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**Committee on the Elimination of Discrimination
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Views

Communication No. 17/2008

Submitted by: Maria de Lourdes da Silva Pimentel, represented
by the Center for Reproductive Rights and
Advocacia Cidadã pelos Direitos Humanos

Alleged victim: Alyne da Silva Pimentel Teixeira (deceased)

State party: Brazil

Date of communication: 30 November 2007 (initial submission)

References: Transmitted to the State party on 5 February 2008
(not issued in document form)

Date of adoption of views: 25 July 2011

Annex

**Views of the Committee on the Elimination of
Discrimination against Women under article 7, paragraph 3,
of the Optional Protocol to the Convention on the
Elimination of All Forms of Discrimination against Women**

concerning

Communication No. 17/2008*

Submitted by: Maria de Lourdes da Silva Pimentel (acting in her own name and on behalf of her family), represented by the Center for Reproductive Rights and Advocacia Cidadã pelos Direitos Humanos

Alleged victim: Alyne da Silva Pimentel Teixeira (deceased)

State party: Brazil

Date of communication: 30 November 2007 (initial submission)

The Committee on the Elimination of Discrimination against Women, established under article 17 of the Convention on the Elimination of All Forms of Discrimination against Women,

Meeting on 25 July 2011,

Adopts the following:

Views under article 7, paragraph 3, of the Optional Protocol

1. The author of the communication, dated 30 November 2007, is Maria de Lourdes da Silva Pimentel, mother of Alyne da Silva Pimentel Teixeira (deceased), acting in her own name and on behalf of the family of the deceased. They are represented by the Center for Reproductive Rights and Advocacia Cidadã pelos Direitos Humanos.¹ They claim that Alyne da Silva Pimentel Teixeira is a victim of a violation by the State party of her right to life and health under articles 2 and 12 of the Convention on the Elimination of All Forms of Discrimination against Women.

* The following members of the Committee participated in the examination of the present communication: Ms. Ayse Feride Acar, Ms. Nicole Ameline, Ms. Olinda Bareiro-Bobadilla, Ms. Magalys Arocha Dominguez, Ms. Violet Tsisiga Awori, Ms. Barbara Evelyn Bailey, Ms. Meriem Belmihoub-Zerdani, Mr. Niklas Bruun, Ms. Naela Mohamed Gabr, Ms. Ruth Halperin-Kaddari, Ms. Yoko Hayashi, Ms. Ismat Jahan, Ms. Soledad Murillo de la Vega, Ms. Violeta Neubauer, Ms. Pramila Patten, Ms. Maria Helena Lopes de Jesus Pires, Ms. Victoria Popescu, Ms. Zohra Rasekh, Ms. Patricia Schulz and Ms. Dubravka Šimonović, Ms. Zou Xiaogiao. In accordance with rule 60 of the Committee's Rules of Procedure, Committee member Ms. Silvia Pimentel did not participate in the examination of the present communication.

¹The Committee received amicus curiae briefs from the Latin American and Caribbean Committee for the Defence of Women's Rights, the International Commission of Jurists and Amnesty International, providing general information with regard to the right to health and maternal mortality in Brazil and drawing attention to the international obligations of States.

The Convention and its Optional Protocol entered into force for the State party on 2 March 1984 and 28 September 2002, respectively.

The facts as presented by the author

2.1. Alyne da Silva Pimentel Teixeira, a Brazilian national of African descent, was born on 29 September 1974. She was married and had a daughter, A.S.P., who was born on 2 November 1997.

2.2 On 11 November 2002, Ms. da Silva Pimentel Teixeira went to the Casa de Saúde Nossa Senhora da Glória de Belford Roxo (the health centre) suffering from severe nausea and abdominal pain. She was in her sixth month of pregnancy at the time. The attending obstetrician-gynaecologist prescribed anti-nausea medication, vitamin B12 and a local medication for vaginal infection, scheduled routine blood and urine tests for 13 November 2002 as a precautionary measure and sent Ms. da Silva Pimentel Teixeira home. She began to take the prescribed medications immediately.

2.3 Between 11 and 13 November 2002, Ms. da Silva Pimentel Teixeira's condition worsened considerably and on 13 November 2002, she went to the health centre together with her mother in order to see if the obstetrician-gynaecologist could see her before her scheduled blood and urine analysis. The obstetrician-gynaecologist examined her and admitted her at 8.25 a.m. to the health centre.

2.4 Another doctor examined Ms. da Silva Pimentel Teixeira in the maternity ward and could not detect a foetal heartbeat. By 11 a.m., an ultrasound had confirmed this.

2.5 The doctors at the health centre informed Ms. da Silva Pimentel Teixeira that she needed to be given medication to induce the delivery of the stillborn foetus and began to induce labour at about 2 p.m. By 7.55 p.m., Ms. da Silva Pimentel Teixeira had delivered the stillborn, 27-week-old foetus. She became disoriented immediately afterwards.

2.6 On 14 November 2002, some 14 hours after the delivery, Ms. da Silva Pimentel Teixeira underwent curettage surgery to remove parts of the placenta and afterbirth, after which her condition continued to worsen (severe haemorrhaging, vomiting blood, low blood pressure, prolonged disorientation and overwhelming physical weakness, inability to ingest food). Her mother and husband did not visit the health centre that day because they relied on assurances given by phone that Ms. da Silva Pimentel Teixeira was well.

2.7 The author submits that on 15 November 2002, Ms. da Silva Pimentel Teixeira became more disoriented, her blood pressure remained low, she continued to vomit, had difficulty breathing and she continued haemorrhaging. Staff of the health centre performed an abdominal puncture but found no blood. Ms. da Silva Pimentel Teixeira received oxygen, Cimetidina, Mannitol, Decadron and antibiotics. The doctors explained to her mother that her symptoms were consistent with those of a woman who had never received prenatal care and that she needed a blood transfusion; at that point she called Ms. da Silva Pimentel Teixeira's husband, who then went to the health centre. At 1.30 p.m. staff asked Ms. da Silva Pimentel Teixeira's mother for the prenatal medical records because they could not locate any at the health centre.

2.8 The doctors at the health centre contacted both public and private hospitals with superior facilities in order to transfer Ms. da Silva Pimentel Teixeira. Only the municipal Hospital Geral de Nova Iguaçu had available space but refused to use its only ambulance to transport her at that hour. Her mother and husband were unable to secure a private ambulance and Ms. da Silva Pimentel Teixeira waited in critical condition for eight hours, with manifested clinical symptoms of coma for the last two hours, to be transported by ambulance to the hospital.

2.9 When Ms. da Silva Pimentel Teixeira arrived at the hospital with two doctors and her husband at 9.45 p.m. on 15 November 2002, she was hypothermic, had acute respiratory distress and presented a clinical picture compatible with disseminated intravascular coagulation. Her blood pressure dropped to zero and she had to be resuscitated. The hospital placed her in a makeshift area in the emergency room hallway because there were no available beds.

