PROMOTION OF THE AVAILABILITY AND ACCESSIBILITY OF MISOPROSTOL UNDER THE CEDAW:
POSTPARTUM HAEMORRHAGE AMONG THE RURAL WOMEN OF THE KYRGYZ REPUBLIC

by

Gulnaz Naamatova

Supervisor: Professor Rebecca J. Cook

A thesis submitted in conformity with the requirements
for the degree of LL.M.
Graduate of School of Law
University of Toronto

© Copyright by Gulnaz Naamatova (2011)
Promotion of the availability and accessibility of misoprostol under the CEDAW:

Postpartum haemorrhage among the rural women of the Kyrgyz Republic

Gulnaz Naamatova

LL.M., 2011

Faculty of Law, University of Toronto

Maternal mortality in Kyrgyzstan is a discrimination of women not only based on sex, but also on rural/urban setting. Rural women are most likely to die of haemorrhage than urban women in Kyrgyzstan. Postpartum haemorrhage constitutes 45 per cent of all maternal deaths in Kyrgyzstan. This work concentrates on the obligations of Kyrgyzstan under articles 12 and 14.b of the Convention on Elimination of all Forms of Discrimination against Women (CEDAW). The work analyses the nature and scope of state obligations under respective articles. Kyrgyzstan has obligations to respect, protect and fulfill rural women’s human rights to address discriminations against rural women, provide appropriate health services and ensure availability and accessibility of misoprostol to rural women. Misoprostol is more suitable to the conditions of rural area than traditionally used oxytocin. Therefore, the availability and accessibility of rural women to misoprostol will prevent avoidable maternal deaths in haemorrhage.

Key words: CEDAW, articles 12 (Health) and 14 (rural women), postpartum haemorrhage, Misoprostol, Kyrgyz Republic
Devoted to all women in Kyrgyzstan,

who died in pregnancy and childbirth,

among whom was my aunt.
Acknowledgement

I appreciate the International Reproductive and Sexual Health Law Program at University of Toronto for making it possible for me to enroll in this program and develop my expertise in the field of reproductive and sexual health law. I deeply thank Professor Rebecca Cook for always challenging me with the purpose of my growth. I thank Joanna Erdman for becoming my shining example. I also want to thank my life mentor, Professor Isabel Marcus, for helping me to find my passion and constant guidance. Finally, I want to thank my family for believing in me and supporting me.

Sincerely, Gulnaz
PROMOTION OF AVAILABILITY AND ACCESSIBILITY OF MISOPROSTOL UNDER THE CEDAW: POSTPARTUM HAEMORRHAGE AMONG THE RURAL WOMEN OF THE KYRGYZ REPUBLIC:

CONTENT

INTRODUCTION.................................................................................................................. 1

I. ISSUE
   A. Postpartum haemorrhage in Kyrgyzstan ................................................................. 5
   B. Misoprostol ............................................................................................................. 11
   C. Misoprostol in Kyrgyzstan ..................................................................................... 17

II. Situating the Issue under the CEDAW ................................................................. 20

III. THE OBLIGATION OF KYRGYZSTAN UNDER CEDAW

   1. Scope of the obligations of Kyrgyzstan under Articles 12 and 14 (b) with regards to maternal mortality

      A. Health care ........................................................................................................ 26
      B. Access to health care ......................................................................................... 31
      C. “Appropriate services” and “Adequate health care facilities” .......................... 34
      D. Eliminate discrimination .................................................................................... 37
      E. Equality ............................................................................................................. 39
      F. Particular problems of rural women ..................................................................... 41
      G. All appropriate measures .................................................................................. 44

   2. Implementation of the obligations

      A. Obligation to respect .......................................................................................... 46
      B. Obligation to protect ......................................................................................... 48
      C. Obligation to fulfill ......................................................................................... 49

CONCLUSION ........................................................................................................... 51

BIBLIOGRAPHY ...................................................................................................... 53
INTRODUCTION

The Kyrgyz Republic has an obligation to respect, protect and fulfill rural women’s human rights to adequate health care that ensures safe childbirth and pregnancy by making misoprostol available and accessible to rural women for the prevention and treatment of postpartum haemorrhage.

Kyrgyzstan is a small country of 5 million people in Central Asia, struggling for its democratic formation, the development of its market economy and the observance of human rights after the Soviet Union’s collapse. In April of 2010 Kyrgyzstan went through a political revolution, as a result of which 87 people died and more than 300 were wounded. The death of these people became the cause of national mourning. Since then the 7th of April has become a national holiday.

However, the people of Kyrgyzstan forget other regular deaths of women caused by pregnancy and childbirth. A joint report of the WHO, UNFPA, and the World Bank\(^1\) revealed that in 2008, 98 women died due to pregnancy and childbirth. Due to a number of unrevealed mortalities, and the rise of maternal deaths in the last few years, the real number of women died could be over hundred. Moreover, it is revealed that for every woman who died in pregnancy and childbirth, another 30 suffered injury, infection and disability. This means that each year in Kyrgyzstan there are over 100 deaths and more than 300 wounded women. 75% of these women are women from rural areas.

---

These deaths of women are silent deaths. No one remembers them on a national level. No national day of mourning has been declared. The state has disregarded them, letting rural women silently die and suffer. Maternal deaths are an issue of rural women’s human rights. Rural women are discriminated against throughout their life-cycle, including in the health care field, and therefore their rights to life and health are violated.

Maternal mortality is fully avoidable with cost-effective interventions such as appropriate and timely health care services and medicines. Therefore it is not entirely an issue of development. “There is no country that is so poor that it cannot do something to improve the reproductive health of its people.” The revolutionary “Green Book” on reproductive health and human rights by Cook, Dickens, and Fathalla, reveals the truth that “society grants the health care system the “legitimacy” to function and the resources to operate. In this ‘social contract’, society expects a return.”

Maternal deaths do not only constitute a violation of women’s human rights to life and health. They are also a violation of the human right to non-discrimination. Rural women continue to die because they are discriminated against in both public and private arenas. Women face discrimination in the health care sector, too. Excessive bleeding is the main cause of maternal deaths in Kyrgyzstan. It is fully possible to prevent and treat excessive bleeding in childbirth with cheap medicines available in the market. However, rural women cannot receive such medicines within their village medical unit (rural health post), because nurses working at such medical units are not legally able to provide such medicines to women. Therefore, women die on the way to city hospitals. Failure to ensure the availability and accessibility of life saving

---

2 Maternal mortality is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. (World Health Organization, Trends in Maternal Mortality: 1990 to 2008 Estimates developed by WHO, UNICEF, UNFPA and The World Bank (WHO: 2010), at 4).
4 Ibid., at 34.
services and medicine to women of rural villages constitutes discrimination against rural women in the health care field.

Kyrgyzstan ratified the Convention on Elimination of All Forms of Discrimination against Women\textsuperscript{5} (hereinafter “CEDAW”) on February 10, 1997, and, thus, it is fully obliged to respect, protect and fulfil women’s human right stipulated under the CEDAW. Maternal mortality within a State party is both an indication and effect of discrimination against women. Kyrgyzstan has obligations under articles 12 and 14 (b) of the CEDAW to ensure appropriate reproductive health care services and medicines to rural women. If Kyrgyzstan does not meet its obligations, it should be accountable under the CEDAW for failing to prevent maternal deaths among rural women.

Therefore, this thesis work is aimed at promoting and advocating for the availability and accessibility of misoprostol, a medicine which is lifesaving, effective, safe, and applicable to the rural setting of Kyrgyzstan for use in excessive bleeding in pregnancy and childbirth. This promotion and advocacy for the availability and accessibility of misoprostol to rural women is invoked under the CEDAW framework under articles 12 (access to health care services) and 14 (b) (health of rural women).

The first chapter of the thesis work will identify the issue of maternal mortality in Kyrgyzstan, reveal what misoprostol is and explain the discrimination against rural women by state due to failure to ensure the availability and accessibility of misoprostol in rural areas. The second chapter situates the issue of high maternal deaths due to excessive bleeding of rural women, unavailability of a lifesaving medicine, misoprostol, and discrimination against rural women under the CEDAW framework. The last chapter analyzes the scope of Kyrgyzstan’s

obligations under articles 12 and 14 (b). The first part of the chapter scrutinizes interpretive issues of the obligations; the second part of the chapter focuses on particular obligations of the Kyrgyz Republic in implementing its obligations under CEDAW, such as respect, protect and fulfill women’s human rights.
I. ISSUE

A. Postpartum haemorrhage among rural women

Motherhood is an object of high value of the whole society of the Kyrgyz Republic and of “primary” protection by the Constitution of the state.6 Unfortunately, the latest 2007 report7,8 of Kyrgyzstan to the CEDAW Committee reveals that the health of pregnant women remains a serious problem for Kyrgyz health care.9 Unfortunately, particularly the majority of rural women in Kyrgyzstan experience instances of tragedy in maternity. The Ministry of Health of the Kyrgyz Republic (hereinafter the “Ministry of Health”) reveals through the statistics that maternal mortality is especially high among rural women.10

Postpartum haemorrhage, which is excessive bleeding of more than 500 ml after childbirth,11 is the main cause of maternal mortality in Kyrgyzstan. The 2009 Joint report for the period of 2005-2006 by the Ministry of Health and UNICEF states that haemorrhage constitutes 47% of all causes of maternal mortality.12 Moreover, the third periodic report to the CEDAW Committee states that anaemia is a contributing factor for maternal mortality and death in hemorrhage.13 The periodic report to the CEDAW Committee states that 60% of pregnant

