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Report - Mistreatment and violence against women during reproductive health care
with a focus on childbirth

The Public Defender of the State of São Paulo presents this Report, in accordance to
the Rapporteur invitation for relevant information to share contributions and inputs
for her report

<https://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/Mistreatment.aspx>

- 1. Please indicate whether in your country there are cases of mistreatment and violence against women during reproductive health care, particularly facility-based childbirth. If so, please specify what kind of cases and describe your country's response and any good practices, including protection of human rights;**
 - a. cases of mistreatment and violence against women during reproductive health care, particularly facility-based childbirth*



According to the Perseu Abramo Foundation, in a research conducted in 2010, 25% of Brazilian women have suffered some kind of violence during childbirth¹.

In June, 2013, the Mixed Parliamentary Commission of Inquiry, that investigated violence against women in Brazil, published its final report². The report considered the data in the dossier made by NGO *Parto do Princípio*, which concluded that Brazilian women are submitted to a series of unnecessary procedures that violate rights.

The dossier also collected registers and stories told by women who had suffered violence during childbirth. Among the violations, it mentioned cases of health facilities denying women's accompany during childbirth - in spite of the Brazilian law n. 11.108/2005, that obligates public health facilities to permit the accompany -, and the restriction of accompany under the condition of fee payments. Considering procedures during labor and childbirth, there were enlisted cases of episiotomy without consent and the "husband stich" in the suture; procedures with "didactic" intentions, to train future health personnel; interventions to verify and to accelerate the childbirth – such as oxytocin drips, amniotomy, uterine fundal pressure, using forceps and other manual procedures; lack of proper explanation and consent to procedures; restrictions on childbirth position and; restrictions on choosing the health facility to give birth. Nonetheless, the dossier noted the high incidence of caesarian sections, in many cases, unnecessary or made for the doctor's convenience. There were also cases of women that were dissuaded from vaginal birth or persuaded to get a caesarian section³.

In addition, stories of cases of mistreatment during childbirth were collected for the dossier. The episodes included the search for availability on health care facilities – considered one of the main sources of maternal mortality -; information omission; neglect; contempt and humiliation; threats and coercion; prejudice and discrimination, including

¹ FUNDAÇÃO PERSEU ABRAMO. Mulheres brasileiras e gênero nos espaços público e privado. August, 2010. Available in: <https://fpabramo.org.br/publicacoes/publicacao/pesquisa-mulheres-brasileiras-e-genero-nos-espacos-publico-e-privado-2010/>

² The final report is available in: <https://www12.senado.leg.br/institucional/omv/entenda-a-violencia/pdfs/relatorio-final-da-comissao-parlamentar-mista-de-inquerito-sobre-a-violencia-contra-as-mulheres>

³ For more information on these episodes, see <https://www.senado.gov.br/comissoes/documentos/SSCEPI/DOC%20VCM%20367.pdf>



racism, xenophobia, homophobia and social stigmatization; harassment and sadism ; blaming; not considering different cultural standards of indigenous people; mistreatment of women during abortion, by assuming it was induced⁴.

Leal et al., in “Obstetric interventions during labor and childbirth in Brazilian low-risk women” (2014), brought the results of a research conducted in 2011-2012 that interviewed 23,894 women. It found out that

A peripheral venous catheter was used in more than 70% of cases, while an oxytocin drip and amniotomy were used in around 40% of cases. Spinal/epidural analgesia was used in around 30% of cases. During childbirth, the supine or lithotomy position, uterine fundal pressure maneuver and episiotomy were used in 92%, 37% and 56% of cases, respectively⁵. (...)

The same article also addressed the high incidence of caesarian section, with the rate of 45.5% among low-risk women – and 89.9% of women who use the private health system.

It is important to address the racial issue within VAW during childbirth. According to the official page of the campaign “SUS sem Racismo” (*Unified Health System without Racism*), promoted by the Ministry of Health and the Secretariat of Human Rights in 2014, 46.2% of white women had companion during childbirth, against 27% of black women and 60% of maternal mortality cases were among black women, against 34% of white women⁶. In addition, a research found out that black women get less analgesic when giving birth and that is associated with social perceptions that there are biological differences between black and white people, in a way that black people would be more resistant to pain⁷.

