CEDAW Committee

39th. Session

Brazil Report

Introduction

1. Since April of 2007, Conectas Human Rights and Geledés – Institute for Black Women have been developing, with resources from the European Union, a project called "The Right to Health for Black Women." This project has as its main objective to implement the right to health for Black women through the combat of institutional racism in public health services and the promotion of public health policies geared toward specific needs of Black women.

2. Moreover, Conectas Human Rights has a paradigmatic litigation program focused on human rights, called Artigo 1o. – in reference to the Article 1st. of the Universal Declaration of Human Rights – which has taken claims to the Brazilian Federal Supreme Court. Under this program, we have worked on a case for the decriminalization of abortion.

3. In this manner, having consultative status and interest in implementing women's human rights, we hereby present some considerations for the improvement of Brazilian implementation of the commitments assumed with the ratification of the Convention for the Elimination of all Forms of Discrimination against Women.

Black Women's Right to Health

Ethnic breakdown in the area of health

4. The 2005 briefing from UNDP (UN Development Program) that analyzes and compares HDI (Human Development Index) in 177 countries affirms that in Brazil, 46.9% of the national income is concentrated in the hands of the richest 10%; the poorest 10% of the population keeps 0.7% of the national income. [1] If we take into account the ethnic/racial breakdown, "Blacks represent 45% of Brazil's population, but make up nearly 65% of the population in poverty and over 70% of the population in extreme poverty, while Whites represent 54% of the entire population, but make up

[1] PNUD. *Informe sobre Desarollo Humano*, Espanha:Madri. Grupo Mundi-Prensa, 2005: p. 62.

only 35% of the poor and 30% of the extremely poor."[2] In view of this reality, in which the overwhelming majority of the population below the poverty line is Black, it becomes evident that this group is much more frequently exposed to human rights violations, since they have less access to goods and services. With respect to Black women, these violations are systematic as they are doubly discriminated against, for being women and for being Black, constituting one of the most vulnerable groups in Brazilian society.

5. The ramifications of this double discrimination are innumerable. According to Lopes, "the environment that excludes and denies [Black women] the natural right of belonging determines special conditions of vulnerability."[3] According to Ayres, vulnerability is "the combination of individual and collective aspects related to the degree and form of exposure to a certain situation [in this case, access to health] and, in an indissoluble manner, to the greater or smaller access to adequate resources to protect oneself from the undesirable consequences of that situation [in this case, deficiency of health][4]." Therefore, there remains no doubt that Black women find themselves, in Brazilian society, more vulnerable than other groups, since they are exposed to racism and sexism.

6. After the Brazilian state recognized the existence of racism, [5] the government slowly came to incorporate public policies from the ethno-racial perspective, especially in the area of health, because the absence of such policies generates a great harm. The objective, at least in the public policies geared toward the implementation of the right to health, is to reach material equality– not merely formal –, as well as equity in the health system. For this reason, it is imperative to combat institutional racism in health services and, moreover, be able to identify specific needs of the Black population, offering it adequate and efficient treatment.

[2] LOPES, Fernanda. Experiências Desiguais ao Nascer, Viver, Adoecer e Morrer: Tópicos em Saúde da População Negra no Brasil. In: FUNASA. *Saúde da População Negra no Brasil – Contribuições para a Promoção da Equidade*. Ministério da Saúde, 2005: p. 12.
[3] LOPES, Fernanda. *Ob. cit.*, 2005: p. 9.
[4] AYRES, José Ricardo de C. M. *Raça como conceito emancipador e vulnerabilidade como norte para políticas de eqüidade em saúde*. In: Cad. Saúde Pública, Rio de Janeiro, 23(3):497-523, mar, 2007: p. 519
[5] LOPES, Fernanda. *Ob. Cit.,* 2005: p.17.