---

6 Constitution of the Kyrgyz Republic accepted through the referenda, June 27, 2010, article 36, para. 1.
7 According to article 18 of CEDAW the state party has an obligation to submit periodic reports at least every four years for consideration by the Committee on the Elimination of Discrimination against Women. (Hereinafter “CEDAW Committee”).
9 Third periodical report, at para. 289.
women have anaemia.\textsuperscript{14} Other causes of maternal mortality include preeclampsia (25%), sepsis (10%), hysterorrhaxis (3%), and others (15). \textsuperscript{15}

From a global standpoint, the majority of maternal deaths are caused by haemorrhage (25%), infection (sepsis) (15%), eclampsia (convulsions) (12%), obstructed labor (8%), and unsafe abortion (13%).\textsuperscript{16} If we compare the share of causes of maternal mortality in Kyrgyzstan with the world average data of maternal mortality, it is evident that the share of maternal mortality due to haemorrhage in Kyrgyzstan is double the share of maternal mortality due to haemorrhage from the global standpoint (Chart 5). It is important for the Ministry of Health to address to this discrepancy and reveal the causes of peculiarly high instances of mortality due to haemorrhage.

\begin{figure}
\centering
\includegraphics[width=\textwidth]{chart1.png}
\caption{Causes of Maternal mortality}
\end{figure}

\begin{table}
\centering
\begin{tabular}{|c|c|}
\hline
Cause & Percentage \\
\hline
Haemorrhage & 47\% \\
Sepsis & 10\% \\
Preeclampsia & 25\% \\
Other & 15\% \\
Hysterorrhaxis & 3\% \\
\hline
\end{tabular}
\caption{Causes of Maternal Mortality in Kyrgyzstan (Ministry of Health, UNICEF)}
\end{table}

\textsuperscript{14} Ibid.
\textsuperscript{15} Ministry of Health and UNICEF, \textit{Maternal and Newborn Health in Chui province and Kyrgyzstan: Assessment and Implications for Interventions} (UNICEF: 2009), at 20.
Unfortunately, there are no data on the instances of haemorrhage divided by urban and rural settings. However, the National Statistics Committee of the Kyrgyz Republic provides separate data on the Maternal Mortality Ratio\textsuperscript{17} (hereinafter “MMR”) in the Kyrgyz Republic for rural and urban women. The MMR in urban areas is 42.6, whereas in rural areas the MMR is 74.5. In some regions it reaches 105.5, particularly in the mountain region of Naryn oblast.\textsuperscript{18, 19} The MMR in rural areas is 73% higher than the MMR in the capital city, Bishkek. This means that a woman from rural village has 73% higher risk of dying than a woman from Bishkek.

\textsuperscript{17} According to international standards, maternal mortality is estimated with a Maternal Mortality Ratio (MMR) that represents the number of maternal deaths in a population divided by the number of live births; thus it depicts the risk of maternal death relative to the number of live births (WHO, \textit{Trends in Maternal Mortality: 1990 to 2008 Estimates developed by WHO, UNICEF, UNFPA and The World Bank} (WHO: 2010), at 5.).

\textsuperscript{18} Oblasts are administrative regions in the Kyrgyz Republic. There are 7 oblasts in Kyrgyzstan. Each oblast has its own central city and administrative subdivisions. Each administrative subdivision consists of a regional town and further sub-regions, where villages are located. Naryn oblast is the most mountaneous oblast in the republic.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Kyrgyz Republic</td>
<td>31.5</td>
<td>62.7</td>
<td>33.6</td>
<td>42.3</td>
<td>45.5</td>
<td>43.8</td>
<td>53.5</td>
<td>49.3</td>
<td>50.9</td>
<td>60.1</td>
<td>55.5</td>
<td>51.9</td>
<td>55</td>
<td>63.5</td>
</tr>
<tr>
<td>Urban areas</td>
<td>52.3</td>
<td>104.2</td>
<td>42.1</td>
<td>45.9</td>
<td>60.3</td>
<td>35.1</td>
<td>43.1</td>
<td>34.5</td>
<td>40.1</td>
<td>47.8</td>
<td>43.1</td>
<td>36.2</td>
<td>43.2</td>
<td>42.6</td>
</tr>
<tr>
<td>Rural areas</td>
<td>24</td>
<td>48.6</td>
<td>30.4</td>
<td>40.9</td>
<td>39.4</td>
<td>47.4</td>
<td>57.9</td>
<td>55.7</td>
<td>56.5</td>
<td>66</td>
<td>61.5</td>
<td>59.9</td>
<td>61.2</td>
<td>74.5</td>
</tr>
<tr>
<td>Naryn oblast</td>
<td>67.2</td>
<td>84.9</td>
<td>98.2</td>
<td>58.5</td>
<td>32.4</td>
<td>145.5</td>
<td>75.2</td>
<td>43.9</td>
<td>89.4</td>
<td>89.6</td>
<td>60.5</td>
<td>62.3</td>
<td>46.2</td>
<td>105.5</td>
</tr>
<tr>
<td>Bishkek</td>
<td>80.6</td>
<td>189.2</td>
<td>21.2</td>
<td>51.2</td>
<td>69.6</td>
<td>19.3</td>
<td>17.5</td>
<td>32.7</td>
<td>21.5</td>
<td>13.5</td>
<td>18.3</td>
<td>17.3</td>
<td>22</td>
<td>20.4</td>
</tr>
</tbody>
</table>

Chart 3: MMR in Kyrgyzstan (National Statistics Committee)

Rural women represent about 32% of the total population of the country. Rural women constitute a particular intersectional segment of the general population of the Kyrgyz Republic, facing harsher or incomparable challenges (multiple and intersectional discrimination) in comparison with urban women.

Postpartum haemorrhage is the number one killer in maternal mortality, composing almost half of the causes of maternal mortality in Kyrgyzstan. Postpartum haemorrhage being the most common complication during the pregnancy is significantly preventable and treatable. The WHO estimates that 88 to 98 percent of maternal mortalities are preventable. \(^{20}\) Whereas postpartum haemorrhage is effectively managed in developed settings, it becomes intolerably tragic in settings where there are no treatment or preventative measures available for postpartum haemorrhage. That is most likely to be in the rural setting in Kyrgyzstan. This reveals the delay in accessing care once the facility is reached. \(^{21}\)

However, there are two more delays that vitally contribute to maternal mortality. There might be a delay in seeking care, since the major challenge in avoiding postpartum haemorrhage is that it cannot be predicted beforehand. There are no early warnings of postpartum haemorrhage. It was revealed that many high-risk women deliver normally and the majority of

---


\(^{21}\) Ibid.
haemorrhage cases occur in low risk women.\textsuperscript{22} Moreover, the WHO warns that even healthy, non-anaemic women can have catastrophic blood loss.\textsuperscript{23} Lastly the third delay for the rural women is in reaching a health care facility.\textsuperscript{24} Remote locations such as the mountainous setting in Naryn oblast makes many women too late to reach life-saving equipped obstetric services. Therefore, postpartum haemorrhage interventions should be targeted at all women during childbirth.

Postpartum haemorrhage is mainly caused by uterine atony, which is the failure of the uterus to contract properly after childbirth.\textsuperscript{25} After the birth of the newborn, which is known the third stage of labor, the placenta separates from the uterine wall and is compressed by endogenous uterotonic hormones, which cause contraction of the uterus.\textsuperscript{26} The placenta leaves a vast 20 centimeter diameter wound on the inside of the uterus.\textsuperscript{27} Naturally, the uterus contracts to close around blood vessels, as the umbilical cord is clamped and the placenta delivered. In about 15\% of the cases uterus fails to contract properly and woman can bleed out in hours.\textsuperscript{28} Other reasons for postpartum haemorrhage are tears of the genital tract causing traumatic postpartum haemorrhage and haemorrhage due to retention of placental tissue.\textsuperscript{29}

\begin{thebibliography}{100}
\item Ibid.
\item Gynuity Health Projects and Family Care International, Postpartum hemorrhage: Responding to the Challenge, Project overview, (2006), at 1.
\item G. J. Hofmeyr and A. M. Gulmezoglu, ‘Misoprostol for the prevention and treatment of postpartum haemorrhage’, Best Practice & Research Clinical Obstetrics & Gynaecology (December 2008), 22 (6), 1025-1041, at 1026.
\item C. Abraham, ‘We can’t use this drug…women will use it for abortions!’, Globe and Mail, June 26, 2010, at F 9.
\end{thebibliography}
In addition to being the most important direct cause of maternal morbidities and mortalities, postpartum haemorrhage is also one of the most preventable. Post-tragic bleeding can be avoided by powerful uterine contractions and the complete expulsion of all placental material. Effective and standard intervention for prevention of postpartum haemorrhage is a procedure called “active management of the third stage of labor”. Undertaken immediately after the childbirth, active management is a set of clinical interventions aimed at speeding the delivery of the placenta and preventing uterine atony. According to the International Confederation of Midwives (ICM) and the International Federation of Gynecology and Obstetrics (FIGO), basic and non-surgical components of active managements include: the administration of a uterotonic drug, controlled cord traction, and uterine massage after the delivery of the placenta.