2.10 The medical attendants did not bring her medical records to the hospital. Instead, they provided the treating physician with a brief oral account of her symptoms.

2.11 On 16 November 2002, Ms. da Silva Pimentel Teixeira's mother visited her. She was pale and had blood on her mouth and on her clothes. The hospital staff sent Ms. da Silva Pimentel Teixeira's mother to the health centre to retrieve her medical records. At the centre, she was questioned as to why she wanted the records and made to wait for them.

2.12 Ms. da Silva Pimentel Teixeira died at 7 p.m. on 16 November 2002. An autopsy found the official cause of death to be digestive haemorrhage. According to the doctors, this resulted from the delivery of the stillborn foetus.

2.13 On 17 November 2002, at the request of the hospital, Ms. da Silva Pimentel Teixeira's mother again went to the health centre to retrieve her daughter's medical documents. The doctors at the health centre told her that the foetus had been dead in the womb for several days and that this had caused the death.

2.14 On 11 February 2003, Ms. da Silva Pimentel Teixeira's husband² filed a claim against the health-care system for material and moral damages.

The complaint

3.1 The author argues that article 2 of the Convention on the Elimination of All Forms of Discrimination against Women requires immediate action to address discrimination against women as defined in article 1 of that Convention when a woman's right to life is violated by the failure to secure her safety during pregnancy and childbirth.

3.2 The author argues that article 2 (c) of the Convention requires States parties not only to guarantee in law measures to combat discrimination, but also to ensure the practical implementation of these measures and the realization of rights without delay. The Committee has established that States parties must ensure that legislation and executive action and policy comply with the obligation to respect, protect and fulfil women's right to health care and put in place a system which ensures effective

² The case file has contradictory information as to who exactly filed the civil claim on 11 February 2003. In some places it mentions the mother of the deceased while in other places it mentions her husband.

judicial action. Failure to do so would constitute a violation of article 12 of the Convention. Furthermore, the Committee has noted that special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups and that the duty to eliminate discrimination in access to health care includes the responsibility to take into account the manner in which societal factors, which can vary among women, determine health status.

3.3 The author submits that the obligations in the field of health care under articles 2 and 12 of the Convention are obligations of immediate effect, because the rights to life and non-discrimination are immediately enforceable and violations require urgent governmental action. Referring to the International Covenant on Economic, Social and Cultural Rights, the author argues that the obligations to "ensure" are more immediate in character and not subject to the qualification of progressive realization, in contrast to obligations to "recognize".

3.4 The author claims that Brazil failed to ensure access to quality medical treatment during delivery, thereby violating its duties under articles 2 and 12 of the Convention.³ Given that the main reason pregnant women die is because of avoidable delays in obtaining proper emergency care during a complicated pregnancy — as was the case for Ms. da Silva Pimentel Teixeira — skilled assistance at pregnancy, including assistance that provides for obstetric emergencies, is a vital factor in preventing maternal death.

3.5 While Ms. da Silva Pimentel Teixeira was treated by a gynaecologist-obstetrician and thus nominally had access to a skilled health-care professional, the poor quality of the care she received was a critical factor in her death. A competent health-care provider would reportedly have been alerted to the fact that the severe nausea and abdominal pain of which Ms. da Silva Pimentel Teixeira complained during her sixth month of pregnancy was a sign of a potentially serious problem and would have ordered appropriate treatment. Had blood and urine tests been performed the same day, it would have been discovered that the foetus had died and that delivery should be induced immediately. This would have prevented Ms. da Silva Pimentel Teixeira's condition from deteriorating.

3.6 The author alleges that Ms. da Silva Pimentel Teixeira should have had surgery immediately after her labour was induced in order to remove the afterbirth and placenta, which had not been fully expelled during the process of delivery as they normally are, and which may have caused her haemorrhaging and complications and, ultimately, her death. They state that she also should have been transferred to a better-equipped facility for the surgery, given that the surgery took place in response to an abnormal situation. Instead, Ms. da Silva Pimentel Teixeira had been operated on the morning following the delivery and the surgery was performed at the health centre. Attempts to transfer her to a hospital reportedly did not begin until a full day had gone by after Ms. da Silva Pimentel Teixeira had begun to haemorrhage severely. The transfer, which had reportedly taken over eight hours, was ineffective in helping her obtain skilled care, because she was largely left unattended in a makeshift area in the hallway of the hospital for 21 hours until she died. The

³ In this connection, the author makes reference to general recommendation No. 24 (1999) of the Committee on the Elimination of Discrimination against Women on article 12 of the Convention (women and health) and to general comment No. 14 (2000) of the Committee on Economic, Social and Cultural Rights on the right to the highest attainable standard of health (art.12).

inability to make a timely and effective referral was another example of the incompetent care that Ms. da Silva Pimentel Teixeira received.

3.7 The author maintains that the lack of access to quality medical care during delivery is emblematic of systemic problems in the way human resources are managed in the Brazilian health system more generally. The provision of skilled care during pregnancy is critically dependent on a functioning health system⁴ and this requires an adequate number of skilled attendants deployed where they are needed; satisfactory pay scales and career advancement opportunities; supportive supervision mechanisms; functioning mechanisms for quality improvement; and a working transport and referral system to ensure timely access to high-level care, especially in an emergency. Studies by United Nations agencies reveal that Brazil's national health system has considerable weaknesses in each of these areas. Problems relating to low staff qualifications, an excess of poorly qualified staff and a shortage of well-qualified staff are said to be greater at the municipal level, for example, in health centres like the Casa de Saúde Nossa Senhora da Glória de Belford Roxo Health Centre, than at the state or federal levels.

3.8 The author maintains that Brazil has failed to ensure timely access to emergency obstetric care in violation of articles 2 and 12 of the Convention. At least three indicators relating to accessibility and the quality of emergency obstetric care are particularly relevant, given the specific failures in this case and the more systemic failures of the State party in eliminating preventable maternal deaths. The indicators to which the author refers are included in the guidelines for monitoring the availability and use of obstetric services (October 1997) of the United Nations Children's Fund (UNICEF), the World Health Organization (WHO) and the United Nations Population Fund (UNFPA), as follows:

(a) Equitable geographic distribution of emergency obstetric care facilities (four basic emergency obstetric care facilities and one comprehensive emergency obstetric care facility for every 500,000 persons in the population);

(b) Women's need for emergency obstetric care met (at a minimum, most women who need emergency obstetric care should be receiving services);

(c) The proportion of women with obstetric complications who are admitted to a facility with emergency obstetric care services and die should be no more than 1 per cent.

The author argues that a negative result in any of the three categories suggests that a State is not complying with its obligations to provide maternity care.

