- Ensure that private health care facilities comply with national and international standards on reproductive health care;
- Ensure that adequate sanctions for health professionals when they violate women's reproductive rights; and
- Reduce preventable maternal deaths through the implementation of the National Pact for the Reduction of Maternal Mortality at the state and municipal levels, including maternal mortality committees where they still do not exist, in accordance with the final observations of the recommendations made to Brazil, adopted August 15, 2007 (CEDAW/C/BRA/CO/6).

Previous follow-up information:

14 February 2012. Brazilian government sends its first report to CEDAW regarding implementation of the Alyne decision.

16 April 2012. CRR submits its response to CEDAW Committee, including proposed implementation framework for the Ministry of Health, and requests further information from government of Brazil.

3 September 2012. Brazil submits its response to CEDAW Committee.

15 January 2013. CRR responds to CEDAW Committee, and requests additional information from Brazil.

18 March 2013. Brazilian government establishes Grupo de Trabalho Interministerial (GTI) (Inter- Ministerial Working Group) to implement CEDAW recommendations regarding the Alyne Case. The GTI has a renewable term of 180 days and is comprised of representatives from: Ministry of External Relations, Ministry of Health, Secretariat of Women's Policies, Secretariat of Human Rights, and the Secretariat of Policies for the Promotion of Racial Equality.

4 April 2013. Ordinance No. 035 from Brazil's Minister of State, Head of the Secretariat of Policies for Women appoints the members of the Inter-Ministerial Working Group.

April 2013. Brazilian government submits third response to CEDAW Committee.

October 2013. The legal mandate for Brazil's Inter-Ministerial Working Group (GTI) expires.

December 2013. The Rio de Janeiro Trial Court issues a decision awarding moral monetary damages of R$406,800 and a pension for Alyne's daughter, Alice, of a monthly salary at minimum wage, from the time of Alyne's death until Alice turns 18. However, in contrast to the CEDAW Committee, the court does not find the State directly responsible for the poor healthcare provided at the private healthcare center.

24 January 2014. CRR submits response to CEDAW on Brazil's compliance with its concluding observations as well as the Alyne case recommendations.

February 2014. CRR holds a follow-up meeting with Brazilian government in Brasilia. The Brazilian government signs agreement with CRR to pay individual reparations to Maria Lourdes da Silva Pimentel, which is approved by CEDAW. Individual reparations of US$ 46,195.17 to

Alyne's daughter are still pending.

25 March 2014. Brazilian government holds a public event in Brasilia to recognize Alyne's death and give financial reparations to Maria de Lourdes da Silva Pimentel in the amount R$131,239.48 (US$ 55,537). Brazilian government promises financial reparations to Alice Pimentel, Alyne's daughter, if Alice does not benefit from any other financial reparation provided through municipalities.

3 April 2014. Brazilian government holds symbolic reparations ceremony at Maternidade Mariana Bulhões in Nova Iguaçu.

4 April 2014. The Brazilian government holds a public seminar on the Alyne Case in Rio de Janeiro, "Sexual and Reproductive Rights: Confronting Maternal Mortality in Brazil."

5 April 2014. Brazilian government holds symbolic reparations ceremony at Maternidade do Hospital Estadual da Mãe – Unidade Mesquita in Mesquita .

July 2014. CRR submits response suggesting a series of indicators that respond to quality and accountability to measure implementation of the CEDAW recommendations.

August (November) 2014. Brazil submits response to CEDAW asserting it has complied with individual and general recommendations.

3 March 2015. CRR submits response to CEDAW expressing concern about Brazil's position in its November 2014 response that it fully complied with the CEDAW recommendations.

27 -31 July, 2015. CRR finances an independent technical delegation composed of Professors Alicia Ely Yamin, JD MPH of Harvard University, USA, and Sandra Valongueiro, MD, PhD of the Federal University of Pernambuco, Brazil (hereafter "Follow-up Commission"), travel to Brasilia and Rio to meet with government stakeholders, conduct facility visits, and meet with civil society actors, with the aim of producing a technical report on the state of implementation with respect to the CEDAW Committee's General Recommendations.

This technical Follow-up Commission is welcomed by the Brazilian government, and is given complete independence by CRR. Absolutely no expectations of certain findings, recommendations or even topics to consider were given to the experts before, during or after the Follow-Up Commission's visit.

Schedule of Follow-Up Commission Visit:

27July. (Brasilia): Meeting with Inter-ministerial Working Group (GTI); Meeting with Ministry of Health and other government representatives

28 July. (Rio de Janeiro): Meeting at Secretaria de Saúde and Secretaria de Políticas para as Mulheres of Rio de Janeiro.
29 July. Visit to Belford Roxo (Rio de Janeiro): Meeting with Procuradora Federal, Rio de Janeiro.

30 July. Visit to Nova Iguaçu-- Maternidade Mariana Bulhões.

31 July. (Rio de Janeiro): Meetings Maria de Lourdes da Silva Pimentel and Alice Pimentel; Meeting with key stakeholders from civil society.

Key Findings:

Patterns of maternal mortality always reveal fundamental issues regarding the social and economic status of women in a society, as well as the functioning of a health system. As noted by the CEDAW Committee, Alyne da Silva Pimentel's death was emblematic of patterns in the Brazilian health system, which in turn reflects intersecting issues of discrimination in Brazilian society, based both on both gender and race.

Close to five years after the decision by the CEDAW Committee, the Follow-up Commission sought to move beyond identifying gaps in "compliance". Rather, it concentrated on issues that might catalyze re-engagement by national level actors, both governmental and non-governmental, with the aim of advancing the CEDAW Committee general recommendations through not only the creation, but also effective implementation, of policies and programs that promote women's sexual and reproductive rights in practice, including their rights to safe motherhood.

