Inputs to the Committee on the Elimination of Racial Discrimination (CERD)

General Recommendation No. 37 on Racial Discrimination in the Enjoyment of the Right to Health

**AUGUST 2023**

CONTRIBUTIONS FROM:

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FEDERAL PUBLIC DEFENDERS’ GENERAL OFFICE

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Brasília, August 4, 2023.

**OPINION OF THE NATIONAL HUMAN RIGHTS DEFENDERS' SYSTEM OF THE FEDERAL PUBLIC DEFENDERS’ OFFICE (DPU) OF BRAZIL IN CONTRIBUTION TO THE DRAFT GENERAL RECOMMENDATION No. 37 ON RACIAL DISCRIMINATION IN THE ENJOYMENT OF THE RIGHT TO HEALTH, TO BE PRESENTED BY THE COMMITTEE ON THE ELIMINATION OF RACIAL DISCRIMINATION (CERD)**

# 1) BRAZILIAN CONTEXT OF ACCESS TO HEALTH BY BLACK PEOPLE

According to Silvio Almeida, “racism is a **systematic form of discrimination that has race as its foundation**, and that manifests itself through conscious or unconscious practices that culminate in disadvantages or privileges for individuals, depending on the racial group to which they belong”.1 In turn, “racial discrimination” is conceptualized by the author as the “attribution of differential treatment to members of racially identified groups”. 2

It is, therefore, the mechanics of power used as an instrument for maintaining privileges and structures of domination, which is revealed mainly in the institutional sphere, when choosing the form of treatment to be given to each citizen or group of people.

It is to be known that the historical Brazilian social and racial inequality stems greatly from the way the process of colonization occurred. In particular, the process of enslavement and formal abolition of slavery in the country, combined with the unequal distribution of land materialized by the Lands' Law from 1850 and by the issuance of penal norms that criminalized cultural conduct of freed slaves.

The dispute for the occupation of urban areas has built a country structurally marked by the poor distribution of income and criminalization of racially identified groups, factors that have made it difficult to realize the rights of millions of people over the years. Thus, the formal liberation of tens of thousands of African slaves and the subsequent criminalization of their bodies drove them away from opportunities for social mobility and access to rights. These dynamics resulted in processes of “favelization” and institutionalization (in correctional centres and penitentiaries) that impacted on the perpetuation of inter-generational poverty of their descendants.

This way of maintaining privileges within the structure of an essentially unequal society reveals the political choice of the State in selecting certain social and/or racial groups through processes of discrimination, both directly and indirectly.

Indirect discrimination occurs when the formulation of public policies fails to consider the peculiarities that certain groups—usually the most vulnerable ones—typically present, thus resulting in greater disadvantages for these groups compared to the hegemonic ones.

It is important to highlight that, when it comes to ethno-racial policies, addressing human rights requires “confronting the secular process of dehumanisation that is imposed on black people through processes of permanent extermination or through the most varied practices of death in life that mark their trajectories”.3

The difficult social mobility within the political-economic structure of the country “condemns” thousands of people to live on the margins of society, with no knowledge, no access to health, no basic sanitation, transportation, leisure and conditions to claim their most basic rights, whereas the same rights are naturally enjoyed by other social groups.

In this perspective, ALMEIDA points out that “if black people are discriminated against in their access to education, they are likely to

have difficulty getting a job, in addition to having less contact with information about healthcare. Consequently, with lower purchasing power and less access to information, the black population will find it more difficulty not only to get a job, but also to remain in it. Furthermore, poverty, lack of formal education and medical care contribute to reinforce racist stereotypes, such as the ludicrous belief that black people have little propensity to do intellectual work, thus completing a circuit in which discrimination generates even more discrimination”. 4

It is noteworthy that, in 2022, Brazil enacted the Inter-American Convention against Racism, Racial Discrimination and Related Forms of Intolerance, in accordance with the article 5, Paragraph 3 of the Federal Constitution. Therefore, the international regulation began to have the force of an amendment to the Constitution. As for the protection of the right to health, the Convention provides that:

The States Parties undertake to **adopt legislation that clearly defines and prohibits** racism, racial discrimination and related forms of intolerance, applicable to all public authorities as well as to all individuals or natural and legal persons, both in the public and in the private sectors, particularly in the areas of **employment**; participation in professional organizations; **education**; training; **housing**; **health**; social protection; exercise of economic activity; access to public services and other areas; and to repeal or amend any legislation that constitutes or produces racism, racial discrimination and related forms of intolerance.