3.9 The author claims that the facts of the present case and data from studies on maternal mortality in Brazil demonstrate non-compliance with the obligation to provide maternity care. Evidence shows that emergency obstetric care facilities are inequitably distributed geographically (indicator 1), that women have higher than acceptable levels of unmet need (indicator 2), and that obstetric deaths in facilities occur at higher than acceptable rates (indicator 3), thereby demonstrating the failure of the State party to ensure accessibility and quality of emergency obstetric care as per its obligations on the right to health under article 12 of the Convention.

⁴ See "Making pregnancy safer: the critical role of the skilled attendant", a joint statement by the World Health Organization (WHO), the International Confederation of Midwives and the International Federation of Gynaecology and Obstetrics (2004).

3.10 Partly due to the uneven distribution of higher-level health facilities, Ms. da Silva Pimentel Teixeira faced serious challenges in gaining access to a hospital during a period when she needed immediate emergency care: the only hospital that would take her was in a neighbouring municipality some two hours away. Considering that the nearest available hospital required travel time equal to the amount of time an average woman in her condition has to live, she had no reasonable access to necessary emergency services. Similar inequities exist in the distribution of health-care facilities between states.

3.11 The author claims that in the present case, the absence or failure of a referral system between the health centre and higher-level facilities and the lack of coordination between prenatal and delivery care critically delayed the victim's access to services and may have cost her her life. Only one hospital among those contacted had available space. There were no means of transporting Ms. da Silva Pimentel Teixeira to that hospital because it did not want to use its only ambulance. The health centre did not have its own means of transportation and her mother could not find a private ambulance. There were no available beds at the hospital and doctors from the health centre failed to send her medical records to the hospital.

3.12 Given Ms. da Silva Pimentel Teixeira's own experience and the numerous studies on maternal mortality in Brazil that identify poor quality of health care in treating obstetric emergencies as a major reason for Brazil's high maternal mortality rate, and a fatality rate in many facilities that can be said to be at higher than acceptable levels, the author submits that the incompetence and negligence of the health-care providers and the lack of timely access to services were key factors in her death.

3.13 The author submits that the State party violated the rights of Ms. da Silva Pimentel Teixeira under article 2 (c) of the Convention by failing to ensure the effective protection of women's rights. They refer to the Committee's jurisprudence in communication 5/2005 (*Şahide Goekce (deceased) v. Austria*) under which the Committee held that the establishment by a State party of legal and other remedies [to address domestic violence] must be supported by State actors who adhere to the State party's due diligence obligations. The author also refers to the emphasis placed by the Inter-American Commission on Human Rights on the obligations of States to organize their government structures in order to ensure that violence and discrimination against women are prevented, investigated and punished and, further, that women are provided with redress. The facts of the case show that the State party has clearly failed to put into place a system that ensures effective judicial action and protection in the context of reproductive health violations. They submit that the lack of responsiveness on the part of the judicial system clearly points to the systematic failure of the State party to recognize the need to adopt measures of reparation that compensate and provide restitution to women who have been treated in a discriminatory manner.

3.14 As to the exhaustion of domestic remedies, the author maintains that access to justice is illusory. The husband of the deceased, on his own behalf and on behalf of their five-year-old daughter, filed a civil claim for material and moral damages on 11 February 2003, three months after her death, and asked for *tutela antecipada* twice.⁵ The first request made on 11 February 2003 by the family of the deceased

⁵ *Tutela antecipada* is a judicial mechanism that requests the judge to anticipate the protective

was ignored. The judge also denied the second request filed on 16 September 2003. However, over four and a half years later, there has been negligible judicial activity on the civil case and it is likely that it will take several more years for the courts to reach a decision. Specifically, there has been no hearing to date and the Court took 3 years and 10 months to appoint a medical expert, although court rules require that this be done within 10 days.

3.15 The lack of a meaningful and timely response from the judiciary had a devastating effect on the family, particularly on the daughter of the deceased, who was abandoned by her father and who is now living in precarious conditions (lack of access to psychological services, meagre means for basic necessities, such as food, clothing etc.) with her maternal grandmother. The extraordinary delay in rendering a decision on the requests for *tutela antecipada* and the inaction on the civil claim has further endangered the rights of the victim's daughter and posed a risk of irreparable harm.

3.16 The author also alleges that the prior decisions of the Committee support the applicability of the exception to the rule on the exhaustion of domestic remedies. They claim that the finding of the Committee in regard to the length of judicial proceedings in the case of *A.T. v. Hungary* (communication 2/2003) — i.e. that domestic violence cases do not enjoy priority in judicial proceedings — is analogous to the situation in Brazil, where proceedings involving violence against women and women's health, especially that of women from vulnerable groups, including women from low socio-economic backgrounds and women of African descent, are not given priority in the court system.

3.17 The author maintains that the civil claim cannot be considered an effective means of obtaining redress for the human rights violation denounced in the communication and has undermined the purpose of the remedy — the goal of which is to meaningfully address and repair in a practical and immediate fashion the needs of the family. The delay is tantamount to a denial of justice.

3.18 The author maintains that the matter has not been and is currently not being examined under any other procedure of international investigation or settlement.

Observations of the State party on admissibility and merits

4.1 By its only submission of 13 August 2008, the State party indicates that it considers the following issues to be connected to the present case: (a) the elimination of discrimination against women in access to health services, particularly those related to pregnancy and labour; (b) the legal adoption of public policies and other concrete measures which ensure the provision of reproductive health services; (c) the State's primary responsibility for women's health care; (d) the requirement that available health services, assure full informed consent, respect the dignity of all and guarantee confidentiality, and that health-care workers be sensitive to the particular demands of women. The State party explains that the right to health in articles 6 and 196 of the Brazilian Federal Constitution sets out the subjective right of individuals under which the State party has both positive and negative obligations. It explains that the public health service, through public health policies, is the State apparatus which is responsible for such a right and spells out in

effects of a decision. It may be used to avoid unwarranted delays in the judicial decision that may otherwise lead to irreparable or serious damages.

details both the proactive and defensive role of the State in the field of health. It further notes that the concept of the right to health includes several elements, insofar as health is defined as total social, psychic, and physical well-being, of which the right to health care represents but one aspect. It also highlights the difference between the right to health and the right to health assistance, wherein the latter is restricted to medical actions performed to detect and treat illnesses and relates to the right to health in terms of the ability to cure illnesses or extend life expectancy. The right to health care or health assistance requires by definition the organization and operation of assistance services.

4.2 The State party then proceeds to examine the right to health in the context of its Federal Constitution and the corresponding competencies of the respective political spheres and the private sector. Article 196 of the Federal Constitution defines health as a right of all and a duty of the State assured through policies and universal, equal access to the actions and services aimed at health promotion, protection, and recovery. The execution of health actions and services may be performed directly by the Government or through third parties, with the Government retaining exclusive authority for their regulation, oversight, and control. The State implements these actions and services through a regionalized and hierarchical network composed of a unified health system (Sistema Único de Saúde). Health actions and services, therefore, include health assistance or health care, as well as a number of other functions such as health surveillance, which together comprise the right to health.

