CENTER FOR REPRODUCTIVE RIGHTS

April 20, 2009

The Committee on Economic, Social and Cultural Rights

Re: Supplementary Information on Brazil
Submitted to the Committee on Economic, Social and Cultural Rights for the periodic review of Brazil in its 42nd session

Distinguished Committee Members:

The Center for Reproductive Rights (CRR), a non-governmental, international legal organization, submits this letter to supplement the second periodic report of the government of Brazil to the Committee on Economic, Social and Cultural Rights (the Committee), scheduled to be reviewed by the Committee in its upcoming 42nd session. We hope to further the work of the Committee by providing independent information concerning the rights protected under the International Covenant on Economic, Social and Cultural Rights (ICESCR). In this letter, we will address one issue of particular concern regarding women's health and rights in Brazil – maternal mortality– and include a list of recommendations that we hope the Committee will consider submitting to the Brazilian State.

As reproductive rights are fundamental to women's health and equality, it is imperative that States Parties demonstrate a serious commitment to ensuring such rights. Reproductive health and rights receive broad protection under the ICESCR. Article 12(1) of the Covenant recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[1] In interpreting this right in General Comment 14, the Committee has explicitly defined the right to health to "include the right to control one's health and body, including sexual and reproductive freedoms,"[2] and explicitly confirmed that "[t]he realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health."[3] Moreover, the Committee has asserted that States Parties are required to take "measures to improve child and maternal health, sexual and reproductive health services, including access to family planning . . . emergency obstetric services and access to information, as well as to resources necessary to act on that information."[4]

Articles 2(2) and 3 of the ICESCR guarantee the right to non-discrimination, specifically as to "sex, social origin or other status."[5] To that end, the Committee has characterized the duty to prevent

[1] International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976), art. 12(1) [hereinafter ICESCR], *available at* http://www2.ohchr.org/english/law/pdf/cescr.pdf.
[2] Committee on Economic, Social and Cultural Rights, *General Comment 14*: *The Right to the Highest Attainable Standard of Health*, para. 8, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter CESCR General Comment 14], *available at* http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En.
[3] *Id.* at para. 21.
[4] *Id.* at para. 14.
[5] ICESCR, *supra* note 1, at arts. 2(2) and 3.

discrimination in access to health care as a "core obligation" of the state.[6] Despite these protections and the Committee's interpretive guidance, the reproductive health of women in Brazil, particularly, their rights to safe pregnancy and child birth, are being neglected and violated.

Maternal Mortality in Brazil – An Overview

Brazil accounts for almost one-third of maternal deaths in Latin America, with 4,100 women dying of causes related to pregnancy and childbirth each year.[7] Moreover, Brazil's maternal mortality rates are "considerably higher than those of countries with lesser levels of development, and . . . generally conceded to be unacceptable"[8] and are marked by drastic disparities based on race, economic status and urban/rural distributions.[9]

Studies confirm that governments are capable of developing, and have developed, effective health-care interventions to combat high maternal mortality rates. For example, China, Cuba and Malaysia, reduced their maternal mortality rates by establishing community-based maternal health-care systems and referral systems for obstetric emergencies.[10] The World Health Organization (WHO) cites their successes as evidence that "a country's overall economic wealth is not in itself the most important determinant of maternal mortality."[11]

Another example is Sri Lanka, a lower-middle-income country that, similar to Brazil, had challenges in serving isolated rural populations. Sri Lanka's maternal mortality ratio declined from between 500 and 600 in 1950, to just 60 in recent years.[12] Its success has been attributed to the government's concerted effort to extend health services, including maternal health care, through an extensive rural health network.[13] Sri Lanka also systematized the use of health data and focused on improving the quality of care for its most vulnerable groups.[14]

By contrast, women in Brazil have suffered from the same high risk of maternal death since at least 1990.[15] Brazil reports its maternal mortality ratio to be 50 deaths per 100,000 live births,[16] but according

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[6] CESCR General Comment 14, *supra* note 2, at para. 19.