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Institutional racism and diseases prevalent in Black women

7. According to Fernanda Lopes, "racism is not a choice, a will, or a personal opinion. More than a reflex, it is a justification, a project, a social programming, an ideology. As an ideological phenomenon, racism subdues everyone, without differentiation, revitalizes and maintains its vigor with the evolution of society, historical conjectures, and interests of the dominant groups. It authorizes and naturalizes differential and unequal treatment of one group by another. Racism is the historical condition that brings with it prejudice and discrimination, affecting the quality of life and health of the Black population, at all phases of the life cycle, embedded in all social levels, resident in urban or rural areas in whichever micro-region of the country. It reaffirms itself in everyday life through a common language, it maintains itself and feeds on tradition and culture; it influences life, the functioning of institutions, organizations, and also relationships between people."[6]

8. If racism is an ideology incorporated into Brazilian society, it is evident that its influence in health services engenders institutional racism, which is defined as follows, according to Lopes: "it is the failure of institutions and organizations to provide professional and adequate services to people because of the color of their skin, culture, racial or ethnic origins. It manifests itself through discriminatory norms, practices, and behaviors adopted in the everyday work environment, resulting from ignorance, lack of attention, prejudice, or incorporation and naturalization of racist stereotypes. In any case, institutional racism always imposes, on people of racial or ethnic groups which are discriminated against, a situation of disadvantage in the access to benefits from the State, institutions, and public and private organizations."[7]

9. Some scholars on the topic of women's health have conducted research aiming to compare services offered to Black and White women. The results show the perversity of racism and its impact on the health of Black women.

10. Maria do Carmo Leal, Silvana Granado Nogueira da Gama and Cynthia Braga da Cunha[7] conducted a study that demonstrates evidence of a persistent unfavorable situation regarding the

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[6] LOPES, Fernanda. Racismo Institucional e o Direito Humano à Saúde. In: *Democracia Viva*, n. 34, jan-mar, 2007: p. 9.

[7] LOPES, Fernanda. *Ob. Cit.*, 2007: p. 12.

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access to pre-natal health services for Black and biracial women in relation to their White counterparts. The conclusion was that the disadvantages observed by Black and biracial women had surpassed simply socioeconomic indicators and had extended to the areas of assistance with health and conception. This disproved the argument that the problem was a question of social class and not race, as it verified that the socioeconomic indicators of this population grew worse with darker skin color.

11. Concurrently, Maria do Carmo Leal *et al*. undertook a study regarding the mortality rate and peri- and neonatal attention in the city of Rio de Janeiro[8], attempting to (1) better understand the determining factors of mortality rates, in particular those characteristic of young mothers and (2) evaluate aspects of informational systems regarding the quality of assistance that has been given. The conclusions of this study were also indicative of the fact that Blacks (both Black and biracial) are in a more vulnerable situation with regards to mother-child health services.

12. Besides, the ratio of maternal mortality, for its part, has Black women (and also Asian women) among its highest percentages, although this is a problem of public health that affects women of all colors, social classes, and educational levels. According to Alaerte Martins[9], a researcher on this subject, there is a consensus that women suffering from maternal mortality are those with low income and little education, which, in the Brazilian case, is represented in large part by Black women. The author cited his masters degree thesis[10] to demonstrate that, with relation to the distribution of the female population and the ratio of maternal deaths by color, in the year 1993, the relative risk of death for Black women was 7.4 times higher than that of White women, and the risk of death for Asian women was 5 times higher than for White women. In this study only 2.2% of the women were Black, yet 8.2% of maternal deaths had been those of Black women.

13. The factors involved in access to health services are innumerable. But, there is no doubt about the weight that racism has when it comes to the health of Black women. This racism is translated not only into actions, but also into omissions, mainly the disregard of specific demands of Black women to implement their right to health care. It is well known that there are innumerable diseases prevalent among the Black population, and more specifically in the Black female population – such as Miomas, Arterial Hypertension, Pelvic Inflammatory Disease, Diabetes

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Mellitus, and Lupus, among others[11]. The lack of attention of the Brazilian state to meet this specific need is clearly negligent and a violation of the Black women's right to health.