4.3 The Federal Constitution mandates that the private sector may only provide health assistance. It is not authorized to execute the health-care actions prescribed in article 200 of the Constitution,⁶ which bear no connection to health care. Private institutions may participate in the health system in accordance with its guidelines by means of a public law contract or agreement. As regards the distribution of responsibilities among the political spheres, section VII of article 30 of the Constitution mandates that the municipal governments provide health services to the population with the technical and financial cooperation of the federal and state governments.

4.4 The division of responsibilities, as outlined in the Constitution, indicates that the duties corresponding to the right to health, in its broadest positive dimension, including health care and other health actions and services, are the sole purview of the State, as are their regulation, enforcement, and control. The private sector is authorized to provide health assistance, which encompasses medical and pharmaceutical services, while municipalities retain sole responsibility over the

⁶ According to this provision, it is incumbent upon the unified health system, in addition to other duties, as set forth by the law: to supervise and control proceedings, products and substances of interest to health and to participate in the production of drugs, equipment, immuno-biological products, blood products and other inputs; to carry out actions of sanitary and epidemiological surveillance, as well as those relating to the health of workers; to organize the training of personnel in the area of health; to participate in the definition of the policy and in the implementation of basic sanitation actions; to foster, within its scope of action, scientific and technological development; to supervise and control foodstuffs, including their nutritional contents, as well as drinks and water for human consumption; to participate in the supervision and control of the production, transportation, storage and use of psychoactive, toxic and radioactive substances and products; and to cooperate in the preservation of the environment, including that of the workplace.

health services intended for the general population. The scope of State action, therefore, is far broader than that prescribed for the private sector. Health policies, in other words, are the exclusive domain of the political spheres, as are the actions aimed at monitoring the health assistance services provided by the private sector.

4.5 The State party further explains its duty to regulate, enforce, and control health actions and services. The Ministry of Health establishes the national audit system (Sistema Nacional de Auditoria) and coordinates the technical and financial evaluation of the health system throughout the national territory with the technical cooperation of the states, municipalities, and the Federal District. The national audit system undertakes technical and scientific evaluation, accounting, financial, and asset audits of the health system through a decentralized process. Decentralization is ensured through state and municipal bodies and branch offices of the Ministry of Health in each Brazilian state and the Federal District.

4.6 Private institutions may legally be incorporated into the health system only in the event that service availability is insufficient to guarantee coverage to the population of a given geographical area. The role of private institutions within the health system, therefore, is to provide health assistance, not to perform enforcement, control or regulatory actions, or implement public policies under the system. These institutions are subject to the principles of the health system and the national audit system in respect of evaluation of service quality.

4.7 With regard to the allegations that the State party violated articles 2 and 12 because of its failure to adopt measures aimed at eliminating discrimination against women in the field of health care, directly leading to the substandard medical attention provided to Ms. da Silva Pimentel Teixeira, the State party notes that a number of public policies that address the specific needs of women are under development, particularly those in situations of vulnerability, which affect the equality of men and women. It involves, in fact, a complaint about lack of access to medical care, insofar as the communication does not offer a single link between Ms. da Silva Pimentel Teixeira's gender and the possible medical errors committed. The State party refers to the finding of the technical visit report of the Rio de Janeiro Audit Department which concluded that the failures in the medical assistance provided to Ms. da Silva Pimentel Teixeira did not fall under discrimination against women, but rather deficient and low-quality service provision to the population resulting in the facts described. The State party admits that Ms. da Silva Pimentel Teixeira's vulnerable condition required individualized medical treatment, which was not forthcoming, but claims that the alleged lack of specific medical care was not denied because of an absence of public policies and measures encompassed within the obligation of the State party to combat discrimination against women in all fields. The case describes a potential failure in the medical assistance provided by a private health institution, indicating errors in the mechanisms used to contract private health services and, by extension, the inspection and control thereof, not a lack of commitment on the part of the State to combat discrimination against women.

4.8 The State party argues that this line of reasoning has been confirmed by the State Committee on Maternal Mortality which concluded in the investigative report on maternal death issued by the State Health Secretariat of Rio de Janeiro that Ms. da Silva Pimentel Teixeira's death was non-maternal and that the probable cause of death was digestive haemorrhage. Further, the report contains a summary

of information on her death, including the initial medical care provided, her admission to hospital and her ultimate death, with reference, in addition, to the cause of death, the critical junctures in her treatment, and comments and recommendations. The summary investigative report is the document the State Committee on Maternal Mortality analyses and uses, in conjunction with other reports, to prepare an annual report setting out case studies and the prevention measures implemented to reduce maternal mortality.

4.9 The State party further submits that the present case reveals possible failures in the health assistance provided by the Casa de Saúde e Maternidade Nossa Senhora da Glória, which, according to the National Registry of Health Establishments, is a private for-profit hospital authorized to perform procedures of medium and high complexity. The Casa de Saúde operates through an agreement between the health system and the municipal administrator. In response to the author's allegations that the private institution violated Ms. da Silva Pimentel Teixeira's right to health care and that the municipality of Belford Roxo failed to carry out its duty to evaluate and control the health services provided, the Ministry of Health requested that the National Audit Department of the health system conduct a technical visit to the municipalities of Belford Roxo and Nova Iguaçu, Rio de Janeiro, to gather the facts of the case and determine possible medical negligence or error in the care provided to the expectant mother. The technical visit report recommended forwarding the matter to the Professional Councils (Conselhos de Classe) to verify the facts pertaining to the health professionals (doctors and nurses) who treated Ms. da Silva Pimentel Teixeira and to the National Steering Committee on the Reduction of Maternal and Neonatal Mortality under the Ministry of Health.

4.10 With regard to the legal action filed on 11 February 2003 by Ms. da Silva Pimentel Teixeira's family and others seeking damages, the State party submits that the case entered the judgement phase following oral arguments by both sides on the formal expert report (*laudo pericial*) and, no unjustified delays being foreseen, a judgement on the merits was expected in July 2008. Given the complexity of the civil action, which involves more than one defendant and requires expert proof, the case had not extended beyond the normal time frame for legal actions of this nature.