⁴ For more information on these episodes, see <https://www.senado.gov.br/comissoes/documentos/SSCEPI/DOC%20VCM%20367.pdf>

⁵ LEAL, Maria do Carmo et al. Obstetric interventions during labor and childbirth in Brazilian low-risk women. *Cad. Saúde Pública*, Rio de Janeiro, 30 Sup:S1-S31, 2014. p. S4. Available in: http://www.scielo.br/scielo.php?pid=S0102-311X2014001300005&script=sci_arttext&tlng=en

⁶ See <https://www.facebook.com/SUSnasRedes>

⁷ HOFFMAN et. al *apud* LEAL, Maria do Carmo et al. The color of pain: racial iniquities in prenatal care and childbirth in Brazil. *Cad. Saúde Pública*, Rio de Janeiro , v. 33, supl. 1, e00078816, 2017. p. 10. Available



Furthermore, it is important to notice that obstetric violence can be defined as any act by the doctor, the hospital team, a relative or companion that offends, verbally or physically, pregnant women, during labor or postpartum. In Brazil, it has been common that women under social vulnerability situations, with problematic use of narcotics or that are incarcerated situation are deprived on their right to motherhood.

What has been noticed in Brazil, as well as in many other places in the world, is that it is expected that women should fulfill a reproductive function and, when they do, motherhood is not allowed to all of them. Women under social vulnerability have been deprived on their right to motherhood and their children are taken to a substitute family. There is no guarantee that women who face this situation will have the necessary and full social support they need, even though there are national protocols establishing a diverse procedure.

b. Brazil's response and good practices

The program “Rede Cegonha” (*Stork Network*) was instituted within the Unified Health System by the Ministerial Order n. 1459, in 2011. According to Article 1,

The Stork Network, instituted within the Unified Health System, is a care network that aims to ensure women the right of reproductive planning and humanized pregnancy care, from birth to postpartum, as well as children's right to a safe birth and healthy growing and development, named Stork Network.

In 2017, the Ministry of Health claimed that the Stork Network was then developing actions in 5,488 cities, reaching 2.6 million women. Since its creation, R\$3.1 billion were invested in it. Among the actions of the network, there was the implementation of Normal Childbirth Centers; rise of the number and quality of hospital beds to high-risk pregnant women; capacitation programs for obstetric nurses⁸.

in: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2017001305004&lng=en&nrm=iso

⁸ See <http://portalms.saude.gov.br/acoes-e-programas/rede-cegonha/panorama>



Through the Ministerial Order n. 569, June 2000, the *Prenatal and Birth Humanization Program* (in the Brazilian acronym, PHPN) was instituted. Its main goal is to ensure, to women and their newborns, better quality of access, assistance, coverage and quality of prenatal care, childbirth and postpartum assistance. The PHPN has three main goals⁹, and it was structured under the following principles:

every pregnant woman has the right to access to decent and quality care during pregnancy, childbirth and puerperium;

every pregnant woman has the right to know and has guaranteed access to maternity in which she will be cared for at the time of childbirth;

every pregnant woman has the right to care in childbirth and puerperium and this [care] will be performed in a humane and safe manner, in accordance with the general principles and conditions established in medical practice;

every newborn has the right to neonatal care in a humanized and safe way.

⁹ In a loose translation: “Component I – Incentive to Prenatal Care – [*this component*] aims at stimulating states and cities to accomplish adequate prenatal and pregnant women’s registration, according to principles and criteria established, instituting, to that, funding incentives. (...)

Component II - Organization, Regulation and Investments in Obstetrical and Neonatal Assistance - [*this component*] aims at the development of technical and operational conditions for the organization and regulation of obstetric and neonatal care through structuring the Regulation Centers and mobile systems for prehospital and inter-hospital care; and also funding to public and philanthropic hospitals, members of the Unified Health System. These hospitals should provide obstetric and neonatal care, resulting in increased quality of care and of installed capacity.

