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Submission on Human Rights related to Reproductive Health Determination in Brazil by the Grupo Curumim[1] and CLADEM Brazil[2]

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[1] The Group Curumim works since 1989 to strengthen the citizenship of women in all stages of your life hrough the promotion of Human Rights, full health, sexual rights and reproductive rights, from the perspective of ethnic equality race and gender, social justice and democracy. (www.grupocurumim.org.br)

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Abstract

Grupo Curumim and CLADEM Brazil submit information on persisting rights violations related to maternal health in Brazil to the UN Human Rights Council 13th Universal Periodic Review (UPR). While average rates of evitable maternal mortality, since the early 2000's remains stable in Brazil, they are unacceptably high when considering Brazilian levels of income, the coverage of pre-natal and obstetric care high, and the fact that over 90 % of deliveries are performed in hospitals.

Brazil has signed international conventions that oblige the state to guarantee and protect the right to health and ensures all women the right to life, health and non-discrimination.

The recent United Nations Human Rights Council Resolution on Preventable Maternal Mortality and Morbidity and Human Rights[3] has recognized that maternal mortality and morbidity are pressing human rights concerns and that addressing these issues requires effective protection of the human rights of women and girls.[4] The Brazilian Ministry of Health has also recognized that maternal mortality constitutes a violation of the human rights in Brazil.[5]

In July 25th 2011, the CEDAW Committee issued a decision on the case of Alyne da Silva Pimentel, an Afro Brazilian woman who died of maternal mortality in 2002. This decision

[3] U.N. H.R.Council. Res. on Preventable Maternal Mortality and Morbidity and Human Rights, 11th Sess., U.N. Doc. A/HRC/11/L.16 (June 12, 2009).

[4] *Id.* ¶ 2.

[5] Ministério da Saúde, *Pacto Nacional pela Redução da Mortalidade Materna e Neonatal* (versão preliminar), 2 (March 2004) *available at*: http://dtr2002.saude.gov.br/proesf/Site/Arquivos_pdf_word/pdf/Pacto%20Aprovado%20na%20Tripartite.pdf [hereinafter Ministério da Saúde, *Mortalidade Materna e Neonatal*].

makes it critical to provide accurate and up - dated epidemiological data on maternal and on the regrettable persistence of rights violations in the realm of maternal health and women's right to life.

1. The context: MATERNAL MORTALITY EPIDEMIOLOGICAL DATA

Maternal mortality in Brazil remains at high levels in all its five regions. According to the latest estimates conducted by the Ministry of Health, the Maternal Mortality Ratio is around 75 per 100,000 live births[6], in spite of the women's universal access to health care and its 98% of hospital birth[7]. While indicators are stabilized since the beginning of the decade of 2000, signs of elevation have occurred in some regions, probably as consequence of improvement in collection of information, including in relation to race/skin color of women who were victims of maternal deaths. [8]

Maternal mortality mostly affects poor and black women, housewives and agricultural workers, and those residing in small towns; the majority of whom are dependent on the services provided by the public Universal Health System (SUS). The obstetric care model that prevails in Brazil presents many distortions. It is highly medicalized and characterized by the unjustifiable misuse of technology during the childbirth, expressed by the high rates of cesarean. Studies also demonstrate increased vulnerability of black women to maternal mortality. [9,10,11].

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[6] Ministério da Saúde. *Saúde Brasil 2009: Uma análise da situação de saúde e da agenda nacional e internacional de prioridades.* Ministério da Saúde, 2010.

[7] Ministério da Saúde. Datasus, available at: http://www2.datasus.gov.br/DATASUS/index.php?area=0205&VObj=http://tabnet.datasus.gov.br/cgi/deftohtm.exe?sinasc/cnv/nv

[8] Ministério da Saúde. *Saúde Brasil 2008: 20 anos de Sistema Único de Saúde (SUS) no Brasil.* Ministério da Saúde, 2009.

[9] Alaerte Leandro Martins, *Mortalidade materna das mulheres negras no Brasil*, 22 (11) Cad. Saúde Pública, 2473-2479, 2006..

