressive measures incompatible with the core obligations under the right to health . . . constitutes a violation of the right to health.”⁸⁶ Where retrogressive measures are deliberately taken:

[T]he State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party’s maximum available resources.⁸⁷

able at <http://www2.ohchr.org/english/bodies/cescr/comments.htm> (click on the hyperlink found at number “14”).

82. *Id.* ¶ 30.

83. ICESCR, *supra* note 80, art. 2(1); CESCR, *General Comment No. 14*, *supra* note 81, ¶ 30; Hunt & De Mesquita, *supra* note 47, at 5.

84. CESCR, *General Comment No. 14*, *supra* note 81, ¶¶ 43(a), 43(e), 44(a).

85. *Id.* ¶ 47.

86. *Id.* ¶ 48.

87. *Id.* ¶ 32.

1. *Right to Maternal and Reproductive Health*

The CESCR has stated that Article 12 establishes a right to maternal and reproductive health, and “may be understood as requiring measures to improve . . . maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.”⁸⁸ The former Special Rapporteur on the Right to Health has stated the right to health specifically includes entitlements to several health interventions, including emergency obstetric care, a skilled birth attendant, education and information on sexual and reproductive health, safe abortion services where not illegal, family planning services, and primary health care services.⁸⁹

To fulfill the right to health, States Parties must comply with a four-pronged standard articulated by the CESCR.⁹⁰ Under this standard, health care goods and services must be: (1) physically accessible and affordable; (2) of high quality; (3) widely available; and (4) provided in a manner acceptable to women, including without discrimination.⁹¹

The government of Nepal has failed particularly significantly in meeting the first and second standards, which require that quality services to prevent, detect, and treat uterine prolapse are provided in places accessible to women. Goods and services, including information, must be physically and economically accessible without discrimination.⁹² As discussed in Part II.A., uterine prolapse occurs as a result of the inaccessibility of a number of reproductive health services, including trained birth attendants, information on medically-indicated resting periods prior to and following labor, adequate family planning goods and services, and safe abortion services. Without access to trained health providers, women resort to unskilled providers who may jeopardize their health by employing unsafe methods. Women have difficulty recognizing uterine prolapse due to the inaccessibility of informa-

88. *Id.* ¶ 14.

89. Hunt & De Mesquita, *supra* note 47, at 5.

90. CESCR, *General Comment No. 14*, *supra* note 81, ¶ 12.

91. *Id.*

92. *Id.* ¶ 12(b).

tion explaining its symptoms and how and where women can seek treatment. Women are further unable to access treatment for uterine prolapse as a result of geographic distances to health camps and centers, concomitant travel costs, and costs of services and goods needed for treatment. The Nepalese government's recent decision to cut travel stipends in half for women seeking treatment for uterine prolapse serves as a further barrier to accessibility and constitutes a retrogressive measure in violation of international law. To comply with its obligation under the right to health, the government of Nepal must take steps to increase accessibility to these goods and services.

The third standard, availability, obligates States Parties to ensure an adequate number of goods, services, and facilities necessary to prevent, detect, and treat uterine prolapse, as well as sufficient numbers of qualified personnel to staff the services.⁹³ Women in Nepal, particularly rural Nepal, face significant challenges in accessing trained maternal health care providers; only 19% of births are attended by skilled birth personnel nationwide.⁹⁴ Women who suffer from uterine prolapse also face significant difficulties in availability of services; the government targets for 2008–2010 only provide for surgery for 20,000 women total,⁹⁵ which is only 10% of the 200,000 women currently estimated to need immediate surgery for uterine prolapse.⁹⁶ The recent reduction in provision of surgeries for women with uterine prolapse from 12,000 per year to 8,000 per year⁹⁷ violates the availability standard as well as the obligation to refrain from retrogressive measures. The availability standard is also violated by the government's focus on the provision of surgery without a similar focus on awareness campaigns to prevent and detect uterine prolapse, or programs to treat women with earlier stages of uterine prolapse who need pessary rings or other non-surgical interventions.⁹⁸

93. *Id.* ¶ 12(a).

94. UNFPA, *Nepal Key Indicators*, <http://nepal.unfpa.org/en/statistics/> (last visited Mar. 10, 2010).

95. Rai, *supra* note 3.

96. Kumari, *supra* note 9.

97. Rai, *supra* note 3.

98. See Farkouh, *supra* note 7, at 35.

Finally, the fourth standard, acceptability, requires that “[a]ll health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, [and] . . . sensitive to gender”⁹⁹ Governments are responsible for ensuring that programs contain strategies that take into account cultural norms.¹⁰⁰ In the case of uterine prolapse, States Parties must implement interventions that facilitate the detection of uterine prolapse in a culture where issues relating to genital health are considered shameful and are stigmatized.

2. *Right to Underlying Determinants of Health*

Uterine prolapse is caused and contributed to by a lack of access to several underlying determinants of health, including adequate nutrition, healthy occupational and housing conditions, and information on reproductive health.¹⁰¹ The CESCR has stated that:

The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.¹⁰²

Further, the CESCR has stated that realizing the right to health may require “preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.”¹⁰³ The four-pronged standard described above applies to the underlying determinants of health as well.¹⁰⁴

99. CESCR, *General Comment No. 14*, *supra* note 81, ¶ 12(c). *See also* Hunt & De Mesquita, *supra* note 47, at 6 (discussing acceptability as it relates to maternal mortality).

100. Hunt & De Mesquita, *supra* note 47, at 5–6.

101. *See infra* Part II.A.

102. CESCR, *General Comment No. 14*, *supra* note 81, ¶ 11.

103. *Id.* ¶ 21.

104. *See id.* ¶ 12.

Access to underlying determinants of health plays a significant role in the incidence of uterine prolapse in Nepal. As discussed in earlier sections of Part II, women who are malnourished are physically weakened and therefore more susceptible to uterine prolapse,¹⁰⁵ and malnourishment has been identified as a major contributor to uterine prolapse in Nepal as well.¹⁰⁶ Uterine prolapse is also likely to occur among women who have chronic or severe coughs, which put pressure on the uterine ligaments.¹⁰⁷ Many women report that working in small, unventilated kitchens leads to smoke inhalation resulting in coughing and uterine pressure.¹⁰⁸ Such pressure also occurs as a result of unsafe occupational conditions, including the need to perform farm work or heavy labor immediately preceding and following childbirth.¹⁰⁹

B. *The Right to Life*

*"[A] 45 year-old woman, from Saptari district, died from a sever[e] [sic] infection after her uterus fell off. Like most victims of prolapse, she was poor and lower caste."*¹¹⁰

Uterine prolapse violates right to life where it results in death and where it deprives women of quality of life. International legal instruments such as the Universal Declaration of Human Rights (UDHR) and the International Covenant on Civil and Political Rights (ICCPR) obligate States Parties to protect the inherent right to life and the freedom from arbitrary deprivation of life,¹¹¹ recognizing that "everyone has the right to life, liberty and security of the person."¹¹² The Human Rights Committee (HRC), which monitors compliance with the ICCPR, interprets the right to life broadly and requires that States Parties take positive measures to ensure enjoyment of

105. Bodner-Adler et al., *supra* note 18, at 1344.

106. *Id.*

107. *Id.* at 1345; *see supra* notes 22–23 and accompanying text.

108. *See supra* note 36 and accompanying text.

109. *See supra* notes 26–36 and accompanying text.

110. The Advocacy Project, *supra* note 8.

111. *See* Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. Doc. A/810 (Dec. 10, 1948) [hereinafter UDHR]; Int'l Covenant on Civil & Political Rights, Dec. 19, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR], available at <http://www.un.org/en/documents/udhr/>.

112. UDHR, *supra* note 110, art. 3.

the right.¹¹³ The right to life also obligates States Parties to take measures to safeguard individuals from arbitrary and preventable loss of life.¹¹⁴ This includes steps to protect women against the unnecessary loss of life related to pregnancy and childbirth¹¹⁵ and to ensure that health services are accessible.¹¹⁶ Governments are expected to understand the right to life in broad terms and to take positive measures to “increase life expectancy.”¹¹⁷ Fulfilling this obligation entails taking measures to ensure that health services are accessible¹¹⁸ as well as maintaining and reporting data on pregnancy- and childbirth-related deaths of women.¹¹⁹ Where uterine prolapse is fatal, it constitutes a violation of the right to life.

