



Bogotá, January 24, 2014

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Ref. Interim report for the Fifty-Seven (57th) Session of the CEDAW Committee, on the Concluding Observations of the CEDAW Committee to the Brazilian State during its Fifty-First (51st) Session

Distinguished members of the CEDAW Committee:

1. In 2012, during its Fifty-First session, the United Nations (UN) Committee on the Elimination of Discrimination against Women (CEDAW Committee) requested the Brazilian State an interim report on compliance with the treaty around two specific issues contained in paragraphs No. 21 and No. 29:¹ trafficking in persons² and women's access to reproductive health and rights, respectively.³ The second issue included mechanisms to reduce maternal mortality (MM),⁴ promotion of legal abortion,⁵ and plans to combat the feminization of HIV/AIDS and STDs.⁶

2. In particular, related to MM reduction, the CEDAW Committee acknowledged in its 2012 Concluding Observations (CO) that Brazilian health services *"are under expansion and that the State party has implemented a number of measures aimed at reducing the maternal mortality rate, such as the establishment of the Rede Cegonha (Stork Network) programme (2011). However, it is concerned that this programme might not sufficiently address all causes of maternal mortality as it merely focuses on care services for pregnant women"*.⁷ The CEDAW Committee specifically recommended Brazil to *"Continue its efforts aimed at enhancing women's access to health care and monitor and assess the implementation of the Rede Cegonha programme with the view to effectively reducing the maternal mortality rate, in particular within disadvantaged groups of women."*⁸ It further requested *"the State party to provide, within two years, written information on the steps undertaken to implement the recommendations contained in paragraphs 21 and 29 above"*.⁹

3. The Center for Reproductive Rights (CRR) presents this report related to the CEDAW Committee's recommendations to Brazil during its 51st sessions. CRR is an NGO dedicated to promoting the equality of women around the world by guaranteeing their reproductive rights as human rights. CRR presents this communication as an NGO especially concerned about Brazil's compliance with its international obligations in relation to women's access to healthcare. In particular, we refer to the Brazilian State's failure to fully comply with recommendation contained in paragraph 29(a) of the CEDAW Committee's CO (hereinafter Recommendation 29(a)), which responds to effective compliance with article 12 (right to health without discrimination) of the Convention on the Elimination of All Forms of Discrimination against Women,¹⁰ specifically related to the implementation of the Rede Cegonha (RC) in the context of the recommendations issued by the CEDAW Committee in the case of the *Alyne da Silva Pimentel Case v. Brazil*¹¹ (the Alyne Case), which condense priority actions to ensure women's right to access health services without discrimination.

4. This CRR interim report addresses i) the issue of MM in Brazil, ii) CEDAW Committee's general recommendations to Brazil in the Alyne Case, and iii) Brazil's progress in the implementation of the Recommendation 29(a), according to the State's response on the implementation of the Alyne Case and a report presented by the DHESCA Platform¹² on the situation of the healthcare institutions that provided services to Alyne, eleven years ago.

A. Context: maternal mortality in Brazil

5. As described in CRR's supplementary information submitted before the CEDAW Committee for its 51 session in January 2011,¹³ although Brazil has reduced its MM rate¹⁴ from 103.43 (deaths per 100,000 live births) in 1998 to 56 in 2010,¹⁵ which "[...] represent[s] a 51% decrease,¹⁶ averaging an annual rate of decline of 3.5%,"¹⁷ MM persists as a serious public health issue,¹⁸ being far above the World Health Organization's (WHO) acceptable rate of 10-20 deaths per 100,000 live births. According to the WHO, by 2008, Brazil accounted for over a quarter of all maternal deaths in Latin America.¹⁹ 2009 saw an alarming *increase* in the ratio to 72.25, when it reached its highest point in five years.²⁰ The World Bank classifies Brazil as an upper-middle-income country,²¹ but its MMR greatly overpasses that of other upper-middle-income countries like Chile (16.9 in 2008)²² and Argentina (39.7 in 2008).²³ These deaths are evitable: The Brazilian Government notes that 90% of these **maternal deaths** could be prevented with adequate healthcare.²⁴ Preventable MM is both a form and a symptom of discrimination against women and deprives women of their right to live a healthy life on a basis of equality with men.

6. Country-wide statistics mask severe disparities based on race, economic status, region, and urban/rural distributions. Historically, MM rate is higher in the Brazilian North and Northeast, with a greater share of poverty and larger rural populations than the rest of the country. In a 2002 survey on reproductive age mortality, the estimated MM ranged from 42 in the south region to 73 in the northeast region.²⁵ This is connected to the differential provision of health services in different regions. The World Bank has commented upon the comparatively low levels of health spending in some regions that "*not only fail to compensate for regional inequalities in health status but actually compound them.*"²⁶ Public health funds are allocated largely based on historical consumption patterns, thus regional inequalities are perpetuated.