Internationally, the right to health is also provided for in several international instruments to which the Brazilian State has adhered and internalized, among them:

1. World Health Organization (WHO) - the *right to health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*. The WHO regulations were internalized in the Brazilian system through Decree No. 26,042, of December 17, 1948.
2. United Nations (UN), through article 25.1 of the Universal Declaration of Human Rights (1948) – it *should be guaranteed that every human being has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, housing, medical care and other necessary social services*.
3. Organization of American States (OAS), through the American Declaration of the Rights and Duties of Man - *every person has the right to the preservation of his health through sanitary and social measures relating to food, housing and medical care, to the extent permitted by public and community resources.*

At the internal level, the rights to life and equality are provided for in article *5* of the Constitution of the Federative Republic of Brazil, which ensures protection without distinction of any kind. The right to health is also provided for in the Constitution. It covers the entire population indistinctly and is a duty of the State:

Art. 196 Health is a right of all and a duty of the State, and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal access to actions and services for its promotion, protection and recovery.

To regulate and structure the public health system, Federal Law No. 8,080/90 was issued, providing in its article 2 that “health is a fundamental right of the human being, and the State must provide the indispensable conditions for its full exercise”. This Federal Law also establishes that the State’s duty to guarantee health consists in the formulation and implementation of economic and social policies that aim to reduce the risks of illnesses and other aggravation and to establish conditions that ensure universal and equal access to actions and services for health promotion, protection and recovery.

In addition, article 6 brings that the following provisions are included in the work carried out by the Brazilian Unified Health System:

1. - the implementation of actions related to:
2. **health surveillance;**
3. epidemiological surveillance;
4. the worker's health; and
5. comprehensive therapeutic assistance, including pharmaceutical assistance;
6. - participation in the formulation of the policy and in the implementation of **basic sanitation actions; III**- organization of the training of human resources in the health area;
7. - **nutritional surveillance and dietary guidance;**
8. - collaboration in the protection of the **environment**, including **the labour environment;**
9. - formulation of policy on medicines, equipment, immunobiological and other inputs necessary for health services, including the participation in their production; VII - the control and supervision of services, products and substances of health interest;
10. - the supervision and inspection of food, water and beverages for human consumption;
11. - participation in the control and supervision of the production, transport, storage and use of psychoactive, toxic and radioactive substances and products; X - the increase, in its area of activity, of scientific and technological development;

XI - the formulation and implementation of the blood and blood products policy.