[10] Adesse, L. e Monteiro, M. *A Magnitude do Aborto: aspectos epidemiológicos e sociais*. Rio de Janeiro: Ipas Brasil e IMS/UERJ, 2007

[11] Formiga, MCC. *Morte materna e desigualdade social segundo o perfil de raça/cor: aplicação da técnica de análise de correspondência aos dados da região Nordeste brasileira.* Sinopse apresentada no 19^{0} SINAPE, São Pedro, SP, 2010.

Deaths resulting from pregnancy related hypertension (pre-eclampsy and eclampsy) are still the leading cause of maternal death. The second, third and fourth main causes of maternal deaths are hemorrhage, infections and unsafe abortions, respectively.

Poor quality of prenatal care, lack of proper training, weak regulation and supervision of obstetric assistance and postpartum care, misuse of medical technology, unwanted pregnancy and related unsafe abortions, are the main factors explaining the relatively high rates of maternal mortality. In relation to unsafe abortion related mortality, decriminalization and measures of harm reduction can effectively reduce the numbers of maternal deaths.

2. HUMAN RIGHTS VIOLATIONS RELATED TO MATERNAL MORTALITY IN BRAZIL

2.1 The Right to Life

The right to life in the context of preventable maternal death means that the State must ensure "the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and will provide couples with the best chance of having a healthy infant."[12, 13, 14, 15, 16, 17]

[12] Cook R. & Dickens B., *Advancing Safe Maternity through Human Rights*, WHO Occasional Paper 5 (2001), at 32-33 (translated by CEPIA in September, 2003); Cairo Programme of Action, supra note 78, at ¶ 7.2.

[13] International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200ª (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 52, art. 6(1), U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [hereinafter ICCPR].

[14] Human Rights Committee, *General Comment 6: Right to Life,* ¶ 5, U.N. Doc. HRI/GEN/1/Rev.6 at 129 (2003).

[15] *Id.*

[16] Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/189, UN GAOR, 34th Sess., Supp. No. 46 at 193, art. 1, U.N. Doc. A/34/46 U.N.T.S. 13 (*ratified by Brazil* Feb.1, 1984) [hereinafter CEDAW].

[17] ADVOCACI and CLADEM, MONITORING ALTERNATIVE REPORT ON THE SITUATION OF MATERNAL MORTALITY IN BRAZIL TO THE COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS (April 2003), *available at http://www.cladem.org/english/regional/monitoreo_convenios/descMMbrasili.asp*; *see* also CEDAW, *supra* note 83, art. 2; CECSR Committee, *General Comment 14: The Right to the Highest Attainable Standard of Health*, ¶ 30, U.N. Doc. E/c.12/2000/4 (Aug. 11, 2000) [hereinafter *CESCR General Comment 14*]. ("States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised

2.2. The right to health

The right to health in relation to maternal mortality requires that States parties ensure women's access to timely, safe, and effective health services and procedures in order to avoid preventable maternal deaths. [18,19, 20 The] Brazilian scenario of maternal mortality demonstrates the extent to which Brazilian state is neglecting to comply with its international obligations under the ICESCR.[2122,2324,25]

2.3 The right to equality and non-discrimination in access to health care

Regional and income disparities affect women's risk of maternal mortality,[26] while social inequalities intersect with race and gender to affect education, employment, and health. [27,28] Afro-descendant women, for example, have less access to education, lower socio-economic

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without discrimination of any kind."; "the notion of the 'highest attainable standard of health'…takes into account…the individual's biological and socio-economic conditions.") See also CEDAW Committee, *General Recommendation No. 24: Women and Health*, 20th Sess., ¶ 12, U.N. Doc. A/54/38 (1999) [hereinafter CEDAW, *General Recommendation No. 24*].

[18] International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3 (*ratified by Brazil* Jan. 24, 1992), in State of São Paulo General Attorney's Office, *International Instruments of Human Rights*, Researching Center, Series Documents n. 14, December 1996.

[19] Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, U.N. Doc. e/c.12/2000/4 (Aug. 11, 2000).

[20] CEDAW, *supra* note 83, art. 12(2).