14. The aforementioned studies are scientific in nature and demonstrate the reality that this state, although it has a National Plan for the Health of the Black Population on paper, still has not effectuated this in practice, resulting in negligence with respect to the health of Black women. To combat the institutional racism as well as to meet the needs of this group, it is necessary to work with health care professionals and to include information regarding the question of color in the health databases of the state.

The importance of the color question

15. It is evident that there is a resistance on the part of health professionals to acknowledge the practice of racism within their institutions, and moreover the racist actions that they themselves take, or that are taken by their closest colleagues. Racism in Brazil is still a taboo and is exercised in a silent, veiled manner. It is necessary, then, as Martins points out, to promulgate the work of awareness and education with health professionals to demonstrate the importance of egalitarian attention within health care practices. There is also a gap in the academic discourse regarding the impact of recognizing institutional racism in health care institutions, as well as in the work of health care professionals. The mere perception that there is not racism is certainly a great barrier to the creation of a more just and humane health policy.

16. One of the most important aspects resulting from the absence of capacitated health professionals is the inclusion and the correct fulfillment of the color question in the forms and information systems/databases of the Ministry of Health. An effort on the part of the Brazilian government is necessary to raise professional awareness of the importance of this question to the elaboration of specific public policies. In accordance with Oliveira: "The color question, or racial identification, is an important and indispensable item with respect to health services, as much with respect to the diagnosis as to the prognosis, the prevention, and the dignified treatment of all of the illnesses currently considered racial/ethnic. It is possible to conduct an epidemiological diagnosis regarding the situation of racial or ethnic groups and to delimit, with the utmost precision, the indifference, the omission, the difficulty of access, and the possibility of viewing the institutionalization of

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racism as a social practice and as a natural and acceptable policy whenever any one of these groups lives under racial/ethnic oppression. It demonstrates how the Black population becomes ill, for example, and dies. (…)[12]".

17. In this sense, ignoring the color question, even under the argument that it is done to eliminate a possible racial discrimination, makes impracticable any analysis of racial differences in the field of health. Moreover, with adequate attention, specific racial groups can come to benefit from public health policies that attend to their needs in the realm of health/sickness processes. Thus, the definition advanced by the Ministry of Health of the Brazilian government in March of 1996 of standardization of information regarding race and color of Brazilian citizens and foreigners is of no importance if those professionals who attend daily to the population in the Heath System are not conscious of the relevance of the information and, therefore, of the necessity of its correct usage.

Conclusive remarks on Black women's right to health

18. It has become evident that there is a necessity for the continuation of the policy of the implementation of the color question, with an attempt to sensitize health professionals to the importance of attention to health, registration and analysis of the facts regarding race/color/ethnicity to attempt to reduce inequalities.

19. The effort of the Brazilian government to combat racism present in Brazilian society is, at least as it relates to the health of Black women, a verbal and analytical effort that remains on the plane of discourse, but must be concretized through practice and results[13].

20. In the words of doctor and activist of the Black feminist movement, Fátima Oliveira, "[the] indifference with relation to the health of the Black Brazilian population has shown itself to be one of the most perverse faces of racism perpetrated in Brazil. It is perverse because it systematically negates the possibility of promoting and maintaining dignified conditions of health to this group (...)[14]". This is, without a doubt, the responsibility of the Brazilian state: to guarantee universal and egalitarian access to health services, which implies different treatment for different groups, with the goal of reaching equity in health care. Only thus, with the implementation of their right to

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health, will Black women be able to fully exercise their citizenship. Only by guaranteeing these rights for all will citizens be able to have similar experiences of "birth, life, sickness, and death[15]". This is still not the case in Brazil, as Black women are deprived of their rights as a consequence of a doubled discrimination based both on their gender and race.

