CENTER FOR REPRODUCTIVE RIGHTS

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CEDAW Secretariat
Office of the High Commissioner for Human Rights (OHCHR)
Palais Wilson
52, rue des Paquis
CH-1201 Geneva - Switzerland

Re: Supplementary Information on Brazil, scheduled for review by the U.N. Committee on the Elimination of Discrimination against Women during its 51st Session (February 2012)

Honorable Committee Members,

This letter is intended to supplement the periodic report submitted by Brazil, which is scheduled for review by the U.N. Committee on the Elimination of Discrimination against Women ("the Committee") during its 51st Session in February 2012. The Center for Reproductive Rights ("the Center"), an independent non-governmental organization, hopes to further the work of the Committee by providing independent information concerning the rights protected in the Convention on the Elimination of Discrimination against Women ("CEDAW").[1] This submission highlights the Committee's groundbreaking decision in the recent case of *Alyne da Silva Pimentel v. Brazil (Alyne v. Brazil)*,[2] and emphasizes the Brazilian government's obligation to take immediate action to implement the Committee's recommendations in order to improve the quality of maternal healthcare, eliminate discrimination in healthcare, and consequently reduce its maternal mortality rate.

Reproductive rights are an essential component of women's rights to life, health and equality, and as such, they are broadly and explicitly protected by CEDAW. The prevention of maternal mortality is a critical element of reproductive health and implicates the rights to life, health, equality, non-discrimination, information, and education as recognized in CEDAW. The reduction of maternal mortality rates, the provision of quality maternal healthcare and the eradication of discrimination in access to healthcare are specifically recognized as obligations in the fulfillment of States parties' obligations under CEDAW.[3]

This submission will particularly address Brazil's obligations under CEDAW to guarantee the right to safe and healthy pregnancy for all women, providing an overview of maternal mortality in Brazil and Brazil's obligation to implement the Committee's recommendations in the case of *Alyne v. Brazil*. Second, it will address the individual reparations and the measures of non-repetition issued by the Committee in the case of *Alyne v. Brazil*, specifically elaborating upon the structural deficiencies contributing to Brazil's high maternal mortality rate, the low quality of maternal healthcare and discrimination in access to healthcare. This report suggests specific concrete measures that are critical for the Brazilian government to take in order to effectively implement the Committee's recommendations. Third, it will comment on the State's most recently enacted legislation

purporting to address maternal mortality, which ignores the rights-based approach to women's health and infringes on women's rights to privacy, confidentiality and informed consent, as recognized under CEDAW article 12, the right to health, and article 2, the right to nondiscrimination. Finally, this submission presents to the Committee several questions and recommendations that may be useful in Brazil's review during the session.

I. Brazil is obligated to fulfill the right to safe and healthy pregnancy and childbirth for all women without discrimination (Articles 2, 10, 12, 14)

a. Maternal Mortality in Brazil

The Committee has repeatedly registered its concern with the high maternal mortality rate in Brazil in its Concluding Observations.[4] In 2007, it noted that the high maternal mortality rate "indicat[ed] precarious socio-economic conditions, low levels of information and education, family dynamics associated with domestic violence and particularly difficult access to quality health services."[5] The maternal mortality ratio in Brazil remains high, with 1,800 women dying of pregnancy- and childbirth-related causes each year.[6] By the government's own account, 90 percent of these deaths are preventable.[7] Additionally, for each maternal death worldwide, 20 other women suffer from pregnancy-related complications and health problems.[8] By the State's own maternal mortality estimates,[9] it has significantly lowered its maternal mortality ratio over the last decade, from 103.43 (deaths per 100,000 live births) in 1998 to 68.43 in 2008.[10] Yet, 2009 saw an alarming *increase* in the ratio to 72.25, reaching its highest point in five years.[11] Additionally, there are indications that this reported maternal mortality rate is markedly lower than the actual rate due to discrepancies in reporting. A 2002 article in the Brazilian Journal of Epidemiology[12] estimated that the number of reported maternal deaths should be multiplied by 1.4 in order to account for underreporting and misreporting of maternal deaths,[13] which would put the actual maternal mortality ratio at 105.

In 2005, the United Nations Common Country Assessment for Brazil noted that Brazil's maternal mortality rates are "considerably higher than those of countries with lesser levels of economic development, and are generally conceded to be unacceptable."[14] Similarly situated middle-income countries in the region have drastically lower maternal mortality rates. As of 2009, the Pan American Health Organization reported Brazil's maternal mortality rate to be 72.3, while it measured Chile's[15] rate to be 16.9,[16] and Argentina's[17] to be 55.[18] By Brazil's own estimates, the ratio will be nearly double its Millennium Development Goal target by its due date of 2015.[19]

Brazil's reduction in its overall maternal mortality rate masks the regional, socioeconomic and racial disparities in access to maternal health. The rate of maternal death among Afrobrazilians nationwide is approximately seven times higher than that of white women in Brazil.[20] A 2006 study found that the maternal mortality ratio may be as high as 562 per 100,000 live births for black women in Sao Paulo,[21] making it the second leading cause of death among black women in Sao Paulo.[22]

Maternal mortality disproportionately affects the North and the Northeast, which have higher poverty rates and greater rural populations. While the maternal mortality ratio in the wealthier South region is 42, it is 73 in the Northeast.[23] One third of families that are victimized by maternal death earn less than 75% of the minimum wage per capita each month.[24] Correlating with the higher maternal mortality rates among the poor, the rate is also much higher for women with little or no education. In a study of three states, the illiteracy rate among victims of maternal death was 9.3%, which is higher than the general population,[25] and almost 40% had an incomplete primary education.[26]

b. Brazil's obligations to guarantee access to nondiscriminatory, quality maternal healthcare services under the right to health (Article 12)

Safe and healthy pregnancy is recognized as a human right by numerous international treaties and their monitoring bodies, including CEDAW;[27] the Convention on the Rights of the Child;[28] the International Covenant on Economic, Social and Cultural Rights;[29] and the International Covenant on Civil and Political Rights.[30] CEDAW contains robust protections for the right to maternal health, and explicitly recognizes the right to safe and healthy pregnancy as a component of the right to health, stating that "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."[31] States parties are required to guarantee women´s right to health through safe motherhood services and prenatal assistance.[32] The CEDAW Committee has routinely expressed concern over State parties' high maternal mortality rates,[33] framing the issue as a violation of the right to life,[34] the right to health[35] and the right to nondiscrimination.[36] Maternal mortality can also constitute a violation of the rights to equality, information, education, and to determine the number and spacing of one's children.

According to CEDAW, States have the obligation to "take all appropriate measures to eliminate discrimination against women," including modifying laws, customs and practices that discriminate against women.[37] Likewise, States must eliminate discrimination against women in the area of healthcare and "take all appropriate measures to…ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."[38] In order to achieve women's equality, States have an affirmative duty to "respect, protect, and fulfill women's rights to health care."[39] States' failure to provide healthcare services that only women need is understood as a form of discrimination against women. Brazil's obligations under CEDAW articles 2 and 12—to ensure women's equal enjoyment of the right to life and to eliminate discrimination against women in the field of health care—became immediately applicable upon ratification. These obligations include the duty not only to refrain from infringing upon women's human rights, but also to take positive measures to advance them,[40] using the maximum available resources to ensure women safe pregnancy and childbirth.[41]

c. Brazil's Obligation to Implement the Committee's Recommendations in *Alyne v. Brazil*

In August 2011, the Committee decided the case of *Alyne v. Brazil*, wherein a pregnant woman died as a result of low quality medical care, inadequate emergency medical treatment, negligence by healthcare professionals, and systematic discrimination. The Committee found that Brazil was responsible under the CEDAW for violating its obligations under international law because Brazil was unable to guarantee Alyne maternal health care services of quality and without discrimination, and she died as a result. The Committee stated that "the lack of appropriate maternal health services in the State party clearly fails to meet the specific, distinctive health needs and interests of women" in violation of CEDAW Articles 12 (the right to health) and 2 (the right to nondiscrimination).[42] The Committee emphasized that States must create policies that not only address the specific needs of women, but that are also results-oriented and adequately funded.[43] The Committee determined that the deceased was discriminated against based on her sex in addition to "her status as a woman of African descent and her socioeconomic background."[44] The Committee also found that Brazil failed to fulfill its "due diligence obligation to take measures to ensure that the activities of private actors in regard to health policies and practices are appropriate."[45] The Committee elaborated upon Brazil's due diligence obligations, noting that when States contract with private providers for the provision of public medical services, they remain responsible for regulating and monitoring the services.[46]

In finding Brazil responsible for Alyne's death, the Committee recognized the right to reparations for the mother of the deceased as well as her daughter. The Committee noted that it "recognizes the moral damages caused to the author by the death of her daughter, as well as the moral and material damages suffered by the daughter of the deceased who has been abandoned by her father and lives with the author in precarious conditions."[47] The Committee determined that Brazil must "provide appropriate reparation, including adequate financial compensation, to the author and to the daughter of Ms. da Silva Pimentel Teixeira commensurate with the gravity of the violations against her."[48]

As part of its decision, the Committee also issued a series of recommendation that address the obligation to implement measures of non-repetition. The Committee issued six general recommendations:

- "Ensure women's right to safe motherhood and affordable access for all women to adequate emergency obstetric care, in line with General Recommendation No. 24 (1999) on women's health;
- Provide adequate professional training for health workers, especially on women's reproductive health rights, including quality medical treatment during pregnancy and delivery, as well as timely emergency obstetric care;
- Ensure access to effective remedies in cases where women's reproductive health rights have been violated and provide training for the judiciary and law enforcement personnel;
- Ensure that private health facilities comply with relevant national and international standards on reproductive health care;

- Ensure adequate sanctions are imposed on health professionals who violate women's reproductive rights; and
- Reduce preventable maternal deaths through the implementation of the National Pact for the Reduction of Maternal Mortality at state and municipal levels, including by establishing maternal mortality committees where they still do not exist, in line with the recommendations in its concluding observations for Brazil, adopted August 2, 2007 (CEDAW/C/BRA/CO/6)."[49]

The Center applauds the Committee for its firm stance on States' obligations to reduce maternal mortality and to respect, protect and fulfill the reproductive rights of all women. In the Committee's decision in *Alyne v. Brazil*, the Committee affirmed that State parties are not only obligated to reduce their overall maternal mortality rates, but also that it is impermissible and a human rights violation for States to ignore marginalized sectors of their populations in the provision of reproductive health services. As the first decision from a treaty monitoring body on maternal mortality, the Committee's decision is a milestone for women's rights and reproductive health worldwide. To adequately and appropriately implement the *Alyne* decision, it is critical that Brazil address each of the recommendations delivered by the Committee, with special emphasis on improving the quality of healthcare provided to women during pregnancy, delivery and the postpartum period. Furthermore, in contrast to the most recently enacted law addressing maternal mortality in Brazil, the process for reforming the current system must include a participatory framework that allows consultations with stakeholders, including the various Ministries, civil society organizations and public health experts.

The following section addresses the Committee's individual recommendations for reparations to Alyne's family, as well as the general recommendations of measures of non-repetition issued in the decision.

II. Brazil must immediately act to implement the Committee's recommendations in *Alyne v. Brazil*

1. Individual measures

The Committee determined that Alyne's family, her mother and her daughter, had the right to reparations for the human rights abuses she suffered that ended in her death. In accordance with international human rights doctrine, States "shall provide reparation to victims for acts or omissions which can be attributed to the State and constitute gross violations of international human rights."[50] Reparations must be proportionate to the gravity and resulting harm of the human rights violations.[51] Forms of reparations include restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition. *Restitution* should seek to restore the victim to his or her situation prior to the human rights violation.[52] *Compensation* should provide for economically assessable damages, including "physical or mental harm; lost opportunities, including employment, education and social benefits; material damages and loss of earnings, including loss of earning potential; moral

damage; [and] costs required for legal or expert assistance, medicine and medical services, and psychological and social services."[53] *Rehabilitation* includes legal and social services, as well as medical and psychological care.[54] *Satisfaction* includes implementation of measures to cease ongoing violations; public apology, including acknowledgement of the facts and acceptance of responsibility; and judicial and administrative sanctions against those liable for the violation.[55] *Guarantees of non-repetition* include ensuring due process, fairness and impartiality in legal proceedings; human rights training for members for all sectors of society, including law enforcement; strengthening the independence of the judiciary; and reviewing and reforming laws that contribute to or allow human rights violations to occur.[56]

Under international law, a State may not evade liability to provide reparations for human rights violations by claiming its domestic laws or federal structure absolves its liability or prevents it from fulfilling its obligations.[57] In accordance with international law, the State is responsible for making reparations for the human rights violations its agents commit, regardless of any domestic provisions to the contrary.[58] As stated in the Vienna Convention on the Law of Treaties, "a party may not invoke the provisions of its internal law as justification for the failure to perform its treaty obligations."[59] States should also enforce domestic judgments against non-states actors, such as private individuals or entities, which are responsible for human rights violations.[60]

The Commission recognized the moral damages inflicted upon Alyne's mother and the moral and material damages caused to Alyne's daughter, ordering the State party to provide adequate compensation. Moral damages include emotional harm and psychological suffering, while material damages include measurable economic harm suffered as a result of the violations, such as loss of income or earnings.

Until this moment, Brazil has not provided Alyne´s family with reparations for the human rights violations suffered. We ask the Committee to urge Brazil's government to provide reparations for Alyne´s family as stated in the decision taking into consideration the international human rights standards mentioned.

2. Measures of non-repetition

There is currently a great opportunity for Brazil to implement progressive, effective measures to comply with the recommendations set forth by the Committee. It is essential for the fulfillment of women's right to safe and healthy pregnancy and childbirth that Brazil enacts measures to implement the various recommendations set forth in the *Alyne* decision, utilizing a rights-based approach to maternal healthcare.

The Brazilian public Unified Health System (SUS) offers universal health services to the population, and 75% of the Brazilian population relies exclusively on SUS services.[61] The creation of the SUS has greatly expanded healthcare services throughout Brazil, with approximately 93% of people seeking health care receiving treatment.[62] The Brazilian

healthcare system has nearly universalized prenatal care, with up to 98% of women receiving prenatal care in some areas.[63] Furthermore, 88% of women are accompanied by a physician during childbirth, while up to 98% of women are accompanied by at least a trained health service provider.[64] Despite these advances, the maternal mortality rate in Brazil remains unacceptably high. As access to health services is not the prevalent cause, experts indicate that it is the quality of health services that must be improved.[65]

Four of the six general recommendations issued by the Committee in *Alyne v. Brazil* address the quality of maternal healthcare, while two address the issue of accountability in the healthcare sector. While there are innumerable measures that could be implemented in order to improve the quality of maternal healthcare and increase accountability, the following emphasizes specific measures that have been identified as being critical in order to effectively and sustainably comply with the recommendations in *Alyne v. Brazil*.

It is critical that Brazil implements effective quality control measures to improve the provision of health services. These measures should specify the procedures that must be provided during prenatal visits, delivery and post-natal care; instate medical protocols to address common causes of maternal mortality; and remediate the ineffectiveness and fragmentation of the current referral system to guarantee women in labor access to a hospital with an available obstetric bed. Furthermore, in order to enhance accountability within the healthcare sector, mistreatment within the SUS must be eradicated in order to prevent women's reproductive rights from being violated, and mechanisms designed to hold healthcare professionals accountable for reproductive rights violations must be reformed and strengthened.

In the following sections, this submission will first address the four general recommendations regarding quality of care, and then will address the two recommendations that address accountability, providing specific guidance in terms of concrete measures to implement such recommendations.

a. Brazil must ensure women's right to safe motherhood and affordable access for all women to adequate emergency obstetric care

i. Brazil must implement and enforce treatment protocols for common direct causes of maternal death

By the Brazilian government's estimates, 90% of maternal deaths in Brazil are preventable.[66] Three of the most common direct causes of maternal death are hypertension, which causes preeclampsia/eclampsia; sepsis; and hemorrhage. All three of these can be managed with the proper equipment, medications and medical treatment; nonetheless, studies in Brazil demonstrate that in many instances, these disorders are either not properly diagnosed or not properly treated. For example, detecting hypertension is very simple and cost-effective, as it can be detected by measuring blood pressure during prenatal consultations. Yet, a study of prenatal consultations in Brazil found that 44% of women did not have their blood pressure taken during prenatal care.[67] Furthermore, it is well-

established in medical literature and advised by the WHO that if eclampsia is imminent or occurring, magnesium sulfate should be administered to reduce risks associated with the convulsions.[68] One study found that less than 10% of women in Brazil who died from eclampsia were treated with magnesium sulfate, while other studies have put this number closer to 50%.[69] Furthermore, 43% of hospitals in Sao Paulo were found not to even have magnesium sulfate.[70] As such, it is clear that the treatment being administered for common causes of maternal mortality is frequently of substandard quality.

The Ministry of Health is responsible for developing treatment protocols that include detailed information on diagnosis, treatment, and monitoring of patients for particular ailments.[71] These protocols are based on internationally recognized technical and scientific evidence and provide information ranging from the characterization of the disease; treatment that should be provided, including proper drugs to be prescribed, administration and duration of use; the expected benefits; and guidelines for monitoring patients.