7. Regional disparities are connected to racial and ethnic inequality: the poorer the region, the higher concentration of afro-Brazilian and indigenous communities where MM increases. According to Brazil's Ministry of Health, Afro-Brazilian women are 50% more likely to die of obstetric-related causes than white women.²⁷ Other studies suggest that the MM rate of Afro-descendant women is three times that of their white counterparts.²⁸ Indigenous and low-income women are also affected by a high risk of MM, particularly adolescents and women from rural areas.²⁹ These women tend to receive fewer health services and low quality health care, increasing their MM risk.³⁰ According to a UN study, 66% of black women and 74% of indigenous women nationwide received fewer than six prenatal visits, compared to 45% of white women.³¹ Afro-Brazilian women were also provided with less information about pregnancy, delivery and post-natal children care.³² The primary direct causes of MM in Brazil are eclampsia, pre-eclampsia, hemorrhage, infection, and unsafe abortion,³³ but the root causes are racial, socio-economic and gender-based disparities in access to healthcare.³⁴ The Brazilian State admits that "*poverty is concentrated on black or Afro-descending women.*"³⁵ In 2006 the Minister of Health publicly admitted the existence of racism in public health services provided by the SUS to Afro-descendant patients.³⁶

8. In addition to the global statistics on MM in Brazil, particular examples show the current precarious situation of both public and private maternal healthcare services in Brazil. According to a report produced by the

Rapporteur on Sexual and Reproductive Rights of the DHESCA platform in 2013,³⁷ based on visits conducted in March 2013 to the health center “Casa de Saúde N. Sra. da Gloria” and the hospital “Geral de Nova Iguaçu”, the quality of health services that those institutions provide has not improved in 11 years, considering the problematic infrastructure, the lack of adequate obstetric equipment, the poor hygiene conditions, and the low quality obstetric procedures. This two examples show that the State has not improved its public health system to promote quality maternal healthcare, especially for women belonging to vulnerable social groups. They portray that public policies aiming at the reduction of maternal mortality have not reached municipalities. As such, the RC has not solved the quality and access issues for all women seeking maternal healthcare.

B. The *Alyne v Brazil* Case

9. In November 16, 2002, Alyne da Silva Pimentel Texeira, a young, poor and pregnant woman of afro descent died, leaving behind her 5-year-old daughter. She arrived to the health center “la Casa de Saúde Nossa Senhora da Gloria” in Belford Roxo on November 11, after presenting high-risk pregnancy symptoms. The doctor sent her home. Her symptoms exacerbated in the following two days, so she returned to the health center. The doctors discovered her fetus lacked heart beats. Her delivery was induced six hours later, producing a stillborn fetus. The surgery to extract her placenta occurred fourteen hours later. She became increasingly sick so she was transferred to a higher capacity hospital with the only available bed: “Hospital Geral de Nova Iguaçu.” After waiting for a long period of time for transfer, and then not being placed in a bed at the hospital’s emergency room, Alyne died, five days after she first requested medical attention.

10. The CEDAW Committee found Brazil responsible for the violation of articles 2(c) (access to justice), 2(e) (States due diligence obligation to ensure that private actions in the provision of health services are appropriate), and 12 (access to health) of the CEDAW. Concrete, Brazil was determined responsible for: 1) the maternal death of Alyne; 2) not ensuring her the appropriate healthcare during her pregnancy; 3) not exercising its due diligence obligation to undertake the necessary measures to ensure appropriate activities of private actors that provide healthcare; 4) the violation of women’s rights to life and to not be subjected to discrimination; 5) the violation of Alyne’s right to not be discriminated on the basis of her racial status as an Afro-Brazilian woman and her socio-economic background; 6) not ensuring effective judicial action and protection; and 7) the moral damage to Alyne’s mother and daughter.

11. The CEDAW Committee issued individual and general recommendations in the case. The general recommendations, as non-repetition measures are the following:

“(a) Ensure women’s right to safe motherhood and affordable access to all women to adequate emergency obstetric care, in line with general recommendation No. 24 (1999) on women and health;

(b) 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;

(c) Ensure access to effective remedies in cases where women’s reproductive health rights have been violated and provide training for the judiciary and for law enforcement personnel;

(d) Ensure that private health care facilities comply with relevant national and international standards on reproductive health care;

(e) Ensure that adequate sanctions are imposed on health professionals who violate women’s reproductive health rights; and

(f) 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 on 15 August 2007 (CEDAW/C/BRA/CI/6)."