The problem in Kyrgyzstan is the application and access to uterotonic drugs. Effective uterotonic drugs such as oxytocin and ergometrine have existed for many years. Nowadays, oxytocin is number one choice to treat and prevent postpartum haemorrhage. It is highly effective and has a high safety profile. However, the main drawback for oxytocin is that it requires administration through an intravenous drip (IVD) or by injection, thus requiring

---

37 Ibid., at S118.
skilled personnel, as well sterile equipment for the injections. Finally the main challenge for rural places of Kyrgyzstan is refrigeration. Four manufacturers of oxytocin were registered in Kyrgyzstan. They are Gedeon Richter (Hungary), Immunnopreparaty (Russia), Beolek (Ukraine) and Dalhimfarm (Russia). The average required storage for oxytocin is from +2 to +15 degrees C. With hot summer temperatures averaging +30 degrees C, rural settings in Kyrgyzstan face a big issue with refrigeration. Firstly, vast numbers of rural health posts are underequipped. Secondly, the problem with power is omnipresent throughout the country. The government exercises major power shutoffs for hours or even weeks due to shortages of power. These shutoffs occur especially often in rural areas. Therefore, oxytocin does not best suit the rural conditions of Kyrgyzstan, where skilled personnel and means of refrigeration are lacking.

B. Misoprostol

Misoprostol has been arguably the most discussed and researched drug in sexual and reproductive health since the early 1990s. Misoprostol is a synthetic analogue of the natural prostaglandin E1. Misoprostol has been used by millions of people for the last twenty years as a long-term ulcer drug, invented and marketed under the trade name Cytotec. As happens with many drugs, misoprostol was also found to be lifesaving in obstetrics and gynecology.

38 Gynuity Public Health Program, Program Brief: Postpartum Haemorrhage, (November 2010) at 1, online: <http://gynuity.org/resources/topic/Postpartum%20Hemorrhage>.
Misoprostol was seen to stimulate uterine contractility in early pregnancy and at term,\(^{44}\) and to prevent and treat postpartum haemorrhage.

Recent studies confirm that misoprostol is an effective drug to treat postpartum haemorrhage, and thus, should be available world-wide.\(^ {45,46}\) There are health programs such as Gynuity Health Programs and Venture Strategies for Health promoting and licensing misoprostol for postpartum haemorrhage prevention and treatment around the world. Misoprostol has a number of advantages in comparison with oxytocin:

- **Misoprostol has well-established uterotonic effects.**\(^ {47}\) When used immediately after delivery, it can prevent up to 80% of severe postpartum haemorrhage cases.\(^ {48}\) If heavy postpartum haemorrhage occurs, misoprostol effectively stops bleeding for 9 out of 10 women within 20 minutes.\(^ {49}\) Better management of postpartum haemorrhage with misoprostol could contribute to the international goal of reducing maternal deaths by 75% by the year 2015.\(^ {50}\)
- **It has a long shelf life and may be stored at room temperature,**\(^ {51}\) and thus does not require refrigeration.\(^ {52}\)
- **Misoprostol can be used orally, vaginally, sublingually or rectally.**\(^ {53}\) This gives the opportunity for misoprostol to be used by traditional birth attendants, or to be self-

\(^{49}\) Ibid.
\(^{50}\) Ibid.
administered at births taking place remote from health services and health personnel, where women are at most risk from the rapidly fatal effects of severe postpartum haemorrhage.54

- It is cheap,55 costing as little as US $0.10.56
- The only side-effects of note are diarrhea and shivering, both are dose dependent and self-limiting.57

Despite the lifesaving potential of misoprostol, there were significant issues of availability of misoprostol for obstetrics and gynecology. Misoprostol’s manufacturer, Pfizer, has not applied for licenses in any country for reproductive health indications, despite the abundant literature and trials on its safe and effective use for reproductive health purposes.58 Secondly, the WHO was reluctant to include the drug on the list of essential medicines in order to encourage other manufacturers of misoprostol to produce and apply for state licensing. Despite many years of availability battle, now misoprostol is used in combination with mifepristone for medical abortion by more than 100,000 women a year.59

Finally, recently the WHO recognized misoprostol to be clinically equivalent to oxytocin when used to stop excessive postpartum haemorrhage due to uterine atony in women.60 In March of 2011 at the 18th meeting of the WHO expert committee on the selection and use of essential

58 Ibid.
medicines, after reviewing the application for inclusion of misoprostol by Gynuity Health Projects and Venture Strategies for Health, the WHO List on Essential Medicines was amended as follows:

- 200 micrograms [of misoprostol] was added, based on evidence of its safety and efficacy for the prevention of postpartum haemorrhage where oxytocin is not available or cannot be safely used;
- 200 micrograms misoprostol to be moved to the core list\(^{61}\) of the WHO List of Essential Medicines;
- The required dose for the prevention of postpartum haemorrhage was approved to be 600 micrograms orally administered achieved with the 200 micrograms presentation;
- A vaginal tablet of 25 micrograms for use in induction of labour was to be moved from the complementary list\(^{62}\) to the core list\(^{63}\).

Now the List reads: “for the management of incomplete abortion and miscarriage, and for the prevention of postpartum haemorrhage where oxytocin is not available or cannot be safely used”\(^{64}\).

As for the treatment of postpartum haemorrhage with misoprostol, the WHO Committee was reluctant to include misoprostol on the WHO List of Essential Medicines for the treatment. Comparing the use of 800 micrograms misoprostol sublingually with oxytocin, the Committee stated oxytocin was superior as a first line treatment. In addition, [the Committee stated] there is no evidence to support the safety of the 800 microgram dose of misoprostol for treatment of

---

\(^{61}\) Core list presents a list of minimum medicine needs for a basic health-care system, listing the most efficacious, safe and cost-effective medicines for priority conditions.

\(^{62}\) Complementary list presents essential medicines for priority diseases, for which specialized diagnostic or monitoring facilities, and/or special medical care, and/or specialist training are needed.


\(^{64}\) Ibid.
postpartum haemorrhage when given to women who have previously received a prophylactic dose of 600 micrograms of misoprostol orally.65

However, large-scale, multi-site, randomized controlled clinical trials stand behind the decision of the WHO experts committee’s on treatment of postpartum haemorrhage with misoprostol. These trials were undertaken by Gynuity Health Project in collaboration with investigators in Burkina Faso, Ecuador, Egypt, Turkey, and Vietnam. The results were published in articles by Blum et al. and Winikoff et al. and data from these trials revealed that sublingual misoprostol (800 micrograms) is a safe, effective and acceptable alternative first-line treatment for postpartum haemorrhage due to uterine atony.66, 67

Therefore, based on the last trials showing the effectiveness and safety of misoprostol for treatment of postpartum haemorrhage criticism has arisen against the WHO for causing confusion on approval of misoprosol.68 Potts, Prata and Sahin-Hodoglugil inform that misoprostol is used by millions of people to treat gastric ulcers at high doses of 800 micrograms a day for a much longer period of time than those used in obstetrics.69 Potts and his colleagues warn that there could be more maternal deaths in this decade than in any previous decades due to the increase in numbers of women of reproductive age, if urgent actions are not taken.70,71

65 Ibid.
69 Ibid.
70 Ibid.
Additionally, analysis on the cost-effectiveness of maternal mortality interventions is vital. Kyrgyzstan does not differ much from the description of developing countries by Prata and her colleagues, who characterized poor settings by “electricity outage, lack of transportation or viable roadways to reach higher level facilities, absence of potential trainees for professional clinical position, and professional migration”. Considering gloomy conditions and low-resource settings, some advocate that traditional birth attendants undertake misoprostol’s management. Some studies reveal that even illiterate traditional birth attendants are able to apply their knowledge and provide basic maternal care applying misoprostol.

The study of Bradley et al. reveals that in a cohort of 10,000 births, 1,647 cases of severe postpartum haemorrhage could be prevented with traditional birth attendants training and use of misoprostol. The misoprostol strategy would also save $115,336 in transport, hospital fees, IV therapy, and blood transfusions. The total savings was estimated to be $13,991-$1,563,593 per 10,000 births. Because the misoprostol strategy would prevent severe disease and save money, it dominates the standard approach of traditional birth attendants referring women with postpartum haemorrhage to hospitals.

---

72 Ibid., at 132.
Therefore, it is the state’s responsibility to undertake effective interventions to address avoidable maternal mortality taking into the account the urgency of the problem, low-resource settings and the lifesaving characters of misoprostol.

C. Misoprostol in Kyrgyzstan

As for the situation with misoprostol in Kyrgyzstan, in 2007 misoprostol was included in the List of medicines permitted for import and use in medical practice in the territory of the Kyrgyz Republic. Registered misoprostol is in a tablet form of 200 micrograms, manufactured by Beijing Zizhu Pharmaceutical Co. Ltd, China. The same order has registered mifepristone by Beijing Zizhu Pharmaceutical Co. Ltd. Further, in 2008 misoprostol was permitted for medical application by the order of the Ministry of Health. Therefore, according to the Law on medicines, misoprostol is considered to have state registration and is permitted to be legally sold and used in the territory of the state.

However, misoprostol is still not available for rural women. The main problem is that the state does not ensure the availability of lifesaving medicine in rural areas. First, misoprostol is not on the national list of essential medicines. Since it is not considered to be an essential medicine, misoprostol is not included on the list of medicines and medical products to be provided at rural health posts.

---


80 Order of the Ministry of the Kyrgyz Republic N 211 On permission of medicines and products of medical purposes for medical application, dated May 13, 2008.

81 List of medicines and medical products permitted for disposal at rural health post, attachment 5 to the order of the Ministry of Health dated February 17, 2005 N66.
Secondly, the problem in rural areas is with rural health posts’ structure and functions. Rural health posts in Kyrgyzstan are under the supervision of the Family medicine division and are responsible for providing primary medical care to the population or as it is called “pre-medical first aid”\(^{82}\). 24.4% of the rural population is served by those rural health posts.\(^{83}\) The number of people served by one rural health post can vary from 500 to 25,000 people.\(^{84}\) Besides the problems identified by the National program on health care reform that there is a significant lack of rural health posts in the country, weak material equipment, an absence of transportation, and a lack of human resources. There is a problem in the services that rural health posts should provide.