With the aim of understanding the functioning of the health system in relation to the general recommendations issued by the CEDAW Committee, the Follow-Up Commission analyzed aspects of the Brazilian health system at all stages of the policy-making cycle, and the following findings are organized in keeping with the "circle of accountability" set out in the *United Nations Technical Guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality,* adopted by the Human Rights Council in 2012. (UN Doc. A/HRC/21/22). The UN *Technical Guidance, which is the only inter-governmentally approved guidance on what a human-rights-based approach to health in the context of maternal mortality consists in,* aims to assist policymakers in devising, implementing, and monitoring policies and programs in accordance with human rights principles such as accountability and participation. Thus the organization of findings are meant to highlight issues in all aspects of the policy cycle that would enable Brazil to enhance its fulfillment of international human rights obligations, and in particular those recommendations related to the Alyne case.

Enabling Legal and Policy Framework

The advancement of women's reproductive health rights, including their rights to safe motherhood, requires an enabling legal and policy environment that recognizes women's reproductive health, both freedoms/autonomy and access to entitlements, as fundamental to enabling women to live lives of dignity, and participate fully as equal members of society.

In this regard, the Follow-Up Commission notes first of all the over-arching significance of the constitutional recognition of the right to health in Brazil's 1988 Constitution, and the extraordinary achievement of its institutionalization through the universal health system, or

"Sistema Único de Saúde" (SUS).

Additionally, the Follow-Up Commission notes a number of positive actions adopted by the Brazilian state with respect to reproductive health in particular, including the National Pact for the Reduction of Maternal and Neonatal Death, and the creation of National Comprehensive Women's Health Care Policy (PNAISM, by its acronym in Portuguese), which coordinates actions with regard to women's rights and access to health; treatment for unsafe abortions which is based on a humanized approach, [2] epidemiological surveillance system for maternal mortality; reproductive planning initiatives; assistance in cases of domestic and sexual violence; HIV/AIDS prevention and treatment; cancer treatment; menopause care; assistance for gynecological complaints; assisted human reproduction assistance; mental health care; assistance to traditionally excluded sectors of the female population.

Further, it applauds the adoption of a National Policy on Sexual Rights and Reproductive Rights, as well as Law No. 11108/2005 ("Lei do Acompanhante", ensuring pregnant women in SUS the right to a companion); and the Law Nº 11.634/ 2007, which provides the right of pregnant women to information regarding the maternity center where she will receive care under the SUS.

Many other legal regulations and ordinances relating to safe motherhood have been passed since the CEDAW Committee issued its recommendations, which are of note, including: Ordinance No. 1020 establishing the National Guidelines for High Risk Maternity, Newborn and Postpartum Healthcare and defining the criteria for the implementation and qualification of healthcare services to treat high-risk pregnancy; Ordinance No. 904 instituting Seminars on Best Neonatal and Obstetric Practices to finance the Centers for "Normal" (vaginal) Birth ("Centros de Parto Normal").

The Follow-Up Commission however notes with preoccupation the lack of legislation explicitly defining and sanctioning all forms of obstetric violence, which includes any dehumanizing treatment or abuse of medicalization by health professionals during pregnancy, childbirth or post-partum periods. We believe that an explicit statutory proscription on obstetric violence would not only create a clear standard of practice, but would also make visible certain social norms that manifest themselves in the treatment of women's health in Brazil. Such a proscription would align Brazil's legislation with others in the region, and would be in keeping with the Declaration of Fortaleza of the WHO (1985) which underscored that pregnancy is not a disease or pathology, as well as with subsequent guidelines from the International Federation of Gynecology and Obstetrics (FIGO) and the Centro Latinoamericano de Perinatología (CLAP).[3]

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[2] *Atenção Humanizada ao Abortamento: norma técnica.* Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas . (2005: Brasília, Ministério da Saúde, updated 2010).

[3] World Health Organization. Appropriate Technology for Birth. *Lancet*, 1985, 326(8452): 436-437; FIGO Safe Motherhood and Newborn Health (SMNH) Committee. Prevention and Treatment of Post-partum Hemorrhage in Low-resource Settings. *International Journal of Gynecology and Obstetrics,* 2012, 117(2): 108-118; Stones W, FIGO Safe Motherhood and Newborn Health (SMNH) Committee. I349 FIGO Guideline on Care during the Second Stage of Labour. *International Journal of Gynecology and Obstetrics,* 2012, 119(3): S248; Pan American Health Organization. Latin American Center for Perinatology (CLAP), Women

The Follow-Up Commission is also deeply troubled by the ongoing lack of regulation of private actors in the Brazilian health system, which, as evidenced by the facts in the Alyne case itself, undermines women's reproductive health rights, as well as the political promise of the SUS as a core social institution. In the more than twenty years since the SUS was created, the provision of health care in Brazil, as elsewhere, has undergone a series of transformations, due both to epidemiological and demographic transitions, as well as to the ever-evolving technology in the medical field. In this context, and in the current climate of increasing privatization, which is particularly noticeable in the state of Rio de Janeiro, failure to establish parameters for contracting private health care, together with standards of performance, presents a significant legal and regulatory gap, with serious repercussions for the equitable delivery as well as accountability of reproductive (and other) health care services.[4]