It is critical that the Ministry of Health develop, disseminate and enforce evidence-based protocols for the common causes of maternal mortality – namely hypertension, preeclampsia/eclampsia, hemorrhage and sepsis. Necessary medications for treating these common maternal ailments should be required by all healthcare facilities. As studies indicate that established protocols to manage high-risk pregnancies are often not adhered to,[72] it is critical that training on these protocols are provided to health service professionals and sanctions are imposed on those who harm patients by failing to abide by these protocols.

ii. Brazil must implement a monitoring system to evaluate the quality of prenatal, delivery and postnatal healthcare

In 2007, a study found that of cases of maternal deaths in women who had received prenatal care, the prenatal care received was inadequate in almost 80% of cases.[73] It has been observed that "certain basic procedures…were less frequently performed than more costly procedures of doubtful effectiveness."[74] One study found that 44% of women did not have their blood pressure taken, 44% were not weighed, and between 20-40% were not tested for syphilis, toxoplasmosis, rubella or HIV.[75] Further demonstrating the poor quality of maternal health care, one study found that in cases of congenital syphilis,[76] 75% of the women who were diagnosed with it were nonetheless left untreated.[77]

There are also regional and sociodemographic disparities in the quality of prenatal care. A study in 2008 found that eight out of twelve of the prenatal procedures which were examined were more likely to be performed on women with higher incomes.[78] Among women with different skin colors, a similar pattern was found with these procedures being less frequently performed on black women.[79]

There is also evidence that women are receiving inadequate post-natal care. A study in Sao Paulo found that over two-thirds of maternal deaths occurred during the post-partum period.[80] Another study found that in 25% of maternal deaths, the women had already been

discharged from the hospital, indicating that there is inadequate post-partum monitoring.[81] There is also evidence of women being released from the hospital prematurely, including within 48 hours of having a cesarean section, and when exhibiting signs of infection.[82] These practices elevate the risk of re-hospitalization and maternal death.[83]

While Brazil currently monitors the provision of prenatal care through the Programa de Humanização no Pré-natal e Nascimento, it does not have a systematic method for evaluating the quality of prenatal, delivery and post-natal care. While Maternal Mortality Committees provide in-depth analyses of the pre-natal, delivery and post-natal care received by victims of maternal mortality, they do not provide systematic monitoring of the quality of care received by all women, by those who come close to suffering from maternal death but recover (known as near-miss epidemiological surveillance), or by those who suffer from maternal morbidity. Furthermore, Maternal Mortality Committees currently investigate roughly 40% of maternal deaths,[84] and therefore the information they do collect remains incomplete.

In order to identify the specific aspects of prenatal, delivery and post-natal care that are deficient and are contributing to maternal mortality and morbidity, it is critical that the State create and implement a mechanism to monitor quality of care. This mechanism should identify aspects of care that are of poor quality and identity populations that are receiving low-quality care, specifically examining the care provided to Afrobrazilians and rural populations. The data collected should inform a national plan to address these deficiencies and ensure access to high-quality care to all populations in Brazil.

iii. The referral system in Brazil must be reformed to ensure women in labor have access to proper healthcare facilities

To reduce maternal mortality, Brazil must ensure that women in labor have access to the proper medical facilities and that these facilities have available space to care for women referred there. The majority of women in labor in Brazil are forced to seek refuge at multiple hospitals before finding one willing to admit them.[85] This search for hospitals by women in labor is such a common, well-known phenomenon in Brazil that it has been labeled a "pilgrimage" in both academic reports and the media.[86] Women already in labor travel from one hospital to another, seeking one with an open bed and of the proper complexity level that is willing to admit her.

Although 90% of births in Brazil take place in public hospitals,[87] in practice women in labor are not guaranteed access to a bed, even for high-risk pregnancies.[88] Most commonly women have to go to multiple hospitals due to the limited number of beds in metropolitan areas, lack of staff in rural areas,[89] or because the hospital they go to is of the incorrect complexity level—women with low-risk pregnancies seeking care in high-complexity maternity hospitals, or women with high-risk pregnancies seeking care in low-complexity hospitals.[90] One study found that 31.8% of black women, 28% of women pardas and 18% of white women in labor had to go to more than one hospital to receive care,[91] demonstrating the racial disparities in hospital admissions for women in labor.

One study of maternal deaths found that while 74% of the women who died needed to be in an intensive care unit, 37% did not have access to one.[92] Another study found that 28% of maternal deaths were women who needed to be transferred to facilities providing more complex services.[93] Women with high-risk pregnancies must have access to referrals for proper care. The shortage of beds has also been linked to early release of women from the hospital after giving birth, at times including women who are exhibiting signs of infection, which in turn leads to re-hospitalization or maternal death.[94]

Over the past decade, there have been a number of federal initiatives regulating the referral systems throughout Brazil, yet the statistics demonstrate that these measures have not effectively ensured women access to the proper facilities. Under the 1998 Program to Support the Implementation of State System of Reference Hospitals for the Care of High-Risk Pregnancies, each state was required to have a statewide reference system for high-risk pregnancies. Under the 2001 and 2002 Operational Norms for Health Care, states and municipalities are to have a regulation center designed to ensure appropriate access to care, a Central of Beds to monitor referrals, and a Commission to Authorize Procedures of High Complexity and Hospital Admissions to organize referrals. Under the 2008 Policy for the Regulation of the SUS, each state is required to have a Regulatory Central for Consultations and Exams and a Regulatory Central for Hospital Admissions, and must manage their bed occupancy to ensure access to proper health services. Under Portaria 1559 of 2008, states must have a regulatory complex to identify available beds. And finally, since 2007 under Law 11.634/2007, every pregnant woman has legally been guaranteed a bed in a hospital, and the right to previously know and be linked to a maternity where she will give birth. Although this law has been in force for over four years, it was never implemented or enforced until the creation of Rede Cegonha, a program that is just now in its initial stages of implementation.[95] This demonstrates that although Brazil may have a number of laws regulating referrals, these laws lack implementation and enforcement, which prevents them from being effective. While the Rede Cegonha seeks to improve referrals by linking women to a maternity where they will give birth, this fails to recognize that it is not just one aspect of the referral system which is not functioning properly; it is the referral system as a whole that is not providing proper access to necessary healthcare services.

In the past, the Brazilian government has unsuccessfully attempted to ensure proper referrals through the confluence of aforementioned measures. In order to create an effective, functioning referral system, much more is needed than assigning women to a healthcare facility, as that has legally been a right for four years and still is not in practice fulfilled. It is of paramount importance that Brazil reevaluates and reforms the fragmented and disjointed referral system. The referral system must be more comprehensive and should take into account the various regions' diverse geographical settings and populations' access to transportation. The number of hospital units and obstetric beds must be evaluated and the government must commit to actually increasing the number of hospitals and obstetric beds in order to equitably fulfill the needs of the population. It is unacceptable

that women in labor are turned away at healthcare facilities' doors. The referral system must be overhauled to guarantee women in labor are admitted to hospitals and receive qualified birth assistance.

b. Brazil must provide adequate professional training for health workers, especially on women's reproductive health rights, including quality medical treatment during pregnancy and delivery, as well as timely emergency obstetric care and ensure adequate sanctions are imposed on health professionals who violate women's reproductive rights

i. Brazil must implement a policy to address institutional gender-based violence in the SUS

Institutional gender-based violence is a prevalent yet overlooked problem in Brazil's public Unified Healthcare System (SUS), affecting access to, quality of and effectiveness of health services.[96] The three recognized types of violence committed by health workers in maternity care are neglect; verbal violence, including rough treatment, threats, scolding, shouting, and intentional humiliation; and physical violence, including denial of pain-relief when medically indicated.[97]

A study investigating patients' reflections on hospitalization in a hospital in the Northeast of Brazil found that 83.6% of patients categorized their experience as "degrading" and "humiliating."[98] Only 16.4% of the experiences in the hospital were considered "caring."[99] Patients reported being treated as "nothing"[100] and being stigmatized and ridiculed based on their poverty levels.[101]

A recent study found that 25% of women reported some form of violence during hospitalization for childbirth.[102] This violence was more common in public health services, with 27% of women reporting violence, than in private health services, where 17% reported violence.[103] Women at the top of the reproductive social hierarchy, such as those who are white, married and have a higher education, are less likely to experience such violence, [104] while Afrobrazilians and young women are particularly vulnerable to violence and neglect.[105]

A nationwide policy should be implemented to address and prevent gender-based violence in the SUS. This policy should be developed in collaboration with consumer protection and women's rights groups and should address the various types of abuse within healthcare systems. It should specifically address groups that are particularly vulnerable to abuse within the SUS, such as Afrobrazilians, young women, and women in poverty, and protect the human rights of all patients and provide mechanisms for reporting and redressing abuse within the SUS. This policy must be widely disseminated among both services users and providers, and training should be provided for SUS workers to achieve its implementation.

Researchers suggest that the eradication of abuse towards patients should begin in medical and nurse training. Attention should be given to ethics, anthropology, communication, and

human rights including reproductive and sexual rights.[106] Health workers must be trained to communicate genuinely with patients, which include "mutual agreement and decisions on treatments, and a recognition that patients are ultimately responsible for their own lives and moral decisions."[107] The Ministry of Health should mandate that health service providers receive training in these fields.