[21] CESCR, General Comment 14, UN ESCOR, 2000, Doc. No. E/C.12/2000/4.

[22] CESCR Concluding Observations: Brazil, 2003, ¶ 27, U.N. Doc. E/C.12/1/Add.87.

[23] *Id.* ¶ 62.

[24] CESCR Concluding Observations: Brazil, 2009, ¶ 28, U.N. Doc. E/C.12/BRA/CO/2.

[25] CEDAW Committee Concluding Observations: Brazil, 2007, ¶ 29, U.N. Doc. CEDAW/C/BRA/CO/6.

[26] World Bank, MATERNAL AND CHILD HEALTH, *supra* note 2, at 20-21.

[27] World Bank, GOVERNANCE IN BRAZIL'S UNIFIED HEALTH SYSTEM (SUS): RAISING THE QUALITY OF PUBLIC SPENDING AND RESOURCE MANAGEMENT, REPORT NO. 36601-BR, 56 (2007).

[28] *See e.g.,* IPEA/Instituto de Pesquisa Econômica Aplicada (Institute of Applied Economic Research), SPM/Secretaria Especial de Políticas para as Mulheres (Special Secretary of Women's Policies) and UNIFEM/Fundo de Desenvolvimento das Nações Unidas para a Mulher **(**United Nations Development Fund for Women), RETRATO DA DESIGUALDADE DE GÊNERO E RAÇA NO BRASIL (Portrait of Gender and Race Inequalities in Brazil), (3d ed. 2008), *available at* http://www.ipea.gov.br/sites/000/2/pdf/081216_retrato_3_edicao.pdf

status, more precarious living conditions and greater chances of dying during pregnancy.[29, 30,31] . Certain populations and groups of women can be subject to multiple levels of discrimination based on level of education,[32] socio-economic condition,[33] race or ethnicity,[34] place of residence, and regional disparities[35] and are therefore more vulnerable to maternal mortality and morbidity. [36, 37, 38]

3. Human rights norms applicable to maternal mortality in Brazil

The Brazilian Federal Constitution defines motherhood as a social right in the Article 6°. This provision can be invoked in combination with other constitutional articles, such as Article 5°, caput, item I and XLI related to right to equality. In addition, Article 196 protects the right to equal access to actions and services for health promotion, protection and recuperation.

4. a) The tragedy of maternal death: the case of DVSL (2008)

[29] *See e.g.,* Alaerte Leandro Martins, *Mortalidade materna das mulheres negras no Brasil*, 22 (11) Cad. Saúde Pública, 2473-2479 (2006).

[30] Convention on the Elimination of All Forms of Racial Discrimination, G.A. Res. 2106 (XX), Annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195 (*ratified by Brazil* Mar. 27, 1968) [hereinafter CERD].

[31] *Id.* art. 5(iv).

[32] Alearte Leandro Martins, *Mortalidade materna de mulheres negras no Brazil*. ("Maternal mortality among black women in Brazil") Cad. Saúde Pública, Rio de Janeiro, 22 (11) 2474, 2473-2479 (2006).

[33] Black women in Brazil earn 37.6% less than white women, and women in general earn approximately 63% of a man's salary.

[34] *See* IPEA et. al., RETRATO DA DESIGUALDADE, *supra* note 56. (According to the IPEA (Institute of Applied Economic Research), poverty and indigence in Brazil vary according to the population race (skin color). In 2006 the Institute found that 41.7% of the black population lived below the poverty line as opposed to 20% of the white population. About 17% of the black population received less than one quarter of the minimum wage per capita while only 6.6% of the white population lived in this situation.)

[35] CPI Report, (*Perfil Social da Mulher*), *supra* note 92. (21% of the population in the North and 43% of the population in the Northeast suffers from poverty as opposed to the Central West and South where 18% and 15% of the population, respectively, suffers from poverty.)

[36] CPI Report, (*Perfil Social da Mulher*), *supra* note 92.

[37] *Id.* (*Cor/Raça).*

[38] *Id.* 33.