Even where uterine prolapse is not fatal, it wreaks havoc on the day-to-day existence of women living with the condition.¹²⁰ A failure to address uterine prolapse can be understood as a violation of the right to quality of life, which has been interpreted by regional and domestic courts as an aspect of the right to life. The UDHR declares the right to life to include the right to “liberty and security of the person,”¹²¹ which includes at least the right to food, clothing, housing, medical care, and necessary social services, as well as the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood due to circumstances beyond a person’s control. These rights are considered an inherent part of an adequate standard of living and quality of life.¹²² The HRC has interpreted the right to life to include obligations to “adopt positive measures” that would ensure an improved

113. U.N. Human Rights Comm., *General Comment No. 6: The Right to Life (art. 6)*, ¶¶ 3, 5 (Apr. 30, 1982) [hereinafter HRC, *General Comment No. 6*], available at <http://www.unhcr.ch/tbs/doc.nsf>.

114. *Id.* ¶ 3.

115. HRC, *General Comment No. 28: Equality of Rights Between Men and Women (art.3)*, U.N. Doc. CCPR1C/21/Rev.1/Add.10, ¶ 10 (Mar. 29, 2000) [hereinafter HRC, *General Comment No. 28*], available at <http://www.unhcr.ch/tbs/doc.nsf>.

116. HRC, *Concluding Observations of the Human Rights Committee: Mali*, ¶ 14, U.N. Doc. CCPR/CO/77/MLI (Apr. 16, 2003) [hereinafter HRC, *Concluding Comments*].

117. See HRC, *General Comment No. 6*, *supra* note 113, ¶¶ 3, 5.

118. HRC, *Concluding Comments*, *supra* note 116, ¶ 14.

119. See HRC, *General Comment No. 28*, *supra* note 115, ¶ 10.

120. See discussion *supra* Part II.B.

121. UDHR, *supra* note 111, art. 3.

122. *Id.* art. 25.

quality of life.¹²³ Similarly, the Inter-American Court of Human Rights (IACHR) has recognized that the right to life includes more than the mere right to existence, and that it implicates the right to live with dignity. In *Villagrán-Morales v. Guatemala*, the IACHR found that “restrictive approaches to [the right to life] are inadmissible” and that the right to life includes the right “not [to] be prevented from having access to the conditions that guarantee a dignified existence.”¹²⁴ The Court also found that “[t]he arbitrary deprivation of life is not limited to the illicit act of homicide; it extends itself to the deprivation of the right to live with dignity.”¹²⁵ The quality of life arguments recognized in these cases and statements are directly applicable to the case of uterine prolapse. Women living with uterine prolapse experience a range of morbidities that hamper everything from walking to carrying heavy objects to having a normal and healthy sex life. Without treatment, women are deprived of their dignity and often forced to live as social outcasts.

C. *The Right to Nondiscrimination*

The ICCPR contains an anti-discrimination provision as well as an equality provision, which states that:

All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as . . . sex, . . . national or social origin, . . . birth or other status.¹²⁶

Similarly, the ICESCR states that “States Parties to the present Covenant undertake to ensure the equal right of men and

123. HRC, *General Comment No. 6*, *supra* note 113, ¶ 5 (The “protection of this right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for States parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.”).

124. *Villagrán-Morales v. Guatemala*, Inter-Am. C.H.R., (ser. C) No. 63, ¶ 144 (1999).

125. *Id.* ¶ 4.

126. ICCPR, *supra* note 108, art. 26.

women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant."¹²⁷

High incidences of maternal morbidities, including uterine prolapse, violate the right to nondiscrimination. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) Committee has clearly set out the government's positive obligation to "ensure women's right to safe motherhood and emergency obstetric services,"¹²⁸ and has instructed states to "allocate to these services the maximum extent of available resources."¹²⁹ Because only women can become pregnant, violations of the right to maternal health disproportionately affect women. Denying health protection that only women need results in inequality and discrimination.¹³⁰ The CEDAW Committee has stated that:

Measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women.¹³¹

The CESCR has further elaborated on the right to health and the principles of nondiscrimination on the basis of equal treatment by observing that women's inability to access reproductive health care is discriminatory because it deprives them of their ability to fully enjoy economic, social, and cultural rights on an equal basis with men.¹³² The HRC has noted

127. See ICESCR, *supra* note 80.

128. CEDAW, Comm. on the Elimination of Discrimination Against Women, *General Recommendation No. 24*, ¶ 27, U.N. Doc. a/54/38 (1999) [hereinafter CEDAW, *General Recommendation No. 24*], available at <http://www.un.org/womenwatch/dcw/cedaw/recommendations/recomm.htm>.

129. *Id.* ¶ 17 (stating that "[t]he duty to fulfill rights places an obligation on States Parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care. Studies such as those that emphasize the high maternal mortality and morbidity rates worldwide . . . provide an important indication for States Parties of possible breaches of their duties to ensure women's access to health care."). See also CEDAW, *opened for signature* Mar. 1, 1980, 1249 U.N.T.S. 12, art. 26 [hereinafter CEDAW].

130. CEDAW, *General Recommendation No. 24*, *supra* note 128, ¶ 11.

131. *Id.*

132. U.N. Econ. & Soc. Council, Comm. on Econ. [ECOSOC], Soc. & Cultural Rights: *Dominican Republic*, ¶ 22, U.N. Doc. E/C.12/1/Add.6 (Dec. 6, 1996), available at <http://www>

that women's equality is essential to their ability to enjoy and exercise all other rights guaranteed by the ICCPR, including the right to health.¹³³ If a State Party does not provide appropriate health services to prevent, detect, and treat uterine prolapse, it violates women's right to equality and nondiscrimination.

In addition to constituting a discriminatory barrier to women's ability to enjoy their other fundamental human rights, a government's failure to reduce the incidence of uterine prolapse violates its obligation to eliminate existing forms of discrimination against women. Studies have repeatedly found that uterine prolapse is a product of gender discrimination and can be prevented if there is a reduction in gender discrimination.¹³⁴ Under the CEDAW, States Parties bear a legal obligation to "condemn discrimination against women in all its forms, [and] agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women."¹³⁵ The CEDAW Committee also places an obligation on States Parties to "refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation."¹³⁶ Governments' obligations to eliminate discrimination in access to health care includes the responsibility to take into account the manner in which "societal factors," which can vary among women, determine health status.¹³⁷ The CEDAW Committee has noted that "special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups"¹³⁸ The following sections will discuss these obligations to eliminate discrimination as it pertains to uterine prolapse, including harmful tradi-

.unhchr.ch/tbs/doc.nsf; U.N. Econ. & Soc. Council, *Follow-up to the Consideration of Reports Under Articles 16 and 17 of the Covenant: Dominican Republic*, U.N. Doc. E/C.12/1/Add.16 (Feb. 3, 2000).

133. HRC, *General Comment No. 28*, *supra* note 115, ¶ 2.

134. See UTERINE PROLAPSE STUDY REPORT, *supra* note 6, at 15; Earth & Sthapit, *supra* note 19, at 282.

135. CEDAW, *supra* note 129, art. 2.

136. *Id.* art. 2(d).

137. CEDAW, *General Recommendation No. 24*, *supra* note 128, ¶ 6.

138. *Id.*; see also CESCR, *General Comment No. 14*, *supra* note 81, art. 12, ¶ 34 ("In particular, States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including . . . minorities, . . . to preventive, curative and palliative health services . . .").

tional practices, inequality in marriage and family relations, and marginalization of vulnerable groups such as rural women and children.