According to the regulation on rural health posts, among obstetric services rural health posts provide are only observation after pregnancy begins\(^{85}\), determination of possible obstetric complications\(^{86}\) and referral to the birth-delivering hospitals\(^{87}\) (located in the regional cities). Surely, such activities as consultations on family planning\(^{88}\), determination the term of pregnancy\(^{89}\), and the insertion of intrauterine devices are vital\(^{90}\) in lowering possibilities of pregnancy, and consequently in lowering the chances of maternal mortalities. However, the current rural health posts, are unfortunately not capable and have no uterotonic medicines to address postpartum haemorrhage.
Therefore, there should not be wonder for the reason why the majority of maternal mortalities are in rural areas. Simply, women bleed out until they reach regional city hospitals. Despite the National program on health care reform, National strategy on protection of reproductive health of the population of the Kyrgyz Republic\(^91\) and orders of the Ministry of Health for a plan of activities on maternal mortality reduction\(^92\), effective, realistic and urgent intervention should be undertaken in order to reduce maternal mortality in rural areas. Currently misoprostol is such an intervention. Further failure to eliminate maternal mortality and the systematic growth of maternal mortality among rural women in Kyrgyzstan indicates possible discrimination against women in the field of health care and consequently a breach of its international obligations before CEDAW. This will be elaborated on in the next chapter.

---

\(^91\) National strategy on the protection of the reproductive health of the population of the Kyrgyz Republic until 2015, approved by the Decree of the President of the Kyrgyz Republic dated July 15, 2006 N387.

\(^92\) Order of the Ministry of Health of the Kyrgyz Republic On approval of a plan of activities on maternal mortality reduction for 2010 in the Kyrgyz Republic, dated March 10, 2010, N130.
II. SITUATING THE ISSUE UNDER THE CEDAW

Maternal mortality is an issue of women’s human rights, rather than of even development in Kyrgyzstan. Rural women in Kyrgyzstan constitute about 32% of the total population of the country, amounting to the most populous social group, exceeding rural men and all urban citizens. However, because rural women face constant discrimination through their life-cycle in the public, as well as private spheres, they became invisible and, thus, further discriminated against. This was also said by the Center for Reproductive Rights as “maternal mortality is a reflection of the devaluation of female life and a measure of the social neglect of women.”93 An un-prevented yet preventable high maternal mortality is an effect and indicator of discrimination against women. This chapter analyzes discrimination against rural women and locates the issues of maternal mortality, postpartum haemorrhage, and unavailability of an essential life-saving medicine, misoprostol, under the CEDAW.

The international community has recognized that maternal mortality is a matter of human rights, particularly of women’s human rights to health, life and non-discrimination.94,95,96,97,98 The CEDAW Committee is concerned about the increase in the rates of maternal mortality in Kyrgyzstan. The CEDAW Committee also has stated that the high rate of maternal mortality in a state is an indication of possible breaches of treaty obligations in ensuring women’s access to health care.99 Kyrgyzstan has an obligation under Article 12 and 14 to eliminate discrimination

93 Center for Reproductive Rights, Claiming Our Rights: Surviving Pregnancy and Childbirth in Mali, (Center for Reproductive Law & Policy, 2003), at 74.
against rural women in the field of health care in order to ensure access to appropriate and adequate reproductive health services to rural women.

Maternal mortality is not an issue of development. Maternal mortality is one of the few major public health problems for which medical treatment is a solution. Berer provides an example of Myanmar. Berer states, “in Myanmar, one of the world’s poorest countries, a pilot study of prophylactic misoprostol to prevent post-partum haemorrhage, given by midwives during the third stage of labour, found no cases of haemorrhage among either high risk or randomly chosen post-partum women.” This is also visible in the examples of Europe and North America during the 19th and early 20th centuries, when mortalities from many causes were reduced. The reduction was initially thought to be from improvement of standards of living and general development. However, when there the first data on maternal mortality in England and Wales for the period of 1850 to 1930 became available, it became understood that maternal mortality does not react to the development and improvement of life-style, because the numbers of maternal mortality remained almost the same.

Maternal mortality is a condition faced by women only due to discrimination and failure to address women’s needs and interests. It is a fact that maternal mortality can be avoided. Hunt stated that “human rights is not just about torture, but also about avoidable deaths from preventable health conditions.” Maternal mortality is not simply an issue of development, but an indicator how much of value the woman has in the society. Fathalla spoke at the National

---

103 Ibid., at 572.
Reproductive Health Summit that “women are not dying during pregnancy and childbirth because of conditions that difficult to manage. They are dying because the societies in which they live did not see fit to invest what is needed to save their lives.”\(^{106}\) He continues that “it is a question of how much the life of a woman is considered to be worth.”\(^{107}\)

Cook and Dickens have stated the following on maternal mortality:

“The failure to address preventable maternal death represents one of the greatest social injustices. A human rights approach shows that women’s maternal mortality result not simply from their disadvantages but frequently from cumulative denials of their human rights. Acknowledgement that women suffer through the neglect of their basic health care needs, which is denial of their human rights.”\(^{108}\)

Behind maternal mortality is a failure to ensure women’s human rights.\(^{109}\) Since maternal mortality is preventable, but not prevented, therefore it is discrimination and constitutes a violation of human rights. The CEDAW Committee has developed General Recommendation No. 24 to the CEDAW to clarify the scope and meaning of Article 12 for state parties such as Kyrgyzstan. The Committee requires the state parties to address women’s health rights from “the perspective of women’s needs and interests”.\(^{110}\) This difference is vital since women’s health needs and interests are different from men’s. If the state fails to recognize women’s difference from men and, thus, fails to address their different needs and interests, this failure constitutes the discrimination against women, by denying the specific needs of women.

\(^{107}\) Ibid.
\(^{110}\) General Recommendation No. 24, at para. 12.
Maternal mortality can be experienced only by women, thus, it is an interest of only women. The failure to act and eliminate avoidable maternal mortality constitutes discrimination against women, denying women the enjoyment of their human rights such as rights to life and health. “Maternal death is not inevitable: women have a right to lifesaving care.”\textsuperscript{111} Lifesaving care connected to pregnancy and childbirth, i.e. access to reproductive health services and goods, is a need only of women. Denial to ensure access to reproductive health services and goods constitutes discrimination against women. Therefore, misoprostol should be widely available to women in Kyrgyzstan not only because it is an essential drug, included on the core WHO list of essential medicines, but also since misoprostol is a medicine particularly needed by women and without which rural women lose their lives and health. The failure to ensure the availability of misoprostol to rural women, who are in severe need of it, constitutes not only a breach of their human rights to health and life, but also discrimination, since it is a denial based on sex and rurality.

The former UN Special Envoy on HIV/AIDS in Africa, Stephan Lewis, stated “the number of annual [maternal] deaths has not changed in … thirty years. You can bet that if there was something called paternal mortality, the numbers wouldn’t be frozen in time for three decades.”\textsuperscript{112} There is no sole cause of death and disability for men between the ages of 15 and 44 that is close to the scale of maternal death and disability.\textsuperscript{113}

Maternal mortality is an issue of discrimination against women lasting for centuries. As Hunt recognizes, maternal mortality’s social and political dimensions resulted in obscuring deaths in pregnancy and childbirth as a natural and inevitable cost of women’s role in


reproduction.\textsuperscript{114} Despite wide knowledge, easy applicability and affordability of lifesaving knowledge and technologies in pregnancy and childbirth, women still face barriers in accessing simple health care services. The only reason behind this is discrimination against women. CEDAW claims from its preamble that "the role of women in procreation should not be a basis for discrimination."\textsuperscript{115}

Surely the question stating whether we should first eliminate discrimination then maternal mortality disappears or we should first ensure access to sexual and reproductive health and only then gender equality will be achieved is like the question about the chicken and the egg. The Committee on the Status of Women “reaffirms that gender equality cannot be achieved without promoting and protecting the right of women to enjoy the highest attainable standards of physical and mental health, including sexual and reproductive health.”\textsuperscript{116} However we can all agree that maternal mortality is both human rights and development issue and therefore, it should be solved in interconnection.

Kyrgyzstan has ratified both CEDAW and its Optional protocol. Kyrgyzstan is fully responsible to fulfill its obligations under the Convention, to eliminate discrimination against women and to ensure access to adequate health care services and goods to women in pregnancy and childbirth. The following chapter focuses on the obligations of the Kyrgyz Republic under articles 12 (access to health care services) and 14 (b) (health of rural women). First, the scope of the obligations will be analyzed and then concrete steps of implementation will be provided.

\textsuperscript{114} P. Hunt, \textit{Supplementary note on the UN Special Rapporteur’s report on maternal mortality in India} (April, 2010), at 2, online: <http://www.essex.ac.uk/human_rights_centre/research/rth/Supplementary%20Note%2021%20April%202010.doc>

\textsuperscript{115} CEDAW, at Preamble.

Therefore, the thesis work advocates for the elimination of maternal mortality and the promotion of misoprostol through more of a *right-to-health approach* under CEDAW, rather than a *human rights approach*, since the focus is on health care medicine in pregnancy and childbirth, rather than on other human rights, such as the right to life. 117 In the Special Rapporteur’s opinion, there is little (if any) difference, in policy and practice, between these two approaches.”118

---

117 P. Hunt, *Supplementary note on the UN Special Rapporteur’s report on maternal mortality in India* (April, 2010), at 2, online: <http://www.essex.ac.uk/human_rights_centre/research/rth/Supplementary%20Note%2021%20April%202010.doc>  
118 Ibid., at 10.
III. THE OBLIGATIONS OF KYRGYZSTAN UNDER CEDAW

1. Scope of the obligations of Kyrgyzstan under articles 12 and 14 (b) with regards to maternal mortality

Article 12
1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Article 14
1. States Parties shall take into account the particular problems faced by rural women and the significant roles which rural women play in the economic survival of their families, including their work in the non-monetized sectors of the economy, and shall take all appropriate measures to ensure the application of the provisions of the present Convention to women in rural areas.