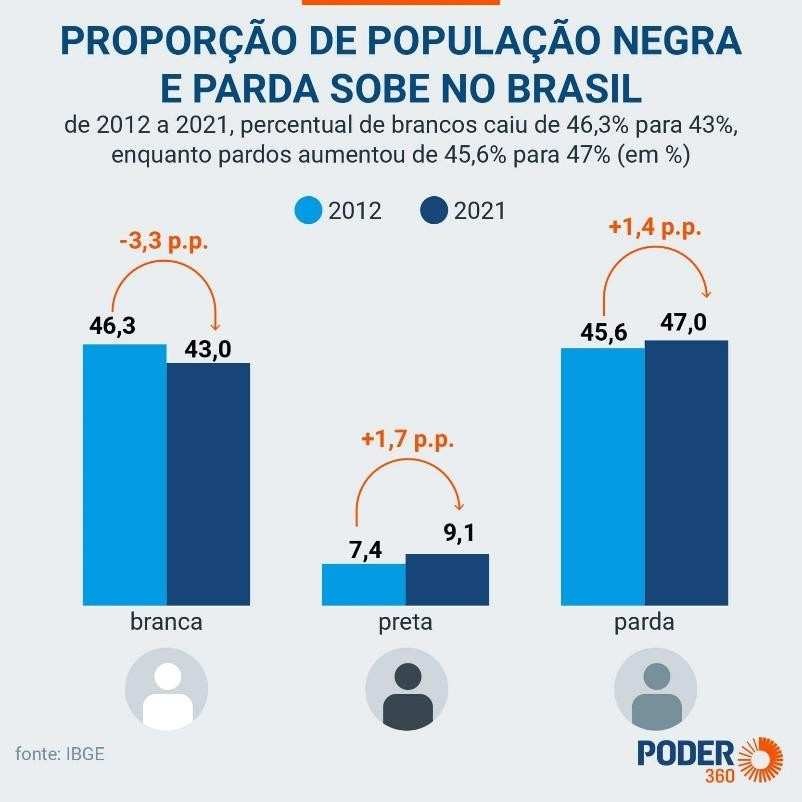
In order to prevent discrimination in the access to the right to health, Law No. 12,288—Statute of Racial Equality—was enacted on July 20, 2010. This law provides that the Public Administration of the Federal Government, the States, the Federal District and the Municipalities are responsible:

to adopt strategic actions towards the black population, consolidating the “National Policy for the Full Health care of the Black Population”, which intends to reduce ethnic inequalities and combat racial discrimination within the Brazilian Unified Health System (SUS); to improve the collection and analysis of disaggregated data according to race, ethnicity, and gender, in order to support further research on racism and health issues; and to include black people’s specific health issues in the educational training offered to health professionals.

Notwithstanding the robust regulation on the right to health in Brazil, the factual reality is in serious disagreement with what the legislative panorama intends.

According to data from the Brazilian Society of Family and Community Medicine, 67% of the Brazilian citizens who depend exclusively on SUS are black (black and brown) 5. This information is reinforced when we analyse the lethality rate of Covid-19 on the black population. According to the Brazilian Institute of Geography and Statistics (IBGE) and the Oswaldo Cruz Foundation (FIOCRUZ), the number of deaths among black people was higher than among white people 6.

According to data from the National Household Sample Survey (PNAD), updated in the 2nd half of 2022, there was a growth in the population of black and brown people in Brazil, when comparing to the non-black population. The numbers correspond to 56% of the Brazilian population7.



Source: Graphic from the website Poder 360⁸

Based on that, one can trace the predominant profile of those who have access to supplemental health insurance. Health insurance plans are mostly reached by white people whereas they are a minority of the Brazilian population.

It should be noted that the pandemic situation is not an isolated fact in the Brazilian health context.

In addition to access to medication, hospital equipment and medical procedures, the right to health also comprises the guarantee of food and nutrition security, basic sanitation, good working conditions, adequate housing and humanized treatments in public institutions.

It is known that housing conditions directly impact people’s health and quality of life. Places at risk of natural disasters, located near dumps, with no basic sanitation or good water quality show higher rates of illness and mortality. In Brazil, there is a greater presence of racially identified groups—such as black people or indigenous ethnic groups—living in these conditions.

According to a recent study by FIOCRUZ Bahia, ethno-racial inequalities directly interfere with infant mortality in Brazil. The study, which was published in The Lancet Global Health in October 2022, recorded 19,515,843 million children born between January 1st, 2012, and December 31, 2018. For the evaluation, data from the Live Birth System (SINASC) were compared with data from the Mortality System (SIM), indicating the presence of 224,213 children under 5 years of age in the SIM.

The study pointed out that “for black mothers, there is a 39% higher risk of life interruption before the age of 5”, especially due to poor nutrition and epidemiological risks9.