1. *Discriminatory Practices and Stereotypes*

A State Party's obligation to eliminate discrimination in access to health care includes the responsibility to take into account the manner in which "societal factors" – which can vary among women – determine health status.¹³⁹ Child marriage is one such societal factor that the national government has the legal duty to eliminate. The U.N. Special Rapporteur on Violence Against Women highlighted child marriage as a form of violence against women in part because child marriage jeopardizes girls' health and lives due to early pregnancy and childbirth.¹⁴⁰ The Committee on the Rights of the Child (CRC) has noted with concern the connection between child-forced marriage and high maternal and infant mortality rates.¹⁴¹ Additionally, stereotypes about women as procreators also fall within the "societal factors" that the State Party has the duty to eliminate. The CEDAW clearly states that "the role of women in procreation should not be a basis for discrimination."¹⁴² Also, the CEDAW guarantees women the right to control their fertility by requiring States Parties to ensure that women have "the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."¹⁴³

The high incidence of uterine prolapse in Nepal is indicative of the government's failure to address deep-rooted discriminatory practices and stereotypes in Nepal. Experts note that "[b]irth [in Nepal] is seen as a natural occurrence requiring lit-

139. CEDAW, *General Recommendation No. 24*, *supra* note 128, ¶ 6.

140. ECOSOC, Comm'n on Human Rights, *Cultural Practices in the Family that Are Violent Towards Women*, ¶ 56, U.N. Doc. E/CN.4/2002/83 (Jan. 31, 2002) (*prepared by Radhika Coomaraswamy*) ("She will have to submit to sex with an older man and her immature body must endure the dangers of repeated pregnancies and childbirth.").

141. U.N. Comm. on the Rights of the Child [CRC], *General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, ¶ 31, U.N. Doc. CRC/GC/2003/4 (July 1, 2003).

142. CEDAW, *supra* note 129, pmbl.

143. *Id.* art. 16(e).

tle special attention,"¹⁴⁴ leading to discriminatory practices including traditional post-delivery rest periods that fail to recognize the necessary healing time needed after labor.¹⁴⁵ Women are also unable to access maternal health services even where they are available, as husbands and in-laws typically make decisions about health expenditures.¹⁴⁶ Furthermore, women may not be permitted to travel alone, which requires others to be willing to accompany them before they can seek care.¹⁴⁷

Women living with uterine prolapse are further harmed by the stereotypical role of women as sources of labor. Women in Nepal "disproportionately bear the burden of rural life due to a greater workload, lower status in a rigid social hierarchy, and limited decision-making power."¹⁴⁸ There is a direct link between a woman's value and her ability to work.¹⁴⁹ Without the ability to work, a woman's place in the family structure is threatened, and she may be insulted by the community or by her mother-in-law for not working.¹⁵⁰ This situation may compound the mental and physical distress experienced by women suffering from a prolapsed uterus, especially as their condition worsens and their medical needs remain neglected.

2. *Inequality in Marriage and Family Relations*

Equality within marriage is a basic human right.¹⁵¹ Women must be able to make important decisions about marriage and pregnancy free from violence and coercion and must be able to protect themselves against major health risks.¹⁵² This right to equality within marriage is set out in the CEDAW, which says that states must "eliminate discrimination against women in all matters relating to marriage and family relations,"¹⁵³ and in the ICCPR, which obligates States Parties to take affirmative

144. Farkouh, *supra* note 7, at 34.

145. See Earth & Sthapit, *supra* note 19, at 289.

146. See *id.* at 286.

147. See *id.*

148. Farkouh, *supra* note 7, at 34.

149. Bonetti et al., *supra* note 5, at 172.

150. *Id.*

151. See UDHR, *supra* note 111, art. 16.

152. *Id.*; see also CEDAW, *supra* note 129, arts. 10-12, 16.

153. CEDAW, *supra* note 129, art. 16(1).

measures to ensure equality in marital relationships.¹⁵⁴ The CEDAW Committee has linked harmful cultural practices to women's unequal status in marriage and family relations, and in one instance has urged systematic and sustained action to eliminate female stereotypes and cultural practices against women.¹⁵⁵ The Committee has suggested several specific measures to eradicate sex-role stereotypes in the family, including promoting change using local media,¹⁵⁶ starting awareness-raising campaigns,¹⁵⁷ and implementing programs targeted at both men and women.¹⁵⁸ Uterine prolapse is significantly caused by inequality in marriage, both due to unequal division of labor and food as well as due to early marriage.¹⁵⁹ As discussed in Part II.A.2, women in Nepal bear 12 to 22% more of the workload than men, and their workload tends not to change even after they become pregnant or give

154. ICCPR, *supra* note 111, art. 23(4).

155. See CEDAW, Comm. on the Elimination of Discrimination Against Women, *Concluding Comments of the Comm. on the Elimination of Discrimination Against Women: Vanuatu*, ¶ 22-23, U.N. Doc. CEDAW/C/VUT/CO/3 (June 11, 2007).

156. See, e.g., CEDAW, Comm. on the Elimination of Discrimination Against Women, *Concluding Comments of the Comm. on the Elimination of Discrimination Against Women* (Dec. 18, 1979), available at <http://www.un.org/womenwatch/daw/cedaw/>. Since 1979, the following countries have ratified the Convention on the Elimination of All Forms of Discrimination Against Women in support of this proposition: Albania, Angola, Austria, Azerbaijan, Belarus, Bhutan, Bolivarian Republic of Venezuela, Bosnia and Herzegovina, Burkina-Faso, Burundi, Canada, Cape Verde, China, Croatia, Cuba, Czech Republic, Democratic Republic of the Congo, Dominican Republic, Estonia, Fiji, Germany, Ireland, Kazakhstan, Kenya, Luxembourg, Maldives, Nicaragua, Peru, Poland, Portugal, Republic of Moldova, Slovenia, Sri Lanka, Switzerland, Tajikistan, Turkey, Uganda, Uruguay, Uzbekistan, Vanuatu, and the former Yugoslav Republic of Macedonia (Follow links on left side of general website to locate country reports on ratification.). *Id.*

157. See, e.g., *id.* Since 1979, the following countries have ratified the Convention on the Elimination of All Forms of Discrimination Against Women in support of this proposition: Albania, Austria, Azerbaijan, Bangladesh, Barbados, Belarus, Benin, Bolivarian Republic of Venezuela, Bosnia and Herzegovina, Burkina-Faso, Cape Verde, China, Cyprus, Czech Republic, Democratic Republic of the Congo, Denmark, Eritrea, Equatorial Guinea, Ethiopia, Fiji, Gambia, Georgia, Germany, Guatemala, Hungary, Ireland, Italy, Japan, Kazakhstan, Kyrgyzstan, Lao People's Democratic Republic, Lebanon, Luxembourg, Malawi, Malaysia, Mali, Malta, Mauritius, Morocco, Namibia, The Netherlands, Norway, Peru, Philippines, Portugal, Republic of Moldova, Russian Federation, Saint Lucia, Spain, Sri Lanka, Suriname, Switzerland, Tajikistan, Thailand, Togo, Turkey, Turkmenistan, Uganda, Uruguay, Uzbekistan, Yemen, and the former Yugoslav Republic of Macedonia. *Id.*

158. See, e.g., *id.* Since 1979, the following countries have ratified the Convention on the Elimination of All Forms of Discrimination Against Women in support of this proposition: Bhutan, Brazil, Czech Republic, El Salvador, Dominican Republic, Guatemala, Ireland, Kenya, Portugal, and Turkey.

159. See discussion *supra* Part II.

birth.¹⁶⁰ Despite bearing a disproportionate share of the workload, women are often malnourished due to a gender-stratified eating hierarchy that curtails women's and girls' food consumption.¹⁶¹ As a result, one in four non-pregnant women suffer from chronic energy deficiency malnutrition, and at least 70% of pregnant women are estimated to be at risk of nutritional anemia.¹⁶²

For adolescent women, inequality in marriage may also occur as a result of their age. The CEDAW Committee has stated that the minimum age for marriage should be eighteen years of age, citing a World Health Organization report noting that "when minors, particularly girls, marry and have children, their health can be adversely affected and their education is impeded. As a result, their economic autonomy is restricted."¹⁶³ Although the legal age for marriage in Nepal is eighteen for women, in practice 42% of women have been married by age nineteen and at least 23% give birth before that age.¹⁶⁴ State Party failures to prevent child marriage, with its accompanying harms, including uterine prolapse, violate the right to equality within marriage.