12. The implementation of the CEDAW Committee's general recommendations in the Alyne Case directly relates to the CEDAW Committee Recommendation 29(a), as it establishes mechanisms to reduce MM while improving women's access to quality healthcare, and accountability mechanisms to monitor and enforce the effective reduction of MM for all women, including those belonging to disadvantaged groups. Thus, the implementation of the CEDAW Committee's general recommendations in the Alyne Case is essential for the Brazilian State to comply with Recommendation 29(a).

C. Brazil's progress in the implementation of the recommendation contained in paragraph No. 29(a) of the CEDAW Committee's Concluding Observations

13. The Brazilian State launched the RC through Ministry of Health's Directive No. 1459 of 24 June 2011, and it is currently in its implementation phase.³⁸ This program was set to comply with Brazil's international obligations related to the reduction of MM in general, but it also responds to recommendations 2(a) and 2(f) by the CEDAW Committee on the Alyne case. The program was examined by the CEDAW Committee in its 51st session's CO. The Committee concluded that it might not sufficiently address all the causes of MM, and recommended Brazil to monitor and assess the implementation of the program in order to effectively reduce MM rates.³⁹

14. The RC is a "State strategy executed through the Ministry of Health and contracted within the Tripartite Inter-Management Commission for the purpose of implementing an assistance network to ensure the right of women to reproductive planning and humanized care during pregnancy, delivery, childbirth, and postpartum and children the right to safe birth and healthy growth and development".⁴⁰ It revolves around: expanded access and enhanced quality of prenatal care, pregnant women's affiliation to reference delivery units and safe transportation, implementation of good practices for child delivery such as the right to a chosen companion during and after delivery, healthcare for children 0 to 24 months, and access to reproductive planning.⁴¹

15. The RC is guided by for main principles: "i) respect for and protection and realization of human rights; ii) respect for cultural, ethnic, and racial diversity; iii) promotion of equality; iv) gender focus; v) guaranteed sexual rights and reproductive rights for women, men, young adults, and adolescents; vi) participation and social mobilization; and vii) compatibility between the activities of the maternal and infant health care networks under development in the states".⁴² These principles operate through enhancing the "qualifications of professionals engaged in Natural Delivery Centers (Centros de Parto Normal),"⁴³ producing training materials for public administrators and professionals involved in Primary Care and Hospital Care.⁴⁴

16. According to the Brazilian State, the RC is a priority, and the Ministry of Health is projected to invest a total R\$ 9.4 billion.⁴⁵ Until October 2012, the government had directed its financial resources to "the construction of a health care network negotiated between public administrators of the Regional Inter-Administration Commissions, with a view to ensuring women the right to reproductive planning and humane assistance in the prenatal, childbirth, and postpartum phases".⁴⁶ Until March, 2013, the financial resources had benefited 5,007 counties, covering approximately 2,701,510 women in the country.⁴⁷ As the Brazilian State suggests, these municipalities included Rio de Janeiro State, which joined the RC in July 2011 encompassing among others the cities of Rio de Janeiro, São Gonçalo, Belford Roxo, Duque de Caxias, Nova Iguaçu, and Niterói.⁴⁸ However, as the government suggests, the implementation of the RC in this State varies according to the membership of each region, and the qualification of their action plans.⁴⁹ The Ministry of Health starts monitoring and evaluating the program's implementation one year after the funds' transfer.⁵⁰

17. According to the information on the implementation of the CEDAW Committee's general recommendations for the Alyne Case, the RC presents a series of challenges: i) it is in its initial stages, ii) Natural Delivery Centers (NDCs)⁵¹ are not prevalent through the country, iii) the State has not provided information on targets and indicators to promote the delivery of quality healthcare, iv) the State has neither provided information on results of surveys conducted by the Ombudsman SUS to evaluate the impact of the RC, and v) it has not improved the healthcare provision in the two facilities that provided medical attention to Alyne, 11 years ago. Such challenges represent the current status of the RC also in relation to Recommendation 29(a), which means that in terms of implementation, the Network is still in its initial stages, and due to the lack of indicators and survey information, it is difficult to monitor whether the program is effectively reducing MM. Moreover, the precarious conditions of the two healthcare facilities that provided medical attention to Alyne reflect the limitations that the RC currently faces.