Component III - New Systematic Payment of Assistance Childbirth - [*this component*] aims at improving the costing of childbirth care in hospitals that are part of the Hospital Information System - SIH/SUS. To this end, it raises the value and form of remuneration of the procedures in the table relating to childbirth, besides the additional on these values for the hospitals that provide assistance to the pregnant women of the Program and for whom the prenatal care complete has been fulfilled”. (PHPN, 2002, p. 7-9). Available in: <http://bvsm.s.saude.gov.br/bvs/publicacoes/parto.pdf>



The Ministry of Health also published the “Caderneta da Gestante” (*Pregnant Woman’s Handbook*)¹⁰, which contains the information of good practices that must be performed in prenatal, childbirth and postpartum care, including warnings on procedures that are exceptional – such as amniotomy, oxytocin drip and episiotomy. It is supposed to be handed to the pregnant woman on her first medical consult under the Unified Health System.

The National Agency of Supplementary Health Care (in the Brazilian acronym, ANS), the regulatory agency responsible for health insurance plans, published the Resolution n. 368, January 2015, in order to stablish rules to stimulate the normal birth, hence, the decrease of unnecessary caesarian sections within the supplementary health care system. Those rules increase the health-insured consumers’ access to information, allowing them to ask for the percentages of caesarian sections and natural births per healthcare facilities and per doctor.

2. Please specify if full and informed consent is administered for any type of reproductive health care and if these include childbirth care;

Full and informed consent, in Brazilian medical practice, is based on the doctors’ obligations established by the Code of Medical Ethics¹¹. The Code has the rules that must be followed by doctors in medical practices, in general – therefore, must be followed on reproductive health care. In its article 22, there is the prohibition in not obtaining the patient’s consent after one is informed about the procedure to be performed, except for cases of imminent risk of death. Article 24 states that de doctor must observe the right of the patient to freely decides on his/her own well-being. The doctor also cannot use his/her authority to restrict that right. (*é vedado ao médico (...) Art. 24. Deixar de garantir ao paciente o exercício do direito de decidir livremente sobre sua pessoa ou seu bem-estar, bem como exercer sua autoridade para limitá-lo*) Finally, article 31 forbids the doctor on disrespecting the patient’s right to decide freely on diagnosis and therapeutic practices, except for cases of imminent risk of death.

Considering these rules, in childbirth care, full and informed consent is the woman’s declaration expressed on the birth plan, or in an Anticipated Will Declaration,

¹⁰ See <http://portalarquivos.saude.gov.br/images/pdf/2016/marco/01/Caderneta-Gest-Internet.pdf>

¹¹ See <https://portal.cfm.org.br/images/stories/biblioteca/codigo%20de%20etica%20medica.pdf>



registered in a notary's office, after receiving all the information. The birth plan is a document that contains a list of all the procedures that the woman agrees or not on prenatal, childbirth and postpartum care. It must be handled to the hospital chosen for the delivery, as well as to the doctor.

In addition, certain rules were established regarding caesarian sections. The Federal Medical Council (in the Brazilian acronym, CFM) in Resolution n. 2144/2016, determined that

Article 1. It is the right of the pregnant woman, in elective situations, to choose to have a cesarean section, guaranteed by her autonomy, since she has had received all the information in detail about natural birth and cesarean section and their respective benefits and risks.

Sole Paragraph. The decision must be recorded in a Term of Free and Informed Consent, in a language that is easy to understand, respecting the sociocultural characteristics of the pregnant woman.

Article 3. Is it ethical that the doctor performs the cesarean on request, and if there is disagreement between the medical decision and the will of the pregnant woman, the doctor may claim their right of professional autonomy and in such cases, refer the patient to another professional¹².

Ordinance n. 206, March 2016, by the Ministry of Health, stipulates that it is mandatory that the pregnant woman is aware of the potential risks and adverse events related to the procedures or medications for the caesarian section¹³.