2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:

(b) To have access to adequate health care facilities, including information, counselling and services in family planning;

A. Health care

The CEDAW Committee affirms that “access to health care, including reproductive health, is a basic right.” General Comment No. 12 to the International Covenant on Economic, Social and Cultural Rights (hereinafter “ICESCR”) also clarifies the concept of health care. While interpreting the obligations of Kyrgyzstan under CEDAW it is useful to refer to the ICESCR not only because Kyrgyzstan is a party to the ISESCR, but also because the CEDAW

119 General Recommendation No. 24, at para. 1.
itself goes hand in hand with the principles of the ICESCR. General Recommendation No. 24 to CEDAW states that it seeks to elaborate on article 12 of CEDAW and to address measures to eliminate discrimination in order to realize the right of women to the highest attainable standard of health.

In the right to health two concepts are visible: right and health care. The right to health care represents the basic inalienable human right to health. General Comment No. 14 to the ICESCR clarifies that “the right to health is not to be understood as a right to be healthy”. It is continued that “the right contains both freedoms and entitlements.” The “freedoms” are understood to include “the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment, and experimentation.”

“Entitlements” to health, differing from “freedom”, include “the right to a system of health protection that provides equality of opportunity for people to enjoy the highest available standard of health.” Hunt, former Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, also stated that “it [right to health] is not a right to be healthy: it is a right to a variety of services, facilities, goods and conditions that promote and protect the highest attainable health”. This could be said from another angle, it is an obligation of the state to take such measures that women attain the highest standard of reproductive health; or in relation to pregnancy and childbirth an obligation of the state to take such measures that women undergo safe and healthy pregnancy and childbirth. General Recommendation No. 24 to CEDAW highlights that states have to take measures to

121 Ibid.
122 Ibid.
123 Ibid.
124 P. Hunt and J. B. de Mesquita, “Reducing Maternal Mortality The contribution to the highest attainable standard of health”, University of Essex, at 5.
ensure women appropriate services in connection with pregnancy, confinement and the post-natal period.125

To achieve such a goal, health care in article 12 is not limited merely to the provision of health services, but it should be understood broadly as an “effective and integrated health system”, which includes health care itself and underlying determinants of health, which is responsive to national and local priorities, and accessible to all.126,127 This is important in the context of maternal mortality. Often lower-level workers are blamed for lack of competence, or women themselves for late referral; however, systematic service delivery constraints and managerial problems are not being addressed.128 Therefore, the whole health system of the state should be woman centered129 in order to provide appropriate services addressing “women’s needs and interests”.130 Freedman stated on this regard that “an equitable, well-resourced, accessible and integrated health system is widely accepted as a vital pre-condition for guaranteeing women’s access to the interventions than can prevent or treat the causes of maternal deaths.”131

The CEDAW Committee affirms that the right to reproductive health care is a part of the right to general health care.132 The Programme of Action developed at the International Conference on Population and Development (hereinafter “ICPD Programme”) adopted a definition of reproductive health, as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to reproductive system

125 General Recommendation No. 24, at para. 26
126 Ibid.
127 P. Hunt, Report of Special Rapporteur on The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, General Assembly (September 13, 2006), sixty-first session, A/61/338, at para. 14.
130 Ibid., at para. 12.
132 General Recommendation No. 24, para. 1.
and its functions and processes.”\textsuperscript{133} The ICPD Programme further states that it is implicit that reproductive health includes “the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth.”\textsuperscript{134}

The ICPD Programme defines the scope of health services necessary to achieve reproductive health and states that “reproductive health care is defined as a constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems.”\textsuperscript{135} Therefore, maternal mortality being a problem of reproductive health should be addressed, prevented and solved by the state using a constellation of health care methods, techniques and services.

Maternal mortality is one of the primary concerns of CEDAW.\textsuperscript{136} CEDAW explicitly notes the duty of the State party to ensure women’s rights to safe motherhood and emergency obstetric services and that they should allocate to these services the maximum extent of available resources.\textsuperscript{137} At the same time in order to ensure safe motherhood, State parties must ensure not solely reproductive services, but also reproductive medicine which is embedded into reproductive services.

General Comment No. 14 to the ICESCR lists core obligations that State parties have to ensure. To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs, is one of the core obligations. Therefore, Kyrgyzstan has a core obligation to ensure the availability of misoprostol for rural women in Kyrgyzstan because of three main reasons. First of all, misoprostol is an essential drug that women need in pregnancy

\textsuperscript{134} Ibid.
\textsuperscript{135} Ibid.
\textsuperscript{136} General Recommendation No. 24, at para. 26.
\textsuperscript{137} Ibid.
and childbirth. Second of all, access to essential medicines is an essential component of health care. Last, misoprostol is lifesaving medicine needed by women, and failure to ensure its availability constitutes discrimination against women.

The Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health emphasizes the importance of access to medicines in the event of sickness, prevention, treatment and control of diseases, which are central features of the right to the highest attainable standard of health.\(^{138}\) Hunt states that “access to medicines forms an indispensable part of the right to the highest attainable standard of health. Numerous court cases, as well as resolutions of the Commission on Human Rights, confirm that access to essential medicines is a fundamental element of the right to health.”\(^{139}\)

Also access to misoprostol concerns the realization of women’s right to reproductive autonomy, which requires “access to the benefits of scientific progress”\(^{140}\) The ICESCR explicitly guarantees “the right to enjoy the benefits of scientific progress and its applications.”\(^{141}\)

Reproductive health care, as explained by the “Green Book” by Cook, Dickens and Fathalla, “deals with mostly healthy people, they often have to take into consideration the interests of more than one ‘client’ at the same time, they deal mostly with women and they have to deal and interact with society.”\(^{142}\) If this is applied to maternal mortality, it is understood that

\(^{138}\) P. Hunt, Report of Special Rapporteur on The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, General Assembly (September, 2006), A/61/338, Sixty-first session, at para. 40.

\(^{139}\) Ibid.

\(^{140}\) Center for Reproductive Rights, Using Millennium Development Goals to Realize Women’s Reproductive Rights (September, 2008), at 15.


maternal mortality is not a disease; maternal mortality has an effect on society as a whole and on separate other people as women’s close ones’ (her child, family); and maternal mortality can only be experienced by women.

As Fathalla stated maternal mortality is not a disease and should not be clustered with and compared for priority against diseases.\textsuperscript{143} Maternal mortality is a social function that women undertake risking their lives. Therefore, Fathalla asserts that society should have more of an obligation to prevent maternal mortality than to prevent deaths from diseases.\textsuperscript{144}

As the CEDAW Committee states, reproductive care is basic care. Women denied reproductive health will fail to enjoy their other human rights. As it is said health is not everything, but without health everything is nothing. Only when women enjoy their human rights together with reproductive rights will they be able to achieve their own objectives and fully participate in every sector of society.\textsuperscript{145}

**B. Access to health care**

The CEDAW Committee has linked high rates of maternal mortality to lack of access to and insufficient availability of comprehensive reproductive health services with such State parties as Georgia, Mongolia, and Morocco.\textsuperscript{146} Similarly, high rates of maternal mortality among rural women because of preventable and treatable postpartum haemorrhage indicate lack of access to and insufficient availability of comprehensive reproductive health services.


\textsuperscript{144} Ibid.

\textsuperscript{145} Center for Reproductive Rights, *Using Millennium Development Goals to Realize Women’s Reproductive Rights* (September 2008), at 3.

Misoprostol was proved to be lifesaving in postpartum haemorrhage and embedded in the “comprehensive reproductive health services”. Therefore Kyrgyzstan must ensure the availability and accessibility of misoprostol to women in rural areas.

In understanding the concepts of “availability” and “accessibility” General Comment No. 14 to ICESCR is significant. The availability of health care services includes functioning public health and health-care facilities, goods and services.\textsuperscript{147} Also programmes have to be available in sufficient quantity within the State party. The availability of health care services also includes the “underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.”\textsuperscript{148} Therefore, as an essential drug, misoprostol should be available within functioning public health and health-care facilities. Hunt reported after the mission in India that community-based access to antibiotics and misoprostol may have an important role to play in reducing maternal mortality.\textsuperscript{149}

Accessibility means that health facilities, goods and services are accessible to everyone without discrimination, as well as accessible physically, economically and in information aspect. Non-discriminative accessibility requires that “health facilities, goods and services accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.”\textsuperscript{150} Therefore, since misoprostol is needed by only women and it is crucial to rural women, an essential medicine should be accessible in Kyrgyzstan to rural women based on equality among man and urban women.

\textsuperscript{147} General Comment No. 14, at para. 12 (a).
\textsuperscript{148} Ibid.
\textsuperscript{149} P. Hunt, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health: Mission to India, General Assembly, Human Rights Council, (April 15, 2010), Fourteens session, A/HRC/14/20/Add.2, at 6.
\textsuperscript{150} General Comment No. 14, at para. 12 (b)
Physical accessibility represents health facilities, goods and services that are within safe physical reach for all sections of the population, especially vulnerable or marginalized groups.\textsuperscript{151} It is important for rural women in Kyrgyzstan to receive lifesaving service in pregnancy and childbirth within their rural health posts rather than to be referred to a central hospital an hour away. Misoprostol makes lifesaving care accessible to rural women within the rural health posts.