18. The RC is still in its initial stages. According to Brazil, for instance, in the metropolitan regions of Rio de Janeiro state, including Belford Roxo and Nova Iguaçu, where Alyne Pimentel was treated, the initiative must be fully executed in the period 2012-2014.⁵² However, as mentioned, the implementation depends on the presentation and approval of action plans by each municipality, and further monitoring to ensure quality only starts one year after that.⁵³ In that sense, the early stages of the RC limit the possibility to fully assess its effectiveness in MM reduction and in the improvement of women's quality healthcare, as Recommendation 29(a) establishes.

19. NDCs that are part of the RC are not prevalent through the country. Part of the funding allocated to implementing the RC is designated for their construction, expansion and renovation. In April 2012 there were 25 NDCs across Brazil,⁵⁴ demonstrating that they are not prevalent throughout the country.⁵⁵ The National Register of Health Facilities has not registered a single NDC in the North, South and Midwest regions. One of the goals of the Ministry of Health's Multiyear Plan 2012-2015 is the creation of 249 new NBCs, which would result in the expansion from 25 centers in 2011 to 274 by 2015.⁵⁶ Without equitably distributed and large number of NDCs, it is difficult to implement the RC and thus effectively reduce MM throughout the country, as the CO suggests.

20. The State has not provided information on targets and indicators to promote the delivery of quality healthcare through the RC. Brazil mentions that implementation of the Network in Rio de Janeiro is in contracting stage, which includes the negotiation of targets and indicators to promote the delivery of quality assistance, improving maternity wards in the region, and guaranteeing women the right to freely choose companions during delivery. However, the State has not provided any information on how such policies are set in place, or how targets and indicators are developed. Moreover, it is also unclear if such policies and indicators are used throughout the Network.⁵⁷ The lack of information limits the possibility to monitor and assess the implementation of the Program, as recommended in the CO.

21. Furthermore, in the information exchange between the petitioners and the Brazilian State on the implementation of the Alyne Case, in April 2013, the State determined that "*The Inter-Ministerial Working Group shall: elaborate a Plan of Work aimed at implementing and monitoring actions to be taken by the Brazilian government in compliance with the recommendations of CEDAW on case Alyne Pimentel v. Brazil; (...) The Programme of Work will be submitted to the Inter-Ministerial Working Group and will contain indicators (targets and deadlines).*"⁵⁸ The Inter-Ministerial Working Group was created for a six-month period starting in May 2013. Its legal existence expired in October 2013. However, neither indicators of compliance nor a working plan were presented in October when the group's term legally ended.⁵⁹ The lack of indicators limit the possibility

to fully understand the level of implementation of the RC, as recommended in the CO. The following are some of the guidelines for the construction of such indicators, which were presented by CRR on January, 2013 to the Brazilian State and the CEDAW Committee, to implement the general recommendations on the Alyne Case.⁶⁰ CRR identified seven transversal issues that are crucial in order to address the structural problems in access to quality maternal health services without discrimination. The guidelines reflect upon quality access to maternal healthcare and reduction of MM, which are central in the rationality behind the general recommendations issued by the Committee in the Alyne Case and Recommendation 29(a). Each guideline also offers the current challenges that the Brazilian State faces in terms of compliance:

- I. **Quality of Prenatal and Postnatal Care:** Quality maternal healthcare for all women is essential to ensure that even those women belonging to vulnerable groups have timely and adequate access to prenatal and postnatal care. As stated by the CEDAW Committee's CO, the issue is not whether such care is provided but rather that it is often inadequate for specific groups of women. The State should identify specific groups of women, such as Afro-Brazilians, indigenous and low-income, whom are not receiving adequate maternal healthcare; and further monitor the implementation of programs to ensure universal quality maternal services for these vulnerable social sectors, in order to reduce MM while improving quality healthcare.⁶¹
- II. **Right to Companion:** Federal Law No. 11.108 guarantees women in labor the right to have a companion of their choice present, as a means to ensure quality maternal health services. The problem is that the law has not been implemented. The State should enforce the law and further provide evidence of its effective implementation, based on indicators.⁶²
- III. **Blood Network:** Accessible blood banks are fundamental to ensure quality maternal healthcare in emergency cases. However, blood banks are scarce and not equitably distributed throughout Brazil. Low-income regions have less access to this essential service. The State must ensure equitable geographical distribution as well as available and accessible blood banks for all the women living in Brazil.⁶³
- IV. **Referral System:** Brazil mentions that one of the main aims of the RC is to ensure that women have proper access to healthcare facilities.⁶⁴ The RC seeks to guarantee pregnant women affiliation to a reference unit and to safe transportation. Since 2007, under Law 11.634, every pregnant woman has been legally guaranteed a bed in a hospital and the right to previously know and be linked to a maternity ward where she can give birth; however, the law has not been implemented or enforced. The State should enforce the law, and build indicators to assess such implementations through the RC, the quality of the referral systems, and the effective availability of a bed for every woman in labor.⁶⁵
- V. **National Guidelines on Humanized Abortion Care:** Unsafe abortion is one of the main causes of MM in Brazil. Humanized abortion care can tackle this MM cause. The State should provide indicators on the implementation of the National Guidelines on Humanized Abortion Care, including sanctions for failure to abide, and whether there has been any training for health professionals on the guidelines, particularly in relation to post-abortion care.⁶⁶
- VI. **Natural Delivery Centers:** NDCs and midwives diminish the practice of cesarean sections, thus, they are essential to diminish MM and improve quality maternal healthcare in Brazil. The State should address the expansion of trainings for professionals in NDCs and midwives.⁶⁷ The State should monitor the trainings through indicators that reflect upon the quality of the information provided, and the number and geographical distribution of professionals effectively trained.
- VII. **Maternal Mortality Committees:** MM Committees investigate maternal deaths; however, they lack the power to investigate all the cases and determine strategies to prevent MM. The State should ensure that these committees investigate all deaths of women of childbearing age and determine respective counteractive strategies. It should also build indicators on the number of functioning MM Committees and whether they have gained formal power to strengthen their work.⁶⁸