3. *Vulnerable Subgroups of Women*

Women who are members of low-income and marginalized social groups are among the most vulnerable and disadvantaged. The CEDAW Committee has noted that "special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups."¹⁶⁵ Further, the CESCR has stated that States Parties must ensure "equitable distribution of all health facilities, goods and services"¹⁶⁶ and that these obligations must be met "even in times

160. See Earth & Sthapit, *supra* note 19, at 287.

161. *Id.* at 285.

162. *Id.*

163. CEDAW, Comm. on the Elimination of Discrimination Against Women, *General Recommendation No. 21*, ¶ 36 (1994).

164. UNFPA, *Nepal Key Indicators*, *supra* note 94.

165. CEDAW, *General Recommendation No. 24*, *supra* note 128, ¶ 6. See also CESCR, *General Comment No. 14*, *supra* note 81, ¶ 34 ("In particular, States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including . . . minorities, . . . to preventive, curative and palliative health services.").

166. CESCR, *General Comment No. 14*, *supra* note 81, ¶ 43(e).

of . . . resource constraints.”¹⁶⁷ Adolescent girls receive further special protections through the Convention on the Rights of the Child, established by the CRC to require States Parties to ensure adolescents’ access to comprehensive reproductive health services.¹⁶⁸ The CEDAW Committee has noted that certain groups of women have more difficulty in accessing reproductive health care, including young women,¹⁶⁹ low-income women,¹⁷⁰ and rural and marginalized women.¹⁷¹ The CRC has echoed these concerns for adolescent women living in rural areas,¹⁷² while the HRC has urged States Parties take additional measures to ensure rural and adolescent women’s access to health and education facilities.¹⁷³

IV. PRAKASH MANI SHARMA V. GOV’T OF NEPAL (2008)

The Supreme Court of Nepal’s recognition of the governmental obligation to respond to the high incidence of uterine prolapse marked the first time a legal body, national or international, has directly applied the human rights framework to uterine prolapse. The *Sharma* decision, adjudicated by Justice Kalyan Shrestha, provided a thorough analysis of uterine

167. *Id.* ¶ 18.

168. CTR. FOR REPROD. RIGHTS, THE REPRODUCTIVE RIGHTS OF ADOLESCENTS: A TOOL FOR HEALTH AND EMPOWERMENT, 5–8 (Sept. 2008), available at http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/adolescents%20bp_FINAL.pdf; Convention on the Rights of the Child, opened for signature Nov. 20, 1989, 1577 U.N.T.S. 3.

169. See, e.g., CEDAW, Comm. on the Elimination of Discrimination Against Women, *Concluding comments of the Comm. on the Elimination of Discrimination Against Women* (Dec. 18, 1979), available at <http://www.un.org/womenwatch/daw/cedaw/>. Since 1979, the following countries have ratified the Convention on the Elimination of All Forms of Discrimination Against Women in support of this proposition: Ireland, Mexico, Paraguay, Peru, Venezuela, and Zimbabwe.

170. See, e.g., *id.* Since 1979, the following countries have ratified the Convention on the Elimination of All Forms of Discrimination Against Women in support of this proposition: Bangladesh, Hungary, Mexico, Peru, and South Africa.

171. See, e.g., *id.* Since 1979, the following countries have ratified the Convention on the Elimination of Discrimination Against Women in support of this proposition: Bangladesh, Benin, Estonia, Equatorial Guinea, Lao People’s Democratic Republic, Kazakhstan, Kenya, Lithuania, Malawi, Mexico, Mongolia, Morocco, Paraguay, Peru, South Africa, Suriname, Togo, and Ukraine.

172. See, e.g., *id.* Since 1979, the following countries have ratified the Convention on the Elimination of All Forms of Discrimination Against Women in support of this proposition: Eritrea, Mali, and Tunisia.

173. See, e.g., U.N. Int’l Convention on Civil & Political Rights, Human Rights Comm., *Concluding Observations of the Human Rights Comm: Argentina*, ¶ 14, U.N. Doc. CCPR/CO/70/ARG (2000), *Ireland*, ¶¶ 27–28, U.N. Doc. A/55/40 (2000), *Ecuador*, ¶ 11, U.N. Doc. CCPR/C/79/Add.92 (1998).

prolapse as a reproductive health issue and recognized that the government of Nepal's international legal commitments obligate the state to address uterine prolapse as a human rights issue. This section will first provide an introduction to the facts and procedural posture of the case. Following that, this section will present the Court's holding and discuss the role of international law in the *Sharma* decision. Ultimately, this section will argue that the Court's analysis of the Interim Constitution's right to reproductive health was generally informed by international human rights norms on reproductive rights, particularly as a result of gaps in the domestic legislation executing the constitutionally recognized fundamental right to reproductive health.

A. Procedural and Legal Background on the Sharma Case

The *Sharma* case was brought by attorneys from the Nepalese legal organization Pro Public after receiving repeated reports of significant numbers of women suffering from uterine prolapse and unable to access treatment.¹⁷⁴ After reports on the issue were published by two other organizations in Nepal—Women's Rehabilitation Center (WOREC) and the Safe Motherhood Network Federation (SMNF)—Pro Public sent advocacy letters out to government agencies requesting a response.¹⁷⁵

Following a year of lobbying and waiting for a government response, Pro Public decided to file a public interest litigation (PIL).¹⁷⁶ PILs permit any citizen to bring a claim in the public interest, even if the citizen has not suffered the harm personally. PILs essentially allow for a relaxed standing requirement, such that a petitioner may bring a claim on behalf of a group of other individuals or even based on research findings proving violations of the rights of a vulnerable group. Based on WOREC's and SMNF's reports, Pro Public filed a PIL in the Supreme Court of Nepal claiming that the incidence of uterine prolapse violated Article 20(2) of the Interim Constitution of Nepal, which guarantees the "right to reproductive health and

174. Interview with Sarmila Shrestha, Advocate for Pro Public, Ctr. for Reprod. Rights, in N.Y., N.Y. (Feb. 3, 2010).

175. *Id.*

176. *Id.*

other reproductive rights,” as well as international human rights treaties.¹⁷⁷ In the petition, Pro Public argued that “no effective programs have been initiated by the State to redress the problem of uterus prolapse” and that “special provision should be made wherein women should be entitled to free consultation, treatment, and health services from the medical centers, sub-centers, and from health workers.”¹⁷⁸ Pro Public further requested that the Court issue an order directing the government of Nepal to draft and consider in Parliament a bill on women’s reproductive health as well as directing that public awareness programs be initiated in the media to address uterine prolapse.¹⁷⁹

In its decision, the Supreme Court held that women’s rights to reproductive health are rooted both in international human rights law as well as in the fundamental rights provisions of the Interim Constitution,¹⁸⁰ and that, under these rights, the government of Nepal has an obligation to enact laws, policies, and programs to enable citizens to exercise the fundamental right to reproductive health.¹⁸¹ The Court held that “[t]he right established as [a] fundamental right should be made consumable by the State through the formulation of necessary laws and programs. In the absence of any mechanism . . . the court may issue necessary order[s] or directive[s] to fulfill those responsibilities.”¹⁸² Noting that “no laws till [this] date [have] been enacted or implemented . . . , nor any procedure . . . prescribed for the enjoyment of this right,” the Court ordered the Prime Minister and the Office of the Council of Ministers to consult with health-related experts and stakeholders to draft a bill and submit it before the Parliament as soon as possible.¹⁸³ The Court also directed the Ministry of Women, Children & Social Welfare and the Ministry of Population & Health to “prepare special work plans and to provide free consultation,

177. *Sharma v. Nepal*, Writ No. 064 (2008) (SC) para. 1 (unofficial translation by National Judicial Academy).

178. *Id.*

179. *See id.* para. 2.

180. *Id.* para. 12 (“Right[s] of women and reproductive rights [are] matters of human rights which [have] been incorporated as . . . fundamental rights in the Interim Constitution.”).

181. *See id.* para. 28.

182. *Id.* para. 29.