Economic accessibility (affordability) means that health facilities, goods and services must be affordable for all.\textsuperscript{152} CEDAW explicitly states that services in connection with pregnancy, confinement and post-natal period should be granted for free where necessary.\textsuperscript{153} Rural women are a vulnerable segment of the population, who should be socially taken care of. Moreover, health care in Kyrgyzstan should be accessibility to all. Therefore, misoprostol should be included on the list of essential medicines in Kyrgyzstan and provided for free to rural health posts as other essential medicines are.

Last, information accessibility includes the right to seek, receive and impart information and ideas concerning health issues.\textsuperscript{154} Rural women in Kyrgyzstan should know the real risks in pregnancy and childbirth, especially taking into the account that most of them are anemic. Women have a right to know not only about their health and the ways to secure their health, but also the statistics on maternal mortality, the allocation of the budget for health care particularly in connection with pregnancy and childbirth, as well as the budget of their rural health post.

\textsuperscript{151} Ibid.
\textsuperscript{152} Ibid.
\textsuperscript{153} CEDAW, at article 12.2.
\textsuperscript{154} General Comment No. 14, at para. 12 (b).
C. “Appropriate services” and “Adequate health care facilities”

The CEDAW Committee determines inappropriate measures to eliminate discrimination if a health-care system lacks measures to prevent, detect and treat illnesses specific to women.155 The “Green Book” by Cook, Dickens and Fathalla states that “reproductive health puts women at the centre of process, and recognizes, respects, and responds to needs of women and not only to those of mothers.”156 The CEDAW Committee continues emphasizing that State parties should undertake health care policies and measures addressing the health rights of women from the perspective of women’s needs and interests.157 Therefore, State parties are obliged to put women at the centre and form their design policies and take actions, considering not only the objective side coming from the medical sphere, but also the subjective side of women’s interests.

It is essential to act from the perspective of women, since women’s needs and interests might be different. However, at the same time rural women’s needs and interests are different even from urban women. Hunt has stated the “right to health takes into account an individual’s biological and socio-economic preconditions”.

General Recommendation No. 24 to CEDAW explains that women and men are different in their biological factors, as their reproductive functions.158 Cook and her colleagues commented on it, stating “the right to non-discrimination also entails treating significantly different interests in ways adequately respects those differences. The right to sexual non-discrimination requires that societies treat different biological interests, such as pregnancy and

155 General Recommendation No. 24, at para. 11.
158 General Recommendation No. 24, para 12.
childbirth, in ways that reasonably accommodate those differences.”¹⁵⁹ This means that Kyrgyzstan has to recognize the biological differences of women and address the maternity needs of women.

The CEDAW Committee state that women’s needs and interests can also depend on socio-economic factors that vary for women in general and some groups of women in particular. Cook and Dickens stated “crucial interventions as emergency obstetric care cannot be fully implemented without taking account of the host of social factors affecting pregnancy-related illness and death.”¹⁶⁰ In the case of Kyrgyzstan, it is vital to consider the remoteness of rural health posts from central hospitals where women are referred from rural health posts. By the time women reach central hospitals medical help could be too late. It is also important to consider that for rural women, who are mostly anemic, timely help could determine life or death in cases of postpartum haemorrhage. The CEDAW Committee singles out the importance of timely and affordable access to reproductive service.¹⁶¹ Therefore, it is important to consider those crucial factors in the promotion of misoprostol availability at rural health posts.

Along considering biological and socio-economic uniqueness of rural women of Kyrgyzstan in designing the programs, it is also vital to ensure with simple intervention such as access and availability to life saving services and medicines. Hunt “emphasizes the crucial importance of all States having an up-to-date national medicines policy and detailed implementation plan.”¹⁶² He questions conformity with States obligations if a state does not

¹⁶¹ General recommendation No. 24, at para. 21.
¹⁶² P. Hunt, Report of Special Rapporteur on The right of everyone to the enjoyment of the highest attainable standard of physical and mental health (September 13, 2006), General Assembly Sixty-first session, A/61/338, at para. 81.
have an up-to-date and appropriate national medicines policy, implementation plan and essential medicines list, prepared by way of a participatory inclusive process.163

Moreover, Hunt defined the concept of “appropriate” after his mission to India reporting on maternal mortality. He stated the following:

“To be “appropriate”, however, health interventions must be consistent with the best evidence in clinical medicine and public health. Governments may not disregard compelling scientific evidence. While the right to health is subject to progressive realisation, this does not mean that a State is free to choose whatever maternal health interventions it wishes so long as they are broadly going in the right direction. Countries are required to prioritise those health interventions that are the best available to them, taking into account epidemiological evidence, resource availability and other human rights considerations.

Hunt continues:

Today, there is a growing international consensus around four cornerstone interventions to reduce maternal mortality: family planning, skilled birth attendance, effective referral networks and emergency obstetric care.164 In relation to maternal mortality, these are the minimum “appropriate” measures required by international human rights law. In some contexts, additional (not alternative) measures, such as community-based access to antibiotics and misoprostol, where supported by evidence, may have an important role to play.165

163 Ibid.
165 R. Horton, “What will it take to stop maternal deaths?”, The Lancet (2009), 374, No.9699, at 1400.
166 P. Hunt, Supplementary note on the UN Special Rapporteur’s report on maternal mortality in India, (April, 2010), at 13, online: <http://www.essex.ac.uk/human_rights_centre/research/rth/Supplementary%20Note%2021%20April%202010.doc>
Therefore, appropriate or adequate services are services that put women at the centre of perspective, considering her needs and interests that might vary depending on biological factors and socio-economic status. Appropriate services are health services that can fulfil reproductive women’s needs and interests, ensuring them basic reproductive health care, including access to essential medicines that women need. Moreover, appropriate and adequate health care services are attentive to women providing them non-discriminatory, respectful and responding to their needs reproductive services.

D. Eliminate discrimination

In understanding what gender/sex discrimination is, Article 1 of the CEDAW identifies discrimination against women as “any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women… on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.”

Cook and Cusack analyze article 1 of CEDAW in detail in their book “Gender Stereotyping: Transnational Legal Perspectives”. The below definitions encompass discriminations from deliberate acts and passive omissions and cover the actions of both government officials and private parties.  

The book analyzes whether law, policy or practice distinguishes between women and men, any exclusion of women, or any restriction of women’s human rights and fundamental freedoms. Distinctions between women and men are created by the laws, and policies and practices that “fail to treat similar interest of women and men in the same way, or that fails to

---

167 Center for Reproductive Rights, Claiming Our Rights: Surviving Pregnancy and Childbirth in Mali, (Center for Reproductive Law & Policy, 2003), at 74.
treat significantly different interests between them in a way that adequately respects that
difference." An example is given in relation to health service, which should treat men and
women equally by reference to incidence levels of diseases on populations. Fathalla reveals “a
paradox in many societies is that they discriminate against women where differences between the
sexes should not matter, but ignore the distinction where differences really matter.”

Exclusion of women happens when law, policy or practice includes men and excludes
women from any field by denying women benefits, opportunities, or entitlements provided to
men. Restriction appears when a law, policy or practice limits or impedes the exercise or
enjoyment of rights and freedoms. It could be a law, policy or practice restricting women’s
access to essential medicine or maternity health care.

Women suffer from both direct and indirect forms of discrimination in accessing health
care. Forms of direct discrimination include laws, policies or practices that deny women access
to health care that only they need. Indirect discrimination in the area of health care occurs
when law, policy or practice is sex or gender-neutral on its face, but it has an unfavorable effect
on women when implemented. Or when health care system has relatively few resources
devoted to women’s particular health-care needs.

---

168 R. J. Cook and S. Cusack, Gender Stereotyping: Transitional Legal Perspectives (University of Pennsylvania
169 M.F. Fathalla, Human rights aspects of safe motherhood, Best Practice & Research Clinical Obstetrics and
170 R. J. Cook and S. Cusack, Gender Stereotyping: Transitional Legal Perspectives (University of Pennsylvania
171 Ibid., at 110.
172 Center for Reproductive Rights, Claiming Our Rights: Surviving Pregnancy and Childbirth in Mali, (Center for
Reproductive Law & Policy, 2003), at 74.
173 R. J. Cook and S. Cusack, Gender Stereotyping: Transitional Legal Perspectives (University of Pennsylvania
At the same time, maternal mortality is not unavoidable “a natural order”\textsuperscript{174} that woman has a burden to face since she is who is delivering the birth, but it is a discriminatory injustice that the society is obliged to eradicate.

E. Equality

Freedman stated that “maternal mortality remains the indicator of population health that reveals most starkly the profound inequalities of our time.”\textsuperscript{175}

According to the article 4 of CEDAW, which states “Adoption by States Parties of temporary special measures aimed at accelerating de facto equality between men and women shall not be considered discrimination as defined in the present Convention, but shall in no way entail as a consequence the maintenance of unequal or separate standards; these measures shall be discontinued when the objectives of equality of opportunity and treatment have been achieved”\textsuperscript{176} and General Recommendation No. 25 to CEDAW on article 4 on temporary special measures,\textsuperscript{177} several forms of equality are identifiable.

First there is formal legal equality between men and women, where it is required to treat similar interest and needs of women and men in the same way.\textsuperscript{178} This is when women and men face similar health needs, thus, the health care system formally treats men and women equally without any form of distinction, exclusion or restriction. Thus, formal equality is gender-neutral, providing equal opportunities to both women and men.

