



ALYNE V. BRAZIL

Case of Alyne da Silva Pimentel Teixeira (“Alyne”) v. Brazil

1. GENERAL CONTEXT

Millennium Development Goal 5 seeks to reduce the maternal mortality ratio (number of maternal deaths per 100,000 live births) by 75% by 2015. Between 1998 and 2010, Brazil reduced its maternal mortality ratio from 103.43 to 56,¹ representing a 51% decrease.² Nevertheless, maternal mortality persists as a serious public health issue in the country.³ Indeed, 2009 saw an alarming increase in the ratio when it reached 72.25, its highest point in five years.⁴

Maternal mortality is particularly problematic among low-income,⁵ Afro-Brazilian,⁶ and indigenous women,⁷ as well as women living in rural areas and in the Brazilian north and northeast.⁸ The Brazilian government recognizes that 90% of the country’s maternal deaths could be prevented with adequate medical care.⁹ Preventable maternal mortality is both a form and a symptom of discrimination against women, and it deprives women of their right to live a healthy life on a basis of equality with men. The root causes of maternal deaths in Brazil are socioeconomic and gender-based disparities in access to quality health care.¹⁰ By Brazil’s own admission, “poverty is concentrated [among] black or Afro-descending women.”¹¹ In 2006, the Minister of Health publicly admitted the existence of racism against Afro-descendant patients in the public health care system.¹²

Why Is This Case Important?

Alyne v. Brazil is the first case on maternal mortality to be decided by an international human rights body. In the words of renowned legal scholar Rebecca Cook, *Alyne* marks “the first decision of an international treaty body holding a government accountable for a preventable maternal death.”¹⁷ This case has played a critical role in advancing the recognition of reproductive rights not only in Brazil but also in Latin America and around the globe. It is particularly important for the recognition of women’s rights to safe motherhood and to access quality essential health services without discrimination.

The case revolves around two central issues: (i) quality maternal health care for all women free from discrimination, including on the basis of their race, income, or geographical location; and (ii) accountability for the state’s obligation to ensure quality maternal health care services. The CEDAW Committee’s decision responds to these issues, touching not only on the specific situation of Alyne da Silva Pimentel Teixeira but also on the situation of millions of women in Brazil and throughout the world who currently lack access to quality and timely maternal health care.

Brazil has ratified several international human rights conventions, including the Convention on the Elimination of Discrimination against Women (CEDAW)¹³ and its Optional Protocol.¹⁴ This means that Brazil is obligated to ensure the right to health without discrimination.¹⁵ The right to health includes the right to sexual and reproductive health. According to the United Nations Committee on Economic, Social and Cultural Rights, certain components of the right to health—such as the obligation to guarantee access to health services without discrimination, including access to sexual and reproductive health services—are immediate obligations, as opposed to obligations that, due to their nature, imply progressive compliance.¹⁶ Thus, as part of its duty to fulfill the right to health, the Brazilian state must provide access to reproductive health care without discrimination on an immediate basis. Reproductive health care includes maternal health care, which is described under article 12(2) of CEDAW as “appropriate services in connection with pregnancy, confinement and the post-natal period.”

2. FACTS

On November 11, 2002, 28-year-old Alyne da Silva Pimentel Teixeira—a poor, pregnant woman of Afro-Brazilian descent—visited the private health clinic, La Casa de Saúde Nossa Senhora da Glória in Belford Roxo, in the state of Rio de Janeiro. Despite presenting symptoms of a high-risk pregnancy, her doctor sent her back home. However, her symptoms worsened during the course of the following two days, so she returned to the clinic. By that time, the doctors were unable to detect a fetal heart beat. Her delivery was induced six hours later, producing a stillborn fetus. The surgery to extract her placenta occurred fourteen hours later, though it should have occurred immediately after the delivery was induced. Due to the fact that Alyne’s health was steadily deteriorating she had to be transferred to a higher tier public health care institution, however, she had to wait more than eight hours before being transferred to Hospital Geral de Nova Iguaçu. Alyne died after more than 21 hours without receiving medical attention. She left behind her five-year-old daughter.