183. *Sharma v. Gov’t of Nepal*, Writ No. 064 (2008) (SC) para. 53 (unofficial translation by National Judicial Academy).

treatment, health services and facilities” to women suffering from uterine prolapse, as well as “to set up various health centers and initiate effective programs with the aim of raising public awareness on problems relating to reproductive health of women and the problem of uterus prolapse.”¹⁸⁴

B. The Court's Reliance on International Law

International law is generally applied throughout the *Sharma* decision, from citation of specific treaty provisions to reference to legal principles established by international consensus documents.¹⁸⁵ The decision is remarkable in that the Court presents an understanding of human rights and constitutional rights as legal frameworks that inform and enrich each other, and works toward reconciling the two sources of law into one cohesive system to protect the human rights of Nepal's people.¹⁸⁶ This section presents an analysis of the Court's reliance on international law and argues that the Supreme Court's understanding of the role of human rights law in Nepal creates a mandate for human rights bodies to support implementation of the decision.

The centrality of human rights law in the *Sharma* decision is apparent both from the number of pages that Justice Shrestha devotes to discussion of these obligations, as well as from the placement of international legal analysis before constitutional legal analysis.¹⁸⁷ Translated into English, the decision contains at least three pages outlining the international legal framework on reproductive health generally.¹⁸⁸ The Interim Constitution provides a strong domestic framework for reproductive rights. Article 12 of the Interim Constitution guarantees that “[e]very person shall have the right to live with dignity”¹⁸⁹ Under Article 20 of the Interim Constitution, “[n]o woman shall be discriminated against in any way on the basis of gen-

184. *Id.*

185. *See id.* para. 8, 24–26.

186. *See id.*

187. *See id.*

188. *Id.* para. 22–28.

189. NEPAL (INTERIM) CONST. art. 12, § 1.

der.”¹⁹⁰ This provision echoes Article 13, which states that “[t]here shall be no discrimination against any citizen in the application of general laws on grounds of . . . gender,” and that “[t]he State shall not discriminate among citizens on grounds of . . . gender”¹⁹¹ The Article 20 nondiscrimination provision, however, explicitly states in subsection 2 that “[e]very woman shall have the right to reproductive health and other reproductive rights.”¹⁹² The Interim Constitution also contains a broader guarantee for women and men to have access to basic health care in Article 16.¹⁹³ Despite this framework, however, reference to international law has proved instrumental in adjudicating reproductive rights cases, as demonstrated in the *Sharma* decision.¹⁹⁴ Justice Shrestha’s opinion provided at least three grounds for citing international law: international law, domestic Nepali law, and principles of legal interpretation.¹⁹⁵

First, the Court held that the government of Nepal should execute treaty obligations pursuant to international law.¹⁹⁶ The Court noted two reasons for this decision, including Nepal becoming a party to human rights documents such as the UDHR, the CEDAW, the ICCPR, the ICESCR, and the CRC, and Nepal’s participation in international assemblies such as the Teheran International Conference on Human Rights, Beijing Fourth World Conference on Women, and the Cairo International Conference on Population and Development (ICPD).¹⁹⁷ Both of Nepal’s actions “formally expressed its commitment towards those instruments, . . . [T]he Member State should exercise its capacity to the maximum and should

190. NEPAL (INTERIM) CONST. art. 20, § 1. English translations of Article 20(1) vary, with another translation stating that “no one shall be discriminated in any form merely for being a woman.”

191. NEPAL (INTERIM) CONST. art. 13, § 2-3. English translations of Article 13 vary, with some translations using the word “gender” and others using “sex.”

192. NEPAL (INTERIM) CONST. art. 20, § 2. English translations of Article 20(2) vary, with some translations stating that the text sets forth a “right to reproductive health and other reproductive rights” and others interpreting the text as saying there is a “right to reproductive health and other rights relating to reproduction.” A third translation is that Article 20(2) articulates a “right to reproductive health and other reproductive matters.”

193. NEPAL (INTERIM) CONST. art. 16, § 2.

194. See *Sharma v. Nepal*, Writ No. 064.

195. See *id.* paras. 24-26

196. *Id.* paras. 25-26.

197. *Id.* paras. 24-25.

prepare an infrastructure for the universal protection of human rights."¹⁹⁸

Second, pursuant to Section 9(1) of the Nepal Treaty Act, which states that treaties that Nepal has ratified, acceded to, approved, or accepted should be treated as law and that contradictory domestic laws should be held invalid,¹⁹⁹ Nepalese courts "have without any bias accepted and recognized the contribution made by international laws and tried to maintain coordination between the international and national law."²⁰⁰ Specifically, Justice Shrestha noted that "[i]n many instances, the Court has issued directive orders to formulate laws pursuant to those treaties."²⁰¹ Similarly, Justice Shrestha held that reference to international law is appropriate under "Article 35(21) of our Constitution, which expresses its allegiance to the Charter of the United Nations."²⁰² The Court's ruling directly contradicted arguments made by the Prime Minister and the Office of the Council of Ministers claiming that *locus standi* does not arise on the basis of international treaties.²⁰³

Finally, the *Sharma* opinion put forth a third reason for referencing international human rights law—to ensure that the human rights of the Nepali people are truly protected.²⁰⁴ Justice Shrestha stated:

[W]here such treaties are executed on a national level, we would not only be exercising our international responsibilities, but on the other hand we, pursuant to the direction provided by the international law relating to human rights, would be protecting the human rights of the people.²⁰⁵

The decision explained that "it is evident that adherence to the contemporary international laws is not only obligatory but also fruitful."²⁰⁶ The Court's statements reflect that even after

198. *Id.* para. 25.

199. Nepal Treaty Act, Act No. 16 of 2047, § 9(1) (Nov. 11, 1990), available at <http://www.unhcr.org/refworld/docid/3ae6b51724.html>.

200. *Sharma v. Nepal*, Writ No. 064 at para. 26.

201. *Id.*

202. *Id.* para. 25.

203. *Id.* para. 6.

204. *Id.* para. 25.

205. *Id.*

206. *Id.* at para. 25.

putting aside the enforceability of treaty obligations, international human rights principles reflect the consensus of the global community and can play a useful role in interpreting domestic rights.²⁰⁷

C. Post-Sharma: Status of Implementation of the Court's Orders

The *Sharma* decision was the basis for a few broad-scale maternal health initiatives in Nepal that potentially address several root causes of uterine prolapse; however, these initiatives ultimately fail to prevent the government of Nepal from taking retrogressive programmatic measures which re-expose Nepali women to the harms of uterine prolapse. The case's legal mandate, which includes focusing on the need for providing effective interventions for the prevention, detection, and treatment of uterine prolapse specifically, has yet to be fully implemented.

Government officials understood the case as a general critique of the maternal health system, but not as a call to action on the specific issue of uterine prolapse. Reflecting the Nepalese government's perception, the Ministry of Women, Children and Social Welfare described the *Sharma* case as:

[O]ne of the landmarks where the SC [(Supreme Court)] has issued [a] writ of mandamus to MoHP [(Ministry of Health & Population)] for the enactment of laws regarding women's reproductive health and reproductive right[s] including special measures as guaranteed by Article 20(2) of the Interim Constitution. The SC also issued an order for the essential treatment for the reproductive health related diseases. Moreover, it has issued a directive order for the formation of [an] 'Experts Committee'²⁰⁸

The Ministry neither mentions uterine prolapse as the focus of the case nor discusses the Court's specific direction to the government to "provide free consultation, treatment, health services and facilities to the aggrieved women and to set up various health centers and to initiate effective programs with

207. *Id.*

208. CEDAW, Gov't of Nepal Ministry of Women, Children & Soc. Welfare, *Fourth and Fifth Periodic Reports*, ¶ 155, U.N. Doc. CEDAW.C.NPL.4-5 (July 2009), available at <http://www2.ohchr.org/english/bodies/cedaw/docs/AdvanceVersions/CEDAW.C.NPL.4-5.pdf>.

the aim of raising public awareness on problems relating to reproductive health of women and *the problem of uterine prolapse*.”²⁰⁹

Consistent with the Ministry’s case interpretation, the Nepalese government’s actions implementing the case generally focused on improving maternal health care. One lawyer involved in the case stated that following the decision, the Ministry of Health & Population began working with the Safe Motherhood Network Federation, which authored one of the reports on uterine prolapse that served as the basis for the PIL. Together, the two entities drafted a Safe Motherhood and Newborn Health Bill, which, if passed, will provide legislation executing the constitutional right to reproductive health.²¹⁰ Following the decision, the government introduced a new maternal health incentive scheme, which is aimed at providing financial assistance covering food and delivery costs for pregnant women who deliver in health institutions.²¹¹

The reformation of the maternal health system did not include programs and policies designed to specifically address uterine prolapse. After the *Sharma* decision, instead of either increasing budget allocations for treatment of uterine prolapse or adding more comprehensive programming to address the complex societal and medical causes of the condition, the legislature slashed the treatment budget for uterine prolapse by one-third. This reduction came after the Court criticized the previous budget allotment as insufficient.²¹² Prior to the Court’s order in the case, the government of Nepal made budget allocations for the Fiscal Year 2008–2009 providing for surgical treatment to 12,000 women with uterine prolapse through twenty-five mobile surgery camps set up through donations by the UNFPA, the World Bank, and other donors.²¹³

209. *Sharma v. Nepal*, Writ No. 064 at para. 53.