4.11 The State party rejects the author's allegation that what occurred to Ms. da Silva Pimentel Teixeira reflects the State party's lack of commitment to reduce maternal mortality and that the State party suffers from a systemic failure to protect the basic rights of women. It provides a detailed overview of the various measures implemented in the country to date, as well as of the national machinery in place and national plans for the realization of the rights of women, and in particular women's health, sexual rights, and reproductive rights which attest to the State party's concerted policy to eliminate discrimination against women. The State party recognizes preventable deaths of women of fertile age as human rights violations, and it is for this reason that the federal Government, particularly in the current administration, has made women's health a priority. It further provides data demonstrating a reduction in maternal mortality, particularly in the south-eastern and southern regions, and argues that the present case represents an exception caused by professional negligence, overwork, inadequate infrastructure and lack of professional preparedness. With regard to the existence of discrimination, insofar as the case involves an Afro-Brazilian woman from the urban periphery, the State party highlights the fact that the technical visit report prepared by the audit department of the health system found no evidence of discrimination. However, the State party

does not rule out the possibility that discrimination may have contributed, to some extent but not decisively, to the event. Rather, the convergence or association of the set of elements described may have contributed to the failure to provide necessary and emergency care to Ms. da Silva Pimentel Teixeira, resulting in her death.

4.12 The State party explains that one of the priorities established in the National Plan for Women's Policies involves promoting qualified and humanized obstetric care, particularly for Afro-Brazilian and indigenous women, including attention to unsafe abortions so as to reduce maternal morbidity and mortality. To this end, 18 actions are provided for through 2011, with the Ministry of Health being responsible for implementing them. In 2004, the Ministry of Health launched the National Policy for the Comprehensive Health Care of Women — Principles and Guidelines (Política Nacional de Atenção Integral à Saúde da Mulher — Princípios e Diretrizes) reflecting the commitment to implement health actions that contribute to guaranteeing the human rights of women and reducing morbimortality arising from preventable causes. In respect to the policy's formulation, the State party stresses the participation of the Special Secretariat for the Promotion of Racial Equality (Secretaria Especial de Promoção da Igualdade Racial), the women's movement, the Afro-Brazilian women's and rural workers' movement, scientific associations, professional councils, researchers and academics in the field, health system administrators, and international cooperation agencies.

4.13 Lastly, the State party explains in detail its emphasis on the reproductive cycle and actions taken aimed at ensuring comprehensive and quality health care for pregnant women through adequate prenatal care, specialized services for pregnant women at risk, labour and post-natal care in health units, emergency obstetric treatment, and family planning actions.

4.14 The State party concludes that it has clearly not been indifferent or insensitive to its obligation to implement health policies that provide specific care to women. This effort is not restricted to sexual and reproductive rights, but pays broader attention to women's health, which involves offering care for their overall physical and mental well-being.

Author's comments on the observations of the State party on admissibility and merits

5.1 In the submission of 19 January 2009, the author recalls that the obligation to reduce maternal mortality is one of the key obligations that the right to health entails. The author points out that the State party has recognized that preventable deaths are a serious problem in Brazil and that the failure to address these deaths constitutes a serious human rights violation. However, despite its rhetorical recognition of the problem of maternal mortality, the State party has failed to meet its obligation to guarantee women's right to life and health. The author quotes statistics, including from WHO, according to which over 4,000 maternal deaths occur each year in Brazil, representing one third of all maternal deaths in Latin America. The submission also refers to a United Nations assessment, according to which maternal mortality rates are "considerably higher than those of countries with lesser levels of economic development, and are generally conceded to be unacceptable".⁷ The continued high rates of maternal mortality in the State party

⁷ United Nations country team, *A UN Reading of Brazil's Challenges and Potential*, (2005),

constitute a systematic failure to prioritize and protect women's basic human rights. The preventable maternal death of Ms. da Silva Pimentel Teixeira clearly exemplifies this failure.

5.2 The author reiterates that Ms. da Silva Pimentel Teixeira's death constitutes a violation of the right to life enshrined in article 6 of the International Covenant on Civil and Political Rights, the right to effective protection of women's rights, and the right to health, under articles 2(c) and 12 of the Convention. More specifically, the State party has not ensured access to quality medical treatment during delivery and to timely emergency obstetric care, implicating the right to non-discrimination based on gender and race. The inability of her family to obtain reparations from the State party violates the right to effective protection.

5.3 The author challenges the State party's assertion that the case has not extended beyond the normal time frame for legal actions of this nature, implicitly arguing that the case thereby does not fall within the "unreasonably prolonged" exception to the requirement of exhaustion of domestic remedies. This argument ignores the significant delays imposed by the State party that have effectively barred the petitioner from resolving her case in a domestic court. The family originally filed a petition for material and moral damages on February 11, 2003, just three months after the death. Almost eight years have elapsed since this petition was filed, but judicial activity on the case has been minimal and it is not clear when the court will reach a decision. The State party does not adequately address the unreasonably prolonged delay in its comments, stating only that the case is currently in the judgement phase following oral arguments by both parties and that "unjustified delays in concluding the case" are unlikely. However, it is uncontested that the legal action was filed on 11 February 2003 and that the expert's work was not completed until August 2007, over four years later. Furthermore, contrary to the statement by the State party that a judgement on the merits would be issued in July 2008, such a judgement has yet to occur. The author argues therefore that the failure to reach a conclusion on the merits of the domestic case can no longer be considered reasonable and refer, *inter alia*, to the case of *A.T. v. Hungary*, where the Committee found that a three-year delay in a domestic violence case amounted to an unreasonably prolonged delay within the meaning of article 4, paragraph 1, of the Optional Protocol.⁸ The author further refers to the Committee's statement in the same case that domestic violence cases in the State in question do not enjoy priority in judicial proceedings and argue that this finding is analogous to the situation in the State party, where proceedings involving violence against women and women's health, especially that of women from vulnerable groups — including women from low socio-economic backgrounds and of African descent — are not prioritized in the court system.⁹ Moreover, the State party did not clarify why appointing one medical expert should make the case an exceedingly complex one. The family did not act to protract the lengthy judicial proceedings and the conduct of state and judicial authorities has been the primary reason for the unreasonable prolongation of the case. First, it took the domestic court almost four years to appoint a final medical expert, even though court rules require such an appointment within a period of 10 days. Secondly, even after the eventual completion of the expert work and

para. 40, available from [http://www.unodc.org/pdf/brazil/Final%20CCA%20Brazil%20\(eng\).pdf](http://www.unodc.org/pdf/brazil/Final%20CCA%20Brazil%20(eng).pdf).

⁸ Communication No. 2/2003, *A.T. v. Hungary*, Views adopted on 26 January 2005, para 8.4.

⁹ See Inter-American Commission On Human Rights, *Access to Justice for Women Victims of Violence in the Americas*, paras. 208, 212, 213, 215 and 216 (2007).

statements by both parties, more than one year has elapsed and Brazil has not met its own deadline for declaring a judgement on the merits. Thirdly, Brazil does not address the significant judicial delays in the family's use of the provisional remedy of *tutela antecipada*.

