

Bogota, September 19, 2013

Office of the High Commissioner for Human Rights of the United Nations  
Working Group of Experts on People with African Descent  
Attn. Sandra Aragon

**Ref. Implementation of the recommendations of the CEDAW Committee on Alyne da Silva Pimentel Case v. Brazil by the Brazilian State**

Distinguished members of the Working Group:

1. The Center for Reproductive Rights (CRR) is an NGO dedicated to promoting the equality of women around the world by guaranteeing their reproductive rights as human rights. Considering that the Working Group of Experts on People with African Descent will be visiting Brazil from December 4 to December 13, 2013, CRR presents this communication as an NGO particularly concerned about the compliance of Brazil with its international obligations in relation to the reduction of maternal mortality rates (MMR) through the promotion of quality health care for women without discrimination. In particular, we refer to the Brazilian State's failure to comply with its obligations, especially those related to the implementation of the recommendations made by the Committee on the Elimination of Discrimination against Women (CEDAW Committee) in the case of *Alyne da Silva Pimentel Case v. Brazil*<sup>1</sup> (hereafter Alyne Case), which condense priority actions to ensure the right of women to access health services without discrimination.

**A. The issue of maternal mortality in Brazil**

2. Although Brazil has reduced its MMR in the last years<sup>2</sup> from 103.43 (deaths per 100,000 live births) in 1998 to 56 in 2010,<sup>3</sup> which "[...] represent[s] a 51% decrease,<sup>4</sup> averaging an annual rate of

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<sup>1</sup> *Alyne da Silva Pimentel v. Brazil*, Committee on the Elimination of Discrimination against Women (CEDAW Committee) August 10, 2011. UN.Doc. CEDAW/C/49/D/17/2008.

<sup>2</sup> While Brazil argues that it has decreased its rate in 50%, the fact that statistics are unreliable limits a comparative analysis to confirm this assertion.

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

<sup>4</sup> MMR data in Brazil is unreliable and often contradictory. In 2002, it was estimated that the number of reported maternal deaths in Brazil should be multiplied by 1.4 in order to account for under and misreporting of maternal deaths. In 2004, 90.4% of death records were input into the Ministry of Health's Mortality Information System (SIM). Such coverage, however, is not consistent throughout the country, as the North and Northeast regions only record roughly 70% of the deaths in their regions. Since 2000 the Ministry of Health has only included data from the states with SIM coverage equal to or greater than 90% in the calculation of the MMR. A 2007 study in Sao Paulo found that the fields on death certificates indicating the presence of pregnancy or puerperium were only filled out correctly in less than 20% of cases. See: FC Barros et al., *Recent Trends in Maternal, Newborn and Child Health in Brazil: Progress Toward Millennium development Goals 4 and 5*, 100 AMERICAN JOURNAL OF PUBLIC HEALTH 1877, 1878 (2010). Vânia Muniz Néquer Soares et. al., *Subnotificação da mortalidade materna no Estado do Paraná, Brasil: 1991-2005*, 24 CADERNOS DE SAÚDE PÚBLICA 2418, 2419 (2008). Carlos Eduardo Pereira Vega Et Al., *Maternal*

decline of 3.5%,<sup>5</sup> maternal mortality persists as a serious public health issue,<sup>6</sup> being far above the World Health Organization's (WHO) acceptable rate of 10-20 deaths per 100,000 live births. According to the WHO, by 2008, Brazil accounted for over a quarter of all maternal deaths in Latin America.<sup>7</sup> 2009 saw an alarming *increase* in the ratio to 72.25, when it reached its highest point in five years.<sup>8</sup> The World Bank classifies Brazil as an upper-middle-income country,<sup>9</sup> but its MMR greatly overpasses that of other upper-middle-income countries like Chile (16.9 in 2008)<sup>10</sup> and Argentina (39.7 in 2008).<sup>11</sup> These deaths are evitable: The Brazilian Government notes that 90 % of these maternal deaths could be prevented with adequate healthcare.<sup>12</sup> Preventable maternal mortality is both a form and a symptom of discrimination against women and deprives women of their right to live a healthy life on a basis of equality with men.