[7] WHO, UNFPA, UNICEF, WORLD BANK: MATERNAL MORTALITY IN 2005 29, annex 3 (2007). [hereinafter MATERNAL MORTALITY IN 2005], *available at* http://www.unfpa.org/upload/lib_pub_file/717_filename_mm2005.pdf.

[8] UN COUNTY TEAM: A UN READING OF BRAZIL'S CHALLENGES AND POTENTIAL 14, at para. 40 (2005) [hereinafter A UN READING OF BRAZIL'S CHALLENGES AND POTENTIAL], *available at* http://www.unodc.org/pdf/brazil/Final%20CCA%20Brazil%20(eng).pdf.

[9] BRAZILIAN HEALTH MINISTRY, BRAZIL HEALTH 2006: AN ANALYSIS OF INEQUALITY IN HEALTH (MINISTÉRIO DA SAÚDE, SAÚDE BRASIL 2006 – UMA ANÁLISE DA DESIGUALDADE EM SAÚDE) at 376, 380, 373 (2006) [hereinafter BRAZIL HEALTH 2006: AN ANALYSIS OF INEQUALITY IN HEALTH].

[10] *See* WHO, UNFPA, UNICEF, WORLD BANK: REDUCTION OF MATERNAL MORTALITY 21 (1999) [hereinafter REDUCTION OF MATERNAL MORTALITY], *available at* http://www.who.int/reproductive-health/publications/reduction_of_maternal_mortality/e_rmm.pdf.

[11] *Id*.

[12] *See* CENTER FOR GLOBAL DEVELOPMENT, MILLIONS SAVED: PROVEN SUCCESSES IN GLOBAL HEALTH: CASE 6 – SAVING MOTHERS' LIVES IN SRI LANKA 1(2004) [hereinafter SAVING MOTHERS' LIVES IN SRI LANKA], *available at* http://www.cgdev.org/section/initiatives/_active/millionssaved/studies/case_6.

[13] *See id*.

[14] *See id.* at 6 (*See* UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP), HUMAN DEVELOPMENT REPORT 209 (2003) [hereinafter UNDP HUMAN DEVELOPMENT REPORT – 2003], *available at* http://hdr.undp.org/en/media/hdr03_complete.pdf.

[15] BRAZILIAN COURT OF AUDIT (TCU), TCU EVALUATION OF MATERNAL MORTALITY MONITORING AND PREVENTION 12 (2003) [hereinafter TCU REPORT] (MMR in 1990: 50, MMR in 1996: 52.06; MMR in 1998: 65.26); according to the

to various studies, this is a substantial underestimate. The WHO and the United Nations Population Fund (UNFPA) estimate Brazil's rate to be 110.[17] Other studies have estimated the maternal mortality rate to be up to 238 in some states.[18] These statistics highlight the Brazilian government's failure to adequately reduce the country's high incidence of maternal mortality in compliance with the international human rights obligations of Brazil and other development commitments such as the Millennium Development Goals (MDGs). This concerning fact is further underscored by the Brazilian government's most recent concession in its 2008 periodic report to the Committee, that 90% of maternal deaths in Brazil are preventable without costly interventions.[19]

Underlying Brazil's failure to prioritize reducing maternal mortality are stark gender and racial inequalities. While women generally have higher levels of education in Brazil, a 2002 World Bank study confirms that women earn only 66% of what men do, making Brazil's gender wage gap one of the largest in the region.[20] Additionally, research confirms that gender bias and stereotypes are taught in Brazil's education system, linking men to public life and women to the private sphere.[21] As such, women's lesser economic and social status as a whole can contribute to the lack of attention paid to women's health and survival, and to obstacles hindering women's access to health care.

In terms of race, Afro-descendants account for 61% of the country's poor,[22] and by Brazil's own admission, "poverty is concentrated on black or Afro-descending women."[23] Brazilian women of African descent "have less access to education, lower social and economic status, and worse housing and living conditions than of white women."[24] The fact that black women are "subject to double

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Ministry of Health, Brazil's MMR in 2004 was 54.4); BRAZIL HEALTH 2006: AN ANALYSIS OF INEQUALITY IN HEALTH, *supra* note 9, at 376, *available at* athttp://portal2.tcu.gov.br/portal/page/portal/TCU/english/publications/institucional_publications/EXECUTIVE_SUMMARIES_1_-_TCU_EVALUATION_OF_MATERNAL.PDF.