The Follow-Up Commission also notes with concern the increasing politicization of and assaults on women's fundamental sexual and reproductive health rights, including in relation to conditions for legal abortion, in the Brazilian Congress, as well as other political bodies. The Brazilian Congress has become the scene of fighting between the pro-life speech by religious and pro-choice position by the feminist movement, described by some researchers since the 1990s[5]. As but one example, draft legislation (Bill 478/07) regarding the "Statute of the Unborn," stipulates that if women do not abort under circumstances of rape, anencephaly, or endangerment of the pregnancy to the woman's life—the only provisions of legal entitlements to abortion in Brazil--the State will assume the costs of an indigent woman raising the child until and unless the father appears. This Bill was named "*bolsa estupro*" or "Rape Basket" as it provides incentives for victims of sexual assault not to exercise their rights to abort.[6] The Follow-Up Commission underscores that regardless of ideological or religious views of elected political representatives, the Brazilian State is bound by international standards to which it has adhered, as well as the interpretation of Brazil's own Constitution by the Supreme Federal Tribunal.

Summary of Key Recommendations Relating to Legal/Policy Framework:

1. In keeping with regional and international guidance, and other national models, enact and enforce legislation that defines, proscribes and establishes sanctions aimed at deterring all forms of obstetric violence.
2. Enact and/or revise, where needed, regulations, and institute and/or improve management and monitoring mechanisms, regarding both public and private delivery of sexual and reproductive health care in order to promote stable and effective compliance with legal obligations under both international and national law.

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and Reproductive Health. *Toolkit for Strengthening Professional Midwifery in the Americas*. 3rd Edition. Montevidio: CLAP/WR, 2014.

[4] Bravo MI, Andreazzi M, de Menezes JS, de Lima J, and Sourza R. A Mercantilizacao da Saúde em Debate: As Organização Sociais no Rio de Janerio. (2015, Rio de Janerio: Cadernos de Saúde Pública).

[5] Rocha, Maria Isabel Baltar. Questão do Aborto no Brasil: o debate no Congresso. Estudos Feministas 38 1 n 2/96. Luna, Naara. Aborto no Congresso Nacional: o enfrentamento de atores religiosos e feministas em um Estado laico. Revista Brasileira de Ciência Política, nº14. Brasília, maio - agosto de 2014, pp. 83-109. DOI: http://dx.doi.org/10.1590/0103-335220141404.

[6] See http://oab-rj.jusbrasil.com.br/noticias/100550204/comissao-da-camara-aprova-bolsa-estupro.

3. Make clear that politicking with women's lives and bodies for ideological and religious reasons is not to be tolerated, as Brazil is bound by both domestic jurisprudence and international agreements on sexual and reproductive health and rights.

National Strategies, Plans of Action and Other Initiatives[7]

The Follow-Up Commission notes the array of strategic measures and plans undertaken by the government to strengthen the implementation of the Pact on the Reduction of Maternal Mortality and Morbidity throughout the country, including: Ministry of Health's Directive No. 1258 (establishing a National Committee on the Prevention of Infant and Neonatal Death); Commitment to Accelerate the Reduction of Inequality in the Northeast Region and Legal Amazon (prioritizing reduction of infant mortality); Integrated Actions to Enhance Care for Women and Newborns in Priority Maternity Wards of the Northeast and Legal Amazon ; Plan for Expanding the Project on Capacitating Care for Women and Newborns in Priority Maternity Wards of the Northeast and Legal Amazon (to bring Ministry of Health's investment allocations to 26 priority maternity wards in the Legal Amazon and Northeast; Ministry of Health's Directive No. 72 (requiring monitoring of infant and fetal mortality in health services, both public and private); Ministry of Health's Directive No. 1459 (establishing inter alia, Postpartum and Comprehensive Child Health Care (0-24 months), and logistical systems to enhance safe transportation); Ministry of Health's Directive No. 653 (instituting mandatory reporting of maternal deaths); as well as Ministry of Health's Directive No. 1119 (from 2008, which preceded the CEDAW decision) regulating the Surveillance Maternal Deaths at the municipal, state and federal levels.

Further, the government has created a plethora of initiatives and programs, including: Assistance to High-Risk Pregnancy initiative; Program for the Humanization of Child Delivery and Childbirth (PHPN, by its acronym in Portuguese); creation of Birth-Maternities Project (including: fast HIV tests, fast maternal syphilis tests, lactation inhibitors, and infant formula); establishment of health classes in schools (including education regarding reproduction, some distribution of contraceptives, and youth participation strategies).

The government has also developed training materials for public administrators, professionals, and providers, including: National Guidelines on Obstetric and Neonatal Care and the Manual of Public Administrators; Distance Education Courses: Training in the Monitoring of Maternal, Infant, and Fetal Death and Participation on Death Prevention Committees. Further, most recently, the Ministry of Health has developed directives for both vaginal and cesarean deliveries, which, if approved and implemented, will create multi-stakeholder, evidence-based protocols for decision-making regarding delivery options.

Among all of these, the government's central initiative and strategy for reducing maternal mortality and morbidity, which was initiated with the aim of accelerating progress on Millennium Development Goal 5, and not directly in response to the Alyne case, is the "Rede Cegonha." The Rede Cegonha, which has been implemented with some variation among regions, focuses on improving the quality of access to health services to ensure safe

[7] See Section 3A of UN OHCHR, "Technical Guidance on the Application of a Human-rights Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality." U.N. Doc. A/HRC/21/22 (2012).

motherhood and affordable access to adequate obstetric care through seminars, workshops and health professionals' training (including resources for the identification and provision of obstetric care to high-risk" women). It also contains a component of data collection on service quality.