3. Country-wide statistics mask severe disparities based on race, economic status, region, and urban/rural distributions. Historically, MMR is much higher in the North and Northeast of Brazil, with a greater share of poverty and larger rural populations than the rest of the country. In a 2002 survey on reproductive age mortality conducted in all state capitals, the estimated MMR varied depending on the region, ranging from 42 in the south region to 73 in the northeast region.<sup>13</sup> This is connected to the differential provision of health services in different regions. The World Bank has commented upon the comparatively low levels of health spending in some regions that “not only fail to compensate for regional inequalities in health status but actually compound them.”<sup>14</sup> Public health funds are allocated largely based on historical consumption patterns, thus regional inequalities are perpetuated.

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*Mortality due to Arterial Hypertension in Sao Paulo City (1995-1998)*, 62 CLINICS 679, 681 (2007). World Health Organization (WHO), United Nations Population Fund (UNFPA), et al., *Trends in maternal mortality: 1990 to 2008 (2010)* Developed by WHO, UNICEF, UNFPA, and The World Bank 17, available at [http://whqlibdoc.who.int/publications/2010/9789241500265\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf) (last visited on July 29, 2011) [hereinafter WHO, *Maternal Mortality in 2008*]. Implementation of the International Covenant on Economic, Social and Cultural Rights: Second periodic report submitted by States parties under articles 16 and 17 of the Covenant, Brazil, para. 418, U.N. Doc. E/C.12/BRA/2 (Jan. 28, 2008).

<sup>5</sup> Rebecca J. Cook. Human Rights and Maternal Health: Exploring the Effectiveness of the Alyne Decision. *Global Health and the Law. JOURNAL OF LAW, MEDICINE AND ETHICS*. Spring 2013. P. 104 based on WHO, *Maternal Mortality in 2010*, *supra* note 4.

<sup>6</sup> World Health Organization *Et. Al. Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA 23-27* (WHO Geneva 2007).

<sup>7</sup> According to WHO, 9,200 women die from pregnancy and childbirth related causes in Latin America and the Caribbean annually. Brazil accounts for 1,800 of those deaths. See WHO, *Maternal Mortality in 2008*, *supra* note 4, at 18, 23.

<sup>8</sup> World Health Organization *Et. Al. supra* note 6.

<sup>9</sup> World Bank, *Country and Lending Groups* (2011), available at [http://data.worldbank.org/about/country-classifications/country-and-lending-groups#Upper\\_middle\\_income](http://data.worldbank.org/about/country-classifications/country-and-lending-groups#Upper_middle_income) (2011) [hereinafter World Bank, *Country and Lending Groups*].

<sup>10</sup> PAHO, *HEALTH INDICATOR DATABASE: COUNTRY HEALTH INDICATOR PROFILE: MATERNAL AND CHILD MORTALITY: CHILE* (2009), available at [http://ais.paho.org/hip/viz/cip\\_maternalandinfantmortality.asp](http://ais.paho.org/hip/viz/cip_maternalandinfantmortality.asp).

<sup>11</sup> PAHO, *HEALTH INDICATOR DATABASE: COUNTRY HEALTH INDICATOR PROFILE: MATERNAL AND CHILD MORTALITY: ARGENTINA* (2009), available at [http://ais.paho.org/hip/viz/cip\\_maternalandinfantmortality.asp](http://ais.paho.org/hip/viz/cip_maternalandinfantmortality.asp).

Implementation of the International Covenant on Economic, Social and Cultural Rights: Second periodic report submitted by States parties under articles 16 and 17 of the Covenant, Brazil, para. 418, U.N. Doc. E/C.12/BRA/2 (Jan. 28, 2008).

<sup>13</sup> Laurenti R, Jorge MHPdM, Gotlieb SLD. A mortalidade materna nas capitais brasileiras: algumas características e estimativa de um fator de ajuste. *REVISTA BRASILEIRA DE EPIDEMIOLOGIA* 2004; 7: 449-460.