However, training is not enough to eradicate institutional violence in healthcare settings. Working conditions need to be improved to provide staff with the time and privacy necessary to properly attend to patients, and staff must have adequate service training, and access to laboratory services, dugs, and treatment.[108] Managers must actively identify abusive staff, and patient complaints should be investigated and immediately addressed.[109] Mechanisms for reporting abuse must be well publicized and actively encourage patients to complain—especially patients who are impoverished, illiterate, or disempowered. It is critical that Brazil provide training for medical personnel and clearly publicize channels to lodge complaints within the SUS.

ii. The National Guidelines on Humanized Abortion Care must be implemented and enforced

Unsafe abortion is the third greatest cause of maternal death in Brazil,[110] accounting for an estimated 8.4% of maternal deaths.[111] Abortion is only legal in Brazil when it is the only method to save a women's life or the pregnancy results from a rape. Nonetheless, there are an estimated 700,000 to one million illegal and unsafe abortions annually in Brazil.[112] Unsafe abortions are often characterized by unsanitary conditions and unskilled medical personnel, resulting in elevated rates of complications and maternal mortality. Exacerbating the dangers of clandestine abortion, its illegality inhibits women suffering from post-abortion complications from seeking medical care, out of fear of stigmatization and being criminalized.[113]

In Brazil, women who seek hospital treatment following a clandestine abortion report being treating with hostility.[114] A recent survey found that 53% of women who required hospitalization for an incomplete abortion or miscarriage reported some form of violence from health providers, including being threatened with imprisonment, denial of information, delay and neglect in assistance and verbal abuse.[115]

The National Guidelines on Humanized Abortion Care address the abuses suffered by women seeking post-abortion care in Brazil. These guidelines include information on ethical and legal aspects of abortion, principles of acceptance and non-judgment that should be followed, standards for clinical attention to abortion care and post-abortion reproductive planning. They emphasize the provision of support, information and counseling to women receiving post-abortion care, including the importance of respect, compassion and sensitivity.[116] They also include clinical information based on the International Federation of Gynecology and the World Health Organization on medical aspects of treating unsafe abortion complications.[117]

Despite the creation of these guidelines, they have not been adequately publicized or implemented, inhibiting their effectiveness. A 2010 study concluded that many health professionals in Brazil are not even aware the guidelines exist.[118] In order to ensure that women suffering complications from clandestine abortions receive proper, adequate and humane medical treatment, Brazil must effectively implement the National Guidelines for Humanized Abortion Care. Measures must be implemented to hold healthcare providers accountable for failing to abide by the guidelines and for mistreating women seeking post abortion care, no matter if the mistreatment manifests itself in the form of neglect, verbal abuse or physical violence. When women suffer abuse at the hands of healthcare professionals, it deters them from seeking immediate treatment for medical complications, such as those resulting from unsafe abortion and those which may result in maternal death.

iii. Federal Law 11.108 must be implemented and sanctions must be created and enforced for health service providers' failure to abide by the law's provisions

In 2005, the Brazilian government passed Federal Law 11.108, establishing that all health service providers must permit women to have a companion present during labor, delivery and the immediate postpartum period.[119] Although the original text of the law included penalties for noncompliance, the final text that was passed did not include any concrete sanctions for health service providers who prevent women from exercising this right. Since 1985, the WHO has recommended that governments guarantee women the right to have a companion during labor. The identified benefits include increasing women's feelings of self-confidence and control during labor; less need for medication and analgesia; decrease in the number of cesarean sections; lower levels of pain, panic and exhaustion; and an increased feeling of satisfaction.[120] Studies indicate that only 16.2% of women in Brazil exercise the right to a companion during labor, delivery and the postpartum period. Of these women, the percentage is markedly lower in the public sector as compared to the private sector, with only 9.5% of women using SUS services and 34.6% of women using private services.[121]

Given that this is already a law and that the benefits of enforcing this law greatly enhance the birthing experience, it is of paramount importance that the Brazilian government better publicizes this law and enforces noncompliance by healthcare providers. By ensuring the right to have a companion present, women can feel that the birthing process is more humanized, less painful and more respectful of their rights. The government should institute a campaign to encourage women to exercise this right and provide specific sanctions for healthcare providers who prevent women from exercising this right.

c. Brazil must ensure access to effective remedies in cases where women's reproductive health rights have been violated and ensure adequate sanctions are imposed on health professionals who violate women's reproductive rights by reforming and strengthening accountability mechanisms

In order to improve maternal healthcare in Brazil, it is critical that accountability mechanisms be improved in order to hold medical professionals responsible for the failure to provide appropriate and adequate healthcare treatment. Furthermore, Brazil must ensure that its entire population, as opposed to just the elite, has access to justice for violations of their reproductive rights.

i. The Federal and Regional Medical Councils must be reformed to enhance accountability for ethical violations

Doctors in Brazil are regulated through the Federal Medical Council[122] (CFM), which is responsible for promulgating the Medical Ethics Code, which contains the ethical rules regulating doctors[123] and which doctors are legally required to abide by. Regional Medical Councils[124] (CRMs) enforce the Medical Ethics Code through hearings that determine whether ethical violations have occurred.[125]

Although these hearings are designed to hold medical professionals accountable for wrongdoings, regional and federal medical councils very rarely suspend or revoke medical licenses, and the issuance of confidential warnings or censures is much more common.[126] In 2005, there were 344 disciplinary actions against physicians in Brazil, as compared to over 6,000 in the United States and over 500 in the state of New York alone.[127] Furthermore, of these 344 cases, only 8 resulted in a license suspension, and only 2 resulted in a license revocation.[128] License revocation is generally reserved for doctors who prove to be particularly incompetent, such as "those who repeatedly commit serious ethical and/or legal violations, particularly where their conduct results in the death of a patient."[129] These councils have also been criticized for failing to administer sanctions that correlate to the gravity of the charged violation.[130] Studies on the proceedings in different CRMs identify gynecology and obstetrics among the specialties most often involved.[131]

Federal and Regional Medical Councils must be reformed to ensure that they more strongly enforce the ethical guidelines associated with the practice of medicine. Reforms must be made to enhance their accountability and make the councils answerable to the public, especially in instances when the ethical guidelines pertaining to maternal mortality are not being adequately enforced.

ii. The judiciary's role in remediating violations of the right to health must be expanded

Access to justice remains very difficult and costly for a significant portion of the Brazilian population, making them unable to have violations of their rights adjudicated. When it is possible to access judicial institutions, the population is faced with lengthy, partial and uncertain judicial proceedings, which are not conducive to redressing rights violations.[132] Groups that are marginalized and discriminated against often have to endure further discrimination when seeking access to justice, in terms of both finding lawyers to represent them and in gaining access to the courts.[133]

The Ministério Público (MP) is responsible for defending the rights of individuals and society from infringements at the hands of the government or individuals.[134] State and federal MPs have the ability to play an active role in the control of public policies and the judicialization of women's rights violations. However, such initiatives are still isolated in Brazil. Thus, the Ministry of Health, the Secretariat of Policies for Women and the National Health Council should work in conjunction with the Ministério Público to create a common action plan to monitor and enforce state and municipal policies for women's health, including issues related to preventable maternal mortality and morbidity.

Similar to the Ministério Público, the Defensoria Pública is an autonomous and permanent institution that is essential to the administration of justice. It provides legal advice and advocacy for people who do not have material resources to bear such expenses.[135] Its main objective is to expand access to justice, reducing the inequities of the system through lawsuits, rights education and various extra-judicial activities in order to ensure the rights of socially vulnerable populations. In Brazil there are approximately 4,515 Defensoria Públicas, amounting to only one advocate for every 32,000 people when considering the target population to be those ages 10 years and older with incomes up to 3 minimum wages.[136] Defensoria Públicas operate in only 42% of all counties[137] and their distribution is not homogeneous: there are proportionally fewer defenders in places and regions that, in theory, are in greater need of Defensoria Pública services.[138] The Defensoria Pública should be installed in locations that have lower human development index, as it indicates that these populations are the ones most in need of its services.[139] The Ministry of Health, in collaboration with the Secretariat of Policies for Women, should promote awareness-raising seminars to train the Defensoria Pública on issues related to women's health, including intervention strategies to reduce maternal mortality.

III. Brazil's most recently enacted measure to address maternal health care violates the rights to rights to privacy, confidentiality and informed consent, as recognized under the right to health, and the right to nondiscrimination (articles 12 & 2)

Despite CEDAW's explicit protections of the right to safe and healthy pregnancy and the Committee's interpretive guidance, reinforced by its recent decision in *Alyne v. Brazil*, the Brazilian government has repeatedly failed to protect, respect and fulfill this right, in violation of its international obligations. The Brazilian government recently demonstrated its unwillingness to embrace the human rights framework in addressing maternal mortality with the passage of Provisional Measure 557 (MP 557).[140] This measure is extremely regressive, stripping women of their decision-making capacity, subjecting pregnant women to involuntary and excessive government regulation and intrusion, depriving women of confidentiality in their receipt of medical care, and depicting the unborn child as the focus of maternal health instead of the woman.

On December 26, 2011, the Brazilian Ministry of Health enacted MP 557, entitled the National System for Registration, Surveillance and Monitoring of Pregnant and Postpartum

Women for the Prevention of Maternal Mortality (*Institui o Sistema Nacional de Cadastro, Vigilância e Acompanhamento da Gestante e Puérpera para Prevenção da Mortalidade Materna*), which creates a national database of pregnant women aimed to monitor their prenatal care. MP557 also provides a stipend for transportation to health facilities for prenatal care, but before it was recently amended by Portaria 68, women had to consent to their confidential medical information being publicly accessible in order to receive this stipend. Despite the measure's title, by requiring mandatory registration without consent and by granting prenatal rights, its effect is to violate women's rights to autonomy and privacy by mandating the registration of all pregnant women and imposing involuntary government monitoring on women during pregnancy. While the State party claims that this measure is intended to prevent and reduce maternal mortality, it fails to take into account various components of the right to health, such as the rights to privacy, confidentiality and informed consent. Furthermore, a close examination of the law demonstrates that it does not address any of the systemic issues that have been identified as contributing to the high maternal mortality rates in Brazil and directly contravenes CEDAW recommendations in the case of *Alyne v. Brazil*.