Within the supplementary healthcare system, ANS established that, when the pregnant woman prefers the caesarian section, even if there is no clinical recommendation for it, the Term of Free and Informed Consent must have: recommendations

¹² Loosely translated from <https://sistemas.cfm.org.br/normas/visualizar/resolucoes/BR/2016/2144>

¹³ See <http://portalarquivos2.saude.gov.br/images/pdf/2016/marco/31/MINUTA-de-Portaria-SAS-Cesariana-03-03-2016.pdf>



and the risks of the caesarian section, the doctor's identification with one's full name, number of professional registration and signature; the patient's identification with one's full name, ID number and signature¹⁴.

In other cases of reproductive healthcare, such as Assisted Reproductive Technology and sterilization procedures, informed consent is also specifically required. In tubal ligation procedures, the law demands the following criterias: women's consent; minimal age of 25 years old; birth of two children; and, if married, the spouse's consent with the procedure. These legal requirements should be considered abusive, since they limit, in an inappropriate way, women's reproductive autonomy.

3. Please specify whether there are accountability mechanisms in place within the health facilities to ensure redress for victims of mistreatment and violence, including filing complaints, financial compensation, acknowledgement of wrongdoing and guarantees of non-repetition. Please indicate whether the ombudsperson is mandated to address such human rights violations;

To report obstetric violence cases, within the Unified Health System, the woman can send a missive, detailing the violation, to the hospital's ombudsman, with a copy to the Board of Directors and the Health Secretariat. Within the supplementary healthcare system, the letter must be sent to the hospital Board of Directors, with copy to the health insurance Board of Directors, to the ANS and the Health Secretariat.

The report can also be made against the health personnel that perpetrated the violence, through one's professional councils (Regional Medical Council for doctors and Regional Nursing Council for nurses and nursing staff).

¹⁴ See <http://www.ans.gov.br/aans/noticias-ans/sobre-a-ans/2926-nota-da-ans-novas-regras-sobre-parto>



In addition, it is possible to report through the phone numbers 180 (communication channel to report VAW) and 136 (general-ombudsman of the Unified Health System).

When obstetric violence cases go to court, as civil liability cases, it is important to notice that obstetric violence is still an incipient subject. Usually, obstetric violence is only considered within the range of medical errors, therefore, other forms of violence – such as restricting a woman’s companion during childbirth – are not considered in terms of liability. Moreover, medical errors in civil liability cases are considered under fault-based liability, which means, it is necessary that the doctor acted with fault (negligence, recklessness, intention or malpractice).

Such interpretation given by courts makes more difficult to address obstetric violence as a women’s human rights violation, since it restricts the hypotheses that could be considered liable to medical errors only. Besides, the lack of using the term “obstetric violence” in such cases increase the invisibilization of this complex form of VAW, failing to consider completely women’s sexual and reproductive rights and the right to live a life free of violence.

A recent worrisome act by the Ministry of Health also could contribute to the invisibilization of obstetric violence in Brazil. An order published in May 3rd, 2019, stated that “obstetric violence” is a term with “inappropriate connotation, does not add value and impairs the search for humanized care in the *continuum* gestation-childbirth-postpartum”¹⁵. Its impropriety would come from the belief that any health personnel would not have the intention to cause any damage to the patient. This statement could have many negative impacts, since the construction of the obstetric violence concept is the result of the greatest scientific evidence, being incorporated to many states and cities’ legislation. Nonetheless, naming this form of violence is important, because it identifies another form of women’s rights violation, aiming to

¹⁵ Loose translation from the original document. Available in: https://sei.saude.gov.br/sei/controlador_externo.php?acao=documento_conferir&codigo_verificador=9087621&codigo_crc=1A6F34C4&hash_download=3a1a0ad9a9529cf66ec09da0eaa100f43e3a71dadcb400a0033aeade6e480607ee223e8f2fb1395ed3ce25c6062032968378cd9f7a37a4dc6dfb5a3aa708709d&visualizacao=1&id_orgao_acesso_externo=0



attribute a social meaning to it, and, therefore, create instruments to combat this form of violence.