5.4 The author states that unreasonable delay has compounded the already devastating effects of the death for the family. Since the filing of the Communication with the Committee in 2007, the family's already precarious economic situation has worsened. The author, who was the family's caregiver and sole source of income was forced to stop working as a housekeeper due to ill health. She receives no unemployment benefits. The family of five is forced to subsist on the little money that A.S.P.'s great-grandfather gives to them. Despite the psychological trauma of losing her mother at the age of five, A.S.P. has not received the necessary medical and psychological treatment due to financial reasons. She has also developed a speaking disability, and she is having difficulties with her education. The author submits that A.S.P.'s current tragic living situation presents an ongoing violation of Brazil's obligations under the Convention, as well as of its own domestic legal system and the Convention on the Rights of the Child.

5.5 Beyond the framework of admissibility, the author argues that the State party does not address the problem of systemic delays within its judicial system which violate the right to effective protection under article 2, paragraph (c), of the Convention on the Elimination of All Forms of Discrimination against Women. The State party has routinely failed to provide adequate judicial remedies for women from vulnerable groups,¹⁰ such as Ms. da Silva Pimentel Teixeira and her family. Judicial delays are compounded for some of the most vulnerable segments of society; women from lower socio-economic backgrounds and women of African descent face widespread difficulties "in availing themselves of judicial remedies to redress acts of violence and discrimination committed against them".¹¹ For the victim's daughter, these delays mean that her day-to-day life has become yet more precarious. Children who have lost their mothers face an increased risk of dying, are less likely to attend school and may receive less health care in their lifetime. For this reason, children like A.S.P. are legally entitled to special measures of protection under Brazil's domestic law.¹² Instead, the continued inaction of the domestic courts means that A.S.P.'s rights are endangered, risking irreparable harm.

5.6 With regard to the obligations of the State party under the Convention, the author argues that the implementation of the right to health entails certain obligations of immediate effect, including eliminating discrimination and taking steps towards full realization of the right. The requirement that health facilities be available on a non-discriminatory basis is therefore an obligation of immediate effect. The right to health entails specific legal obligations for States parties, which must respect, protect, and fulfil the right. Simply adopting a national health strategy does not suffice to meet the obligations of the State party. That strategy must also be implemented and periodically reviewed, on the basis of a participatory and transparent process.¹³ The author refers to the Committee's concluding observations

¹⁰ See *Access to Justice for Women Victims of Violence in the Americas*, paras. 88-89.

¹¹ *Ibid.*, para. 213.

¹² *Estatuto da Criança e do Adolescente*, arts. 4, 11 and 53.

¹³ The author refers in this respect to General Comment No. 14 of the Committee on Economic, Social and Cultural Rights:

in which it made clear that Brazil's implementation of its national health policies remains insufficient for full compliance with the Convention in the field of maternal health. The Committee noted in particular that Brazil was experiencing problems in implementing the provisions of the Convention at all levels of the Federal Republic in a consistent manner, which were linked to the different degree of political will and commitment of state and municipal authorities. The need for impact assessments of policies through indicators and benchmarks had been discussed by the Committee in reference to Brazil, but Brazil had not addressed any effort to such results-based monitoring.¹⁴

5.7 The distinction between obligations of conduct and obligations of result is critical to understanding the right to health. When States act to implement this right, they not only need to create policies designed to realize the right (an obligation of conduct), but must also ensure that those policies actually achieve the desired results (an obligation of result).

5.8 The author argues that the programmes of the State party have not demonstrated the concrete measures and outcomes as required by the Convention. Although the National Pact to Reduce Maternal and Neonatal Death establishes laudable goals for the reduction of maternal mortality, the high levels of maternal mortality have not meaningfully changed. This is due to at least three factors. First, there are a variety of coordination problems. Secondly, Brazil's health policies need to be backed up by adequate funding which is equitably allocated: although 10 per cent of Government spending is dedicated to health, spending on maternal health is minimal in comparison to other programmes. Brazil spent only \$96 per capita on health as of 2003, a distressingly low figure. Thirdly, policies are not linked to the achievement of results through health indicators and benchmarks. For example, financing of the health system is "not linked to results, which in turn are not sufficiently evaluated".

5.9 The author challenges the reasoning of the State party, according to which the communication does not offer a single link between Ms. da Silva Pimentel Teixeira's gender and the possible medical errors committed and therefore they do not fall within the definition of discrimination set out in the Convention. The author argues that this reasoning overlooks the definition of discrimination described in the Convention and other international human rights treaties. Discrimination includes State actions which have the effect of creating a barrier to the enjoyment of human rights, including the right to the highest attainable standard of health. Under article 1 of the Convention, discrimination against women is defined as "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 ... of human rights". Article 2, paragraph (d), of the Convention requires that States "refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation". To ensure the realization of the right to health, States must provide access to maternal health services in a non-discriminatory manner. This requirement is not formalistic, but rather requires States to address the "distinctive features and factors which differ for women in comparison to men", including the biological factors associated with reproductive health.¹⁵ The denial or neglect of

¹⁴ CEDAW/C/BRA/CO/6

¹⁵ See the Committee's General Recommendations No. 24, paras. 11 and 12 and No. 25 (2004)

health-care interventions that only women need is a form of discrimination against women.

5.10 The grossly negligent health care provided to the victim constitutes a form of de facto discrimination under the Convention. The State party has recognized that Ms. da Silva Pimentel Teixeira's status as a pregnant woman should have assured her expedited and qualitatively better access to medical treatment, but concluded that the errors in Ms. da Silva Pimentel Teixeira's maternal health care were almost entirely unrelated to discrimination. The failure to provide adequate maternal health services for the female population of Belford Roxo constitutes a violation of the right to non-discrimination. The fact that the population of the city is largely of African descent further compounds this violation.

5.11 The State party definition of discrimination is overly narrow because it fails to recognize the distinction between de jure and de facto discrimination. The Committee has addressed this problem in its concluding observations regarding Brazil.

5.12 With regard to the responsibility of the State party at the international level, the author refers to article 2 (e) of the Convention, according to which States parties must "take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise". This obligation is further explained in the Committee's general recommendation No. 24 (1999) on article 12 of the Convention (women and health), which in its paragraph 15 requires States parties to "take action to prevent and impose sanctions for violations of rights by private persons and organizations". The State party has acknowledged that States parties cannot absolve themselves of responsibility in these areas by delegating or transferring these powers to private sector agencies. Jurisprudence from the Committee on the Elimination of Discrimination against Women and the Inter-American Court of Human Rights establish State liability for medical malpractice committed in private health institutions. Significantly, in *Ximenes Lopes v. Brazil*, the Inter-American Commission on Human Rights noted that the petitioner had received mental health care from "a private entity licensed by the Federal Government's Single Health System", although Brazil had not contested liability on these grounds.¹⁶ In the ultimate decision of the Inter-American Court, this public/private distinction was no longer a central issue; the liability of the Brazilian State for human rights violations at the publicly licensed private health facility was assumed.¹⁷ Additionally, in *A.S. v. Hungary*, the Committee stated that Hungary was required to monitor both public and private institutions for violations of human rights under the Convention.¹⁸

5.13 The author challenges the assessment of the State party, according to which Ms. da Silva Pimentel Teixeira's death was non-maternal in nature, resulting from a so-called "digestive haemorrhage". The author emphasizes that the State party relied on an unavailable report from the State Committee on Maternal Mortality to reach such an assessment and that the classification of the death as non-maternal ignores

on article 4, para. 1 of the Convention (temporary special measures), para. 8.