In terms of malnutrition, the 2022 Regional Panorama Report on Food and Nutrition Security highlighted that, on an age scale, racial discrimination also affects the mental health of the black population in Brazil. According to data from the Ministry of Health, the suicide rate among black adolescents and young people in Brazil is 45% higher than among the white ones. Data also show that, in recent years, the risk increased 12% for the black population and remained stable among white people10.

For the psychiatrist and black man Frederico Félix, the alarming rate of suicide “derives from a series of inequalities and violences against black people. From lower access to treatments and diagnoses to daily coexistence with discrimination, the black population ends up paying this bill also with their own health.”11 Felix states that “the mental health of black people is intrinsically connected to racism”. It is “a stain that instils in black people a feeling of inferiority, incapacity, and that they will not be able to achieve their goals”.12

In terms of longevity, the black population faces challenges in exercising their right to age. According to data from *Portal do Envelhecimento e Longeviver*, even though the majority of the Brazilian population is black, they only represent 48% of the elderly population, confirming the aphorism “Brazil is black, but its aging is white”13.

When it comes to mortality, obstetric violence gains special prominence, and it is essential to mention the paradigmatic case of Alyne Pimentel, in Brazil. Alyne, a black woman, six months pregnant, resident in the outskirts, 28 years old, married and mother of a five- year-old girl, suffered complications in her pregnancy, having her health condition worsened by medical negligence in the public health system. She eventually had induced labour, giving birth to a stillborn baby, and after several other episodes of medical negligence and lack of hospital structure, she died on the waiting line at a hospital corridor. Therefore, the Report by CEDAW14 Committee on Maternal Mortality presents the decision regarding Alyne’s case, in which this UN committee held Brazil responsible for Alyne’s death due to pregnancy complications, considering that no adequate services to her condition as a pregnant woman were ensured.

The Committee went further in its decision to declare that the Brazilian government’s responsibility is to “take all appropriate measures to eliminate discrimination against women by any person, organization, or company.” In its decision, the Committee adopted a broader definition of discrimination, recognizing the difference between discrimination of right and discrimination in fact, which occurred in Alyne’s case.

Among the causes derived from ineffective services and policies, exemplified in Alyne’s case, it can be mentioned: the lack of access to health equipment and interventions that may save lives in obstetric emergency situations; the lack of hospital beds; the disorganization of health services associated with health professionals’ lack of training to deal with preventable causes of maternal death; and the precarious infrastructure conditions of health services that also contribute to increase the risk of maternal death.

Therefore, the greater dependence of black women on SUS – when compared to the white users – reveals a risk factor aggravated in the context of pregnancy and emergency medical care provided by the public network, corroborating the information that aging in Brazil is white.

And even after Brazil’s accountability to an international body, little practical change has been observed: the case of Andrielli Amanda dos Santos sheds light on the reality faced by black women in accessing public health.

Andrielli was a victim of obstetric violence, structural and institutional racism and intersectional discrimination in the service of assistance to black women experiencing vulnerability. To illustrate the situation experienced by the pregnant woman, Andrieli was overmedicated during labour, became almost unconscious during the procedure, and suffered psychological violence from the health team, who kept saying that her daughter would be given up for adoption. And in fact, shortly after birth, the newborn was separated from her mother, sent to foster care, and fed with industrial products, since breastfeeding was prevented. In addition, parents were prevented from registering their child15. Finally, the young mother underwent a sterilisation procedure without her consent16.

Andrielli is a party to two lawsuits monitored by the DNDH/DRDH System, with the following developments:

1. lawsuit No. 5011470-83.2021.8.24.0091, pending before the Childhood and Youth Court of the Capital's Judicial District - Eduardo Luz - this is an action for terminating parental rights filed by the Federal Prosecution Service against Andrielli Amanda dos Santos, in favour of the **infant Susi dos Santos. After a hearing held on May 9, 2023, it was determined that there should be an uninterrupted resumption of contact between the infant Susi and her mother Andrielli**, with periodic monitoring by the State Government;
2. judicial proceeding No. 5031082-11.2021.4.04.7200, in confidential progress on the 2nd Federal Court of Santa Catarina, is still in the knowledge phase, according to information collected from the referred PAJ.