210. Interview with Sarmila Shrestha, Advocate for Pro Public, Ctr. for Reprod. Rights, in N.Y., N.Y. (Feb. 17, 2010).

211. *Id.*

212. *Sharma v. Nepal*, Writ No. 064 at para. 44.

213. CEDAW, Gov’t of Nepal Ministry of Women, Children & Soc. Welfare, *Fourth and Fifth Periodic Reports*, ¶ 154, U.N. Doc. CEDAW.C.NPL.4-5 (July 2009), available at <http://www2.ohchr.org/english/bodies/cedaw/docs/AdvanceVersions/CEDAW.C.NPL.4-5.pdf>; Farkouh, *supra* note 7, at 35; see also *Sharma v. Nepal*, Writ No. 064 at para. 6.

The Court found that although these budget allocations had been made, “the execution is yet to be seen.”²¹⁴

In January 2010, instead of maintaining or increasing this target, the government of Nepal set a target of providing surgeries to only 8,000 women.²¹⁵ The government stated that the surgical targets were reduced due to pressure by Regional Health Directorates to raise the average per patient cost of each operation by 4,000 rupees (Rs.), from Rs. 8,333 to Rs. 13,333.²¹⁶ While the allocation for the uterine prolapse program remained the same, the total number of surgeries able to be provided was reduced by 4,000 women.²¹⁷ Although the surgeries are now priced at Rs. 4,000 more than during the previous year, the government also reduced the travel allocation given to women who are seeking treatment.²¹⁸ Women who travel to mobile health camps now only receive half of what they were allocated in Fiscal Year 2008–2009—a reduction from Rs 3,000 to Rs. 1,500 for women in the mountains, Rs. 2,000 to Rs. 1,000 for women in the hills, and Rs. 1,000 to Rs. 500 for women in the Terai.²¹⁹

In the absence of a comprehensive program to prevent and treat uterine prolapse, the steps taken by the government to address uterine prolapse languish behind broader maternal health initiatives that have the potential to reduce the incidence of uterine prolapse, but are inadequate, as they fail to include supplies and services specific to uterine prolapse, such as pessary rings or instruction on performing pelvic floor strengthening exercises. Even putting aside the reduction in the budget, the government’s very focus on surgical camps—rather than prevention, detection, and treatment of early-stage prolapse—was criticized by activists as indicating that maternal morbidity initiatives are being prioritized below maternal mortality reduction programs, which focus on preventing maternal deaths generally. Because uterine prolapse surgeries may prevent maternal mortality, they are disproportionately funded relative to other interventions that may actually pre-

214. Sharma v. Nepal, Writ No. 064 at para. 42.

215. Rai, *supra* note 3.

216. *Id.*

217. *Id.*

218. *Id.*

219. *Id.*

vent women from experiencing uterine prolapse or prevent their prolapse from progressing to more serious stages.²²⁰ One activist stated:

While this program indicates that the Nepalese government acknowledges the widespread nature and urgency of uterine prolapse, Nepal's government still has not finalized a uterine prolapse-specific policy or program. In contrast to the number of programs addressing mortality, there is no comprehensive government plan in place to address [uterine prolapse] and no staff at the Health Ministry devoted to the issue.²²¹

Further, by only providing for surgical interventions, the government of Nepal's program fails to treat women who have early-stage uterine prolapse or to prevent their early-stage prolapse from turning into later-stage prolapse.²²² Women with early-stage prolapse can be treated without surgery, meaning that their treatment is less painful and less expensive, and can also reduce the risk that women will ever experience the trauma of later stages.²²³ At least one uterine prolapse activist has stated that the focus on surgeries is an outgrowth of disproportionate focus by donors on preventing maternal mortality over maternal morbidity:

UNFPA, the World Bank, and other donors have provided funding to run mobile surgery camps across the country. However, little attention is being paid to early-stage treatment or prevention. Given the international focus on mortality-reduction and inadequate funds for addressing maternal health, it is not surprising that international agencies prioritize the most severe manifestations of UP.²²⁴

So long as the decision is seen as only requiring broad interventions on maternal mortality and reproductive health, rather than specific measures to address uterine prolapse itself, the legal mandate of the *Sharma* decision will remain unfulfilled. Uterine prolapse needs to be recognized by the gov-

220. Farkouh, *supra* note 7, at 35.

221. *Id.*

222. *Id.*

223. *Id.*

224. *Id.*

ernment of Nepal as a form of morbidity that requires prevention, not merely because it may result in maternal death, but because it deprives women of their ability to enjoy several of their fundamental rights.

V. ADDRESSING UTERINE PROLAPSE IN NEPAL: A MANDATE FOR HUMAN RIGHTS BODIES

Implementation of the *Sharma* decision has thus been unevenly focused on maternal health interventions generally, without focus on uterine prolapse specifically. This section will present two key mandates for human rights bodies when advocating for implementation of the *Sharma* decision. First, this section will argue that the Court's conception of the relationship between human rights and constitutional rights indicates a receptivity to reference human rights standards when articulating the programs and policies the government is constitutionally obligated to undertake. Through an analysis of the relationship between international and domestic law in the *Sharma* decision, this section will argue that the precedent established in this case provides human rights bodies with a unique opening to inform the understanding of reproductive rights in Nepal. Second, drawing from the earlier discussion establishing the human rights standards relating to uterine prolapse, this section will argue that human rights bodies have the substantive expertise to address the disconnect between the steps towards implementation taken by the government of Nepal and the order that the Court actually issued in the case. Through an analysis of uterine prolapse under the standards established by human rights bodies concerning maternal morbidity, this section discusses the scope of the government's obligation in addressing uterine prolapse and the urgent need to take action.

A. *Significance of the Court's Reliance on International Human Rights Law in the Sharma Decision*

Consistent with Justice Shrestha's understanding of constitutional and international law as reconcilable frameworks, the Court's interpretation of the Interim Constitution's Article 20(2) right to reproductive health adopts internationally recognized definitions of "reproductive health." Prior to consid-

ering the claim made by petitioners, the Court sought to undertake a general analysis of uterine prolapse “with regards to the nature of the right to reproductive health and its execution.”²²⁵ The Court notes repeatedly in the decision that although Article 20(2) of the Interim Constitution frames “the right to reproductive health and other reproductive matters” as a fundamental, self-executing right, the right still “awaits sufficient legal provisions for its effective execution.”²²⁶ In the absence of broader guidance from the national level, the Court turned to international human rights law and consensus documents to conclude that “it is necessary to entertain [uterine prolapse] as a matter of constitutional and legal right.”²²⁷ The following section unpacks the Court’s references to international sources of law and norms in relation to uterine prolapse.