Abortion as a public health issue

21. The World Health Organization estimated in its 2000 report that 19 million women a year are subject to unsafe abortions. From these, 18.4 million live in developing countries and 3.7 million in Latin America. Also, 67500 women died in 2000 as a result of such practice in developing countries. In Latin America alone 3700 women died.[8]

22. The high mortality rates resulting from unsafe abortion are directly linked to the fact that abortion is usually illegal in developing countries.[9] It is estimated that illegal abortions account for 100 to 1000 deaths per 100 thousand cases in developing countries, while legal abortions account for 2 to 4 deaths.[10] In Brazil, the estimates are of 1.4 million abortions per year, that is, half of the total number of births.[11]

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[8] WHO, *Unsafe Abortion - global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000*, Geneva, 2004, 4th edition, p. 9, 13.

[9] According to the WHO, among the 48 developing countries, 46 consider abortion a legal practice in order to save the woman' life; 42, to protect the woman's physical health; 41 to preserve the woman's mental health; 39, when the pregnancy resulted from rape; 39, when there is a fetal impairment; 36, for economic or social reasons; and 31, on request. At the same time, among the 145 developing countries, 143 consider abortion a legal practice in order to save the woman' life; 80, to protect the woman's physical health; 79 to preserve the woman's mental health; 44, when the pregnancy resulted from rape; 37, when there is a fetal impairment; 27, for economic or social reasons; and 21, when the pregnant woman asks for it. It means that almost all developed countries establish a good array of reasons to decriminalize the practice, while a good part of developing countries, don't, with the sole exception of saving the woman's life. WHO, *Unsafe Abortion - global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000*, Geneva, 2004, 4th edition, p. 4.

[10] WHO, *Unsafe Abortion - global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000*, Geneva, 2004, 4th edition, p. 5.

[11] The Alan Guttmacher Institute. *Aborto clandestino: uma realidade latino-americana*. New York: AGI; 1994. In: Cesar G. Victora, Intervenções para reduzir a mortalidade infantil pré-escolar e materna no Brasil, *Rev. bras. epidemiol.*, vol.4, no.1, São Paulo, Apr. 2001, available at: http://www.scielo.br/scielo.php?pid=S1415-790X2001000100002&script=sci_arttext&tlng=pt. Access on July 12, 2007.

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23. As stated by Silvia Pimentel and Valéria Pandjiarjian: "[...] States that have legalized voluntary abortions and created accessible programs of family planning, combined with effective access to information, had as a consequence the reduction in the number of abortions. [...] In Latin American countries where abortion is considered illegal or where abortion is only permitted in a few cases, abortion rates may be up to 10 times higher if compared to those of countries where abortion laws have been liberalized"[12].

24. In this vein, Victor Abramovich, Vice President and Rapporteur for the rights of women at the Inter-American Commission for Human Rights, has stated on behalf of decriminalization: "Mi posición personal, y no es la de la Comisión Interamericana de Derechos Humanos porque no ha sido materia de discusión, es que se debería proceder a despenalizarlo. La criminalización del aborto tiene relación directa con la mortalidad materna, produce una afectación a la vida y a los derechos de las mujeres, les pone obstáculos al acceso a la salud y pone en riesgo su integridad. Sería correcto sacar el aborto del ámbito penal, tal vez fijar alguna reglamentación, no tengo claro en qué términos, pero despenalizarlo. El caso más extremo fue la reciente penalización del aborto terapéutico en Nicaragua. Hasta su derogación, estaba claro que estaba permitido cuando hubiera riesgo para la madre y se requerían de tres dictámenes médicos que lo certificaran. En una audiencia que hubo la semana pasada en la Comisión, donde se trató la situación de Nicaragua, se contaron tres casos particulares de médicos enfrentados a situaciones de riesgo de vida de las mujeres: si intervenían cometían un delito, si no la mujer se moría. En uno de los casos la mujer murió. Me parece la situación más terrible. En los otros dos, por cuestiones humanitarias los médicos realizaron el aborto. La norma va contra el sentido común. Ya no es una discusión filosófica."[13]

25. Besides, criminalization leads to secrecy. The CEDAW has already understood in its General Recommendation n. 24 that "while lack of respect for the confidentiality of patients will affect both

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[12] PIMENTEL, Silvia Carlos da Silva ; PANDJIARJIAN, Valéria . Aborto: Descriminar para não incriminar. In: Católicas pelo direito de decidir. (Org.). Aborto legal: implicações éticas e religiosas. São Paulo: Católicas pelo direito de decidir, 2002, available at www.redemulher.org.br, access on May 30, 2005.