The Follow-Up Commission, however, notes certain structural problems in both the approaches taken, as well as the implementation thereof. First of all, as indicated even in its name, the "Rede Cegonha" adopts an approach based on maternal-newborn health, rather than sexual and reproductive health, and that is not a semantic difference. Advancing women's reproductive health rights requires recognizing their agency with respect to their bodies and lives, which includes but goes beyond measures in the health sector. By contrast, the Rede Cegonha's narrowly medicalized approach to a continuum of care reduces women to their pregnancy intentions, and to being instruments of reproduction. This conceptual issue is greatly exacerbated by the Brazilian health system's highly medicalized approach to reproduction, including extraordinarily elevated rates of caesarian sections, as well as other interventions in both pregnancy and especially delivery care (e.g. the use of oxytocin to accelerate contractions).[8] Many of these interventions and practices are not evidence-based, in keeping with best practices in public health or respect for women's health rights.[9] Furthermore, within this system, the Follow-Up Commission observed that women are systematically disempowered from being the protagonists of their own reproduction, are reduced to targets of interventions, and are frequently subjected to obstetric violence.

In this context, the Follow-Up Commission noted with grave concern the abuse of a widespread discourse of "protecting women from suffering" used, for example, to justify performing cesarean sections, as opposed to allowing women to experience the labor pains involved in vaginal deliveries. Needless to say, women are entitled to pain relief if they so choose—and the SUS is authorized to pay for analgesics/anesthesia during labor. Nevertheless, the protection of women from "suffering" appears inextricably linked with a discourse that pathologizes normal delivery processes and converts pregnant women into objects of interventions. Moreover, the supposed concern for women's "suffering" apparently does not extend to women who have abortions. The Follow-Up Commission heard reports, which corroborate other sources, that women seeking abortions are often forced to wait for long hours before a D&C, are generally provided with no information on the procedure, and rarely receive painkillers before and after the procedure.[10]

In short, while the rates /ratios of maternal morbidity and mortality may be reduced by the totality of the Brazilian government's efforts that is not the equivalent of fulfilling women's

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[8] Leal MC, Pereira AP, Domingues RM, Filha MM, Dias MA, Nakamura-Pereira M, Bastos MH, and da Gama SG. Obstetric Interventions during labor and childbirth in Brazilian low-risk women. Birth in Brazil. *Reports in Pulblic Health*, 2014, 30:S17-S32; Lansky S. de Lima AA, da Silva AA, Campos D, Bittencourt SD, de Carvalho ML, de Frias PG, Cavalcante RS, and da Cunha AJ. Birth in Brazil survey: Neonatal mortality, pregnancy and childbirth quality of care. *Reports in Public Health*, 2014, 30: S1-S15.

[9] UN OHCHR, "Technical Guidance on the Application of a Human-rights Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality." U.N. Doc. A/HRC/21/22 (2012).

[10] "Qualidade da atenção ao aborto: o que dizem as mulheres?" Aquino et al., 2012. http://www.scielo.br/pdf/csc/v17n7/15.pdf.

reproductive health rights or respecting their basic dignity and agency as human beings, as was called f or in the Alyne recommendations.

Second, the Follow-Up Commission notes that multiple actors from both government (at federal, state and municipal level) and civil society agreed that there is a substantial gap that exists between the broad array of initiatives and plans introduced by the government, and the effective enjoyment of women's reproductive health rights in practice. Multiple diagnoses of Brazil's maternal health programs and outcomes have confirmed this assessment.[11]

The Follow-Up Commission believes that while there are multiple factors behind the inability to translate the array of strategies and initiatives undertaken by the government into effectible enjoyment of reproductive health rights in practice, they have in common structural problems relating to the management of the health system. The Brazilian health system is decentralized, with differentiated responsibilities among the federal government, 27 state governments, and 5,570 municipalities. For example, while the federal government is the formulator of policies and initiatives, it does not execute or oversee the implementation of those initiatives at local levels.

The fragmentation of responsibilities within the health system in this enormously diverse country, with insufficient oversight and regulation, leads to vacuums of accountability in practice. These vacuums of accountability are exacerbated by the lack of effective regulation not only in the public sector, but also of private actors, which play an increasingly important role in terms of both budgetary allocations and the delivery of services. For example, approximately 70% of deliveries occur in the public sector, which has a cesarean section rate of approximately 46% while in the private sector, where approximately 30% of deliveries take place, there is an estimated cesarean rate of 88%.[12] This disparity cannot be remotely justified by any international technical standards. In turn, they also have impacts on newborn health. For example, the proportion of premature infants is 11.5%, 55% higher than in the UK.[13]

In April 2012, Brazil noted to the CEDAW Committee that the submission by the petitioners (CRR) "gives the impression that SUS measures are not sufficiently effective, requiring the contracting of services from private institutions [] to perform its mandated duties and responsibilities. In this light, we reiterate the explanations provided and submitted previously, which give due emphasis the System and its decentralized character." The Follow-Up Commission wants to underscore that it appreciates the extraordinary achievement of Brazil's unified health system, and makes these observations in the spirit of revitalizing the original

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[11] Galli B, Rocha H, and Queiroz J. Caso Alyne Pimentel: Relatório Sobre Mortalidade Materna no Contexto do Processo de Implementação da Decisão do Comitê CEDAW Contra o Estado Brasileiro. (2014, Plataforma de Direitos Humanos- Dhesca Brasil. UNFPA); Bustreo F & Hunt P. *Women's and Children's Health: Evidence of Impact of Human Rights*. (2013, Geneva: World Health Organization).