22. In response to general recommendations on effective remedies (recommendation c) and adequate sanctions (recommendation e) by the CEDAW Committee in the Alyne Case, CRR requested the Brazilian State that “*The SUS Ombudsman should analyze the complaints that have been reported in order to monitor common trends and take preventative measures,*”⁶⁹ in its April, 2012 communication. The Brazilian State agreed to conduct interviews by means of the Ombudsman SUS office to evaluate the impact of the RC, in its September, 2012 communication.⁷⁰ Brazil had been monitoring and collecting data on the quality of services, and interviewing women interacting with the public health system during pregnancy, delivery and afterwards.⁷¹ Nevertheless, the State has not addressed the results, if any, and how they will be used to improve maternal health care.⁷² The lack of results responding to the recommendations in the Alyne Case also limits the assessment and monitoring of the RC implementation, as the CEDAW Committee Recommendation 29(a) states.

25. The RC has not improved the healthcare provision in the two healthcare facilities that provided medical attention to Alyne, 11 years ago. According to a report produced by the DHESCA platform,⁷³ based on visits conducted in March 2013 to the two health facilities that provided medical attention before and during Alyne’s death, the quality of health services has not improved since her decease. As a result, the General Attorney of Sao Joao de Meriti issued communication No. 126/2013 to inquire for evidence from relevant institutions, regarding such situation.⁷⁴ The negligence reflects upon the ineffectiveness of the RC in improving maternal healthcare for low-income women, particularly Afro-Brazilian women, which implies that Brazil has not complied with Recommendation 29(a).

26. In conclusion, despite the fact that the RC is still under expansion, and that the Brazilian State aims to keep reducing the MM throughout the country, as Recommendation 29(a) suggests, several issues still limit the State’s compliance, as exemplified by the information on the implementation of the Alyne Case.

27. CEDAW Committee’s Recommendation 29(a) establishes the need to assess the effectiveness of the RC in the reduction of MM. In order to monitor said effectiveness, it is desirable that the State provides indicators of compliance and ways to collect this information. We understand the challenges that Brazil faces in the implementation of the recommendations, including that the RC is still in its early stages, and that monitoring starts only one-year after the action plan has been approved and the financial resources have been disbursed to each municipality.⁷⁵ Nevertheless, this does not prevent the State, by means of the Inter-Ministerial Working Group, from creating indicators of compliance to assess the quality of women healthcare services to reduce MM; neither from providing results based on surveys conducted by the Ombudsman SUS to monitor the RC service’s quality.⁷⁶

28. Recommendation 29(a) also points to the reduction of MM particularly within disadvantaged groups of women. However, these women have not gained access to quality healthcare services, as evidenced by two particular examples. First, by April 2012 no NDCs had been created in the North and Northeast, which are the two regions with higher MM rates and the greatest share of poverty in the country. Second, as described by the DHESCA platform, the two healthcare facilities that provided medical attention to Alyne 11 years ago depict precarious conditions. Both facilities were part of the public health system, which is the one providing healthcare to low-income women in Brazil.⁷⁷

29. The Alyne Case recognizes safe motherhood as a human right. Brazil needs to advance towards structural changes in its public policy that approach maternal mortality from a human rights perspective. Such approach aims to guarantee women’s access to quality healthcare without discrimination as set forth in Recommendation



29(a) and general recommendations established in the Alyne Case. Brazil should establish indicators to address the seven essential points mentioned, in order to guarantee that reproductive health services provided under the RC are accessible, affordable and high quality for all women; at this point it has only addressed prenatal and childbirth services.⁷⁸ The lack of implementation of the general recommendations in the Alyne Case demonstrates that in practice Brazil is far from complying with Recommendation No. 29 (a). It is crucial that Brazil adopts a human rights approach when providing those services that particularly tackle discrimination in access to healthcare, in relation to vulnerable groups of women. Brazil should also ensure accountability in the provision of said quality healthcare services.