In understanding what the phrase “reproductive health” entails, the Court specifically cited to several international treaties and consensus documents. The Court began by discussing the meaning of the “right to health” generally, recognizing that the UDHR and the ICESCR guarantee the right to health and the right to the highest attainable standard of physical and mental health, respectively.²²⁸ The Court noted that the ICESCR obligates States to “take steps” towards the reduction of the stillbirth rate, infant mortality, and for the healthy development of the child.²²⁹ The Court further recognized that under the Convention on the Elimination of All Forms of Discrimination Against Women, women have the right to access to information on health under Article 10.²³⁰ Further, under the CEDAW Article 12, States must ensure that women are not discriminated against in the field of health care and are able to access appropriate services in connection with pregnancy and the post-natal period, as well as free services where necessary and adequate nutrition during pregnancy and lactation.²³¹ The Court cited the definition of reproductive health adopted by

225. Prakash Mani Sharma v. Gov’t of Nepal, Writ No. 064 (2008) (SC) para. 13 (unofficial translation by National Judicial Academy).

226. *Id.* para. 28.

227. *Id.* para. 20.

228. *Id.* para. 17.

229. *Id.*

230. *Id.*; CEDAW, *supra* note 129, art. 10.

231. Sharma v. Nepal, Writ No. 064; CEDAW, *supra* note 129, art. 12.

the ICPD, which states that reproductive health requires freedom for women to decide health matters for themselves, with the freedom to decide the “number, spacing, and timing of their children, access to information regarding family planning, right to access health-care services, and privacy of information.”²³² The Court stated that under the ICPD, consideration must be given to “consultation on family planning, information, education, communication, education on pre-natal pregnancy, safe maternity services, post-natal services, breastfeeding, care of mother and child and safe and valid abortion.”²³³ The Court held that obstacles in achieving the standards established in international law “create[] an impact on reproductive health and subsequently on the health of the woman.”²³⁴

Significantly, the Court also adopted the broader conceptual framework of reproductive rights recognized in human rights law. The Court stated that although the right to reproductive health in Nepal has been termed as a matter of health, reproductive health has been understood more generally as being “linked with the right to life[,] right to freedom, right to equality, right against torture, right to privacy and right to social justice and right[s] of woman.”²³⁵ The Court drew from the ICPD definition to state that under Article 20(2), the absence of proper protection for the far-reaching problem of uterine prolapse violates the right to reproductive health.²³⁶ Specifically, the Court supported this statement by establishing that:

[s]ince reproductive health is recognized as a matter of right, the following falls within the ambit of the right: decision regarding reproduction, voluntary marriage, decision as to conceive or not, decision to abort a child pursuant to law . . . determination of number of children, reproductive education, and freedom from sexual violence which have also been prescribed in various treaties and declarations.²³⁷

232. Sharma v. Nepal, Writ No. 064 at para. 18.

233. *Id.*

234. *Id.* para. 19.

235. *Id.* para. 23.

236. *Id.* para. 50.

237. *Id.*

B. Drawing from the Existing Human Rights Framework To Identify Specific Interventions Governments Must Implement To Address Uterine Prolapse

International human rights bodies can play a second key role in the implementation of the *Sharma* decision, which is to shape the government's understanding of the need to address uterine prolapse as an issue of maternal morbidity, and not simply under the existing maternal mortality framework in place. As discussed in Part IV.C. above, a significant barrier to the implementation of the Court's order is that the case has been misapplied locally as standing for the need to reform the maternal health system generally, without any particular initiatives to address uterine prolapse specifically. By applying the standards and guarantees recognized in international human rights law to uterine prolapse specifically, human rights bodies can provide the government of Nepal with guidance on the nature and scope of measures that are required to address the incidence of uterine prolapse within a maternal health framework. Human rights bodies can play a key role in ensuring implementation of the *Sharma* decision by drawing from the human rights standards and guarantees on maternal morbidity to encourage the government to understand uterine prolapse as a specific health crisis requiring tailored interventions within the maternal health framework. When applied specifically to uterine prolapse, this framework provides significant guidance on the scope and nature of the interventions the government of Nepal must undertake to prevent violations of women's rights as a result of uterine prolapse.

One clear example can be seen by examining the standards established by human rights bodies related to the right to health.²³⁸ Under the availability, accessibility, acceptability, and quality framework promulgated under the right to health,²³⁹ for example, government interventions to address uterine prolapse would need to ensure that rural, poor, and/or young women are able to access medical services to prevent, detect, and treat uterine prolapse, including education on how to reduce the risk of uterine prolapse, how to recognize uterine prolapse, and where to go to receive services.

238. See discussion *supra* Part III.A.

239. *Id.*

The government would need to ensure that such services, including follow-up care, are affordable, and that efforts are made to de-stigmatize the condition so women will come forward if they exhibit the symptoms of uterine prolapse. To fulfill the obligation under the right to health to preserve maternal health,²⁴⁰ government interventions should address prevention of uterine prolapse and treatment of early-stage prolapse, not simply surgically-treatable prolapse. The freedoms and entitlements guaranteed under the right to health offer a strong legal basis for preventing uterine prolapse in Nepal by ensuring proper obstetric care and delivery services, increasing the ability to determine the number and spacing of children through family planning education and services, and reducing unsafe abortion, early pregnancy, and malnutrition. Finally, the government must refrain from retrogressive measures in all instances, as uterine prolapse falls under the core obligation of States Parties to further maternal health.

A similar example of human rights standards that might serve to guide Nepal relate to the right to equality and nondiscrimination. Under this right, States Parties are required to address sources of discrimination against women, including traditional practices, stereotypes about the role of women, and inequality in marriage. Complying with these standards entails addressing many of the root causes of uterine prolapse, including harmful stereotypes about the role of women in farm and household labor, traditional practices such as child marriage and inadequate rest periods before and after delivery, and inequitable relations in marriage leading to disproportionate distributions of labor, powerlessness to seek medical care, and inability to control fertility. Complying with these standards also entails state action in reducing stigma against women, including preventing women who suffer from uterine prolapse from experiencing ostracism and stigma by providing prompt and effective services to detect and treat uterine prolapse as early as possible, and by raising community awareness of the condition as a result of gender inequality.

240. CESCR, *General Comment No. 14*, *supra* note 81, ¶ 14.

C. Mandate for Human Rights Bodies To Address Uterine Prolapse

The decision promulgated by the Court itself recognized the binding nature of human rights obligations, as well as the useful role that the statements made by human rights bodies and consensus meetings can play in illuminating the scope and nature of constitutional obligations. The Supreme Court recognized the interconnected nature of international and constitutional obligations and provided a strong mandate for human rights bodies to continue to elaborate on reproductive rights. First, as discussed above, the Court indicated the significance of human rights norms through its reliance on treaties and consensus documents to interpret constitutional provisions. The Court viewed the government of Nepal as accountable for violations of women's reproductive rights as a result of insufficient policies and programs to address uterine prolapse. Under international law, human rights treaty obligations "may receive enhanced protection" in States where a treaty is incorporated into the domestic legal order.²⁴¹ In Nepal, where the Treaty Act directly incorporates human rights treaty obligations into domestic law, and in fact places it higher on the legal hierarchy than domestic law, there is a need for enhanced protection of human rights. The *Sharma* decision provides international human rights bodies with an important opportunity to promote human rights protection at the national level.

Second, human rights bodies have a mandate to express concern and urge implementation of court orders where enforcement would further the State Party's obligation to respect, protect, and fulfill human rights. Human rights bodies are explicitly mandated to "monitor State[s] Parties' compliance with their treaty obligations."²⁴² Human rights bodies have repeatedly expressed concern where States Parties have failed to implement court orders that further human rights,²⁴³

241. See, e.g., HRC, *General Comment No. 31 [80] Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, ¶ 13, U.N. Doc. CCPR/C/21/Rev.1/ Add.13 (May 26, 2004).

242. U.N. Human Rights, Office of the High Comm'r for Human Rights Bodies [OHCHR], <http://www.ohchr.org/EN/HRbodies/Pages/HumanRightsBodies.aspx> (last visited Mar. 10, 2010).