Furthermore, it is critical that during the process of implementing *Alyne v. Brazil*, the State party acts in consultation with the various Ministries, civil society organizations, and public health experts. Provisional measures are a legislative tool that the President may to pass laws without Congressional approval in order to address urgent issues. Once the law has already been enacted, as is the case with MP 557, then Congress can debate and decide whether to approve the law. Provisional Measure 577 was passed by the executive branch on December 26, 2011, while Congress was out of session, and extreme frustration has been expressed by a number of women's rights advocates and members of the government that the process failed to take into account their various perspectives.[141] While it is commendable that the executive branch is grasping the urgency of addressing maternal mortality, the creation of laws to reduce maternal mortality must be an open and democratic process that includes discussions from the various Ministries, civil society organizations, and public health experts in order to ensure that these measures are thorough, thoughtful and effective.

i. The creation of the national database of pregnant women violates the right to health and nondiscrimination (Articles 12 & 2)

MP 557 institutes a national database of pregnant women, and obligates healthcare providers to universally register pregnant patients in this database.[142] Health facilities are obligated to establish committees to monitor the database,[143] which are responsible for registering pregnant patients in the computerized database, including confidential medical information such as their health assessments, various diagnoses, and treatment plans.[144] The measure does not include an obligation to inform patients about the registry, nor to receive patients' informed consent to registration. Further, it mandates "universal" registration and does not include a mechanism for patients to opt out of registration in the national database. The law does not address issues of confidentiality, nor the protection of patients' privacy.

The national registry of pregnant women violates the rights to privacy and to confidentiality in healthcare settings. The right to confidentiality in medical treatment is well established in international human rights law, and is recognized within the right to health in CEDAW.[145] While State parties are obligated to "ensure women's right to safe motherhood and emergency obstetric services and… to allocate to these services the maximum extent of available resources,"[146] these services must "be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice."[147]

By forcing pregnant women to join a national registry, the State is violating women's rights to "autonomy, privacy, confidentiality, informed consent and choice,"[148] as recognized under the right to health in CEDAW. MP 557 violates women's rights to privacy and confidentiality, as their confidential medical information, such as their status as pregnant and their health assessments, various diagnoses, and treatment plans,[149] become part of a national registry. Furthermore, the law fails to explicitly inform women seeking medical care that they will become part of this registry and does not seek their permission to be registered in the database, in violation of their rights to informed consent and choice.

The registration requirement also violates Article 2 of CEDAW, which obligates States to immediately take action to eradicate all forms of discrimination against women.[150] State parties must "take all appropriate measures to eliminate discrimination against women in the field of health care."[151] The Committee has repeatedly condemned State practices compelling women to receive particular medical procedures or medical tests.[152] In this instance, women, as the only sex that can become pregnant, are the only ones compelled to become part of the registry, in violation of the right to nondiscrimination. The registry inherently treats women differently from men, unjustly depriving them of various components of the right to health and therefore violates women's rights to nondiscrimination and equality.

There is also a serious risk that the national registry of pregnant women could be utilized as a mechanism to monitor for clandestine terminations of pregnancies. As all women whose pregnancies are confirmed by doctors are obligated to become part of this registry, there is the potential that the pregnancy could be monitored by the government in order to ensure that it is not terminated. This may result in grave violations of the right to privacy, and may also erode the relationship of trust and confidentiality between doctors and patients. General Comment 24 recognizes that lack of confidentiality in the medical field has a disproportionate impact on women, noting that "while lack of respect for the confidentiality of patients will affect both men and women, it may deter women from seeking advice and treatment and thereby adversely affect their health and well-being."[153] In the context of unwanted pregnancies, MP 557 has a direct, negative impact on the relationship of trust and confidentiality between women and their doctors.

The registry of pregnant women may also cause women who are potentially facing an unwanted pregnancy to become unwilling to seek medical attention to confirm their pregnancy, for fear of being placed on the registry. As a result, women may wait until their

pregnancy progresses further, to verify without medical assistance that they are pregnant before seeking a clandestine abortion, thereby placing themselves at greater risk by delaying the abortion. As the Committee has previously noted, high numbers of unsafe, illegal abortions contribute to high rates of maternal mortality and morbidity in Brazil,[154] and they result in 215,000 hospital admissions each year.[155] MP 557 does not take any positive measures to address the negative health effects of clandestine abortions; instead, it instills in women a fear of seeking medical advice for unwanted pregnancies, encouraging both delays seeking medical treatment or the decision not to seek medical care at all.

ii. The creation of rights in the unborn violates the rights to health and nondiscrimination (Articles 12 &2)

MP 557 states that "Public and private health services are required to ensure pregnant women and the unborn the right to safe and humane prenatal, labor, birth and postpartum care."[156] This creates a right in the unborn to health care services during the prenatal period, birth, and after birth. The Brazilian Constitution does not recognize life as beginning prior to birth, and therefore does not recognize the unborn as rights-holders. In 2008, an attempt to grants rights in embryos was rejected by the Supreme Court (*Supremo Tribunal Federal*), which determined that pre-implantation embryos are not people in the sense referred to in the Constitution.[157] In a recent interview, Fausto Pereira dos Santos, special adviser to the Minister of Health, was unable to publicly explain the logic behind adding this language, the process for its incorporation or the legal repercussions it may have.[158] In the context of a conservative movement attempting to negatively influence policies affecting women's reproductive health and freedom in Brazil, this language and its undemocratic inclusion is cause for very serious concern.

Within the human rights framework, pregnant women are the holders of rights, and are not simply repositories for incubating children. The Committee has made clear that the principles of nondiscrimination and equality require that States prioritize the rights of women over the rights of the unborn. In the case of *L.C. v. Peru*, the Committee expressed serious concern that the interests of the fetus were prioritized over the life and health of the pregnant woman.[159] By attempting to institute rights in the unborn, the Brazilian government is inherently diluting women's rights to autonomy, privacy, and to make decision about their bodies and healthcare.

iii. Before its recent amendment by the Ministry of Health, MP 557 further violated the rights to privacy and confidentiality by making pregnant women's medical information publicly accessible

Under MP 557, pregnant women are granted up to 50.00 Reals as part of the registry in order to pay for transportation costs associated with their medical care.[160] As the measure was initially passed, the amount of these benefits and the names of their recipients were designated as being public information, without restrictions as to who could access them,[161] and to be disclosed through "publicly accessible electronic media,"[162] presumably meaning that it will be available on the internet. The measure did not require that healthcare service providers receive benefit recipients' informed consent to their names being published, nor

did it include any a mechanism for women receiving the benefits to prevent their names from being published. It was not until Portaria 68 was passed by the Ministry of Health on January 11, 2012 that this provision was changed in order comply with Article 5 of the Federal Constitution, which guarantees the right to privacy; Article 216 of the Federal Constitution, which states that the processing of personal information should respect privacy; Law No. 8.159, which regulates access to information; and Decree No. 4553, which protects data, information and documents containing sensitive data or information whose disclosure would put in jeopardy the rights privacy, private life, and honor. Based on these changes, the private information of women receiving a stipend for transportation will no longer be publicly accessible information.

MP 557 is a harmful and intrusive measure that violates the rights to confidentiality, privacy, informed consent and dignity as recognized under the right to health. It has the potential to erode trust within doctor-patient relationships, and may have the perverse effect of causing women to delay or avoid seeking medical attention. Furthermore, it does not address any of the issues causing maternal deaths in Brazil, and does not in any way advance women's reproductive rights of health. We urge the Committee to condemn this recent measure and to encourage the State party to enact progressive legislation that fulfills the guarantees of women's human rights.

IV. Questions

In light of the information provided above, we hope that this Committee will consider addressing the following questions to the government of Brazil:

1. What steps has the State party taken to provide Alyne's mother and daughter with the appropriate material and moral reparations?

2. What steps has the State party taken to better ensure the right to safe motherhood? What steps is the State party planning to ensure all women access to quality maternal healthcare and emergency obstetric care?

3. Has the State party further implemented the National Pact for the Reduction of Maternal Mortality? Does the State plan to adopt measures in such direction?

4. Has the State party established additional maternal mortality committees where they do not yet exist? If not, is the State party planning to do so?

5. Has the State party taken any steps to improve professional training for health workers on women's reproductive rights, quality medical treatment during pregnancy and delivery and timely emergency obstetric care?

6. Has the State party taken measures to ensure that private health facilities comply with relevant national and international standards on reproductive health?

7. Is Brazil taking any steps to ensure women have access to effective remedies when their reproductive rights have been violated?

8. Has the State party planned to create a program to provide training for the judiciary and law enforcement personnel on remediating violations of women's reproductive rights?

9. Is Brazil taking any steps to ensure adequate sanctions are imposed on health professionals who violate women's reproductive rights?

V. Recommendations for the State

In light of the information provided above, we hope that this Committee will consider making Brazil the following recommendations:

1. Urge the State party to provide measures of reparation to Alyne´s mother and daughter taking into consideration the international human rights standards that determine integral reparations should encompass moral, material as well as symbolic measures.
2. Urge the State party to implement the Committee's recommendations in the *Alyne v. Brazil* decision through a participatory procedure where stakeholders such as relevant Ministries, civil society organizations, and experts in public health are allowed to be part of the process and using a rights-based approach to maternal healthcare.
3. Urge Brazil to create a system to monitor the quality of maternal healthcare, instating medical protocols for common causes of maternal death, and remediating the fragmented referral system in order to improve the quality of maternal healthcare.
4. Urge Brazil to create and enforce a policy to address gender-based violence in the Unified Health System, by enforcing the National Guidelines on Humanized Abortion Care, and by implementing and enforcing Federal Law 11.108 in order to ensure the right to safe motherhood and provide adequate training for health workers.
5. Urge Brazil to improve accountability in the healthcare sector by reforming the Federal and Regional Medical Councils and by enhancing the judiciary's role in remediating reproductive rights violations through the expansion of the Minsterio Público and Defensoria Pública.