¹⁶ Inter-American Commission on Human Rights, *Damião Ximenes Lopes v. Brazil*, petition 12.237, report No. 38/02, para. 19.

¹⁷ *Ximenes Lopes v. Brazil*, Inter-American Court of Human Rights, series C, No. 149 (4 July 2006).

¹⁸ Communication No. 4/2004, *A.S. v. Hungary*, Views adopted on 14 August 2006, para. 11.5.

clear medical evidence to the contrary. Medical evidence demonstrates that the death resulted from direct pregnancy-related causes and was preventable.

5.14 WHO defines a maternal death as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes”.¹⁹ The author notes that Brazil officially claims to use these official WHO classifications for maternal death,²⁰ but they have been improperly applied to the case.

5.15 Upon Ms. da Silva Pimentel Teixeira’s initial presentation at the health centre on November 11, 2002, medical professionals should have diagnosed and treated her for intrauterine foetal death, based on her urgent symptoms. However, intrauterine foetal death was not diagnosed until November 13, 2002, at which point the treating doctor should have immediately induced delivery. Following delivery of the stillborn foetus much later that day, her symptoms became much worse. Despite the fact that such symptoms should have led to immediate treatment, she did not receive the necessary curettage surgery to remove placental remnants until the following day. Despite the obvious need for immediate treatment and her continually worsening condition, she was not transferred to the general hospital until 49 hours after delivery. Her medical records were not transferred with her and the personnel at the general hospital were unaware that she had recently been pregnant. The failure to transfer her records and to inform medical personnel that she was pregnant constitutes gross negligence. This chain of events clearly demonstrates that Ms. da Silva Pimentel Teixeira’s death resulted from the series of negligent medical interventions following intrauterine foetal death. Her death was therefore caused by obstetric complications related to pregnancy and should be categorized as a direct obstetric death.

5.16 The author argues that the classification of Ms. da Silva Pimentel Teixeira’s death as non-maternal exemplifies the widespread underreporting and misclassification of maternal deaths in the State party. The State party faces recurring problems with respect to the official death certificates designed to document maternal deaths. The information on death certificates tends to be of poor quality or is simply incorrect. There are two specific informational problems related to death certificates, both of which are likely factors leading to Brazil’s misclassification of Ms. da Silva Pimentel Teixeira’s death as non-maternal. First, doctors commonly fail to record on the death certificate the fact that the patient was pregnant or had recently delivered, leading to the misclassification of many deaths as non-maternal. In Ms. da Silva Pimentel Teixeira’s case, there is no mention of pregnancy on her official death certificate. Second, doctors in Brazil often fail to relate the immediate or final cause of death to the patient’s pregnancy, further leading many deaths to be classified as non-maternal. The Ministry of Health has recognized the difficulties of monitoring maternal mortality when doctors do not relate deaths to the patient’s pregnancy. Physicians often declare the cause of death to be a “terminal complication”, or use other medical terms, such as “haemorrhage”, that are not specifically connected to pregnancy. Ms. da Silva Pimentel Teixeira’s pregnancy is not explicitly mentioned on her death certificate and the phrase

¹⁹ WHO, *Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA, and the World Bank*, p. 4.

²⁰ Ministério da Saúde, *Manual dos Comites de Mortalidade Materna* (3rd ed., 2007), p. 12.

“digestive haemorrhage” does not link her pregnancy to her death. In fact, this cause of death statement is incomplete and insufficient according to both international and Brazilian medical standards. The autopsy process did not meet basic medical standards in regard to its thoroughness and its determination of the cause of death. This brief description of the cause of death closely parallels Brazil’s common reporting problems, raising concerns about its reliability. Furthermore, there is scant information to subsequently review in these official documents that would clarify the nature of Ms. da Silva Pimentel Teixeira’s death.

5.17 Lastly, the author claims that although most states in Brazil have maternal mortality committees, which are designed to investigate suspected maternal deaths on both a state and local level, there is no such committee in the city of Belford Roxo, where Ms. da Silva Pimentel Teixeira lived. Her death was investigated by an outside committee, the health system Mortality Committee, which only examined her medical records and did not conduct any further investigation, even though such an investigation is required by the Ministry of Health. Furthermore, the reliance of the State party on the decision of the Mortality Committee raises concerns because the State has refused to submit this decision to the Committee on the Elimination of Discrimination against Women.

Issues and proceedings before the Committee

Consideration of admissibility

6.1 In accordance with rule 64 of its rules of procedure, the Committee shall decide whether the communication is admissible or inadmissible under the Optional Protocol to the Convention. Pursuant to rule 72, paragraph 4, of its rules of procedure, it shall do so before considering the merits of the communication.

6.2 While noting the State party’s argument that the civil claim of the family of the deceased was still pending and that a judgment was expected in July 2008, the Committee considers that the State has not provided adequate and convincing explanations of some of the issues raised by the author, namely the delay in the appointment of medical expert(s) and delay in the trial and judgements, which remain pending up to now. The Committee also notes the lack of a comprehensive explanation why the two applications of *tutela antecipada* presented on 11 February 2003 and 16 September 2003 were rejected. The Committee is of the opinion that the aforementioned delays cannot be attributed to the complexity of the case or the number of defendants and concludes that the eight-year delay that has elapsed since the claim was filed, despite the statement of the State party that it would be decided in July 2008, constitutes an unreasonably prolonged delay within the meaning of article 4, paragraph 1, of the Optional Protocol.

6.3 The Committee considers that the author’s allegations relating to the violations of articles 2 and 12 of the Convention have been sufficiently substantiated for purposes of admissibility. All other admissibility criteria having been met, the Committee declares the communication admissible and proceeds to its examination on the merits.

Consideration of the merits

7.1 The Committee has considered the present communication in the light of all the information made available to it by the author and by the State party, as provided for in article 7, paragraph 1, of the Optional Protocol.

7.2 The author claims that Ms. da Silva Pimentel Teixeira's death constitutes a violation of her right to life and health, under articles 2 and 12, in conjunction with article 1, of the Convention, as the State party did not ensure appropriate medical treatment in connection with pregnancy and did not provide timely emergency obstetric care, hence infringing the right to non-discrimination based on gender, race and socio-economic background. In order to review these allegations the Committee first has to consider whether the death was "maternal". It will then consider whether the obligations under article 12, paragraph 2, of the Convention, according to which State parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, have been met in this case. Only after these considerations will the Committee review the other alleged violations of the Convention.