[13] Mariana Carbajal, Interview with Victor Abramovich, March 9, 2007, available at http://www.iidh.ed.cr/comunidades/DerechosMujer/noticia_despliegue.aspx?Codigo=3937, access on July 12, 2007.

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men and women, it may deter women from seeking advice and treatment and thereby adversely affect their health and well-being. Women will be less willing, for that reason, to seek medical care for […] incomplete abortion […]." When abortion is illegal, the secrecy is guaranteed.

26. In Brazil, where abortion was the fourth cause of maternal death in Brazil from 2002 to 2004 (according to numbers presented by the State itself in its sixth report), abortion is only explicitly allowed in two cases by the Penal Code: (1) to protect the woman's life and (2) in cases of pregnancy derived from rape. This means that, besides all the individual rights involved in the matter, there is an essential issue at stake: maternal mortality.

27. We would like to highlight two aspects of this matter: (1) abortion in cases of anencephaly, current under analysis by the Brazilian Federal Supreme Court; and (2) abortion among Afro-Brazilians.

Abortion in cases of anencephaly

28. As Conectas Human Rights has already stated in an *amicus curiae* presented to the Brazilian Federal Supreme Court (Superior Tribunal Federal) in the Claim for Disobeying a Fundamental Constitutional Dispositive n. 54/2004 (*Argüição de Descumprimento de Preceito Fundamental* n. 54), the interpretation of articles 124, 126 e 128, I e II, of the Penal Code (which establish the crime of abortion) in accordance with the Brazilian Federal Constitution would imply that it is already legal in Brazil to anticipate delivery in cases of an anencephalic fetus.

29. The issue is of special importance, as Brazil is the fourth country in the world in number of fetuses born with anencephaly. For every 10 thousand children born alive, there are 8,6 anencephalic fetuses.[14] According to medical studies, 65% of all anencephalic fetuses die when they are still in the mother's womb.[15]

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[14] WHO, *World atlas of birth defects*. Geneva, 2003, 2nd edition, available at http://www.who.int/genomics/about/en/anencephaly.pdf, access on July 12, 2007, p. 1.

[15] Volnei Garrafa, Presidente da Sociedade Brasileira de Bioética, *in* interview to the *Jornal do Comércio*, July 6, 2004.

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30. According to José Aristodemo Pinotti, Profesor of Gynecology at the University of São Paulo:[16] "It is not difficult to identify anencephaly. Today, with modern ultra-sound equipments, prenatal identification of anencephaly became a simple matter and it may be done from the 12th week of pregnancy on. There is almost no possibility of mistake. The majority of those born with anencephaly survive for no more than 48 hours after delivery [...]. Women, pregnant of an anencephalic child, commonly have high blood pressure and excess of the amniotic liquid, and, therefore, they are also submitted to increased health-related risks."

31. Finally, according to a research conducted by IBOPE on request of the Catholics for a Free Choice (*Catolicas pelo Direito de Decidir*), 72% of the two thousand people interviewed in more than 140 municipalities agreed with the interruption of pregnancy in cases of anencephaly. Besides, 80% of the interviewees understood that maintaining pregnancy in this case was a torture against the mother. [17]

Abortion among Black women

32. A second aspect to be raised here is related to abortion involving Black women. Data on maternal mortality among Black Brazilian women make it even more clear how much abortion is an issue of public health. While the maternal mortality rate among White women is approximately at 5,42/100 thousand, it is at 11,82/100 thousand among Black women, that is, the mortality rate doubles among the latter group.[18]

33. Facing the problem from this perspective, one may question how much attention is given to the life of women in general and to the life of Afro-Brazilian women in particular. As we realize that an accumulation of vulnerabilities (race and gender) significantly increases the risk of death, we also