There remains a significant gap between the rights protected in the CEDAW and the reality of maternal mortality and maternal healthcare in Brazil. We applaud the Committee for its commitment to the right to safe and healthy pregnancy and childbirth, and in particular its groundbreaking decision in the case of *Alyne v. Brazil*. The strong Concluding Observations and recommendations the Committee has issued to governments in the past

which stress the need to enact, implement, and monitor policies geared toward ensuring women safe and healthy pregnancies and childbirth advance women's rights worldwide.

We hope this information is useful during the Committee's review of Brazil's report. In case any questions in regard to this letter should arise, or if the Committee would like further information, please do not hesitate to contact the undersigned.

Sincerely,

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[1] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, U.N. Doc. A/34/46 (1979), 1249 U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].
[2] Committee on the Elimination of Discrimination Against Women (CEDAW Committee), *Views, Communication 17/2008*, U.N. Doc. CEDAW/C/49/D/17/2008 (2011) [hereinafter CEDAW Committee, *Alyne v. Brazil*].
[3] CEDAW Committee, *General Recommendation No. 24 (Article 12: Women and Health)*, ¶ 31(c), U.N. Doc. A/54/38/Rev.1 (1999) [hereinafter CEDAW Committee, *General Rec. No. 24*].
[4] CEDAW Committee, *Concluding Observations: Brazil*, ¶ 29, U.N. Doc. CEDAW/C/BRA/CO/6 (2007); CEDAW Committee, *Concluding Observations: Brazil*, ¶ 85, U.N. Doc. A/58/38 (2003).
[5] CEDAW Committee, *Concluding Observations: Brazil*, ¶ 29, U.N. Doc. CEDAW/C/BRA/CO/6 (2007).
[6] WORLD HEALTH ORGANIZATION (WHO), TRENDS IN MATERNAL MORTALITY: 1990-2008 23 (2010), *available at* http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf.
[7] Committee on Economic, Social and Cultural Rights (CESCR Committee), *Implementation of the International Covenant on Economic, Social and Cultural Rights: Second periodic reports submitted by States parties under articles 16 and 17 of the Covenant: Brazil*, ¶ 418, U.N. Doc. E/C.12/BRA/2 (2008).
[8] U.N. POPULATION FUND (UNFPA), THE MATERNAL HEALTH THEMATIC FUND: ANNUAL REPORT 2010 6 (2010), *available at* http://www.unfpa.org/public/home/publications/pid/6423.
[9] Since maternal mortality is notoriously difficult to measure, there are a range of estimated maternal mortality rates for all countries. Currently, estimates place Brazil's maternal mortality rate as being between 75 and 100.

[10] PAN-AMERICAN HEALTH ORGANIZATION (PAHO), HEALTH INDICATOR DATABASE: COUNTRY HEALTH INDICATOR PROFILE: MATERNAL AND CHILD MORTALITY: BRAZIL (2009), http://ais.paho.org/phip/viz/cip_maternalandinfantmortality.asp.
[11] *Id.*
[12] *Revista Brasileira de Epidemiologia*
[13] FC Barros et al., *Recent Trends in Maternal, Newborn and Child Health in Brazil: Progress Toward Millennium development Goals 4 and 5*, 100 AM. J. OF PUBLIC HEALTH 1877, 1878 (2010).
[14] UNITED NATIONS COUNTRY TEAM BRAZIL, A UN READING OF BRAZIL'S CHALLENGES AND POTENTIAL, COMMON COUNTRY ASSESSMENT BY BRAZIL'S UNCT ¶ 40 (2005), *available at* http://www.unodc.org/pdf/brazil/Final%20CCA%20Brazil%20%28eng%29.pdf.
[15] World Bank, *Country and Lending Groups* (2011), http://data.worldbank.org/about/country-classifications/country-and-lending-groups#Upper_middle_income.
[16] Pan-American Health Organization (PAHO), *Regional Core Health Data Initiative, Table Generator System*, http://www.paho.org/english/sha/coredata/tabulator/newtabulator.htm (last visited Jan. 27, 2011).
[17] World Bank, *Country and Lending Groups* (2011), http://data.worldbank.org/about/country-classifications/country-and-lending-groups#Upper_middle_income.
[18] Pan-American Health Organization (PAHO), *Regional Core Health Data Initiative, Table Generator System*, http://www.paho.org/english/sha/coredata/tabulator/newtabulator.htm (last visited Jan. 27, 2011).
[19] PRESIDÉNCIA DA REPÚBLICA [OFFICE OF THE PRESIDENCY OF THE REPUBLIC], OBJETIVO DE DESENVOLVIMENTO DO MILÊNIO: RELATÓRIO NACIONAL DE ACOMPANHAMENTO [MILLENNIUM DEVELOPMENT GOALS: NATIONAL MONITORING REPORT] 86 (2010), *available at* http://portal.saude.gov.br/portal/arquivos/pdf/relatorio_acompanhamento_odm5_220910.pdf.
[20] Alaerte Leandro Martins, *Mortalidade materna de mulheres negras no Brasil* [*Maternal Mortality Among Black Women in Brazil*], 22 CADERNOS DE SAÚDE PÚBLICA 2473, 2476 (2006).
[21] *Id.*
[22] *Id.*
[23] Ruy Laurenti, *A mortalidade materna nos capitais brasileiras: algunas características e estimativa de um fator de ajuste [Maternal mortality in Brazilian State Capitals: some characteristics and estimates for an adjustment factor]*, 7 REVISTA BRASILEIRA DE EPIDEMIOLOGIA 449, 449 (2004).
[24] COMISSÃO PARLAMENTAR DE INQUÉRITO DESTINADA A INVESTIGAR A INCIDÊNCIA DE MORTALIDADE MATERNA NO BRASIL [Federal Parliamentary Commission of Inquiry Designed to Investigate the Incidence of Maternal Mortality in Brazil], CPI MORTALIDADE MATERNA 45(2001), *available at* http://www.cfemea.org.br/images/stories/pdf/relatoriofinalcpimortalidadematerna.pdf [hereinafter CPI Study].
[25] *Id.*at 44.
[26] *Id.*
[27] CEDAW, *supra* note 1, Art. 12(2).
[28] Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/2005, Annex, U.N. GAOR, 44th Sess., Supp. No. 49, Art. 24.2(d), U.N. Doc. A/44/49 (1989).
[29] Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health*, 22nd Sess., ¶ 14, U.N. Doc. E/C.12/2000/4 (2000).
[30] Human Rights Committee, *General Comment No. 28, Equality of rights between men and women (article 3)*, para. 10, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000) ("When reporting on the right to life protected by article 6, States parties should provide data on birth rates and on pregnancy- and childbirth-related deaths of women.")
[31] CEDAW, *supra* note 1, Art. 12(2).
[32] CEDAW Committee, *General Rec. No. 24*, *supra* note 3, ¶ 31(c).
[33] *See, e.g.*, Report of the Committee on the Elimination of Discrimination against Women, 59th Sess., Supp. No. 38, ¶ 380, U.N. Doc. A/59/38 (2004); Report of the Committee on the Elimination of Discrimination against Women, 57th Sess., ¶ 52 & ¶ 482, U.N. Doc. A/57/38 (2002).
[34] *See, e.g.*, Report of the Committee on the Elimination of Discrimination against Women, 20th Sess., ¶ 56 & ¶ 393, U.N. Doc. A/54/38 (1999); Report of the Committee on the Elimination of Discrimination against Women, 18th Sess., ¶ 337, U.N. Doc. A/53/38 (1998).