[12] Domingues RM, Dias MA, Nakamura-Pereira M, Torres J, d'Orsi E, Pereira AP, Schilithz AO, and Leal M. Process of Decision-making Regarding the Mode of Birth in Brazil: From the Initial Preference of Women to the Final Mode of Birth. *Reports in Public Health*, 2014, 30: S101-S116.

[13] Blencowe H, Cousens S, Oestergaard MZ, Chou D, Moller AB, Narwal R, Adler A, Garcia CV, Rohde SS, Say L, Lawn JE. *National, regional and worldwide estimates of preterm birth rates in the year 2010 with time trends for selected countries since 1990: a systematic analysis and implications.* (2012: Geneva: World Health Organization).

political vision of the SUS as a core social institution in Brazil's democracy.

Summary of Key Recommendations Relating to National Strategies, Initiatives and Plans of Action:

1. Review the framing of existing national policies and initiatives, including Rede Cegonha, and revise where necessary to reflect a broader approach to sexual and reproductive health and rights, rather than "maternal child health".
2. Systematically ensure that national policies, plans of action, and provider protocols on reproductive health and maternity care are grounded in the best evidence-based practices of public health.
3. Include civil society organizations, especially those that represent women of African descent and other marginalized communities, in the development of national strategies and plans of action (through meaningful deliberation, not merely consultation), and enable them to monitor the delivery of services in practice, as part of ensuring meaningful social accountability.

Budget[14]

The Brazilian federal government spends 9.6% of GDP on the health system, which does not include water and sanitation, and other public health measures that are preconditions to health. This level of health spending is substantial by regional standards, and is on a par with many high-income countries in Western Europe. However, of the 9.6% of GDP that the federal government spends on health, 3.2% goes to the public sector, which serves between two-thirds and three-quarters of the population, and 6.4% goes to the private sector, which serves the rest. At the state level, 12% of the budget goes to health, and the Follow-Up Commission was informed that in Rio de Janeiro approximately half of that spending goes to the public sector and approximately half goes to the private sector. Municipalities are obligated by law to spend at least 15% of their budgets on health, which implies significant variation in per capita spending across the 5,570 municipalities of varying economic capacities. At the municipal level, in Nova Iguacu, the Follow-Up Commission was informed that approximately 60% of the budget goes to salaries, and the remaining 40% goes to equipment, supplies, etc.

The Follow-Up Commission heard many allegations of both extravagant leakage of available resources from corruption within the health sector, and the lack of prioritization for maternity care due to profit-seeking interests of medical and other professionals within the health system. However, the Follow-Up Commission is neither in a position to assess the veracity of such allegations, nor whether or the extent to which those factors might currently result in under-financing of or inequities with respect to reproductive health care.

However, the Follow-Up Commission does note with concern that: (1) spending on health, and reproductive health in particular, is extraordinarily directed at technological and biomedical interventions, rather than approaches that address social and underlying determinants of

[14] See Section 3B. UN OHCHR, "Technical Guidance on the Application of a Human-rights Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality." U.N. Doc. A/HRC/21/22 (2012).

women's sexual and reproductive health, such as gender-based violence, sexuality education (beyond the health classes in schools), and psycho-prophylaxis for delivery care; (2) the absence of attention to social and underlying determinants of health has a disproportionate impact on poor women of African descent, whose social marginalization is aggravated by the narrowly biomedical strategies and model of care; (3) substantial savings could potentially be generated by the employment of more obstetric nurses and midwives throughout the health system, and fewer doctors, which comparative experience from other countries has also shown to be an effective strategy in promoting women's autonomy and reproductive health rights; and (4) spending on technologies is not always evidence-based, as for example in the routine use of three ultrasounds during pregnancy, and more for high-risk women, which implies an enormous expense for the health system.[15]

Summary of Key Recommendations Relating to Budget:

1. Ensure that budgeting priorities are set in accord with best evidence of public health, including with respect to task shifting, and use of technologies;
2. Include citizens, civil society groups, academics, and health providers in the process of budget formulation as well as monitoring, and in particular women of African descent and women from other marginalized communities, which requires *inter alia*, adequate transparency in budgetary allocations and reporting.

Implementation of Programs[16]

As stated above, a substantial gap exists between the creation of policies and strategies and the implementation of programs in practice. The Follow-Up Commission is of the opinion that this is due to both structural issues in the management of the decentralized health system generally, as noted above, as well as a specific failure to align stated policies with programs.

For example, a key recommendation of the CEDAW Committee was to make access to emergency obstetric care (EmOC) available and accessible on an affordable basis. In accordance with technical guidelines from the WHO, basic EmOC includes assisted vaginal delivery as a signal function.[17] In Brazil, however, despite the training courses undertaken by the government, physicians and medical students are rarely trained in the use of vacuum extraction, which is a key component of assisted vaginal delivery, nor are vacuum extractors available in most health facilities. Indeed, in 2015, Federal University of Pernambuco, under the pioneering

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[15] Bricker L, Neilson JP, Dowswell T. Routine Ultrasound in Late Pregnancy (after 24 weeks' gestation). *The Cochrane Database of Systematic Reviews*. 2008;(4):CD001451. doi:10.1002/14651858.CD001451.pub3; Bucher HC, Schmidt JG. Does Routine Ultrasound Scanning Improve Outcomes in Pregnancy? Meta-analysis of Various Outcome Measures. *BMJ*, 1993; 307(6895): 13-17; Ewigman B, LeFevre M and Hesser J. A Randomized Trial of Routine Prenatal Ultrasound. *Obstet Gynecol* 1990; 76(2): 189-194; Whitworth M, Bricker L, Neilson JP, and Dowswell T. Ultrasound for Fetal Assessment in Early Pregnancy.). *The Cochrane Database of Systematic Reviews*. 2010;(4):CD007058. doi:10.1002/14651858.CD007058.pub2.