[16] Alarmingly, Brazil's understanding of its own maternal mortality ratio seems to be amiss. It reports to this Committee that its rate in 2003 was "50 deaths per 1,000 live births." *See Implementation of the International* Covenant on Economic, Social and Cultural Rights*: Second periodic reports submitted by States parties under articles 16 and 17 of the Covenant, Brazil,* para. 417, UN Doc. No. E/C.12/BRA/2 (Jan. 28, 2008) [hereinafter *Brazil Report to CESCR* (2008)], *available at* http://daccessdds.un.org/doc/UNDOC/GEN/G08/403/04/PDF/G0840304.pdf?OpenElement.This would mean that Brazil's ratio of maternal deaths is 5,000 per 100,000 live births– higher than every other country in the world. Although Brazil's rates are indeed high, we suspect that the given ratio of 50 deaths per 1,000 live births must be an error in the state's report. It is probable that state party intended to report 50 deaths per *100,000* live births.

[17] MATERNAL MORTALITY IN 2005, *supra* note 7, at 23, annex 3.

[18] Sandra Valongueiro, *Maternal Mortality: A New Estimate for Pernambuco, Brazil* (paper presented at 2005 meeting of Population Association of America) at 4 (2005).

[19] *Brazil Report to CESCR* (2008), *supra* note 16, para. 41.

[20] *See* WORLD BANK, PUBLICATION NO. 23442-BR, BRAZIL GENDER REVIEW: ISSUES AND RECOMMENDATION 24 (2002), *available at* http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2002/07/16/000094946_02053104030340/Rendered/PDF/multi0page.pdf.

[21] *See id*. at viii.

[22] UN, THE MILLENNIUM DEVELOPMENT GOALS: A LATIN AMERICAN AND CARIBBEAN PERSPECTIVE 127 (2007) [hereinafter MDGS: A LATIN AMERICAN AND CARIBBEAN PERSPECTIVE], *available at* http://www.eclac.cl/publicaciones/xml/0/21540/lcg2331.pdf (citing M. Ortiz, *¿De qué mueren las mujeres?*, ISIS Internacional, Agenda Salud, No. 28, Oct.-Dec. (2002)].

[23] Committee on the Elimination of Discrimination against Women, *Brazil: Consideration of reports submitted by States parties under Article 18 of the Convention on the Elimination of All Forms of Discrimination Against Women*, 60, 29th Sess., U.N. Doc. CEDAW/C/BRA/1-5 (2002) [hereinafter *CEDAW: Brazil(2002*)], *available at* http://documents-dds-ny.un.org/doc/UNDOC/GEN/N02/687/25/pdf/N0268725.pdf?OpenElement.

[24] LATIN AMERICAN AND CARIBBEAN COMMITTEE FOR THE DEFENSE OF WOMEN'S RIGHTS, MONITORING ALTERNATIVE

discrimination," based on their status as women and Afro-descendants,[25] and that they face immense socio-economic discrimination in Brazil, inevitably leads to higher maternal mortality rates among black women in all age groups.[26]

Women's rights to safe pregnancy and childbirth are protected under ICESCR [Articles 12, 3, 2(2), 10, and 15(b)]

Failure to prevent Maternal Mortality – Violation of the Right to Health

The Committee has stated that a State Party's failure to reduce maternal mortality is a violation of the right to health.[27] In 2003, this Committee expressed concern about the prevalence of maternal mortality in Brazil,[28] and requested that the government's next submission include "detailed information, based on comparative data, about maternal mortality and abortion in Brazil."[29] This Committee also urged the state party to "provid[e] sexual and reproductive health services to the population, with particular emphasis on those for women, young people and children."[30]