Two lawsuits—a domestic one and an international one—were filed on behalf of Alyne. The domestic claim was submitted in 2003 before the Brazilian judicial system, demanding material and moral damages for Alyne’s husband and daughter. After a delay of ten years, the Rio de Janeiro Trial Court issued a

decision in December 2013 regarding this claim. It awarded moral damages and a pension for Alyne’s daughter, retroactively from the moment her mother died and until the daughter turns 18. However, it did not find the state directly responsible for the poor health care provided at the private health center.¹⁸

In November 2007, after four years had passed without a decision from the Brazilian judiciary, the Center for Reproductive Rights and *Advocacia Cidadã pelos Direitos Humanos* submitted an international claim before the CEDAW Committee. The claim, submitted on behalf of Alyne’s mother and daughter, argued that the Brazilian state had violated Alyne’s right to access to justice (art. 2), right to health without discrimination (art. 12), and right to life (art. 1). These allegations were based on the following grounds: First, at the time of the claim’s filing, the Brazilian judiciary had not issued a decision regarding the domestic civil claim, violating the right of Alyne’s family to access to justice. Second, the Brazilian state had failed to ensure Alyne’s timely access to quality health services during pregnancy and delivery, risking Alyne’s life, health, and her right to live free from discrimination. This failure was evidenced by the lack of skilled health care professionals and the absence of an effective referral system. This was particularly problematic due to Alyne’s status as a low-income Afro-Brazilian woman.

Why Is This Case Important?

Alyne v. Brazil clearly recognizes that states have an immediate and enforceable human rights obligation to address and reduce maternal mortality, strengthening the recognition of reproductive rights as obligations that must be immediately enforced by the state. The case underscores Brazil’s international obligations resulting from the human rights treaties it has ratified, including CEDAW, and its Optional Protocol and its endorsement of resolutions relating to the prevention of maternal mortality¹⁹ that have been issued by the United Nations Human Rights Council. It further reinforces the commitment to reduce maternal mortality voiced by states during the 1994 International Conference on Population and Development. This commitment was recently reaffirmed during the first session of the Regional Conference on Population and Development in Latin America and the Caribbean, held in Montevideo in 2013. *Alyne v. Brazil* also informed the Technical Guidance on Maternal Mortality²⁰ issued in 2012 by the Office of the High Commissioner on Human Rights.

3. CEDAW COMMITTEE'S DECISION

In 2011, the CEDAW Committee issued its decision, finding the Brazilian state responsible for violations of article 2(c) (access to justice); article 2(e) (the state's obligation to regulate activities of private health providers), in conjunction with article 1 (discrimination against women), read together with General Recommendations 24 (on women and health) and 28 (related to article 2 of the Convention); and article 12 (access to health).²¹ The Committee reasoned as follows:

3.1 Whenever states are legally bound to provide universal access to health, they become directly responsible for monitoring and regulating private institutions that provide health services through outsourcing, making them accountable for their actions.

In its decision, the CEDAW Committee affirmed the state's accountability for the provision of health care services. The Brazilian government had argued that it was not responsible for Alyne's death because a private—not public—institution had provided poor quality medical care to Alyne. However, the government did acknowledge “shortcomings in the system used to contract private health services and, by extension, the inspection and control thereof.”²² The CEDAW Committee recognized that the “State is directly responsible for the action of private institutions when it outsources its medical services, and that furthermore, the State always maintains the duty to regulate and monitor private health-care institutions.”²³ The Committee further explained that the state has a due diligence obligation to ensure that private parties rendering health services develop appropriate activities in accordance with article 2 of CEDAW. The Committee grounded this conclusion on articles 196–200 of the Brazilian Constitution, which recognize the right to health as a human right and guarantee its universal provision by the state.

3.2 In order to protect women's human rights to life, to health, and to live free from discrimination, states are responsible for the provision of timely access to quality maternal health care to all women, regardless of their race or income.

The Committee recognized two main facts in Alyne's case. First, it acknowledged that Alyne's death was a maternal death in light of the fact that it “was indeed linked to obstetric complications related to her pregnancy.”²⁴ Second, the Committee acknowledged that Alyne had not been “ensured appropriate services in connection with her pregnancy.”²⁵ Alyne's case is representative of the overall low quality of maternal health care in Brazil. The CEDAW Committee concluded that systematic problems exist with regard to women's access to quality health care services in the country.²⁶ Despite the fact that several

public policies on access to quality health care services have been issued, they have not been effectively implemented. The Committee recognized that there is a “lack of appropriate maternal health services in the State party that clearly fails to meet the specific, distinctive health needs and interests of women not only constitutes a violation of article 12, paragraph 2, of the Convention, but also discrimination against women under article 12, paragraph 1, and article 2 of the Convention.”²⁷ It also acknowledged that limited access to quality health care services fails to address the specific needs of women and thus constitutes discrimination. The Committee further established that the right to life is violated whenever women are denied access to quality health care services because “the lack of appropriate maternal health services has a differential impact on the right to life of women.”²⁸