\textsuperscript{174} R. J. Cook and B.M. Dickens, Advancing safe motherhood through human rights (WHO: 2001), at 69.
\textsuperscript{176} CEDAW, at article 4.
\textsuperscript{177} CEDAW Committee, General Recommendation No. 25 on temporary special measures, (hereinafter “General Recommendation No. 25”).
\textsuperscript{178} R. J. Cook and S. Cusack, Gender Stereotyping: Transitional Legal Perspectives (University of Pennsylvania Press: 2010), at 108.
However, the CEDAW Committee states that “it is not enough to guarantee women treatment that is identical to that of men.”\textsuperscript{179} This is when substantive equality or \textit{de facto} equality is required. Substantive equality differentiates equal results, intersectional equality, and transformative equality. The CEDAW Committee states that women and men are different due to their biological, social, and cultural construction.\textsuperscript{180} Therefore, under certain circumstances non-identical treatment is required to address such differences between men and women.\textsuperscript{181} It requires different treatment for different needs and interests. Failure to treat different needs differently constitutes a breach of substantive equality.

The CEDAW Committee states that equality of results is the logical consequence \textit{de facto} or substantive equality.\textsuperscript{182} General Recommendation No. 24 to CEDAW strives to eliminate discrimination in order to realize the right of women to the highest attainable standard of health.\textsuperscript{183} Therefore, when article 12 is read on access to health care, it should also incorporate not only equal opportunity in accessing, but also equal results in achieving the fulfillment of the right to the highest attainable standard of health.

Intersectional equality considers equality within social groups of women. The CEDAW Committee warns that certain groups of women, in addition to suffering from discrimination directed against them as women, may also suffer from multiple forms of discrimination based on additional grounds such as race, ethnic or religious identity, class or other factors.\textsuperscript{184} The next section on rural women will reveal the effects of multiple types of discrimination against rural women in Kyrgyzstan.

\textsuperscript{179} CEDAW, General Recommendation No. 25, at para. 8.
\textsuperscript{180} Ibid.
\textsuperscript{181} Ibid.
\textsuperscript{182} General Recommendation No. 24, at para. 2.
\textsuperscript{183} Ibid., at para. 9.
\textsuperscript{184} General Recommendation No 25, at para. 12.
Last, transformative equality as it is stated by article 4 of CEDAW requires State parties to undertake temporary special measures in order to effect the structural, social and cultural changes necessary to correct past and current forms and effects of discrimination against women, as well as to provide them with compensation. The CEDAW Committee states that States parties are required that their health legislation, plans and policies be based on scientific and ethical research and assessment of the health status and needs of women in that country and take into account any ethnic, regional or community variations. Therefore, Kyrgyzstan is required to remedy past discrimination faced by rural women in pregnancy and childbirth by undertaking women centered special measures aimed at correcting high maternal mortality due to postpartum haemorrhage among rural women in order to boost the de facto equality of rural women in comparison with their counterparts from urban setting.

F. Particular problems of rural women

Rural women face higher risks of preventable maternal mortality and morbidity. Being women and from rural setting cumulates into double discrimination, so called multiple or intersectional discrimination which can have a direct effect on their ability to exercise and enjoy their human rights.

Rural women in Kyrgyzstan face different and severe problems in comparison with urban women. The majority of rural women have anaemia. High rates of anaemia among rural women itself indicate the fact that rural women do not enjoy status and significance in the community. While less severe anaemia may not directly cause death, it may contribute towards death from other causes. For instance, anaemic women may not tolerate blood loss to the same

---

185 General Recommendation No. 25, at para. 15.
186 General Recommendation No. 24, at para. 9.
extent as healthy women; their wounds may also fail to heal properly following surgery.\textsuperscript{188} Additionally, it is important to indicate that remote distance of villages to central hospitals, where pregnancy related services are currently provided, fail to fulfill the interests and needs of rural women.

Therefore, the application of formally equal policies among rural and urban women can detrimentally effect rural women. Or “even when women’s access to health care is theoretically equal, some women are more vulnerable to receive inadequate or insufficient care as well as to experiencing violations of dignity.”\textsuperscript{189}

CEDAW is particularly concerned with the plight of rural women, shown by its allocation of special article 14. The CEDAW Committee is concerned about the health situation of women in particular at the inequalities between urban and rural areas\textsuperscript{190} Differential maternity survival rates indicate internal national inequities. It is unjust that all women in the world develop pregnancy related obstetric complications; however, women in developing countries and poor rural settings are much less likely to get prompt, adequate treatment, and are therefore more likely to die.\textsuperscript{191} “The poorest and most vulnerable face the greatest barriers to care”\textsuperscript{192}

Barriers to improving rural women’s health are rooted in social, cultural, economic, legal and related conditions that surpass rural women’s health considerations. Rural vulnerability to discrimination throughout her lifecycle which at the end would lead to the maternal mortality is

\begin{footnotesize}
\textsuperscript{190} CEDAW Committee, \textit{Concluding observation of the Committee on the Elimination of Discrimination against Women: Kyrgyzstan} (November 14, 2008), forty second session, CEDAW/C/KGZ/CO/3, at para. 37.
\end{footnotesize}
present due to various factors as lack of education, no sexual and reproductive health knowledge, lack of employment opportunity and so on.

Also, the CEDAW Committee recognizes that rural women are at risk of gender-based violence because of traditional attitudes regarding the subordinate role of women that persist in many rural communities. Women face maternal mortalities due to systematic inequality and discrimination, perpetuated by laws and policies and prejudicial social norms. Therefore, the CEDAW Committee states that special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as rural women.

Rural women in pregnancy and childbirth possess double vulnerability. Women in general in the last stages of pregnancy and in labor are vulnerable and need competent and sensitive care. Pregnant women who are bleeding… are extremely vulnerable, and their lives depend on the actions of others. The vulnerability of women in pregnancy and childbirth, as well as vulnerability developed due to rurality results in multiple discrimination against rural women in pregnancy and childbirth. At the same time the discrimination could be intersectional that only rural women in pregnancy and childbirth can experience such discrimination that is different from any other discrimination.

The CEDAW Committee states that States parties are required that their health legislation, plans and policies are based on scientific and ethical research and assessment of the health status and needs of women in that country and take into account any ethnic, regional or

---

194 Center for Reproductive Rights, Claiming Our Rights: Surviving Pregnancy and Childbirth in Mali (Center for Reproductive Law & Policy (January 2003), at 7.
community variations. Also, the CEDAW Committee notes the requirement of State parties in taking measures to ensure physical and economic access to productive resources, especially for rural women. Consequently, a national medicines policy must be designed to ensure access for vulnerable individuals and disadvantaged groups, including women. The State is obliged to establish a national medicine supply system that includes programmes specifically tailored to reach the vulnerable and disadvantaged.

G. All appropriate measures

It is not too little resource, but too much of violations, deaths and discrimination. In this case of “too little” women are not in the central position, but resources. However, a rights based approach should bring such policy changes that women, women’s rights, and their well-being are placed at the center. If woman in the center, government policies should conform to human rights principles of participation, non-discrimination, inclusion, and accountability.

Maternal mortality is not a “disease” affecting only women, Fathalla further states that therefore “maternal mortality should not be grouped with, and ranked for priority against, diseases.” “Society has more of an obligation to prevent maternal deaths than to prevent deaths from diseases”. “There can be no more excuses for needless maternal deaths.

196 General Recommendation No. 24, at para. 9.
197 P. Hunt, Report of Special Rapporteur on The right of everyone to the enjoyment of the highest attainable standard of physical and mental health (September 13, 2006), General Assembly, sixty-first session, A/61/338, at para. 52.
198 Ibid., at para. 54.
200 Ibid.
202 Ibid.
Governments must act urgently on their health and human rights commitments to reduce maternal mortality.”

CEDAW states that State parties are obliged to undertake all appropriate measures to ensure the application of the provisions of CEDAW, including health, to rural women. Since maternal mortality is so severe, disadvantaging only women, maternal health must be made a budgetary priority. “Governments must allocate and effectively spend increasing and sustaining resources to strengthen their health systems and make them available, accessible, affordable and acceptable.”

“The right-to-health approach to maternal mortality requires countries to prioritize those interventions that are the best available to them, taking into account epidemiological evidence, resource availability and other human rights considerations.”

The obligation of the state to prevent maternal mortality and morbidity is of immediate effect, since maternal mortality is considered to be a core obligation that requires immediate actions. The Committee on Economic, Social and Cultural Rights asserted that services of maternal health are a core obligation; therefore states have an obligation to undertake “immediate deliberate, concrete and targeted steps” towards fulfilling the right to health related to pregnancy and childbirth.

---


207 General comment No. 14, at para. 30, 43, 44 (a).
2. IMPLEMENTATION OF OBLIGATIONS

“Governments are obliged to respect, protect, and fulfill human rights related to universal access to good quality health services that help prevent maternal mortality and morbidity.”\(^{208}\)

The CEDAW Committee notes that the full realization of women's right to health can be achieved only when the States parties fulfill their obligation to respect, protect and promote women's fundamental human right throughout their life span.\(^{209}\)

Kyrgyzstan is obliged under international human rights law to respect, protect and fulfill human rights of rural women in relation to surviving pregnancy and childbirth.\(^{210}\) The CEDAW Committee urges Kyrgyzstan to ensure accessibility, affordability and adequate health care … to rural women in particular.\(^{211}\)

A. Obligation to Respect

The CEDAW Committee defines the obligation to respect. “The obligation to respect rights requires States parties to refrain from making laws, policies, regulations, programmes, administrative procedures and institutional structures that directly or indirectly result in the denial of the equal enjoyment by women of their civil, political, economic, social and cultural rights.”\(^{212}\) Within the health sector it relates to obstructing action taken by women in pursuit of their health goals. “For example, States parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the


\(^{209}\) General Recommendation No. 24, at para. 7.