Government data indicates that Brazil has not reduced maternal mortality rates since at least 1990, and according to some measures, rates have even been rising.[31] In the government's 2008 periodic report to this Committee, Brazil describes its maternal mortality rates as simply "worrisome," but it does not seem to perceive the increases in maternal deaths as a problem, as evidenced by its statement that the maternal mortality ratio increased "only" in the Northeast.[32] However, under the ICESCR and other international treaties to which Brazil is party, and under the Millennium Development framework,[33] *any* increase in maternal mortality is unacceptable. While conceding that maternal mortality is a "serious concern," the state claims that it is "not one of the ten causes of death of women in reproductive age [sic],"[34] though studies show that maternal mortality *is* actually one of the top ten causes of death for women of reproductive age in Brazil,[35] and is even more common a cause of death for younger women.[36]

REPORT ON THE SITUATION OF MATERNAL MORTALITY IN BRAZIL TO THE ICESCR [hereinafter ALTERNATIVE REPORT ON THE SITUATION OF MATERNAL MORTALITY IN BRAZIL], *available at* http://www.cladem.org/english/regional/monitoreo_convenios/descMMbrasili.asp (*last visited on* April 19, 2009).

[25] MDGS: A LATIN AMERICAN AND CARIBBEAN PERSPECTIVE, *supra* note 22, at 127.

[26] *See CEDAW: Brazil (2002)*, *supra* note 23, at 171.

[27] CESCR General Comment 14, *supra* note 2, para. 52.

[28] *See* Committee on Economic, Social and Cultural Rights (CESCR), *Concluding Observations: Brazil,* para. 27, U.N. Doc. E/C.12/1/Add.87 (2003) [hereinafter *CESCR*: *Brazil* (2003)], *available at* http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/E.C.12.1.Add.87.En?Opendocument.

[29] *Id*. para. 51.

[30] *Id.* para. 62.

[31] The Health Ministry estimated an MMR of 52.06 in 1996; in 1998, 65.26. TCU Report, *supra* note 15, at 12.

[32] *Brazil Report to CESCR* (2008), *supra* note 16, para. 417. ("Among regions, this rate increased only in the Northeast, while dropping considerably in the Southeast (29.9%) and in the South (17.1%) in the same period.")

[33] The fifth Millennium Development Goal calls upon states to "improve maternal health", by reducing "by three-quarters, between 1990 and 2015, the maternal mortality ratio." UN DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS, Statistics Division, *Progress towards the Millennium Development Goals, 1990-2005 available at* http://unstats.un.org/unsd/mi/goals_2005/goal_1.pdf (*last visited on* Apr. 17, 2009).

[34] *Brazil Report to CESCR* (2008), *supra* note 16, para. 418.

[35] According to the Health Ministry, maternal mortality was the ninth most common cause of death amongst women of reproductive age. BRAZIL HEALTH 2006: AN ANALYSIS OF INEQUALITY IN HEALTH, *supra* note 9, at 373.

[36] *See* Nagib Haddad & Maria Barbosa da Silva, *Female mortality in reproductive age in the state of São Paulo, Brazil, 1991-1995,* 34 REV. SAÚDE PÚB. at table 3 (2000), *available at* http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0034-89102000000100012.

Discrimination in Access to Maternal Health Care

The right to non-discrimination in the context of maternal health care requires states to guarantee access to quality health care to the most vulnerable populations, including ethnic minorities and those living in rural and low-income areas. The Covenant requires States Parties to ensure that the right to health may be exercised "without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."[37] When states neglect to ensure that quality specific health care services that only women need such as obstetric, contraceptive, gynecological, and antenatal care is available to all women, they violate women's rights both to health[38] and to non-discrimination,[39] as defined by this Covenant.