The Federal Prosecution Service already sent a recommendation to the Ministry, considering the multiple cases of obstetric violence in Brazil as well as the international understanding of WHO on violence during childbirth and the concept of VAW in the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women¹⁶. The Public Defenders Offices of São Paulo state and Bahia state and the Federal Public Defenders Office also published a technical paper on the issue, but, until now, the Ministry of Health have not responded yet.

4. Does your health systems have policies that guide health responses to VAW and are these in line with WHO guidelines and standards on this issue, see: 1 | 2

Related to the issues addressed in the guides “Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence - A manual for health managers” and “Responding to intimate partner violence and sexual violence against women - WHO clinical and policy guidelines”, we collected a few documents issued by federal agencies.

“Prevenção e Tratamento dos Agravos Resultantes da Violência Sexual Contra Mulheres e Adolescentes” (*Prevention and Treatment of Resulting Injuries from Sexual Violence against Women and Teenagers*) is a technical norm issued by the Ministry of Health, having its third edition released in 2012. It establishes standards for infrastructure, equipment, human resources and capacitation, sets rules for care and psychological and social support, as well as prophylactic procedures, abortion and evidence collection¹⁷.

The “Norma Técnica para a Atenção Humanizada às Pessoas em Situação de Violência Sexual com Registro de Informações e Coleta de Vestígios” (*Technical*

¹⁶ See <http://www.mpf.mp.br/sp/sala-de-imprensa/noticias-sp/mpf-recomenda-ao-ministerio-da-saude-que-atue-contra-a-violencia-obstetrica-em-vez-de-proibir-o-uso-do-termo>

¹⁷ See

http://bvsm.s.saude.gov.br/bvs/publicacoes/prevencao_agravo_violencia_sexual_mulheres_3ed.pdf



Norm for Humanized Care to People in Sexual Violence Situation with Registry of Information and Trace Elements Collection) was released in 2015, as one of the actions of the federal program “Mulher, Viver Sem Violência” (*Woman, to Live without Violence*)¹⁸. It relates to the implementation of the guidelines established by the Presidential Ordinance n. 7958/2013¹⁹, integrating with the “Política Nacional de Atenção Integral à Saúde da Mulher” (*National Politics of Full Care of Women’s Health*; in the Brazilian acronym, PNAISM).

Regarding **women-centered care**, the Technical Norm for Humanized Care to People in Sexual Violence Situation with Registry of Information and Trace Elements Collection established that, as an attribution to all health facilities, the personnel will, among other actions: welcome people under a violent situation in a humanized way, without prejudices and judgements; guarantee the privacy during the consultation, establishing an environment of trust and respect; keep confidentiality on the information given by the victim or the victim’s legal guardian, only telling other professional or other health services the information that are necessary to guarantee proper care; listen carefully the victim’s story, to evaluate possible risk of death or violence’s repetition; guarantee that there will be a person as reference for attendance through booked consultations.

Regarding **identification and care for survivors of intimate partner violence**, the Technical Norm on Prevention and Treatment of Resulting Injuries from Sexual Violence against Women and Teenagers states that, in such cases, the professional should help the victim to establish a bond of individual and institutional trust to evaluate the violence’s history, its risks, the motivation to break up the relationship, as well as the victim’s social and family resources. To avoid routine enquiry, the health personnel team should create a unified registry containing all the information collected by all professionals involved. The same Technical Norm states that, in cases of intimate partner violence, it is necessary to evaluate the need of care and protection, in a way to guarantee help and shelter to the women and her

¹⁸ A program released by the then-President Dilma Rousseff, in 2013, that aims to integrate and expand the public services for women under violent situation, through articulation between specialized health, justice and public security services, the network of social assistance and promotion of financial autonomy.