<sup>14</sup> World Bank, *Brazil: Maternal and Child Health*, ¶ 1.31, at 15 (2002), available at [http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2002/04/12/000094946\\_02040304022680/Rendered/PDF/multi0page.pdf](http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2002/04/12/000094946_02040304022680/Rendered/PDF/multi0page.pdf) (last visited on Nov. 16, 2007) [hereinafter World Bank, *Brazil: Maternal and Child Health*].

4. Regional disparities are connected to racial and ethnic inequality: the poorer the region, the higher concentration of afro-Brazilian and indigenous communities where MMR increases. According to Brazil's Ministry of Health, Afro-Brazilian women are 50% more likely to die of obstetric-related causes than white women.<sup>15</sup> Other studies suggest that the MMR of Afro-descendant women is three times that of their white counterparts.<sup>16</sup> Indigenous and low-income women are also affected by a high risk of maternal death, particularly adolescents and women from rural areas.<sup>17</sup> These women tend to receive fewer health services and low quality health care, contributing to their vulnerability to maternal mortality.<sup>18</sup> According to a U.N. study, 66% of black women and 74% of indigenous women nationwide received fewer than six prenatal visits, compared to 45% of white women.<sup>19</sup> Afro Brazilian women were also provided with less information about pregnancy, delivery and post-natal children care.<sup>20</sup> The primary direct causes of maternal death in Brazil are eclampsia, pre-eclampsia, hemorrhage, infection, and unsafe abortion,<sup>21</sup> but the root causes are racial, socio-economic and gender-based disparities in access to healthcare.<sup>22</sup> By Brazil's own admission, "poverty is concentrated on black or Afro-descending women."<sup>23</sup> In 2006 the Minister of Health publicly admitted the existence of racism in public health services provided by the SUS to Afro-descendant patients.<sup>24</sup>

## B. General obligations in terms of health and particular impact on Afro-Brazilian women

5. The Millennium Development Goal No. 5, assumed by the Brazilian State, establishes that the MMR should be reduced by 75% for 2015. The international obligations that Brazil has undertaken

<sup>15</sup> Brazilian Health Ministry, *Brazil Health 2006: An Analysis of Inequality in Health* (Ministério Da Saúde, Saúde Brasil 2006 – Uma Análise Da Desigualdade Em Saúde) 366 (2006) [hereinafter BRAZIL HEALTH 2006: An Analysis of Inequality In Health].

<sup>16</sup> Seelke, Clare Ribando, "Afro-Latinos in Latin America and Considerations for U.S. Policy" (2008). *Federal Publications*. Paper 486. available at [http://digitalcommons.ilr.cornell.edu/key\\_workplace/486](http://digitalcommons.ilr.cornell.edu/key_workplace/486).

<sup>17</sup> BRAZIL HEALTH 2006: An Analysis of Inequality In Health, *Supra*, note 49. at 367.

<sup>18</sup> Ministério Da Saúde, Política Nacional De Atenção Integral A Saúde Da Mulher: Princípios E Diretrizes 26 (2004); WORLD BANK, Brazil: Maternal and Child Health, ¶ para. 2.8 at 20-21, Report No. 23811-BR (2002), available at [http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2002/04/12/000094946\\_02040304022680/Rend](http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2002/04/12/000094946_02040304022680/Rend ered/PDF/multi0page.pdf)

<sup>19</sup> United Nations (UN), *A UN Reading of Brazil's Challenges and Potential: Common Country Assessment by Brazil's UNCT*, iii, ¶ 41, at 14 (2005), available at [http://www.unodc.org/pdf/brazil/Final%20CCA%20Brazil%20\(eng\).pdf](http://www.unodc.org/pdf/brazil/Final%20CCA%20Brazil%20(eng).pdf) (last visited on Nov. 16, 2007) [hereinafter *UN Reading of Brazil's Challenges and Potential*].

<sup>20</sup> Articulación de Organizaciones de Mujeres Negras Brasileñas (AMNB), Dossier Regarding the Situation of Black Women in Brazil, 25 (July 2007).