According to the state's health ministry, Afro-Brazilian women are 50% more likely to die of obstetric-related causes than are white women.[40] The health ministry also reports that, strikingly, even when controlling for socio-economic and regional factors, Afro-Brazilian adolescent women are still more at risk of maternal death than are other adolescent women.[41] In addition to Afro-Brazilian women, risk of maternal death disproportionately affects indigenous and low-income women, especially adolescents and women from rural areas.[42] Some of the primary causes of these disparities are:

Inequitable distribution of emergency obstetric care facilities

Brazil does not meet the WHO guidelines[43] for the numbers and distribution of emergency and basic obstetric care facilities for women in rural and poor regions facing the greatest lack of facilities. [44] High-income and urban municipalities have much greater numbers of obstetric facilities per capita than do lower-income and rural municipalities.

Health-care funding neglects disadvantaged populations

Brazil's health system, the *Sistema Único da Saúde* (SUS), allocates funds based on historical use

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[37] ICESCR, *supra* note 1, art. 2(2).

[38] *See generally* CESCR General Comment 14, *supra* note 2, paras 12 and 21.

[39] *See generally* Committee on Economic, Social and Cultural Rights*, General Comment 16: The Equal Right of Men and Women to the Enjoyment of All Economic, Social and Cultural Rights*, U.N. Doc. E/C.12/2005/4 (2005), *available at* http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/7c6dc1dee6268e32c125708f0050dbf6/$FILE/G0543539.pdf.

[40] BRAZIL HEALTH 2006: AN ANALYSIS OF INEQUALITY IN HEALTH, *supra* note 9, at 366.

[41] *Id*. at 367.

[42] MINISTÉRIO DA SAÚDE, POLÍTICA NACIONAL DE ATENÇÃO INTEGRAL A SAÚDE DA MULHER: PRINCIPIOS E DIRETRIZES 26 (2004); WORLD BANK, Report No. 23811-BR, *Brazil: Maternal and Child Health,* para. 2.8 at 20-21 (2002) [hereinafter BRAZIL: MATERNAL AND CHILD HEALTH], *available at* http://siteresources.worldbank.org/BRAZILINPOREXTN/Resources/3817166-1185895645304/4044168-1186326902607/32pub_br56.pdf.

[43] *See generally* UNICEF, WHO AND UNFPA: GUIDELINES FOR MONITORING THE AVAILABILITY AND USE OF OBSTETRIC SERVICES (1997), *available at* http://whqlibdoc.who.int/publications/1997/9280631985.pdf.

[44] For example, within the state of Rio de Janeiro, one of the poorest municipalities, Belford Roxo, has only one emergency obstetric facility for its population of almost 500,000. In the neighboring (and higher-income) municipality of São João de Meriti, there are five emergency obstetric facilities, although its population is about the same as Belford Roxo's. *See* INSTITUTO BRASILEIRO DE GEOGRAFIA E ESTATÍSTICA (IBGE), ASSISTÉNCIA MÉDICA SANITÁRIA 2005: MALHA MUNICIPAL DIGITAL DO BRASIL: SITUAÇÃO EM 2005.

patterns, so that states that have long had higher numbers of health facilities and professionals continue to receive more funding than lower-resourced states.[45]

Inadequate referral networks and communication between health-care sectors

For women who rely on the SUS, there is no continuity between antenatal care and delivery care – often, women suffer and die because doctors treating them for emergency obstetric care have never treated them before, and their records are not successfully transferred from their primary care facility to the hospital.

Poor quality of care

In emergency obstetric care facilities, quality of care can vary greatly, and shortages of beds and personnel are common. With no functioning referral network, women can face inappropriate or even detrimental care if they are treated in absence of their records.

A recent profile of health-care facilities conducted by the Brazilian Institute of Geography and Statistics revealed that the proportion of establishments with in-patient facilities, which are important for childbirth, has fallen in recent years.[46]

Inadequate Interventions to Reduce Maternal Mortality

The state of Brazil fails to recognize the severity and scope of the problem both in its 2008 periodic report to this Committee and within national-level policy. In Brazil's Multi-Year Plan for 2004-2007, the government did not include maternal mortality reduction as one of its seven public health priorities.[47] In its most recent periodic report, the only interventions mentioned to reduce maternal mortality are attempts to liberalize the abortion law[48] and setting up "Committees on Maternal Mortality" to study the problem and propose solutions.[49] However, according to the Brazilian Court of Audit, these "Committees" are not an adequate intervention, as most are not functional.[50]