¹⁹ This established guidelines for humanized care of sexual violence victims, within public security personnel and health personnel – under the scope of the Unified Health System. See http://www.planalto.gov.br/ccivil_03/_ato2011-2014/2013/decreto/d7958.htm



children, when necessary, and, mainly, after the moment she decides to report her partner or end their relationship.

The **clinical care for survivors of sexual assault** established in the mentioned Technical Norms includes:

a) emergency contraception, with levonorgestrel as a first choice and the Yuzpe method as a second choice. IUD insertion is not recommended due to high risk of genital infection worsen by sexual violence, however, it should be considered for women under WHO's category n. 2 for Yuzpe method, when there is no levonorgestrel available.

b) In cases of suspected or confirmed pregnancy, the women's will to interrupt the pregnancy should be considered. The health personnel should provide the necessary information to present alternatives to pregnancy interruption, such as prenatal care and adoption. The abortion matter will be later approached for more information.

c) HIV post-exposure prophylaxis is recommended until 72 hours after assault and the decision on the prophylaxis should consider the victim's will to do so. The professionals should give proper information and clarify doubts through all the consultation. The adherence term is under a context where the person not only follow the health personnel's orientations, but also understands and agrees with the need of the treatment and its goals, while taking the proper medicines. Counselling is made in order to establish a trust relationship between the victim and the health professional, to facilitate the overcoming of the traumatic episode.

d) In post-exposure prophylaxis for sexually transmitted infections, it is preferable to use parenteral medication (benzathine penicillin + ceftriaxone + azithromycin). In case oral medication is used, it is recommended that it is given until two weeks after the sexual assault. Hepatitis B vaccination does not need further exams, and is recommended to all women victim of sexual violence that are not immunized or that does not know her vaccination history.

e) Regarding psychological interventions, it is recommended that it should start as soon as possible, preferably, since the first consultation, sustained through all care period and for the time it is needed.



f) The Technical Norm on Prevention and Treatment of Resulting Injuries from Sexual Violence against Women and Teenagers states that the clinical, psychological and social care on health facilities should be extended for a period after the first consultation, and it is necessary that the health personnel evaluates its continuity and the referral to other services and health facilities.

Regarding **training of health-care providers on intimate partner violence and sexual assault**, the Technical Norm on Prevention and Treatment of Resulting Injuries from Sexual Violence against Women and Teenagers states that the health professional should understand that such cases are a social phenomenon capable of causing serious injuries to women's health. Thus, activities on collective reflection on gender violence, mainly, sexual violence, the difficulties of its reporting, the role of the health system and its condition as co-responsible on the guarantee of the victim's rights.

According to the Administration Report (2011 - May 2016), of the Special Secretariat of Politics for Women²⁰, between 2013 and 2016, five editions of the course "Atenção Humanizada às Pessoas em Situação de Violência Sexual com Registro de Informações e Coleta de Vestígios" (*Humanized Care to People in Sexual Violence Situation with Registry of Information and Trace Elements Collection*) happened, for capacitation of health personnel within the Unified Health System in hospitals that are references on sexual assault victims care, as well as public security personnel. Through the five editions, 376 professionals received a certificate within 60 hospitals.

Regarding the **report of intimate partner violence**, Law n. 10778/2003²¹ establishes that it is mandatory that violence against the women that are under care of public and private health services. Article 1, paragraph 1, states that violence against women is any action or conduct, based on gender, also due to discrimination or ethnical inequality, that causes death, damage or physical, sexual or psychological pain to women, in public or private environment. According to the Ministerial Ordinance n. 1968/2001²², it is

²⁰ See <https://pt.org.br/wp-content/uploads/2018/08/relatorio-de-gestao-spm.pdf>

²¹ See http://www.planalto.gov.br/ccivil_03/LEIS/2003/L10.778.htm

²² See http://bvsmms.saude.gov.br/bvs/saudelegis/gm/2001/prt1968_25_10_2001_rep.html



mandatory that, in cases of suspected or confirmed maltreatment, the Unified Health System health personnel must notify the local childcare service.