7.3 Although the State party argued that Ms. da Silva Pimentel Teixeira's death was non-maternal and that the probable cause of her death was digestive haemorrhage, the Committee notes that the sequence of events described by the author and not contested by the State party, as well as expert opinion provided by the author, indicate that her death was indeed linked to obstetric complications related to pregnancy. Her complaints of severe nausea and abdominal pain during her sixth month of pregnancy were ignored by the health centre, which failed to perform an urgent blood and urine tests to ascertain whether the foetus had died. The tests were done two days later, which led to a deterioration of Ms. da Silva Pimentel Teixeira's condition. The Committee recalls its general recommendation No. 24, in which it states that it is the duty of State parties to ensure women's right to safe motherhood and emergency obstetric services, and to allocate to these services the maximum extent of available resources.²¹ It also states that measures to eliminate discrimination against women are considered to be inappropriate in a health-care system which lacks services to prevent, detect and treat illnesses specific to women.²² In the light of these observations, the Committee also rejects the argument of the State party that the communication did not contain a causal link between Ms. da Silva Pimentel Teixeira's gender and the possible medical errors committed, but that the claims concerned a lack of access to medical care related to pregnancy. The Committee therefore is of the view that the death of Ms. da Silva Pimentel Teixeira must be regarded as maternal.

7.4 The Committee also notes the author's allegation concerning the poor quality of the health services provided to her daughter, which not only included the failure to perform a blood and urine test, but also the fact that the curettage surgery was only carried out 14 hours after labour was induced in order to remove the afterbirth and placenta, which had not been fully expelled during the process of delivery and could have caused the haemorrhaging and ultimately death. The surgery was done in the health centre, which was not adequately equipped, and her transfer to the municipal hospital took eight hours, as the hospital refused to provide its only ambulance to transport her, and her family was not able to secure a private ambulance. It also notes that her transfer to the municipal hospital without her

²¹ Para. 27.

²² Para. 11.

clinical history and information on her medical background was ineffective, as she was left largely unattended in a makeshift area in the hallway of the hospital for 21 hours until she died. The State party did not deny the inappropriateness of the service nor refute any of these facts. Instead it admitted that Ms. da Silva Pimentel Teixeira's vulnerable condition required individualized medical treatment, which was not forthcoming due to a potential failure in the medical assistance provided by a private health institution, caused by professional negligence, inadequate infrastructure and lack of professional preparedness. The Committee therefore concludes that Ms. da Silva Pimentel Teixeira has not been ensured appropriate services in connection with her pregnancy.

7.5 The State party argued that the inappropriateness of the service is not imputable to it, but to the private health-care institution. It stated that the allegations revealed a number of poor medical practices attributable to a private institution that led to Ms. da Silva Pimentel Teixeira's death. It acknowledged shortcomings in the system used to contract private health services and, by extension, the inspection and control thereof. The Committee therefore notes 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. In line with article 2 (e) of the Convention, the State party has a due diligence obligation to take measures to ensure that the activities of private actors in regard to health policies and practices are appropriate. In this particular case, the State party's responsibility is strongly anchored in the Brazilian Constitution (articles 196-200) which affirms the right to health as a general human right. The Committee therefore concludes that the State party has failed to fulfil its obligations under article 12, paragraph 2, of the Convention.

7.6 The Committee notes that the author claims that the lack of access to quality medical care during delivery is a systematic problem in Brazil, especially with regard to the way human resources are managed in the Brazilian health system. The Committee also takes note of the argument of the State party that specific medical care was not denied because of an absence of public policies and measures within the State party, as there are a number of policies in place to address the specific needs of women. The Committee refers to its general recommendation No. 28 (2010) on the core obligations of States parties under article 2 of the Convention and notes that the policies of the State party must be action- and result-oriented as well as adequately funded.²³ Furthermore, the policy must ensure that there are strong and focused bodies within the executive branch to implement such policies. The 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. Furthermore, the lack of appropriate maternal health services has a differential impact on the right to life of women.

7.7 The Committee notes the author's claim that Ms. da Silva Pimentel Teixeira suffered from multiple discrimination, being a woman of African descent and on the basis of her socio-economic background. In this regard, the Committee recalls its concluding observations on Brazil, adopted on 15 August 2007, where it noted the existence of de facto discrimination against women, especially women from the

²³ Para. 28.

most vulnerable sectors of society such as women of African descent. It also noted that such discrimination was exacerbated by regional, economic and social disparities. The Committee also recalls its general recommendation No. 28 (2010) on the core obligations of States parties under article 2 of the Convention, recognizing that discrimination against women based on sex and gender is inextricably linked to other factors that affect women, such as race, ethnicity, religion or belief, health, status, age, class, cast, and sexual orientation and gender identity. The Committee notes that the State party did not rule out that discrimination might have contributed to some extent, but not decisively, to the death of the author's daughter. The State party also acknowledged that the convergence or association of the different elements described by the author may have contributed to the failure to provide necessary and emergency care to her daughter, resulting in her death. In such circumstances, the Committee concludes 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.

7.8 With regard to the author's claim under articles 12 and 2 (c) of the Convention that the State party failed to put into place a system to ensure effective judicial protection and to provide adequate judicial remedies, the Committee notes that no proceedings have been initiated in order to establish the responsibility of those in charge of providing medical care to Ms. da Silva Pimentel Teixeira. Furthermore, the civil action, which was filed in February 2003 by the family of the deceased is still pending, despite the contention of the State party that judgement was expected in July 2008. In addition, the two requests for *tutela antecipada*, a judicial mechanism which could have been used to avoid unwarranted delays in the judicial decision, were denied. In such circumstances, the Committee considers that the State party failed to comply with its obligation to ensure effective judicial action and protection.

7.9 The Committee recognizes the moral damage caused to the author by the death of her daughter, as well as the moral and material damage suffered by the daughter of the deceased who has been abandoned by her father and lives with the author in precarious conditions.

Recommendations

8. Acting under article 7, paragraph 3, of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, and in light of all the above considerations, the Committee is of the view that the State party violated its obligations under article 12 (in relation to access to health), article 2 (c) (in relation to access to justice), and article 2 (e) (in relation to the State party's due diligence obligation to regulate the activities of private health service providers), in conjunction with article 1, of the Convention, read together with general recommendations Nos. 24 and 28, and makes the following recommendations to the State party:

1. Concerning the author and the family of Ms. da Silva Pimentel Teixeira:

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 violations against her;

2. General:

(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).

9. In accordance with article 7, paragraph 4, of the Optional Protocol, the State party shall give due consideration to the views of the Committee, together with its recommendations, and shall submit to the Committee, within six months, a written response, including any information on any action taken in the light of the views and recommendations of the Committee. The State party is also requested to publish the Committee's views and recommendations and to have them translated into the Portuguese language and other recognized regional languages, as appropriate, and widely distributed in order to reach all relevant sectors of society.