<sup>21</sup> Brazilian Health Ministry, *Brazil Health 2006: An Analysis of Inequality in Health* (Ministério Da Saúde, Saúde Brasil 2006 – Uma Análise Da Desigualdade Em Saúde) 366 (2006) [hereinafter BRAZIL HEALTH 2006: An Analysis of Inequality In Health] at 38.

<sup>22</sup> 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").

<sup>23</sup> 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 (2002), 29th Sess., U.N. Doc. CEDAW/C/BRA/1-5, available at <http://daccessdds.un.org/doc/UNDOC/GEN/N02/687/25/PDF/N0268725.pdf?OpenElement> (last visited on Nov. 16, 2007) [hereinafter CEDAW, 2002 Brazil Report].

<sup>24</sup> Articulación de Organizaciones de Mujeres Negras Brasileñas (AMNB), Dossier Regarding the Situation of Black Women in Brazil, 23, July 2007 [hereinafter *Dossier Regarding the Situation of Black Women in Brazil*].

by adhering to resolutions 11/8 of June 9, 2009<sup>25</sup>, 15/17 of September 30, 2010<sup>26</sup>, 18/2 of September 28, 2011<sup>27</sup> and the Resolution of September 20, 2012<sup>28</sup> on preventable maternal mortality and morbidity and human rights, by the United Nations Human Rights Council requires Brazil to adopt a human rights perspective in its maternal mortality policy. Said efforts, likewise, are framed on the States' compromise assumed in the International Conference on Population and Development in Cairo (1994) and continued on the first session of the Regional Conference on Population and Development in Latin America and the Caribbean by the CEPAL (2013), on maternal mortality.

6. Afro-Brazilian and indigenous women that often have a lower socio-economic status, as shown, are highly vulnerable populations in terms of access to quality healthcare without discrimination. The obligations of the Brazilian State in this regard, both according to CEDAW Committee's General Recommendation No. 24 and No. 28, and to the recommendations in Alyne Case, require the State to address the particular circumstances of poverty and racial inequality faced by these women, in order to comply with an effective reduction of MMR without discrimination.

### **C. Challenges in the implementation of the of Alyne v Brazil Case Issued by the CEDAW in 2011**

7. In November 16, 2001, Alyne da Silve Pimentel Texeira, a young, poor and pregnant woman of afro descent died, leaving behind her 5 year old daughter. She arrived to the health center "la Casa de Saúde Nossa Senhora da Gloria" in Belford Roxo on November 11, after presenting high risk pregnancy symptoms. The doctor sent her home. Her symptoms exacerbated in the following two days, so she returned to the health center. The doctors discovered her fetus lacked heart beats. Her delivery was induced six hours later, producing a stillborn fetus. The surgery to extract her placenta occurred fourteen hours later. She became increasingly sick so she was transferred to a higher capacity hospital with the only available bed: "Hospital Geral de Nova Iguacu." However, the hospital took a long time to borrow its only ambulance to transfer Alyne. After waiting for a long period of time for transfer, and then not being able even to get a bed at the hospital's emergency room, Alyne died.

8 The CEDAW Committee found that Brazil's was responsible for the violation of articles 2(c) (access to justice), 2(e) (States due diligence obligation to ensure that private actors actions in the provision of health services are appropriate), and 12 (access to health) of the CEDAW. In particular, Brazil was responsible for 1) the maternal death of Alyne; 2) not ensuring her the appropriate healthcare during her pregnancy; 3) not exercising its due diligence obligation to undertake the necessary measures to ensure that the activities of private actors that provide healthcare were appropriate; 4) the violation of women's rights to life and to not be subjected to discrimination; 5) the violation of Alyne's right to not be discriminated on the basis of her racial status as an Afro-Brazilian

<sup>25</sup> Human Rights Council. Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development. A/HRC/11/L.16/Rev.1 (June 12, 2009).

<sup>26</sup> Human Rights Council. Preventable maternal mortality and morbidity and human rights: follow-up to Council resolution 11/8. Resolution 15/17 (Sept. 30, 2010)

<sup>27</sup> Human Rights Council. Preventable maternal mortality and morbidity and human rights. Resolution 18/2 (Sept. 28, 2011).