[16] See Section 4. UN OHCHR, "Technical Guidance on the Application of a Human-rights Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality." U.N. Doc. A/HRC/21/22 (2012).

[17] Monitoring Emergency Obstetric Care: A Handbook. World Health Organization, UNFPA, UNICEF, AMDD. 2009.

leadership of Dr. Elias Melo began training medical residents in the use of vacuum extractors, covering in total a handful of hospitals in Belo Horizonte (Minas Gerais), São Paulo (São Paulo), Porto Alegre (Rio Grande do Sul), and one in Salvador (Bahia). That experience remains an exception in Brazil, despite abundant technical evidence that use of vacuum extraction can significantly reduce infection in comparison with caesarean delivery. In the absence of assisted vaginal delivery skills, prolonged or obstructed labor will invariably require caesarean sections. If assisted vaginal delivery, and other essential obstetric skills in the management of labor are not widely taught in medical schools and practiced in facilities, strategies to reduce rates of caesarean sections will remain hollow, and indeed may also encourage the use of dangerous practices, such as the inappropriate administration of Pitocin, as physicians will be unprepared to manage normal labors.

To provide another example at the state level, when abortion is legal, as defined under Brazilian law, it must be made accessible to women. Yet legal abortion in Rio de Janeiro is not widely accessible; indeed, based upon the information provided to the Follow-Up Commission, there is one service with one only doctor to perform the procedure.

In both of these, as in numerous other examples encountered by the Follow-Up Commission, there is a significant failure to align laws, as well as stated policies and goals, with the training, staffing, supply chains and other programmatic issues that would be necessary to ensure women's rights to safe motherhood and reproductive health in practice.[18]

Summary of Key Recommendations Relating to Program Implementation:

1. Require regular evaluation of the implementation of evidence-based guidelines and practices at local levels, which includes follow up and remedial responses that are not confined to punitive sanctions, but also the re-structuring of resources and systems to enable appropriate training and provision of care. Such evaluation should be based upon bottom-up diagnostic exercises that allow for refinements in the management of the health system at multiple levels, in order to ensure women's enjoyment of sexual and reproductive health in practice.
2. Require (through guidelines, curriculums, accreditations and otherwise) providers to be adequately trained and be evaluated continually on competency in all signal EmOC functions, and to discuss delivery options and patient rights with patients and their families during prenatal care.
3. Incorporate cultural competency and human rights training requirements into medical and other health provider education as well as practice settings to ensure respectful treatment, and provide redress mechanisms for patients in the event they feel they have not received respectful and culturally appropriate care.
4. Promote public displays as well as meaningful understanding of patients' rights charters in accessible formats.

[18] See Section 4. UN OHCHR, "Technical Guidance on the Application of a Human-rights Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality." U.N. Doc. A/HRC/21/22 (2012).

Monitoring and Review[19]

The Follow-Up Commission applauds the intent of the Brazilian government to collect disaggregated data through the Rede Cegonha to assess disparities based upon race, as well as gender and other socio-economic factors. Such disaggregation will be essential to identifying and remedying patterns of substantive inequality noted by the CEDAW Committee in its findings.

The Follow-Up Commission believes, however, that the Brazilian government should engage in a systematic effort to evaluate the array of different strategies initiated with respect to reducing maternal mortality and morbidity. The Follow-Up Commission noted many instances where programming is being carried out without a sufficient technical evidence base to enhance practice. To give but one example, with respect to a fundamental pillar of the government's strategy in Rede Cegonha-- the identification and classification of risk among pregnant women-- the Follow-Up Commission repeatedly found when inquiring as to the number of obstetric complications occurring among women in different risk categories that such information was not available. Such data is fundamental to assessing whether the risk classification is actually working in predicting and preventing severe obstetric complications.

That is, if in fact "low-risk" women are experiencing a greater rate of complications than "high-risk "women, such information would call for further analysis of whether the high-risk antenatal care was in fact preventing complications successfully, and whether it was doing so among women of African descent and other marginalized women in particular. However, the contrary could also be true—that is, that the risk classification does not work and the majority of complications occur in low-risk women because the complications are unpredictable-- which in turn would call for the overall strategy to be modified to provide higher quality antenatal care to all women rather than dedicating expense and energies to risk classification. Currently, however, according to the information shared with the Follow-Up Commission, it is impossible to determine this, as well as the answers to many other basic questions relating to the evaluation of fundamental aspects of Brazil's strategies with respect to reducing preventable maternal mortality and morbidity.

In this regard, the Follow-Up Commission applauds the systematic study of "Birth in Brazil" carried out by the Ministry of Health, with Fundação Oswaldo Cruz – Fiocruz, which contains addressed to different actors, including policymakers; to managers and health professional councils; health professionals; universities and researchers and social movements; upon which to act to reduce cesarean sections in a responsible manner. [20] Further, the Follow-Up Commission acknowledges that the Ministry of Health faces severe challenges with respect to the collection of systematic and standardized information both from municipalities, and from the private sector, which are again due in large measure to structural issues in the health system

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[19] See Sections 5A and 5B. UN OHCHR, "Technical Guidance on the Application of a Human-rights Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality." U.N. Doc. A/HRC/21/22 (2012).

[20] Lansky S. de Lima Friche AA, Moura da Silva AA, Campos D, de Azevedo ,Bittencourt SD, de Carvalho ML, de Frias PG, Cavalcante RS, and Alves da Cunha AJ. Birth in Brazil survey: Neonatal mortality, pregnancy and childbirth quality of care. *Cadernos de Saúde Pública*, 2014, 30: S1-S15.

that produce lacunae of transparency and accountability in relation to the many initiatives undertaken.