Furthermore, the State Party's emphasis on unsafe abortion as the most salient cause of maternal mortality reveals a failure to comprehensively understand the problem. While Brazil reports to this Committee that it has been moving towards liberalizing its currently punitive laws on abortion, their attempt to de-criminalize the procedure failed in May 2008. The primary direct causes of maternal death in Brazil are eclampsia, pre-eclampsia, hemorrhage, infection, and unsafe abortion,[51] but the root causes are socio-economic and gender-based disparities in access to health care.[52]

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[45] BRAZIL: MATERNAL AND CHILD HEALTH, *supra* note 42, at 39, 53.

[46] *See* PAN AMERICAN HEALTH ORGANIZATION, HEALTH SYSTEMS AND SERVICES PROFILE – BRAZIL 34 (2008) [hereinafter HEALTH SYSTEMS AND SERVICES PROFILE – BRAZIL], *available at* www.lachealthsys.org/index.php?option=com_docman&task=doc_download&gid=156.

[47] *See id.* at *23*.

[48] *Brazil Report to CESCR* (2008), *supra* note 16, para. 454.

[49] *Id.* at para. 453.

[50] TCU Report, *supra* note 15, at 13.

[51] BRAZIL HEALTH 2006: AN ANALYSIS OF INEQUALITY IN HEALTH, *supra* note 9, at 38.

[52] BRAZILIAN HEALTH MINISTRY, SUS INDICATORS (2006) (MINISTÉRIO DA SAÚDE, PAINEL DE INDICADORES DO SUS (2006)) ("maternal mortality is associated directly with access to medical services as well as the quality and proceedings of these medical services, which often are inadequate. This is related – strongly—to issues of inequality and social inequity.")

Brazil's failure to reduce maternal mortality is especially striking when compared to its substantial progress towards a number of other MDGs. The country has been hailed as a global leader in its efforts to fight HIV/AIDS, and has made progress in combating extreme poverty.[53] Notably, it reduced *infant* mortality by 40% in the years between 1990 and 2001.[54] In light of these successes, Brazil's failure to reduce maternal mortality over the course of fifteen years reveals not a lack of resources, but a lack of political will.

Given that this Covenant requires states to take "measures to improve . . . maternal health, sexual and reproductive health services, including access to family planning . . . emergency obstetric services and access to information, as well as to resources necessary to act on that information,"[55] Brazil's failure to reduce rates of maternal mortality over the course of more than fifteen years constitutes a serious violation of the ICESCR.

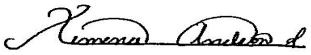
Taking into account the information provided in this letter, as well as Brazil's 2008 periodic report, we hope this Committee will consider issuing the following recommendations to the government of Brazil:

- Prioritize and take effective and progressive measures to reduce the high maternal mortality rates, by, *inter alia*, allocating greater funds to improve health-care facilities in poor and rural regions; ensuring that the maternal mortality programs and policies are oriented to improve the accessibility, availability and quality of maternal health services, including by enhancing the referral system and extending the coverage of Emergency Obstetric Services; and ensure the existence of effective monitoring and accountability mechanisms that could lead to the improvement of programs and policies to combat maternal deaths.

- Eliminate the significant disparities and inequalities confronted by Afro-Brazilian and low-income women in the access to quality maternal health services and take special measures to ensure that they have access to comprehensive sexual and reproductive health care.

We appreciate this Committee's longstanding commitment to reproductive rights and to the eradication of maternal mortality. Please do not hesitate to contact the undersigned should you have any further questions regarding maternal mortality in Brazil.

Sincerely,



Ximena Andión Ibañez
International Advocacy Director

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[53] MDGs: A LATIN AMERICAN AND CARIBBEAN PERSPECTIVE, *supra* note 22, at 35 (fig. II.3a).
[54] UNDP, HUMAN DEVELOPMENT REPORT - 2003, *supra* note 14, at 57.
[55] CESCR General Comment 14, *supra* note 2, para. 14.