IV. - Recommendations

The Center for Reproductive Rights respectfully urges the CEDAW Committee to recommend the Brazilian state to:

Adopt all measures to implement the General Recommendations set forth in the *Alyne da Silva Pimentel Case v. Brazil*.

Respectfully,

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¹ Concluding observations of the Committee on the Elimination of Discrimination against Women. Committee on the Elimination of Discrimination against Women, Fifty-first session, 13 February – 2 March 2012 para. 40. CEDAW/C/BRA/CO/7 <http://www2.ohchr.org/english/bodies/cedaw/docs/co/CEDAW-C-BRA-CO-7.pdf> [hereinafter Concluding Observations].

² *Id.* para. 21.

³ *Id.* para. 29.

⁴ *Id.* para. 29(a).

⁵ *Id.* para. 29(b).

⁶ *Id.* para. 29(c).

⁷ *Id.* para. 28.

⁸ *Id.* para. 29(a).

⁹ *Id.* Para. 40.

¹⁰ Brazil ratified the CEDAW on February 1st, 1984 and its Optional Protocol on June 28, 2002. These legal instruments impose a series of international obligations to Brazil. Specifically, article 12 of the CEDAW establishes that State parties shall take the measures necessary “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. [and] 2. [...] ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period [...]” General Recommendation No. 24 of the CEDAW Committee establishes that States Parties are required “to eliminate discrimination against women in their access to health-care services throughout the life cycle, particularly in the areas of family planning, pregnancy and confinement and during the post-natal period” and indicates that States Parties must also “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.” Thus, Brazil has an international obligation to adopt the mechanisms required to provide women access to maternal healthcare without discrimination. (See: UNITED NATIONS TREATY COLLECTION, <https://treaties.un.org/Pages/> (last visited Jan. 14, 2014). Convention on the Elimination of All Forms of Discrimination against Women, adopted on Dec. 18, 1979, G.A. Res. 34/180, art. 12. Committee on the Elimination of Discrimination against Women, General Recommendation No. 24 (Article 12): Women and Health, chap. I, para. 2, UN Doc. A/54/38/Rev.1 (Jan. 19 - Feb. 5, 1999) [hereinafter CEDAW, General Recommendation No. 24]. Concluding Observations, para. 17.

Brazil also has international obligations based on the Millennium Development Goal No. 5 establishing that MM should be reduced by 75% for 2015; Resolutions 11/8 of June 9, 2009, 15/17 of September 30, 2010, 18/2 of September 28, 2011 and Resolution of September 20, 2012¹⁰ on preventable MM and morbidity and human rights, by the UN Human Rights Council that required Brazil to adopt a human rights perspective in its MM policy. Likewise, the State compromised in the International Conference on Population and Development in Cairo (1994) and continued on the first session of the Regional Conference on Population and Development in Latin America and the Caribbean by the CEPAL (2013), on MM. (See: Human Rights Council. Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development, A/HRC/21/L.10 (Sept. 20, 2012).)

¹¹ *Alyne da Silva Pimentel v. Brazil*, Committee on the Elimination of Discrimination against Women (CEDAW Committee) August 10, 2011. UN.Doc. CEDAW/C/49/D/17/2008.

¹² Brazilian Platform for Economic, Social, Cultural and Environmental Human Rights.

¹³ Center for Reproductive Rights (2011) *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)*, available at: http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/CenterReproductiveRights_for_the_session_Brazil_CEDAW51_en.pdf (last visited on Jan. 22, 2014).

¹⁴ While Brazil argues that it has decreased its rate in 50%, the fact that statistics are unreliable limits a comparative analysis to confirm this assertion.

¹⁵ World Health Organization (WHO), United Nations Population Fund (UNFPA), et al., *Trends in maternal mortality: 1990 to 2010 (2012) Developed by WHO, UNICEF, UNFPA, and The World Bank*, available at: <http://www.who.int/reproductivehealth/publications/monitoring/9789241503631/en/> (last visited on Sept. 3, 2013) [hereinafter WHO, *Maternal Mortality in 2010*].