Moreover, the CEDAW Committee referred to its concluding observations on Brazil from 2007, which acknowledge “the existence of de facto discrimination against women, especially women from the most vulnerable sectors of society such as women of African descent.”²⁹ The Committee emphasized the connection between gender discrimination and other factors that affect women. Although the Brazilian state had argued that discrimination was not a decisive factor in Alyne's death, the CEDAW Committee acknowledged that discrimination on the basis of sex, race, and income affected the lack of access to quality maternal health care services, concluding that “Ms. Da Silva Pimentel Teixeira was discriminated against, not only on the basis of her sex, but also on the basis of her status as a woman of African descent and her socio-economic background.”³⁰

3.3 Brazil should provide effective judicial action, protection, and remedies, making health care providers accountable for their actions and omissions in relation to women's reproductive rights.

The CEDAW Committee called on Brazil to “comply with its obligation to ensure effective judicial action and protection.”³¹ According to the Committee, the state had failed to ensure effective judicial protection and adequate judicial remedies, since (i) no proceedings had been started to establish the responsibility of those providing health care to Alyne; (ii) the civil action filed in 2003 by Alyne's family was still pending at the time of the Committee's decision; and (iii) two requests for *tutela antecipada* (a mechanism to avoid unwarranted judicial delays) had been denied.³²

4. REPARATIONS

4.1 With regard to Alyne's mother and Alyne's daughter, the Committee recommended that the state provide the following reparations:

Provide appropriate reparation, including adequate financial compensation, to the author and to the daughter of Ms. da Silva Pimentel Teixeira commensurate with the gravity of the violation against her.³³

4.2 The Committee also called on the state to undertake the following general measures:

(a) Ensure women's right to safe motherhood and affordable access for 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/CO/6).³⁴

Relevant Human Rights Provisions

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

Article 1

For the purposes of the present Convention, the term “discrimination against women” shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

Article 2

States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake: . . .

(c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination; . . . (e) To take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise; . . .

Article 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

CEDAW GENERAL RECOMMENDATION 24 ON WOMEN AND HEALTH

Paragraph 17

The duty to fulfil rights places an obligation on States parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights

to health care. Studies such as those that emphasize the high maternal mortality and morbidity rates worldwide . . . provide an important indication for States parties of possible breaches of their duties to ensure women’s access to health care. . . .

The Committee is concerned at the growing evidence that States are relinquishing these obligations as they transfer State health functions to private agencies. States parties cannot absolve themselves of responsibility in these areas by delegating or transferring these powers to private sector agencies. States parties should therefore report on what they have done to organize governmental processes and all structures through which public power is exercised to promote and protect women’s health. They should include information on positive measures taken to curb violations of women’s rights by third parties and to protect their health and the measures they have taken to ensure the provision of such services.

Paragraph 26

Reports should also include what measures States parties have taken to ensure women appropriate services *in connection with pregnancy, confinement and the post-natal period*. Information on the rates at which these measures have reduced maternal mortality and morbidity in their countries, in general, and in vulnerable groups, regions and communities, in particular, should also be included.

Paragraph 27

States parties should include in their reports how they supply *free services where necessary* to ensure safe pregnancies, childbirth and post-partum periods for women. Many women are at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include antenatal, maternity and post-natal services. The Committee notes that it is the duty of States parties to ensure women’s right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources.