<sup>28</sup> Human Rights Council. Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development, A/HRC/21/L.10 (Sept. 20, 2012).



woman and her socio-economic background; 6) not ensuring effective judicial action and protection, and 7) the moral damage to Alyne's mother and daughter.

9. The CEDAW Committee issued two types of recommendations to the Brazilian State. First, they recommended that Brazil provide individual reparations to Alyne and her family for the violations committed against them. Second, the Committee recommended several general reparations to improve the quality of maternal health care in Brazil without discrimination, including:

- “(a) Ensure women’s right to safe motherhood and affordable access to all women to adequate emergency obstetric care, in line with general recommendation No. 24 (1999) on women and health;
- (b) Provide adequate professional training for health workers, especially on women’s reproductive health rights, including quality medical treatment during pregnancy and delivery, as well as timely emergency obstetric care;
- (c) Ensure access to effective remedies in cases where women’s reproductive health rights have been violated and provide training for the judiciary and for law enforcement personnel;
- (d) Ensure that private health care facilities comply with relevant national and international standards on reproductive health care;
- (e) Ensure that adequate sanctions are imposed on health professionals who violate women’s reproductive health rights; and
- (f) Reduce preventable maternal deaths through the implementation of the National Pact for the Reduction of Maternal Mortality at state and municipal levels, including by establishing maternal mortality committees where they still do not exist, in line with the recommendations in its concluding observations for Brazil, adopted on 15 August 2007 (CEDAW/C/BRA/CI/6).”

10. Although we applaud several steps undertaken by the Brazilian State in the implementation of CEDAW’s Committee recommendations, after two years of meetings and having accomplished a concrete proposal in terms of the individual and symbolic reparations the State has still not moved forward with providing such reparations. In the sphere of the general recommendations we especially welcome Brazil’s efforts to implement the second general recommendation by creating a series of programs, courses, seminars, public campaigns, and training materials, to train health professionals including nurses, midwives, doctors, on reproductive rights, quality obstetric health care and emergency care, and to diminish gender-based institutional violence.

11. We also applaud the creation of an Inter-Ministerial Working Group (IMWG) tasked to oversee the implementation of the case. However, regarding other recommendations, Brazil has not provided a concrete proposal as to the steps it will take moving forward, nor a work plan of the IMWG created for the implementation of the case. These leave a considerable gap in addressing the underlying issues of discrimination and inequality that contribute to maternal mortality in Brazil which fall within the scope of the recommendations of the case. The State has not produced indicators to measure the decrease in maternal mortality, nor the reproductive health services’ quality. Substantial differences regarding service provision among races, regions, and urban or rural areas, prevail. The State should commit itself to adopt the necessary steps to guarantee women’s right to quality essential health services without discrimination and this must be translated into public policies on maternal mortality.

12. Three essential challenges still persist in relation to the implementation of the Alyne Case:

- i. Effective individual reparations to Alyne's family have not been paid. Although Brazil through more than 5 ex-changes of documents through CEDAW and several in person meetings has agreed to provide individual and symbolic reparations committing to a specific amount, Brazil has not moved forward to set a date and present the conditions for the effective payment.
- ii. Under the framework of negotiation, the State created the IMWG to follow-up Brazil's compliance with CEDAW Committee's recommendations. The Decree 035/2013 officially creating the group with the participation of representatives of two ministries and three secretariats under the Presidency of the Republic was issued in April 4, 2013 for a period of 180 days (renewable for other 180 days). The State committed to develop indicators and a work plan for the group. Nevertheless, there is no known work plan yet and the IMWG will legally dissolve in October. So far, the group coordinator has been changed several times which has also presented institutional challenges to move forward. It is critical that Brazil renews the IMWG's period.
- iii. While Brazil has been determinant in presenting the changes in public policies around maternal health, which without doubt have lowered MMR in general in Brazil, it is yet to provide an action plan moving forward to address the general recommendations. It is crucial that Brazil adopts a human rights approach in those policies that particularly tackle discrimination in access of healthcare for Afro-Brazilians, as well as the quality of the services. The need of addressing these structural problems with an action plan is evidenced by a recent report by the DHESCA network.<sup>29</sup> According to the report that documents visits conducted in March 2013 to the health center "Casa de Saúde N. Sra. da Gloria" and the hospital "Geral de Nova Iguaçu" where Alyne died, the quality of health services has not improved in the past 10 years, since Alyne's death. As a result, the General Attorney of Sao Joao de Meriti issued communication No. 126/2013 to inquire for evidence from relevant institutions, regarding such situation.<sup>30</sup> The negligence reflects upon Brazil's inaction in improving maternal health care for low-income women, and particularly Afro-Brazilian women.