¹⁶ MM data in Brazil is unreliable and often contradictory. In 2002, it was estimated that the number of reported maternal deaths in Brazil should be multiplied by 1.4 in order to account for under and misreporting of maternal deaths. In 2004, 90.4% of death records were input into the Ministry of Health's Mortality Information System (SIM). Such coverage, however, is not consistent throughout the country, as the North and Northeast regions only record roughly 70% of the deaths in their regions. Since 2000 the Ministry of Health has only included data from the states with SIM coverage equal to or greater than 90% in the calculation of the MMR. A 2007 study in Sao Paulo found that the fields on death certificates indicating the presence of pregnancy or puerperium were only filled out correctly in less than 20% of cases. See: FC Barros et al., *Recent Trends in Maternal, Newborn and Child Health in Brazil: Progress Toward Millennium development Goals 4 and 5*, 100 AMERICAN JOURNAL OF PUBLIC HEALTH 1877, 1878 (2010). Vânia Muniz Néquer Soares et al., *Subnotificação da mortalidade materna no Estado do Paraná, Brasil: 1991-2005*, 24 CADERNOS DE SAÚDE PÚBLICA 2418, 2419 (2008). Carlos Eduardo Pereira Vega Et Al., *Maternal Mortality due to Arterial Hypertension in Sao Paulo City (1995-1998)*, 62 CLINICS 679, 681 (2007). World Health Organization (WHO), United Nations Population Fund (UNFPA), et al., *Trends in maternal mortality: 1990 to 2008 (2010) Developed by WHO, UNICEF, UNFPA, and The World Bank 17*, available at http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf (last visited on July 29, 2011). Implementation of the International Covenant on Economic, Social and Cultural Rights: Second periodic report submitted by States parties under articles 16 and 17 of the Covenant, Brazil, para. 418, U.N. Doc. E/C.12/BRA/2 (Jan. 28, 2008) [Hereinafter Implementation ICESCR].

¹⁷ Rebecca J. Cook, *Human Rights and Maternal Health: Exploring the Effectiveness of the Alyne Decision*, Global Health and the Law, JOURNAL OF LAW, MEDICINE AND ETHICS, 2013, at 104 based on WHO, *Maternal Mortality in 2010*, *supra* note 15.

¹⁸ World Health Organization Et. Al. *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA 23-27* (WHO Geneva 2007).

¹⁹ According to WHO, 9,200 women die from pregnancy and childbirth related causes in Latin America and the Caribbean annually. Brazil accounts for 1,800 of those deaths. See WHO, *Maternal Mortality in 2008*, *supra* note 15, at 18, 23.

²⁰ World Health Organization Et. Al. *supra* note 18.

²¹ World Bank, *Country and Lending Groups* (2011), available at http://data.worldbank.org/about/country-classifications/country-and-lending-groups#Upper_middle_income (2011) [hereinafter World Bank, *Country and Lending Groups*].

²² PAHO, HEALTH INDICATOR DATABASE: COUNTRY HEALTH INDICATOR PROFILE: MATERNAL AND CHILD MORTALITY: CHILE (2009), available at http://ais.paho.org/phis/viz/cip_maternalandinfantmortality.asp.

²³ PAHO, HEALTH INDICATOR DATABASE: COUNTRY HEALTH INDICATOR PROFILE: MATERNAL AND CHILD MORTALITY: ARGENTINA (2009), available at http://ais.paho.org/phis/viz/cip_maternalandinfantmortality.asp.

²⁴ Implementation ICESCR, *supra* note 16.

²⁵ Laurenti R, Jorge MHPdM, Gotlieb SLD, *A mortalidade materna nas capitais brasileiras: algumas características e estimativa de um fator de ajuste*, 7 REVISTA BRASILEIRA DE EPIDEMIOLOGIA 2004, 449.

²⁶ World Bank, *Brazil: Maternal and Child Health*, ¶ 1.31, at 15 (2002), available at http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2002/04/12/000094946_02040304022680/Rendered/PDF/multiOpag_e.pdf (last visited on Nov. 16, 2007) [hereinafter World Bank, *Brazil: Maternal and Child Health*].