Summary of Key Recommendations Relating to Monitoring and Review:

1. Ensure that all strategies, policies, and programs aimed at reducing maternal morbidity and mortality, are evaluated to ascertain effectiveness in practice, and alignment with stated goals.
2. Establish management systems and agreements that enable the continuous and adequate collection of data, at municipal, state and national levels, to enable to systematic evaluation of programs for effectiveness as well as for the detection of disparities among populations, and appropriate modification based upon such data collection.

Remedies[21]

The availability of effective remedies in the event of violations of women's reproductive health rights is essential to safeguarding women's dignity, as well as their health. The CEDAW Committee called for the government to ensure such remedies, and training of judicial and law enforcement officials, as well as adequate sanctions for health professionals when they violate women's reproductive rights.

The Follow-Up Commission notes with satisfaction the May, 2015 initiation of a civil compliance suit by the Ministério Público Federal in Rio de Janeiro against the Hospital Maternidade Maria Amélia Buarque de Hollanda to ensure that it was following the requirements of affiliation with the Rede Cegonha, including: best practices, evidence-based care, in accordance with WHO guidelines, accompaniment of pregnant women in delivery in accordance with the law, and appropriate risk classification.[22] The Follow-Up Commission was informed that a similar suit had been filed by the Ministério Público in São Paolo against a different maternity hospital. Although they can take substantial time to be resolved, and the Ministério Público has few powers to enforce compliance with broad judgments, the Follow-Up Commission applauds this initiative by the Ministério Público and notes that it appropriately places emphasis on systemic and structural factors, which are the root of failures of accountability, rather than individual failures.

Nevertheless, the Follow-Up Commission found that there remains a gap in oversight mechanisms of the SUS, and access to administrative and other remedies, with respect to deliberate violations of women's reproductive health rights by practitioners. The SUS Ombuds Office does not currently function effectively as an accountability mechanism. In past communications regarding the Alyne case, the government of Brazil has responded with respect

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[21] See Section 5C. UN OHCHR, "Technical Guidance on the Application of a Human-rights Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality." U.N. Doc. A/HRC/21/22 (2012).

[22] Minsterio Publico Federal. Oficio/PRRJ/GAB/MFCF No. 7540/2015. Inquérito Civil No. 1.30.001.001965/2014-29

to sanctions imposed on health professionals who violate women's reproductive health rights that: 1) Medical standards are regulated under National SUS audit system (Decree No. 1651, 1995), the Medical Ethics Code (Resolution No. 1931, 2010), and the Federal Council of Medicine's Resolution No. 1541 of 1998; and 2) The Project "Listening to Women" will improve the operation of Ombudsman, evaluate women's access to services within the Rede Cegonha and the care offered to women victims of violence. However, the Follow-Up Commission was unable to obtain evidence that the program "Listening to Women" had improved the functioning of the SUS Ombuds office, nor that the audit system sets sufficient standards for the regulation of medical conduct. On the contrary, it appears that a new mechanism, or modified mandates and capacities, are required for the SUS to be able to ensure compliance with ethical standards and appropriate sanctions for deliberate violations of women's reproductive rights.

Summary of Key Recommendations Relating to Remedies:

1. Support and promote public awareness and expanded of the use of civil suits by Ministério Público, to ensure compliance with legal obligations and the enjoyment of women's reproductive rights in practice.
2. Undertake a comprehensive re-evaluation of the existing mandates SUS Ombuds Office and Audit Office, through a participatory process that includes civil society organizations, and in particular organizations representing women of African descent and other marginalized communities, with the aim of transforming them into more effective accountability mechanisms.

Concluding Comments and Over-Arching Recommendations:

Almost five years after the views of the CEDAW Committee were adopted in the Alyne case, the Brazilian government should be applauded for many o fthe initiatives it has undertaken. However, the advancement of women's reproductive health rights in Brazil, including their rights to safe motherhood, still requires the translation of many of the normative recommendations of the CEDAW Committee into effective policies and programs in practice. That translation, in turn, requires not only national political commitment, which is essential in terms of compliance with international obligations. It will also demand catalyzing engagement by multiple levels of government as well as professional and civil society organizations. The following overarching findings, and ensuing recommendations, are thus intended to spur deliberation among an array of actors as to the structural challenges that remain to be addressed.

1. **There is a need to reinvigorate the original vision of the SUS, in order to ensure that it is meeting its full promise and promoting the health and social inclusion of the women of Brazil**. In the era of the Sustainable Development Goals, where increasing importance is being placed upon achieving universal health coverage, Brazil has the opportunity to set an example for the world of what a universal, publicly funded, participatory health system can do and be as a core social institution of democracy, which is far more than an apparatus for the delivery of goods and services. However, in order for this to occur, it is necessary: (1) to re-engage a national conversation regarding public funding and the financing balance of public (versus the private contracted) services in the SUS, as well as to define the

parameters for private actors in the health system; and (2) to establish more effective regulation and oversight of both public and private actors, including effective systems for ongoing accreditation of health centers and hospitals.

At a pivotal juncture in the history of the country's health system, Brazil has an existing series of structures that should enable meaningful political debates regarding the role of the health system in an equitable and pluralistic democracy. Brazil has established National Health Conferences on health already, which could be used this year and in coming years, in conjunction with other activities, to stimulate such discussions. It is essential that these dialogues regarding the management and budget model of the system (and the relation between full public and OS management) be undertaken in a concerted (organized at all levels of government) and deliberative (not consultative) manner, ensuring the full participation of government and private sector actors, as well as civil society, and in particular women's groups.