13. We believe that the working group's visit to Brazil will be an exceptional opportunity to raise this concerning situation and push forward the implementation of the case on a subject matter that is central for the enjoyment of the right to health of afro Brazilian women in Brazil.

#### **D. Relevant actors in the implementation of CEDAW Committee's recommendations**

14. We encourage you to speak to several relevant actors that can provide information on Brazil's compliance with the CEDAW Committee recommendations in particular, and the general reproductive rights' situation, as mentioned on a previous communications sent by Monica Arango on September 2013:

<sup>29</sup> Communication from Maria Beatriz Galli Bevilacqua (National Rapporteur for Sexual and Reproductive Rights) to Dr. Procurador Geral Federal. DHESCA platform (Plataforma Brasileira de Direitos Humanos Economicos, Sociais, Culturais e Ambientais), 2013.

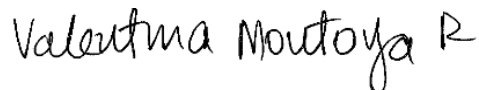
<sup>30</sup> Ministerio Público Federal. Procuradoria da República no Municipio de Sao Joao de Meriti, Oficio N° 126/2013 PRM-JOA-RJ-00012572/2013 (August 1st, 2013).

- Beatriz Galli, LAC policy associate at Ipas, [gallib@ipas.org](mailto:gallib@ipas.org) and Rapporteur for sexual and Reproductive Rights for the DHESCA Platform in Brazil. She is based in Rio de Janeiro.
- Carmen Hein de Campos, Doctor in Criminal Sciences (Doutora em Ciências Criminais, Pontifícia Universidade Católica do Rio Grande do Sul-PUCRS) [charmcampos@gmail.com](mailto:charmcampos@gmail.com). Based in Brasilia.
- Sonia Correa, Sexuality Policy Watch (Observatório de Sexualidade e Política), [scorrea@abi aids.org.br](mailto:scorrea@abi aids.org.br). She is based in Rio de Janeiro.
- Jurema Werneck, Coordinator of “Criola” (It is a civil society organization that promotes the rights of Afro-Brazilian women) at [juremawerneck@criola.org.br](mailto:juremawerneck@criola.org.br), <http://www.criola.org.br/equipe.htm>
- Rodrigo da Costa Lines, General Attorney of the Republic (Procurador da Republica) at [subcoordjursjm@prj.mpf.gov.br](mailto:subcoordjursjm@prj.mpf.gov.br), Tel: (21) 2753-7923/2753-7900. Av. Getulio de Moura, N. 261, Centro Cep. 25.520-660- Sao Joao de Meriti
- Members of the IMWG including the public officials:
  - Ministry of Health: Natali Pimentel Minóia (Full Member), Kátia Maria Barreto Souto (Alternate Member)
  - Ministry of Foreign Affairs: Ambassador Gláucia Silveira Gaich (Full Member), Tatiana Gomes Bustamante (Alternate Member)
  - Human Rights Secretariat: Maria Beatriz Bonna Nogueira (Full Member), Aline Albuquerque Sant’Anna de Oliveira (Alternate Member)
  - Secretariat for the Promotion of Racial Equality: Mónica Alves de Oliveira Gomes (Full Member), Eunice Lea de Moraes (Alternate Member)
  - Secretariat for Women’s Policies from the Presidency of the Republic: Vera Lucia Lemos Soares (Full Member), Rurani Ester Silva (Alternate Member)

Respectfully,



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