\(^{211}\) CEDAW Committee, Concluding observation of the Committee on the Elimination of Discrimination against Women: Kyrgyzstan (November November 14, 2008), forty second session, CEDAW/C/KGZ/CO/3, at para. 38.

authorization of husbands, partners, parents or health authorities, because they are unmarried or because they are women.”

States parties should respect women's rights to have access to health care on both public and private levels. Also, State party should abstain from performing, sponsoring or condoning any practice, policy or measure that violates CEDAW.

In addition to refraining from obstructing actions taken by women, the states have to legally recognize on a national level that maternal mortality is an urgent issue and violates women’s human rights. Hunt notes “a State must not only recognize the right to health in national law, but also ensure that there are more detailed provisions clarifying what is expected by way of health-related services and facilities, including in relation to maternal health e.g…. antenatal care and blood safety. Such clarification may be provided by laws, regulations, protocols, guidelines, codes of conduct, and so on.”

Therefore, Kyrgyzstan has to officially and legally recognize before a nation-wide arena that maternal mortality in Kyrgyzstan among rural women is a severe human rights issue. Kyrgyzstan has to acknowledge its responsibility to take action in correcting the discrimination and violation of women’s right to health care. Kyrgyzstan has to commit to remedy its breach of obligations under CEDAW and commit to take immediate actions towards investigating the issue among rural women and put its best available resources to effectively address issues that only affected women. Both national recognition and detailed provisions are very important in rising or enhancing the accountability.

---

214 General Recommendation No. 28, at para 37 (a).
215 P. Hunt, *Supplementary note on the UN Special Rapporteur’s report on maternal mortality in India* (April, 2010), at 15, online:
<http://www.essex.ac.uk/human_rights_centre/research/rth/Supplementary%20Note%202011%20April%202010.doc>
216 P. Hunt, *Supplementary note on the UN Special Rapporteur’s report on maternal mortality in India*, (April, 2010), at 15, online:
<http://www.essex.ac.uk/human_rights_centre/research/rth/Supplementary%20Note%202011%20April%202010.doc>
However, such a development agenda that recognizes women’s needs and concerns is essential for raising women’s status, but not sufficient.217

B. Obligation to Protect

The CEDAW Committee identifies the obligation to protect rights relating to women's health as a requirement of the States parties, their agents and officials to take action to prevent and impose sanctions for violations of rights by private persons and organizations.218 The obligation to protect also requires that State parties take steps directly aimed at eliminating customs and all other practices that prejudice and perpetuate the notion of inferiority or superiority of either of the sexes, and of stereotyped roles for men and women.219

States parties should report on what they have done to organize governmental processes and all structures through which public power is exercised to promote and protect women's health.220 They should include information on positive measures taken to reduce violations of women's rights by third parties, to protect their health and the measures they have taken to ensure the provision of such services.221

Therefore, Kyrgyzstan under the obligation to protect should protect, including from third parties, promote women’s health in pregnancy and childbirth, and eliminate discrimination in order to achieve reduction of postpartum haemorrhage of women. Kyrgyzstan, for this, should ensure the enactment and effective enforcement of laws and the formulation of policies, including health care protocols and hospital procedures to address the provision of appropriate

---

218 General Recommendation No. 24, at para. 15.
219 General Recommendation No. 28, para.9.
220 General Recommendation No. 24, at para. 17.
221 Ibid.
health services.222 This means Kyrgyzstan should make an amendment adding misoprostol to the national list of essential medicines. Further, special health care protocols should be adopted at rural health posts for the use and application of misoprostol for the prevention and treatment of postpartum haemorrhage. Also Kyrgyzstan should ensure various capacity building and skills advancement trainings to health care workers, including on effective and contemporary measures for preventing and treating postpartum haemorrhage, as well as gender-sensitive trainings.223

C. Obligation to Fulfill

The obligation to fulfill requires State parties to take a wide variety of steps to ensure that women and men enjoy equal rights de jure and de facto, including the adoption of temporary special measures that achieve sex non-discrimination and gender equality in practice.224 In short the obligation to fulfill covers the obligation “to facilitate access to and provide for the full realization of women’s rights.”225 In connection to pregnancy and childbirth the duty to fulfill rights places an obligation on the 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 reproductive health care.226

“Allocating adequate public resources to maternal and reproductive health services is concrete part of fulfilling their commitments to protect women’s rights”227 Towards this end, the States parties should take steps to facilitate physical and economic access to productive resources especially for rural women, and to otherwise ensure that the special nutritional needs of all

222 General Recommendation No. 24, at para. 15 (a).
223 Ibid., at para 15 (b).
224 General Recommendation No. 28, at para. 9, 37 (d).
225 Ibid., at para. 20.
226 Ibid., at para 17.
women within their jurisdiction are met. The Committee asks States parties to report on what they have done to address the magnitude of women's ill-health, in particular when it arises from preventable conditions.

Cook and Dickens stated the following:

*Achieving safe motherhood means fulfilling the human rights of women. Since safe motherhood does only critically depend on the provision and use of good quality reproductive health care, but on involvement of strategies to empower women so that they have access to various resources as education, information and employment.*

For the above reasons, Kyrgyzstan has an obligation to fulfill the right by facilitating access to and providing for the full realization of rural women’s reproductive rights in pregnancy and childbirth. Kyrgyzstan has to take legislative and administrative measures in amending the national list of essential medicines, economic and budgetary measures in the procurement and distribution of wide availability of misoprostol in rural health posts, and administrative measures in amending the curricula of midwives and nurses by ensuring that they can apply misoprostol in postpartum haemorrhage.

---

228 General Recommendation No. 24, at para. 7.
CONCLUSION

The Kyrgyz Republic has an obligation under articles 12 and 14 (b) of CEDAW to respect, protect and fulfill rural women’s human rights to adequate health care that ensures safe childbirth and pregnancy by making misoprostol available and accessible to rural women for the prevention and treatment of postpartum haemorrhage.

Considering (i) high instances of postpartum haemorrhage in Kyrgyzstan, (ii) the high level of anaemia among pregnant women, (iii) high maternal mortality in rural settings, and (iv) the efficiency, effectiveness and easy management of misoprostol, the State is obliged to fulfill its obligations under CEDAW towards rural women and ensure availability and accessibility of misoprostol in Kyrgyzstan in order to take appropriate measures in eliminating the discrimination against women in the field of health care.

The following actions should be undertaken by Kyrgyzstan:

- Officially and legally recognize before a nationwide arena that maternal mortality in Kyrgyzstan among rural women is a serious breach of the human rights of rural women;
- Ensure maternal health is a budgetary priority due to the severity of maternal mortality;
- Include misoprostol on the national list of essential medicines for the prevention and treatment of postpartum haemorrhage in Kyrgyzstan;
- Include misoprostol on the List of medicines and medical products available at rural health posts;
• Ensure the advancement of curricula of nursing and midwifery institutes by incorporating the knowledge required to manage postpartum haemorrhage with misoprostol;
• Ensure sufficient quantity and accessibility of misoprostol at rural health posts for free through economic and budgetary measures.

Therefore, Kyrgyzstan has a core obligation to ensure the availability of misoprostol for rural women in Kyrgyzstan because of three main reasons. First of all, misoprostol is an essential drug that women need in pregnancy and childbirth. Second of all, access to essential medicines is an essential component of health care. Last, misoprostol is lifesaving medicine needed by women, and failure to ensure its availability constitutes discrimination against women. Failure to ensure the availability of misoprostol to rural women, who are in severe need, constitutes not only a breach of their human rights to health and life, but also discrimination, since it is a denial based on sex and rurality.

Rural women are a vulnerable segment of the population, who should be socially taken care of. Therefore, Kyrgyzstan is required to remedy past discrimination faced by rural women in pregnancy and childbirth by undertaking women centered special measures aimed at correcting high maternal mortality due to postpartum haemorrhage among rural women in order to boost de facto equality of rural women in comparison with their counterparts from urban settings.
BIBLIOGRAPHY

Primary Sources:

International

5. CEDAW Committee, General Recommendation No. 25 on temporary special measures.

National

17. List of medicines and medical products permitted for disposal at rural health post, attachment 5 to the order of the Ministry of Health dated February 17, 2005 N66.
18. National program “Manas taalimi” on reform of health care of the Kyrgyz Republic for 2006-2010, approved by the resolution of the Government of the Kyrgyz Republic dated
February 16, 2006 N100, last amendment by resolution of the Government dated December 23, 2008 N710.

19. Regulation on rural health post, attachment 1 to the order of the Ministry of Health dated November 24, 2006 N627.

20. Qualification of rural paramedic at rural health post, attachment 2 to the order of the Ministry of Health dated November 24, 2006 N627.

21. Regulation on obstetrician at rural health post, attachment 5 to the order of the Ministry of Health dated November 24, 2006 N627.

22. National strategy on protection of reproductive health of the population of the Kyrgyz Republic till 2015, approved by the Decree of the President of the Kyrgyz Republic dated July 15, 2006 N387.


Secondary Sources:

International


**Books, Articles**


56. C. Abraham, ‘We can’t use this drug…women will use it for abortions!’, *Globe and Mail*, June 26, 2010.


67. P. Hunt, *Supplementary note on the UN Special Rapporteur’s report on maternal mortality in India* (April, 2010), at 2, online: <http://www.essex.ac.uk/human_rights_centre/research/rth/Supplementary%20Note%2021%20April%202010.doc>.

68. P. Hunt and J. B. de Mesquita, “Reducing Maternal Mortality: The contribution to the highest attainable standard of health”, *University of Essex*.

69. P. Hunt, *Report of Special Rapporteur on The right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, General Assembly (September 13, 2006), sixty-first session, A/61/338.