243. See U.N. Comm. on the Elimination of Racial Discrimination [CERD], *Consideration of Reports Submitted by States Parties Under Article 9 of the Convention: Concluding Observations of the Committee on the Elimination of Racial Discrimination: Colombia*, ¶ 16, U.N. Doc. CERD/C/COL/CO/14 (Aug. 28, 2009).

and urged States Parties to take measures to ensure implementation²⁴⁴ or to “accelerate [the] search for an appropriate solution to the implementation” of constitutional court decisions.²⁴⁵ For example, the Human Rights Committee expressed concern where the government of India failed to implement court orders for habeas corpus, and issued several concrete recommendations including welcoming investigatory action by the National Human Rights Commission, “early enactment of legislation,” and human rights trainings for law enforcement officials.²⁴⁶ The HRC has also repeatedly requested that States Parties report on implementation of court decisions.²⁴⁷ For example, in 2006, the HRC noted that although it welcomes the Supreme Court of the United States’ decision in *Hamdan v. Rumsfeld*²⁴⁸ on treatment of Guantanamo Bay detainees, the decision remains to be implemented and stated that “[t]he State [P]arty should provide the Committee with information on its implementation of the decision.”²⁴⁹

In at least one case, treaty-monitoring bodies have specifically encouraged a State Party to ensure access to reproductive health services as ordered by a national constitutional court where violations of women’s reproductive health continued to

244. See, e.g., U.N. Doc. E/C.12/MEX/CO/4 (June 9, 2006); HRC, *Concluding Observations of the Human Rights Committee: Suriname*, ¶ 25, U.N. Doc. CCPR/C/BIH/CO/1 (Nov. 22, 2006); CRC, Comm. on the Rights of the Child, *Consideration of Reports Submitted by States Parties Under Article 44 of the Convention: Concluding Observations: Estonia*, ¶¶ 34–35, U.N. Doc. CRC/C/15/Add.196 (Mar. 17, 2003); U.N. Int’l Convention on the Elimination of All Forms of Racial Discrimination [CERD], Comm. on the Elimination of Racial Discrimination, *Consideration of Reports Submitted by States Parties Under Article 9 of the Convention: Concluding Observations of the Committee on the Elimination of Racial Discrimination: Russian Federation*, ¶ 20, U.N. Doc. CERD/C/304/Add.5 (Mar. 28, 1996); CEDAW, Comm. on the Elimination of Discrimination Against Women, *Concluding Comments of the Committee on the Elimination of Discrimination Against Women: Pakistan*, ¶¶ 24–25, U.N. Doc. CEDAW/C/PAK/CO/3 (June 11, 2007).

245. CERD, Comm. on the Elimination of Racial Discrimination, *Consideration of Reports Submitted by States Parties Under Article 9 of the Convention: Concluding Observations of the Committee on the Elimination of Racial Discrimination: Austria*, ¶ 14, U.N. Doc. CERD/C/AUT/CO/17 (Aug. 21, 2008).

246. Int’l Covenant on Civil & Pol. Rights, HRC, *Concluding Observations of the Human Rights Committee: India*, ¶ 23, U.N. Doc. CCPR/C/79/Add.81 (Aug. 4, 1997).

247. See CERD, Comm. on the Elimination of Racial Discrimination, *Consideration of Reports Submitted by States Parties Under Article 9 of the Convention: Concluding Observations of the Committee on the Elimination of Racial Discrimination: Austria*, ¶ 14, U.N. Doc. CERD/C/AUT/CO/17 (Aug. 21, 2008).

248. 548 U.S. 557 (2006).

249. Int’l Covenant on Civil & Pol. Rights, HRC, *Consideration of Reports Submitted by States Parties under Article 40 of the Covenant: Concluding Observations of the Human Rights Committee: the United States of America*, ¶ 20, U.N. Doc. CCPR/C/USA/CO/3/Rev.1 (Dec.18, 2006).

occur even following a favorable decision. In its Concluding Observation to Colombia, the CRC stated that:

The Committee takes note of the ruling by the Constitutional Court on 10 May 2006 to liberalize the criminalization of abortion in certain cases, which is likely to lower the maternal mortality rates among adolescent girls. Nevertheless, the Committee is seriously concerned over the high and increasing rate of teenage pregnancies and at the lack of adequate and accessible sexual and reproductive health services, also due to inadequate allocation of resources in these sectors.²⁵⁰

The CRC continued on to state that “[g]iven the ruling of the Constitutional Court on 11 May 2006 to allow abortions in certain cases, the Committee encourages the State party to ensure that safe medical facilities are available for such instances.”²⁵¹

VI. CONCLUSION: OPPORTUNITIES FOR HUMAN RIGHTS BODIES

The need to take steps to ensure the implementation of the *Sharma* decision is quite clear given not only the government of Nepal’s inadequate efforts to reduce the incidence of uterine prolapse, but also due to the retrogressive measures taken despite the lack of success of existing interventions. The interventions that human rights bodies can take to further implementation are numerous. Three key interventions that might be particularly useful in this case, however, are: (1) calls for implementation of the decision in concluding observations to Nepal, such as the observations that the CEDAW Committee is scheduled to issue to Nepal in 2011; (2) inclusion of maternal morbidity generally and uterine prolapse specifically in the upcoming meeting of the Committee on Economic, Social, and Cultural Rights resolution on sexual and reproductive health; and (3) inclusion of a discussion and recommendations on uterine prolapse and maternal morbidity in the Human Rights Council study report following up on its resolution, *Preventable Maternal Mortality and Morbidity and Human Rights*.²⁵²

250. CRC, *Consideration of Reports Submitted by States Parties Under Article 44 of the Convention: Concluding Observations: Colombia*, ¶ 70, U.N. Doc. CRC/C/COL/CO/3 (June 8, 2006).

251. *Id.* ¶ 71.

252. HRC, Res. 11/8, ¶ 6-7, U.N. Doc. A/HRC/RES/11/8 (June 17, 2009), available at http://ap.ohchr.org/documents/E/HRC/resolutions/A_HRC_RES_11_8.pdf.

Concluding observations issued by the CEDAW Committee could express concern about the high incidence of uterine prolapse, particularly among young women in Nepal, and call for the implementation of the *Sharma* decision explicitly, as well as criticize the retrogressive measures taken with impunity by the government of Nepal. The CEDAW Committee should further call for the government to address the causes of uterine prolapse, by directing the government to implement laws prohibiting marital rape and child marriage, and by providing family planning and safe abortion services.

The CESCR is currently drafting a resolution on sexual and reproductive health. It should articulate the obligation of States Parties to prevent, detect, and treat uterine prolapse by directing States Parties to provide services aimed at reducing the incidence of maternal morbidity, as well as maternal mortality. This resolution should clearly articulate the need to address prevalent forms of maternal morbidity with specific interventions. By recognizing that the right to health entails that women receive post-natal care, information on possible signs of morbidity, and supplies such as pessary rings that prevent the escalation of the condition, the CESCR resolution should provide States Parties with guidelines on how to fulfill their obligation to prevent, detect, and treat maternal morbidity.

Finally, the HRC Resolution on maternal mortality and morbidity includes a request for

the Office of the United Nations High Commissioner for Human Rights to prepare a thematic study on preventable maternal mortality and morbidity and human rights, in consultation with States, the World Health Organization, the United Nations Population Fund, the United Nations Children's Fund, the World Bank and all other relevant stakeholders, and requests that the study include identification of the human rights dimensions of preventable maternal mortality and morbidity in the existing international legal framework.²⁵³

The HRC, along with these relevant actors, should include a focus on the obligation of States Parties to specifically address forms of maternal morbidity, in addition to generally strengthening access to maternal health. The study report

253. *Id.* ¶ 6.

should also discuss the obligation of donors to focus on maternal morbidity, as well as mortality, with an understanding that disproportionate focus on mortality or morbidity may result in a skewing of services that leaves women without essential health care services.

By continuing to strengthen the awareness surrounding uterine prolapse as a condition that governments are legally obligated to address, human rights bodies can play a significant role in developing the impetus for implementation of the *Sharma* decision. The mandate for human rights bodies, including treaty monitoring bodies and the Human Rights Council, to play a role in realizing the Court's orders is clear from both human rights bodies' own duty to monitor implementation of human rights obligations, as well as from the Court's reference to and understanding of norms articulated by human rights bodies in its own decision. Importantly, human rights bodies have an opportunity to draw from the domestic application of rights to influence the global understanding of uterine prolapse as a human rights issue.