Further, in assessing the current state of the health system, it is also essential to consider the particular effects on women of the highly medicalized model of care adopted in Brazil, which entails non-evidence-based use of technologies and procedures; untrammeled medical autonomy that operates to the detriment of women's reproductive health rights, and a neglect of social determinants of health, which were historically so critical in Brazil, and which are especially crucial to marginalized women, including women of African descent.

The Follow-Up Commission is convinced that a series of national, state and local dialogues, within the context of already established national public health conferences, but also beyond, about constructing a democratic health system, and in turn of what the diverse people of Brazil –men, women, whites, blacks, indigenous, disabled, and others-- owe to one another as fellow citizens in such a system, can contribute to revitalizing the SUS in ways that promote the reproductive health and rights of the women of Brazil.

2. **There is an urgent need to change the relationship between women and providers to one of entitlement and obligation.** There can be no constructive accountability in the health system if women are disempowered and made to feel like objects of largesse or even worse of obstetric violence, and providers, in turn, have no sense of obligations to the patients they are ostensibly serving. In order to transform relationships between patients and providers, changes are required in medical and other health professional (e.g. nursing) educational curricula and further professional training. All health providers, for example should be taught --and critically—also evaluated on "cultural competence" with respect to women of diverse racial backgrounds, including women of African descent, and training guidelines should include aspects of gender and racial-based competencies. They should also be taught and evaluated on basic human rights and respect for patients' dignity, as well as evidence-based practices. In this regard, the Follow-Up Commission notes that the UN Office of the High Commissioner for Human Rights and Harvard FXB Center have produced a Reflection Guide specifically for health providers to enhance respect for women's sexual and

reproductive health, and in particular maternal health, rights.[23] Countless other training materials are easily accessible by the Brazilian government as well as medical and health professional associations, but it is essential that all such trainings be followed up by systematically evaluating changes in conduct and performance.

At the same time, women, and in particular marginalized women, need to be empowered to demand their rights from health providers. The Follow-Up Commission underscores the urgent need for movements from civil society to strengthen the capacity to demand their rights among poor women, and in particular women of African descent. Successful models of accompaniment of marginalized women might be adapted from other countries in the region, and articulation with appropriate political institutions[24], such as in this case the Secretariat of Racial Issues, in order for women to know and be able to claim their rights.[25]

The Follow-Up Commission is acutely aware of funding shortages in civil society, and therefore proposes exploring possibilities with civil society organizations for strengthening mechanisms for funding through a government institution that is independent of the Ministry of Health and state Secretariats of Health, such as the Ministério Público, or the Secretariats of Women's and Racial Issues. The Follow Up Commission notes that the exact form of such funding necessary in order to guarantee the independence of civil society organizations would require negotiation at the national level, and is beyond the scope of this report.

Additionally, all institutions should publish patients' rights charters prominently and all women receiving prenatal care should obtain such charters, including information regarding psycho-prophylaxis and choice of delivery methods, in an accessible format at their first prenatal visit. Many models for doing so exist from other countries in the region, as well as elsewhere.

Finally, the Follow-Up Commission applauds the initiative and use of civil suits by Ministério Público and believes these should be expanded across country to enforce and establish standards of care at maternity hospitals and improve accountability of providers and institutions. Modifying mandates for SUS Ombuds Office and Audit could also potentially enhance constructive accountability and should be explored with civil society as well as professional associations.

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[23] UN OHCHR and Harvard FXB Center for Health and Human Rights. *Summary Reflection Guide on a Human Rights-based Approach to Health: Application to Sexual and Reproductive Health, Maternal Health, and Under-5 Child Health for Health Policy Makers*. (2015: United Nations).

[24] See discussion of citizen monitoring of health services quality in Peru in, Yamin AE & Frisancho A. Human Rights-based Approaches to Health in Latin America. *The Lancet*, 2014; 385(9975): e26-29.

[25] For example, O Comitê de Mortalidade Materna Estadual de de Pernambuco, que é coordenado pelo movimento de mulheres, tem uma parceria com o Ministério Público de Pernambuco, incluindo a promoção de eventos e com o seu apoio financeiro. See: cartilha http://www.mppe.mp.br/mppe/attachments/article/4240/cartilha%20humanizacao%20do%20parto%20pdf.pdf; See also:Seminário: http://www.mppe.mp.br/mppe/attachments/article/4240/folder%20parto%20humanizado%20grafica.pdf

3. **There is a need to align teaching and programs with policies, and to align all policies and programs with the best evidence in medicine and public health.** The right to health, including the right to safe motherhood, requires the government to adopt practices based upon sound scientific evidence, not the fundamentalisms of religious ideology, nor the fundamentalisms of certain traditions of medical practice. The Follow-Up Commission, as noted above, found numerous instances where widespread practices do not follow the best evidence in public health.

   Further, as noted above, the Follow-Up Commission encountered many situations reflecting a failure to align policies with programs, so that women are unable to exercise their reproductive health rights in practice. In this regard, the Follow-Up Commission notes the invaluable resource available from the findings and recommendations of Maternal Mortality Committees (at local, regional and in states levels), which can be incorporated in the design, execution and evaluation of reproductive and, specifically, maternal, health programs.

The Follow-Up Commission underscores, as noted above, that sustainably aligning policies and programs with evidence requires systematic monitoring and evaluation, which is currently not being undertaken effectively, as well as more effective management and regulation of an extremely complex health system.