[16] Translated from Portuguese: "O reconhecimento da [...] anencefalia é imediato. [...] Hoje, com os equipamentos modernos de ultra-som, o diagnóstico pré-natal dos casos de anencefalia tornou-se simples e pode ser realizado a partir de 12 semanas de gestação. A possibilidade de erro, repetindo-se o exame com dois ecografistas experientes, é praticamente nula. A maioria dos anencéfalos sobrevive no máximo 48 horas após o nascimento. [...] As gestações de anencéfalos causam, com maior freqüência, patologias maternas como hipertensão e hidrâmnio (excesso de líquido amniótico), levando as mães a percorrerem uma gravidez com risco elevado". (grifamos) José Aristodemo Pinotti, *Anencephaly: Opinião,* available at www.febrasgo.org.br, accessed in May 30, 2005.

[17] IBOPE, Pesquisas de Opinião Pública, *Anencefalia, Tortura e Supremo Tribunal Federal*, available at http://www.catolicasonline.org.br, access on May 30, 2005.

[18] Rede Feminista de Saúde, *Dossiê Aborto – Mortes previsíveis e evitáveis,* BH: Rede Feminista de Saúde, 2005, p. 30.

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understand that a refusal to adopt public policies on the protection of women's life in Brazil reflects, among other things, a culture of discrimination based both on gender and on race.

Conclusive remarks on abortion

34. By considering abortion as an issue of public health, we strongly support the complete decriminalization of the practice in Brazil, with the revocation of articles 124 and 126 of the Penal Code. The bill proposed by the former Representative Eduardo Jorge (Bill 21/03), for instance, is a positive step, as it establishes the revocation of article 124, which criminalizes the conduct of provoking abortion by oneself or permitting another to do so. However, it misses the need of also revoking article 126, which criminalizes the conduct of provoking an abortion with the consent of the pregnant woman. The revocation of this latter article is key to decrease the number of unsafe abortions.

35. We also support, as a shorter-term goal, those bills which increase the cases of legal abortions to encompass not only rape and risk to the mother's life, but also the risk to the mother's physical and mental health and cases of fetal mal-formation which makes life outside the womb unviable, such as the bill proposed by Luciana Genro and that proposed by Representative Jandira Feghali.

36. We understand that all branches of the government are obliged before the international documents ratified by the Brazilian State. Therefore, while the legislative branch must consider women's right to life in discussing the afore mentioned bills, the executive branch must promote campaigns to elucidate the public health issue at stake as well as promote effective public policies to guarantee the special protection of Black women in Brazil. By its turn, the judicial branch must comply with the CEDAW obligations assumed by the Brazilian government, concerning the protection of rights, including article 12 of the Convention.

37. In its General Recommendation No. 24, the CEDAW established that States should "prioritize the prevention of unwanted pregnancy through family planning and sexual education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. When

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possible, legislation criminalizing abortion could be amended to remove punitive provisions imposed on women who undergo abortion." (par. 31.c)

38. Finally, the Secretary General highlighted that "[...] in considering the report of Peru, the Committee expressed its concern that [...] clandestine abortions were the main cause of maternal mortality. The Committee noted that 'those provisions not only mean that women are subject to inhumane treatment but are possibly incompatible with articles 3, 6 and 7 of the Covenant'. It consequently recommended the revisions of the Civil and Penal Code, as Peru '[...] must take the necessary measures to ensure that women do not risk their life because of the existence of restrictive legal provisions on abortion.' In considering Colombia's report, the Committee [...] was concerned at the high mortality rate of Colombian women resulting from clandestine abortions, and recommended that priority be given to protecting women's right to life by [...] ensuring access to safe contraception."[19]

39. Considering these concerns on Black women's right to health and on abortion as a public health issue, we would like to submit the matter to analysis by the Committee.

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GELEDES

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[19] HRI/MC/1998/6, Integrating the gender perspective into the work of United Nations human rights treaty bodies - Report by the Secretary-General, 3 September 1998, available at http://www.un.org/womenwatch/daw/news/integrating.htm, access on July 12, 2007, par. 64.