The Technical Norm for Humanized Care to People in Sexual Violence Situation with Registry of Information and Trace Elements Collection also establishes that **infrastructure, equipment and supplies** should be adequate for service, as well as **qualified human resources**. To do so, the responsible for healthcare in states, cities and in the DC should implement and guarantee sustainability to actions and the largest amount possible of reference services. As for **accountability**, the same Technical Norm states that managers and directors of health facilities have to implement permanent evaluation mechanisms.

Regarding **budget and financing**, the Administration Report aforementioned stated that the actions towards women's health are under the responsibility and budget of the Ministry of Health. Through the Ministerial Ordinance n. 2415/2014²³, article 4, the budget for multiprofessional support on full care to people subjected to sexual violence was set within the "Budget Plan 0004 – Stork Network" of the Ministry of Health.

Considering all the information above, it is possible to state that Brazilian policies are partially in line with WHO guidelines. However, it is necessary to address the fact that there are some difficulties when operationalizing such programs and rights are violated because of the current legislation. The main issue on this matter is abortion.

Abortion in Brazil is a crime, except on cases of rape, on cases when it is necessary to save the woman's life or when the fetus has anencephaly. When the pregnant woman provokes the abortion, or consents that others do so, the penalty is one to three years of prison. A current worrisome matter is the voting of the Proposta de Emenda à Constituição n. 29 (proposal to amend the Constitution n. 29; in the Brazilian acronym, PEC), that aims to establish, within Brazilian Constitution, article 5, the "inviolability of life since conceiving". If approved, abortion will be a crime under any circumstance.

Abortion being a crime is a consequence of how gender stereotypes shape the legislation. There is the perception that women play a "reproductive role"

²³ See http://bvsmms.saude.gov.br/bvs/saudelegis/gm/2014/prt2415_07_11_2014.html



in society, alongside with the lack of consideration of their free will over their own bodies. The 2018 edition of the “Atlas da Violência”²⁴ (*Atlas of Violence*) considered voluntary abortions as “reproductive femicide”, since the deaths happen due to politics of control of women’s bodies and the suppression of rights and freedom.

According to the Human Rights Watch, “more than 300 abortion-related criminal cases were registered against women by the courts in 2017”²⁵. In addition, the context of abortion in Brazil is the following:

*Hundreds of thousands of women and girls have abortions in Brazil each year, most clandestinely. Estimates are that by age 40, approximately one in five Brazilian women has terminated a pregnancy. According to Health Ministry data published in Folha de São Paulo, more than 2 million women were hospitalized for complications from miscarriage or abortion from 2008 to 2017, three-quarters of them from induced abortions, and more than 4,400 women died between 2000 and 2016 from miscarriage and abortion-related causes*²⁶.

Nonetheless, black women has 2.5 more chances of dying during an abortion procedure than white women. This relates to the intersectional issue of gender, race and class, since most of black women also do not have financial conditions to pay for safe abortion, resorting to unsafe methods that are prone to cause further health complications²⁷. The high mortality rate also relates to the fact that they tend to do more abortions: the rate among black women is 3.5%, whilst among white women is 1.7%²⁸.

In this sense, abortion remains a highly discussed matter within policies on women’s reproductive rights. A reform on current legislation is needed, in order to

²⁴ A research issued by the Institute for Applied Economic Research (in the Brazilian acronym, Ipea) and the Brazilian Forum on Public Security (in the Brazilian acronym, FBSP), that analyzes high indicators of violence in Brazil. Available in: https://www.ipea.gov.br/portal/images/stories/PDFs/relatorio_institucional/180604_atlas_da_violencia_2018.pdf

²⁵ See <https://www.hrw.org/news/2018/07/31/brazil-decriminalize-abortion>

²⁶ Ibid.

²⁷ See <https://azmina.com.br/reportagens/precisamos-falar-de-aborto-e-como-ele-mata-mulheres-negras/>

²⁸ Ibid.



prevent the death of thousands of women who still do not have the right to make decisions over their own body and lives.

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