ENDNOTES

- 1 World Health Organization (WHO), United Nations Population Fund (UNFPA), et al., *Trends in maternal mortality: 1990 to 2010*, 32 (2012) available at http://whqlibdoc.who.int/publications/2012/9789241503631_eng.pdf.
- 2 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 104 (Spring 2013).
- 3 WHO ET AL., *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA 23-27* (2007) available at http://www.who.int/whosis/mme_2005.pdf.
- 4 PAN-AMERICAN HEALTH ORGANIZATION (PAHO), *Health Indicator Database: Country Health Indicator Profile: Maternal and Child Mortality: Brazil* (2009) available at http://ais.paho.org/hip/viz/cip_maternalandinfantmortality.asp.
- 5 Ministério Da Saúde, *Política Nacional De Atenção Integral A Saúde Da Mulher: Princípios E Diretrizes* 26 (2004); WORLD BANK, *Brazil: Maternal and Child Health*, Report No. 23811-BR, para. 2.8 at 20-21 (2002), available at http://www.wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2002/04/12/000094946_02040304022680/Rendered/PDF/multi0page.pdf [hereinafter WORLD BANK, *Brazil*]; PAHO & US AGENCY FOR INTERNATIONAL DEVELOPMENT, *Health Systems and Services Profile, Brazil, Monitoring and Analysis of Health Systems*, CHANGE/REFORM 21 (2008); CG Victora et al., *Socioeconomic and ethnic group inequities in antenatal care quality in the public and private sector in Brazil*, 25 HEALTH POLICY AND PLANNING 253, 256 (2010).
- 6 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]; Clare Ribando Seelke, *Afro-Latinos in Latin America and Considerations for U.S. Policy*, 486 FEDERAL PUBLICATIONS, (2008), available at http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1491&context=key_workplace.
- 7 BRAZIL HEALTH 2006: An Analysis of Inequality In Health, *supra* note 6 at 367; UNITED NATIONS, *A UN Reading of Brazil's Challenges and Potential: Common Country Assessment by Brazil's UNCT*, iii, para. 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) [hereinafter *UN Reading of Brazil's Challenges and Potential*]; ARTICULACION DE ORGANIZACIONES DE MUJERES NEGRAS BRASILEÑAS (AMNB), *Dossier Regarding the Situation of Black Women in Brazil* 25 (July 2007) [hereinafter AMNB, *Black Women in Brazil*].
- 8 Cesar G Victora et al., *Maternal and child health in Brazil: progress and challenges* 377 THE LANCET 1863 (2011), available at <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2811%2960138-4/fulltext>; Jorge Laurenti R, *A mortalidade materna nas capitais brasileiras: algumas características e estimativa de um fator de ajuste*, 7 REVISTA BRASILEIRA DE EPIDEMIOLOGIA 449 (2004); WORLD BANK, *Brazil*, *supra* note 5.
- 9 STATE PARTIES, *Second periodic Rep. under articles 16 and 17 of the Covenant, Brazil, Implementation of the International Covenant on Economic, Social and Cultural Rights*, para. 418, U.N. Doc. E/C.12/BRA/2 (Jan. 28, 2008).
- 10 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”).
- 11 Committee on the Elimination of Discrimination against Women (CEDAW Committee), *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.
- 12 AMNB, *Black Women in Brazil*, *supra* note 7.
- 13 Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18 1979, G.A. Res. 34/180, U.N. GOAR, 34th Sess., Supp. No. 46, at 47, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3rd, 1981) [hereinafter CEDAW].
- 14 Optional Protocol to the Convention on the Elimination of Discrimination against Women, *adopted* June 28, 2002, UNITED NATIONS TREATY COLLECTION, available at https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtmsg_no=IV-8-b&chapter=4&lang=en (last visited Jan. 14, 2014).
- 15 Universal Declaration of Human Rights, *adopted* on Dec. 10, 1948, art. 3, G.A. Res. 217A (III); CEDAW, *supra* note 13; Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990); International Covenant on Economic, Social, and Cultural Rights, *adopted* Dec. 16th, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/63/16 (1966) (*entered into force* Jan. 3, 1976); American Convention on Human Rights, *adopted* Nov. 22, 1969, O.A.S.T.S. No. 36, O.A.S. Off. Rec. OEA/Ser.L/V/II.23, doc. 21, rev. 6 (*entered into force* July 18, 1978).
- 16 Committee on Economic, Social and Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights, General comment No. 14*, UN Doc. E/C.12/2000/4 (Apr. 25-May 12, 2000).
- 17 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 103 (Spring 2013).
- 18 The domestic decision was finally released two years after the CEDAW Committee's decision. An appeal is still pending.
- 19 Human Rights Council, *Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development*, U.N. Doc. A/HRC/11/L.16/Rev.1 (June 12, 2009); *Preventable maternal mortality and morbidity and human rights: follow-up to Council resolution 11/8*, Res. 15/17 (Sept. 30, 2010); *Preventable maternal mortality and morbidity and human rights*, Res. 18/2 (Sept. 28, 2011); *Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development*, U.N. Doc. A/HRC/21/L.10 (Sept. 20, 2012).
- 20 Office of the High Commissioner on Human Rights, *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* 1, U.N.Doc. A/HRC/21/22 (July 2012).
- 21 CEDAW Committee, *Alyne da Silva Pimentel v. Brazil: Commc'n No. 17/2008*, at 21, U.N. Doc. CEDAW/C/49/D/17/2008 (2011).
- 22 *Id.* para. 7.5.
- 23 *Id.*
- 24 *Id.* para. 7.4.
- 25 *Id.*
- 26 *Id.* para. 7.6.
- 27 *Id.*
- 28 *Id.*
- 29 *Id.* para. 7.7.
- 30 *Id.*
- 31 *Id.* para. 7.8.
- 32 *Id.*
- 33 *Id.* para. 8.1.
- 34 *Id.* paras. 2. a-f.