[35] CEDAW Committee, *Alyne v. Brazil*, *supra* note 2, ¶ 7.5.
[36] *Id.*¶ 7.6.
[37] CEDAW, *supra* note 1, Art. 2.
[38] CEDAW, *supra* note 1, Art. 12.
[39] CEDAW Committee, *General Rec. No. 24*, *supra* note 3, ¶ 7.
[40] *Id.* ¶ 17. ("The duty to *fulfill rights* places an obligation on States parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care.").
[41] *Id.* ¶ 27.
[42] CEDAW Committee, *Alyne v. Brazil*, *supra* note 2, ¶ 7.6.
[43] *Id.* ¶ 7.6.
[44] *Id.* ¶ 7.7.
[45] *Id.* ¶ 7.5.
[46] *Id.* ¶ 7.5.
[47] *Id.* ¶ 7.9.
[48] *Id.* ¶ 8(1).
[49] *Id.* ¶ 8(2).
[50] United Nations General Assembly, *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Violations of International Human Rights and Humanitarian Law*, G.A. Res. 1999/33, U.N. GAOR, 56th Sess., Annex, Agenda Item 11(d), ¶ 15, U.N. Doc. E/CN.4/2000/62 (2000) [hereinafter *Basic Principles and Guidelines*].
[51] *Id.* ¶ 15.
[52] *Id.* ¶ 19.
[53] *Id.* ¶ 21.
[54] *Id.*
[55] *Id.* ¶ 23.
[56] *Id.*
[57] Ben Saul, *Compensation for Unlawful Death in International Law: A Focus on the Inter-American Court of Human Rights*, 19 AM. U. INT'L L. REV. 523, 542 (citing *Garrido and Baigorria Case*, Inter-Am. Ct. H.R. (Ser. C) No. 39, ¶ 46 (encountering no difficulty in denying the right to plead federal structure to an international obligation); *see also "Street Children" Case*, Inter-Am. Ct. H.R. (Ser. C) No. 77, ¶ 61 (specifying "scope, nature, forms and determination of the beneficiaries" to fall under regulation by international law)).
[58] Manuel Leal De Oliveira v. Brazil, Case 12.308, Inter-Am. Comm'n H.R., Report Nº 37/10, ¶ 156 (2010).
[59] *Id.*
[60] *Basic Principles and Guidelines*, *supra* note 50, ¶17.
[61] WHO, *Bulletin, Brazil's March Towards Universal Coverage* (Sept. 2010), http://www.who.int/bulletin/volumes/88/9/10-020910/en/index.html.
[62] Jairnilson Paim et al., *The Brazilian health system: history, advances and challenges*, 377 THE LANCET 1778, 1793 (2011).
[63] Eleonora RO Ribeiro et al., *Risk factors for inadequate prenatal care use in the metropolitan area of Aracaju, Northeast Brazil*, 9 BMC PREGNANCY AND CHILDBIRTH 5, 5 (2009), *available at* http://www.biomedcentral.com/content/pdf/1471-2393-9-31.pdf
[64] MINISTÉRIO DA SAÚDE, PESQUISA NACIONAL DE DEMOGRAFIA E SAÚDE DA MULHER E DA CRIANÇA, PNDS 2006 160-1, *available at* bvsms.saude.gov.br/bvs/publicacoes/pnds_crianca_mulher.pdf
[65] Cesar G. Victora et al., *Maternal and child health in Brazil: progress and challenges*, 377 THE LANCET 1863, 1870 (2011).
[66] CPI Study, *supra* note 24, at 191.
[67] CPI Study, *supra* note 24, at 136.
[68] Carlos Eduardo Pereira Vega et al., *Maternal Mortality due to Arterial Hypertension in Sao Paulo City (1995-1998)*, 62 CLINICS 679, 683 (2007); WORLD HEALTH ORGANIZATION, WHO RECOMMENDATIONS FOR PREVENTION AND TREATMENT OF PREECLAMPSIA AND ECLAMPSIA 2 (2011), *available at*

http://whqlibdoc.who.int/publications/2011/9789241548335_eng.pdf.
[69] Vânia Muniz Néquer Soares, *Mortalidade materna por pré-eclâmpsia/eclâmpsia em um estado do Sul do Brasil* [*Maternal mortality due to pre-eclampsia/eclampsia in a state in Southern Brazil*], 31 REVISTA BRASILEIRA DE GINECOLOGIA E OBSTETRÍCIA 566, 569-70 (2009).
[70] Carlos Eduardo Pereira Vega et al., *Maternal Mortality due to Arterial Hypertension in Sao Paulo City (1995-1998)*, 62 CLINICS 679, 683 (2007).
[71] These protocols are available at http://portalsaude.saude.gov.br/portalsaude/texto/689/187/protocolos-clinicos-e-diretrizes-terapeuticas.html.
[72] Simone Grilo Diniz, *Gender, maternal health and the perinatal paradox*, 4 REVISTA TEMPUS ACTAS SAÚDE COLETIVA 49, 51-2 (2010).
[73] Sandra Valonguiro Alves, *Maternal Mortality in Pernambuco, Brazil: What has Changed in Ten Years*, 15 REPRODUCTIVE HEALTH MATTERS 134, 139 (2007).
[74] Fernando C. Barros & Cesar G. Victora, *Maternal-child health in Pelotas, Rio Grande do Sul State, Brazil: major conclusions from comparisons of the 1982, 1993, and 2004 birth cohorts*, 24 CADERNOS DE SAÚDE PÚBLICA S461, S462 (2008).
[75] CPI Study, *supra* note 24, at 136.
[76] Congenital syphilis is a form of syphilis that is passed from mother to child in utero (National Institutes of Health, *Congenital Syphilis*, http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0002320/ (last updated Nov 2. 2009)).
[77] Pan American Health Organization (PAHO) & USAID, HEALTH SYSTEMS AND SERVICES PROFILE, BRAZIL, MONITORING AND ANALYSIS OF HEALTH SYSTEMS CHANGE/REFORM 26 (2008).
[78] *Id.* at 21; CG Victora et al., *Socioeconomic and ethnic group inequities in antenatal care quality in the public and private sector in Brazil*, 25 HEALTH POLICY AND PLANNING 253, 256 (2010) (these exams were breast and gynecological examinations, counseling about breastfeeding, prescription of vitamins, blood and urine analyses and ultrasound).
[79] CG Victora et al., *Socioeconomic and ethnic group inequities in antenatal care quality in the public and private sector in Brazil*, 25 HEALTH POLICY AND PLANNING 253, 256 (2010).
[80] Carlos Eduardo Pereira Vega et al., *Maternal Mortality due to Arterial Hypertension in Sao Paulo City (1995-1998)*, 62 CLINICS 679, 682 (2007).
[81] CPI Study, *supra* note 24, at 61.
[82] *Id.*
[83] *Id*.
[84] Cesar G. Victora et al., *Maternal and child health in Brazil: progress and challenges*, 377 THE LANCET 1863, 1866 (2011).
[85] Sandra Valonguiro Alves, *Maternal Mortality in Pernambuco, Brazil: What has Changed in Ten Years*, 15 REPRODUCTIVE HEALTH MATTERS 134, 141 (2007).
[86] See, e.g., UNICEF, STRATEGY FOR THE REDUCTION OF MATERNAL, PERINATAL AND INFANT MORTALITY AND MORBIDITY 15, *available at* http://www.unicef.org/lac/TREBOL_-_INGLES%282%29.pdf; Ministério da Saúde, *Actions and Programs, SAMU 192 and UPA 24*, http://portalsaude.saude.gov.br/portalsaude/index.cfm/?portal=pagina.visualizarTexto&codConteudo=2207&codModuloArea=518&chamada=Actions-and-Programs.
[87] World Bank, BRAZIL: MATERNAL AND CHILD HEALTH 39 (2002), *available at* http://siteresources.worldbank.org/BRAZILINPOREXTN/Resources/3817166-1185895645304/4044168-1186326902607/32pub_br56.pdf.
[88] Sandra Valongueiro Alves, *Maternal Mortality in Pernambuco, Brazil: What has Changed in Ten Years*, 15 REPRODUCTIVE HEALTH MATTERS 134, 141 (2007).
[89] *Id*.
[90] Cesar G. Victora et al., *Maternal and child health in Brazil: progress and challenges*, 377 THE LANCET 1863, 1870 (2011).
[91] Maria do Carmo Leal et al., *Racial, Sociodemographic, and prenatal and childbirth care inequalities in Brazil*, 39 REVISTA DE SAÚDE PÚBLICA 1, 3 (2005).
[92] Sandra Valonguiro Alves, *Maternal Mortality in Pernambuco, Brazil: What has Changed in Ten Years*, 15

REPRODUCTIVE HEALTH MATTERS 134, 140 (2007).
[93] CPI Study, *supra* note 24, at 64.
[94] *Id*. at 61.
[95] The Rede Cegonha seeks to improve access to prenatal care, improve referrals for pregnant women, implement best practices in care and delivery, and ensure women have the right to a companion during labor.
[96] Ana Flávia Pires et al., *Violence against women in health-care institutions: an emerging problem*, 359 THE LANCET 1681, 1681 (2002).
[97] *Id*.
[98] Annatália Meneses de Amorim et al., "*Stepped-on like a floor-mat": human experience of hospital violence in the Northeast of Brazil*, 4 REVISTA TEMPUS ACTAS SAÚDE COLETIVA 79, 83 (2010).
[99] *Id*.
[100] *Id*. at 85.
[101] *Id*.
[102] FUNDAÇÃO PERSEU ABRAMO, RELATÓRIO DA PESQUISA A MULHER BRASILEIRA NOS ESPAÇOS PÚBLICO E PRIVADO 176 (2010), *available at* http://www.fpabramo.org.br/sites/default/files/pesquisaintegra.pdf.
[103] *Id*. at 174.
[104] *Id*.
[105] *Id*. at 175.
[106] Ana Flávia Pires et al., *Violence against women in health-care institutions: an emerging problem*, 359 THE LANCET 1681, 1683 (2002).
[107] *Id*.
[108] *Id*. at 1684.
[109] *Id*.
[110] CPI Study, *supra* note 24, at 65.
[111] FC Barros et al., *Recent Trends in Maternal, Newborn and Child Health in Brazil: Progress Toward Millennium development Goals 4 and 5*, 100 AM. J. OF PUBLIC HEALTH 1877, 1883 (2010).
[112] Sonia Correa et al., *The Population and Reproductive Health Program in Brazil 1990-2002: Lessons Learned*, 13 REPROD.HEALTH MATTERS 72, 73 (2004).
[113] WORLD HEALTH ORGANIZATION, UNSAFE ABORTION, GLOBAL AND REGIONAL ESTIMATES OF THE INCIDENCE OF UNSAFE ABORTION AND ASSOCIATED MORTALITY IN 2003 5 (2007), *available at* http://www.searo.who.int/LinkFiles/Publications_Unsafe_Abortion.pdf.
[114] CPI Study, *supra* note 24, at 66.
[115] FUNDAÇÃO PERSEU ABRAMO, RELATÓRIO DA PESQUISA A MULHER BRASILEIRA NOS ESPAÇOS PÚBLICO E PRIVADO 191 (2010), *available at* http://www.fpabramo.org.br/sites/default/files/pesquisaintegra.pdf.
[116] Leila Adesse, *Using Human Rights Principles to Promote Quality of Abortion Care in Brazil*, 13 REPRODUCTIVE HEALTH MATTERS 155, 156 (2005).
[117] *Id*.
[118] GILBERTA S. SOARES ET AL., ADVOCACY PARA O ACESSO AO ABORTO LEGAL E SEGURO: SEMELHANÇAS NO IMPACTO DA ILEGALIDADE NA SAÚDE DAS MULHERES E NOS SERVIÇOS DE SAÚDE EM PERNAMBUCO, BAHIA, PARAÍBA, MATO GROSSO DO SUL E RIO DE JANEIRO 36 (2011).
[119] The text of this law is available at http://www.planalto.gov.br/ccivil_03/_Ato2004-2006/2005/Lei/L11108.htm.
[120] Parto do Princípio, *Benefícios do Acompanhante no Parto*, http://www.partodoprincipio.com.br/lei_beneficio.html (last visited Jan. 27, 2012).
[121] Ministério da Saúde, PESQUISA NACIONAL DE DEMOGRAFIA E SAÚDE DA MULHER E DA CRIANÇA, PNDS 2006 161, *available at* bvsms.saude.gov.br/bvs/publicacoes/pnds_crianca_mulher.pdf.
[122] *Conselho Federal de Medicina*
[123] Kate Duncan Kostrzewa, *The "Ought", the "Is" and Reproductive Reality: A Case Study on the Law and Contraceptive Practice in Brazil* 132 (2003) (unpublished Ph.D. dissertation, University of Texas at Austin), *available at* http://en.scientificcommons.org/9017876.
[124] *Conselhos Regionais de Medicina*
[125] Kate Duncan Kostrzewa, *The "Ought", the "Is" and Reproductive Reality: A Case Study on the Law and*