Despite the policies adopted through the Early Childhood Law and the prioritization of the debate on obstetric violence and its impacts on the rights of women and newborns, according to the survey “Brazilian women and gender in public and private spaces” [11], carried out in 2010 by Perseu Abramo Foundation in partnership with the Social Service of Commerce (SESC), 1 (one) out of every 4 (four) women in Brazil had suffered some type of obstetric violence. In turn, according to information received by the Inter-American Commission on Human Rights, there is an increase in childbirth by caesarean section procedures, which represent 56% of the total population studied. This figure would be extremely high compared to recommendations by the World Health Organization, which indicate an acceptable index to be between 10% and 15%. Thus, these data suggest that Brazilian pregnant women are at greater risk of having their preferences ignored, suffering discrimination, mistreatment, and overmedication, in addition to having no adequate legal protection.

Still regarding women and girls, **period poverty** should also be mentioned. It refers to the lack of adequate menstrual hygiene conditions, caused by the absence of basic items such as feminine pads, tampons and menstrual cups. Since 2014, the United Nations (UN) considers the access to menstrual hygiene, a right that needs to be addressed as a public health and human rights matter.

In this regard, it is worth mentioning PAJ 2021/016-04614, from the 2nd DRDH/RJ, on the investigation of policies to combat period poverty. An Official Letter was sent to the Municipal Health Secretariat requesting information on the supply of sanitary pads to elementary and high school students from the public school system, according to Law 6,603/2019. Also, Public-interest Civil Action No. 5132798-30.2021.4.02.5101 was filed.

In addition, in May 2021, the United Nations Population Fund (UNFPA) and the United Nations Children’s Fund (UNICEF) launched the report “Menstrual Poverty in Brazil: Inequality and Rights Violations.” This report mentions a study indicating that more than 4 million girls do not have access to basic menstrual care items in schools, which often leads to school dropout. It also reveals that 713,000 people who menstruate live with no access to a toilet and/or shower at home.

Difficulties in accessing menstrual hygiene products have physiological, psychological and social impacts on the lives of girls, women, transgender men and other people with a uterus experiencing period poverty. As a result, improvised solutions to contain bleeding, such as the use of unsanitized cloths, newspaper, and even bread, expose women to risks of urogenital infections and to physical and emotional discomforts that violate human dignity.

Regarding the Covid-19 pandemic context, in order to ensure health maintenance and vaccination of the most diverse priority groups, including those experiencing social vulnerability, such as the traditional *quilombola* communities, DPU acted as *amicus curiae* in the Precautionary Measure in the Action Against the Violation of a Constitutional Fundamental Right (ADPF) 742, which was processed before the Federal Supreme Court (STF), obtaining a decision in favour of the *quilombola* population, issued on February 24, 2021, as follows17:

1. formulate, within 30 days, a national plan to combat the Covid-19 pandemic. This plan must consider the specificities of the quilombola population, addressing sanitary measures and protocols aimed at ensuring the effectiveness of their vaccination in the priority phase. Its formulation must also include the participation of representatives from the National Coordination of Articulation of *Quilombolas* Rural Black Communities – CONAQ;
2. set up, within 72 hours, an interdisciplinary and joint working group aimed at debating, approving and monitoring the implementation of such Plan. This group should include members from, at least, the Ministry of Health, the Ministry of Women, Family and Human Rights, the Palmares Cultural Foundation, the Federal Public Defenders’ Office, the Federal Prosecution Service, the National Human Rights Council, the Brazilian Association of Collective Health and representatives of the quilombola communities to be appointed by the National Coordination of Articulation of *Quilombolas* Rural Black Communities;
3. provide, within 72 hours, the inclusion of information on race/color/ethnicity in the registry of Covid-19 cases, ensuring compulsory notification of confirmed cases and wide and periodic publicity;
4. restore, within 72 hours, the content of public information access platforms <http://monitoramento.seppir.gov.br/> and https://[www.gov.br/mdh/ptbr/comunidadestradicionais/programa-brasil-quilombola,](http://www.gov.br/mdh/ptbr/comunidadestradicionais/programa-brasil-quilombola) refraining from deleting public data about population;

Moreover, it was granted the request to suspend “judicial proceedings, notably possessory actions, claims of ownership, actions for taking possession, annulment of administrative processes of titling, as well as the appeals involving those actions, without prejudice to the territorial rights of Quilombola communities” until the end of the pandemic.