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- ³⁰ Ministério Da Saúde, Política Nacional De Atenção Integral A Saúde Da Mulher: Princípios E Diretrizes 26 (2004); WORLD BANK, Brazil: Maternal and Child Health, ¶ para. 2.8 at 20-21, Report No. 23811-BR (2002), available at http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2002/04/12/000094946_02040304022680/Rendored/PDF/multi0page.pdf.
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- ³² Articulación de Organizaciones de Mujeres Negras Brasileñas (AMNB), Dossier Regarding the Situation of Black Women in Brazil, 25 (July 2007) [hereinafter *Dossier Regarding the Situation of Black Women in Brazil*].
- ³³ BRAZIL HEALTH 2006: An Analysis of Inequality In Health, *supra* note 27, at 38.
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- ³⁷ See Annex 1: Plataforma DhESCA Brasil, *Executive Summary. Mission to “Baixada Fluminense” Rapporteurship on the Human Right to Sexual and Reproductive Health* (2013) [Hereinafter Annex 1].
- ³⁸ Reply of the Brazilian State to the CEDAW Committee, dated February 2012, para 41 [hereinafter Reply of the Brazilian State February 2012].
- ³⁹ Concluding Observations, *supra* note 1, para 29(a).
- ⁴⁰ Reply of the Brazilian State February 2012, *supra* note 47, para 37.
- ⁴¹ *Id.* para 39.
- ⁴² *Id.* para 41.
- ⁴³ Reply of the Brazilian State to the CEDAW Committee, dated September 2012, para 49 [hereinafter Reply of the Brazilian State September 2012].
- ⁴⁴ *Id.* para 57.
- ⁴⁵ *Id.* para 39.
- ⁴⁶ *Id.*
- ⁴⁷ Reply of the Brazilian State to the CEDAW Committee, dated April 2012, para 18 [hereinafter Reply of the Brazilian State April 2012].
- ⁴⁸ Reply of the Brazilian State September 2012, *supra* note 52, para. 43.
- ⁴⁹ Reply of the Brazilian State April 2012, *supra* note 56, para 19.
- ⁵⁰ *Id.* para. 23.
- ⁵¹ Centros de Parto Normal for its name in Portuguese.
- ⁵² Reply of the Brazilian State February 2012, *supra* note 47, para 26.
- ⁵³ Reply of the Brazilian State April 2012, *supra* note 56, para 23.
- ⁵⁴ Brazilian Government, *Centros de Parto Normal*, <http://www.brasil.gov.br/sobre/saude/maternidade/parto/centros-de-parto-normal> (last visit April 16, 2012).
- ⁵⁵ Reply of the Center for Reproductive Rights to the CEDAW Committee “Proposed implementation framework”, dated April 2012 at 26 [hereinafter Reply of the Center for Reproductive Rights “Proposed implementation framework”].
- ⁵⁶ Centro Femenista de Estudos e Assessoria, *Governo priorizará no PPA 2012’2015 a redução da mortalidade materna*.
- ⁵⁷ Reply of the Center for Reproductive Rights to the CEDAW Committee, dated January 2013 at 6 and 7 [hereinafter Reply of the Center for Reproductive Rights January 2013].
- ⁵⁸ Reply of the Brazilian State April 2012, *supra* note 56, para 7 and 8.
- ⁵⁹ Decree 035/2013 officially created the Inter-Ministerial Working Group.
- ⁶⁰ Reply of the Center for Reproductive Rights January 2013, *supra* note 66.
- ⁶¹ Reply of the Center for Reproductive Rights January 2013, *supra* note 66 at 9-12.
- ⁶² *Id.*

⁶³ *Id.*

⁶⁴ Reply of the Brazilian State February 2012, *supra* note 47, para 42.

⁶⁵ Reply of the Center for Reproductive Rights January 2013, *supra* note 66 at 9-12.

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ Reply of the Center for Reproductive Rights January 2013, *supra* note 66 at 9-12.

⁶⁹ Reply of the Center for Reproductive Rights April 2012, *supra* note 56 at 35.

⁷⁰ Reply of the Brazilian State, September 2012, *supra* note 52 at para 63.

⁷¹ Reply of the Brazilian State, April 2012, *supra* note 56 at para. 30.

⁷² Reply of the Center for Reproductive Rights January 2013, *supra* note 66 at 6 and 7.

⁷³ Communication from Maria Beatriz Galli Bevilacqua (National Rapporteur for Sexual and Reproductive Rights) to Dr. Procurador Geral Federal. DHESCA platform (Plataforma Brasileira de Direitos Humanos Economicos, Sociais, Culturais e Ambientais), 2013. See Annex 1, *supra* note 37.

⁷⁴ Ministerio Público Federal. Procuradoria da República no Município de Sao Joao de Meriti, Oficio N° 126/2013 PRM-JOA-RJ-00012572/2013 (August 1st, 2013).

⁷⁵ Reply of the Brazilian State April 2012, *supra* note 56, para 23.

⁷⁶ *Id.* para. 30.

⁷⁷ See Annex 1, *supra* note 37.

⁷⁸ Reply of the Center for Reproductive Rights, January 2013, *supra* note 66, at 7.