DVSL, 15 years, student, white, obese, resident in of Igarassu – in the metropolitan region of Recife. DVSL was pregnant for the first time and attended prenatal care in a local health unit and a referral hospital in Recife. In late May 2008, her prenatal consultation in the local unit was cancelled because her doctor was on leave. On June 7th her mother accompanied her to the referral hospital. In the consultation, that mother was not allowed to witness, the doctor assessed the evolution of the vaginal cervix and even though DVSL blood pressure was at 150 x 80 mm HG, she was released. At home, her discomfort worsened and she was taken to the obstetric emergency. On the way she had a seizure, followed by cardiac arrest. Bothe the mother and fetus died. The medical examiner conclusion was that the cause of death was **acute lung edema,** a common consequence of pregnancy related hypertension. The family reported the death to the State Committee of Maternal Mortality, the case was investigated and the death was classified as a premature and avoidable maternal death. The State level Prosecutor Office is following the case.

b) **The tragedy of maternal death: the case of Maria**

Maria was 17 years old; she was black and lived with her husband, her father-in-law, her husband´s cousin, and her son. She did neither work outside the home or used contraceptives. She got pregnant and used a bush tea to provoke a miscarriage. According to her mother, the daughter felt sick and was taken to a first hospital, then to second hospital and then to a third one, where she spent the rest of the day. Later that night she was rushed again to the hospital, because she was dizzy, bleeding a lot and could speak. In hospital she remained in isolation until her death. Even after the death, the body kept bleeding.

1. Existing Policy guidelines and mechanisms

The creation of Maternal Mortality Committees is an evidence of Brazilian government's commitment to reducing maternal mortality in the country. The role of these committees is to monitor and evaluate cases of maternal death in order to determine if these deaths were preventable.[39] Fulfillment of the right to health contains obligations of conduct, in terms of developing health policies, but also of result in terms of actually achieving a reduction of maternal mortality.[40]

The existence of these policy guidelines and mechanism is certainly very positive because the persistent human rights violations experienced by women in exercising their reproductive rights and the right to reproductive health can be reduced and re-dressed by the effective implementation of existing policy guidelines, systematic oversight and improvement in the quality of care.

2. Recommendations

In order to guarantee that women and adolescents can exercise their human rights in the area of health, it is necessary that Government recognizes and promotes accountability mechanisms for the monitoring of policy and for its actual implementation, as listed below.

- Give high and immediate priority to the implementation of recommendations made by the CEDAW Committee in its final decision on the Alyne Silva Pimentel;
- Increase the coverage and improve quality of prenatal, childbirth and post –partum care, training and qualifying professionals of all levels of the system, including health managers and technicians of primary, secondary and tertiary;
- Critically asses the problematic effects of the prevailing model of obstetric care;

[39] In Concluding Observations to Brazil in 2007, the CEDAW Committee recommended that Brazil "(…) monitor closely 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." CEDAW Committee Concluding Observations: Brazil, 2007, ¶ 30, U.N. Doc. CEDAW/C/BRA/CO/6.

[40] International Commission of Jurists (ICJ), *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*, 7, 26 January 1997, available at: http://www.unhcr.org/refworld/docid/48abd5730.html.

- To revise existing punitive measures in relation to abortion and meanwhile law is not yet reformed adopt policy measures of harm reduction in relation to unsafe abortion.
- Create legal mechanisms for monitoring, by the federal level, management of the health indicators of States and cities;
- To expand the number of maternal mortality committees, strengthen the existing ones through systematic supervision of their investigations and final decisions.

We request to the Human Rights Council to adopt and strengthen CEDAW and CSECR Committees previous related recommendations presented to the Brazilian government asking for the necessary reform on the current abortion criminal law to protect women's human rights related to reproductive self-determination. Moreover, the Brazilian government should immediately enact legislation protecting gender equality and women's rights to privacy and confidentiality during police investigations of clandestine abortion clinics and guaranteeing human rights principles of presumption of innocence, due process of law, and proper legal defense especially to vulnerable groups of women.

We appreciate the opportunity to bring information to the Human Rights Council in the process of the Universal Periodic Review. We remain at your disposal for further information needed.