The subject of ADPF was also addressed by the DNDH, together with the Regional Human Rights Defenders’ System in Minas Gerais (DRDH MG), in the Proceeding of Legal Assistance (PAJ) 2020/004-01638, which deals with health, food security and emergency support for traditional peoples during the state of public calamity caused by the COVID-19 pandemic.

Finally, we highlight the problematic prison context in Brazil, as well as the country’s several international accountabilities on that.

It is well known that Brazilian prisons remain in an Unconstitutional State of Things, as declared by the Federal Supreme Court in ADPF 347. In this context, one of the main public health problems faced by the black population is within the overcrowded Brazilian prisons.

According to data from the National Council of Justice - CNJ, Brazil has more than 711,000 people arrested in 2023, occupying the third position in the world’s ranking of incarceration18. Among these, 67.5% are black19. Therefore, there is a huge population held in prison facilities, under the custody of the State, with very poor health conditions and quality of life. These circumstances create an environment conducive to the development of serious respiratory diseases derived from poor hygienic conditions. Furthermore, the alarming occurrence of communicable diseases20 such as AIDS, tuberculosis, syphilis, and hepatitis, combined with the lack of budget for the necessary treatment, are factors that jeopardize the health, safety, and life of thousands of black people in Brazil on a daily basis.

# 2) CONTRIBUTIONS OF THE NATIONAL HUMAN RIGHTS DEFENDERS’ OFFICE (DNDH) ON THE PROPOSALS OF GENERAL RECOMMENDATION No. 37

In general, CERD recommends the adoption of legislative measures and related policies, collection of data and statistics, education, training and access to information, accountability of private actors, accountability of Public Authorities, and international cooperation measures.

Considering that these recommendations mostly include initiatives aimed at the promotion of individual and collective human rights, in line with the institutional mission of the Federal Public Defender’s Office, this National Human Rights Defender’s System is aware of the content of the previous draft, agrees with the listed recommendations, and, in contribution to items A, B, C, D, E and F of Topic IV, it proposes:

1. The formulation of public policies and education in rights aimed at the black population, so they can participate and collaborate assiduously in public research carried out internally, following the already known Demographic Census carried out by the Brazilian Institute of Geography and Statistics (IBGE). This should contribute with public authorities to achieve accurate and realistic results and to consequently support the creation of measures that prevent racial profiling in the access to health;
2. The training of health professionals to feed the data of care service users, following what has been implemented in the Unified Health System (SUS) and its National Policy for the Full Health of the Black Population **-** A SUS Policy**,** a booklet developed by the Ministry of Health to combat inequalities at SUS and to promote the health of the black population in a comprehensive way21;
3. The creation of specific service channels so that victims of racial discrimination can report occurrences;
4. The definition of disciplinary/criminal measures in cases of discrimination against black people practiced by health professionals, and also the creation of mechanisms that can monitor, in real time or as quickly as possible, the care service provided to the black population, prioritizing the investigation of aggressors and their legal accountability;
5. The implementation of audits to improve public policies and guidelines regarding, primarily, the health of the black population. Groups experiencing aggravated vulnerability (elderly, children and adolescents, women and imprisoned people) should be prioritized in the allocation of public funds;
6. Continuous Human Rights education of health professionals, aiming at a dignified health care to black people;
7. In terms of reproductive health, a legislative change is suggested in order to classify cases of obstetric violence as institutional gender-based violence, so that it is covered by the rules that deal with women’s rights.

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