Contraceptive Practice in Brazil 132 (2003) (unpublished Ph.D. dissertation, University of Texas at Austin), *available at* http://en.scientificcommons.org/9017876.
[126] Gerard M. La Forgia & Bernard F. Couttolenc, HOSPITAL PERFORMANCE IN BRAZIL: THE SEARCH FOR EXCELLENCE xxxvi (2008).
[127] *Id.*
[128] *Id.*
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[130] *Id.* at 136.
[131] Maria de Fatima Oliveira dos Santos et al., *Perfil dos médicos envolvidos em processos ético-profissionais – Paraíba: 1999 a 2009*, 19 REVISTA BIOÉTICA 787, 789-790 (2011).
[132] André Gambier Campos, *Texto para discussão n. 1.328, Sistema de Justiça no Brasil: problemas de equidade e efetividade* 9 (Instituto de Pesquisa Econômica Aplicada, Discussion Paper No. 1328, 2008).
[133] INTERNATIONAL COMMISSION OF JURISTS, BRAZIL - ATTACKS ON JUSTICE 2005 8 (2008).
[134] Kate Duncan Kostrzewa, *The "Ought", the "Is" and Reproductive Reality: A Case Study on the Law and Contraceptive Practice in Brazil* 67 (2003) (unpublished Ph.D. dissertation, University of Texas at Austin), *available at* http://en.scientificcommons.org/9017876.
[135] CONSTITUIÇÃO FEDERAL [C.F.] [CONSTITUTION] art 134 (Braz.).
[136] MINISTÉRIO DA JUSTIÇA, III DIAGNÓSTICO DEFENSORIA PÚBLICA NO BRASIL 105-107 (2009), *available at* http://www.anadep.org.br/wtksite/IIIdiag_DefensoriaP.pdf .
[137] *Id.* at 128.
[138] Maria Tereza Aina Sadek, *Acesso à Justiça: visão da sociedade*, 65 Revista Justitia 271, 274-5 (2008), *available at* http://bdjur.stj.jus.br/dspace/handle/2011/33278.
[139] The Union has been a defendant in several civil suits filed by federal prosecutors to implant agencies of the Defensoria Pública of the Union in certain cities, to appoint federal public defenders, to improve service and infrastructure. Examples of this occurred in Sao Paulo (*See* http://noticias.pgr.mpf.gov.br/noticias/noticias-do-site/copy_of_direitos-do-cidadao/mpf-move-acao-para-que-uniao-garanta-assistencia-juridica-integral-em-sao-paulo-como-determina-a-constituicao-federal), Pernambuco (*See* http://www.prpe.mpf.gov.br/internet/Ascom/Noticias/2010/MPF-requer-a-implantacao-de-Defensoria-Publica-da-Uniao-em-Caruaru), Goiás (*See* http://noticias.pgr.mpf.gov.br/noticias/noticias-do-site/copy_of_direitos-do-cidadao/mpf-go-defensoria-publica-da-uniao-descumpre-decisao-judicial), Pará (*See* http://www.amazoniainforma.org/2011/09/falta-de-infraestrutura-minima-na.html), and Ceará (*See* http://www.icoenoticia.com/2011/08/mpf-ce-pede-instalacao-de-defensoria.html).
[140] In Brazil, provisional measures are a legislative tool that the President may invoke in order to pass laws without Congressional approval in order to address urgent issues. Once the law has already been enacted, as is the case with MP 557, then Congress can debate and decide whether to approve the law.
[141] *See* Vi o Mundo, *Beatriz Galli: A MP 557 é um absurdo; em vez de proteger gestantes, viola direitos humanos*, http://www.viomundo.com.br/denuncias/beatriz-galli-a-mp-557-e-um-absurdo-em-vez-de-proteger-as-gestantes-da-morte-evitavel-viola-seus-direitos-humanos.html (Jan. 2, 2012); Vi o Mundio, *Ministra Iriny Lopes: A Secretaria de Mulheres não teve nenhuma participação na MP 557*, http://www.viomundo.com.br/politica/ministra-iriny-lopes-a-secretaria-de-mulheres-nao-teve-nenhuma-participacao-na-mp-557.html (Jan. 12, 2012).
[142] Medida Provisória no. 557, de 26 de Dezembro de 2011, Art. 2 (Braz.).
[143] *Id.* Art. 6.
[144] *Id.* Art. 7.
[145] CEDAW Committee, *General Rec. No. 24*, *supra* note 3, ¶ 31.
[146] *Id.* ¶ 27.
[147] *Id.* ¶ 31.
[148] *Id.*
[149] Medida Provisória no. 557, de 26 de Dezembro de 2011, Art. 7 (Braz.).
[150] CEDAW, *supra* note 1, Art. 2.

[151] *Id.* Art. 12(1).
[152] CEDAW Committee, *Concluding observations of the Committee on the Elimination of Discrimination against Women, The Netherlands*, ¶ 46-47, U.N. Doc. CEDAW/C/NLD/CO/5 (2010) (urging the State party to revise its law mandating sterilization for transgender women); CEDAW Committee, *Report of the Committee on the Elimination of Discrimination against Women*, 30th Sess., ¶ 306, U.N. Doc. A/59/38 (2004) (condemning compulsory pregnancy testing as a condition for employment); CEDAW Committee, *Concluding observations of the Committee on the Elimination of Discrimination against Women*, *Malawi*, ¶ 38, U.N. Doc. CEDAW/C/MWI/CO/6 (2010) (expressing concern over compulsory HIV-testing); CEDAW Committee, *Report of the Committee on the Elimination of Discrimination against Women*, 22nd Sess., ¶ 76, U.N. Doc. A/55/38 (2000) (expressing concern over compulsory HIV-testing).
[153] CEDAW Committee, *General Rec. No. 24*, *supra* note 3, ¶ 12(d).
[154] CEDAW Committee, *Concluding Observations: Brazil*, ¶ 29, U.N. Doc. CEDAW/C/BRA/CO/6 (2007).
[155] *Id.*
[156] Medida Provisória no. 557, de 26 de Dezembro de 2011, Art. 19-J (Braz.) ("Os serviços de saúde públicos e privados ficam obrigados a garantir às gestantes e aos nascituros o direito ao pré-natal, parto, nascimento e puerpério seguros e humanizados.")
[157] Supremo Tribunal Federal, ADI 3.510, Rel. Min. Ayres Britto, 29.5.2008, *available at* http://redir.stf.jus.br/paginadorpub/paginador.jsp?docTP=AC&docID=611723.
[158] Vi O Mundo, *Fausto Pereira: Gestante que não aderir ao pré-natal está dispensada do cadastro*, http://www.viomundo.com.br/entrevistas/fausto-pereira-dos-santos-so-a-gestante-que-nao-aderir-ao-pre-natal-esta-dispensada-do-cadastro.html (Jan. 10, 2012).
[159] L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, ¶ 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).
[160] Medida Provisória no. 557, de 26 de Dezembro de 2011, Art. 10 (Braz.).
[161] Medida Provisória no. 557, de 26 de Dezembro de 2011, Art. 11 (Braz.).
[162] Medida Provisória no. 557, de 26 de Dezembro de 2011, Sole paragraph (Braz.).