Advocacy for Access to Safe Legal Abortion: Similarities in the Impact of Abortion's Illegality on Women's Health and Health Care in PERNAMBUCO, BAHIA, MATO GROSSO DO SUL, PARAIBA, and RIO DE JANEIRO

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Summary

This publication aims to offer an overview of the reality of unsafe abortion in Brazil, based on data collected through research on the magnitude of unsafe abortion and the impact of its illegality on women's health and on the quality of reproductive health care in five Brazilian states: Pernambuco, Bahia, and Paraíba, in the Northeastern region; Mato Grosso do Sul, in the Central-Western region; and Rio de Janeiro in the Southeastern region. The methodology used a combination of quantitative and qualitative data. Overall, the abortion care situation is similar in the various states researched, where there is predominantly inhumane treatment that discriminates against, stigmatizes, and punishes the women who undergo abortion. Data from Bahia and Mato Grosso do Sul, states with a high percentage of black and indigenous women, respectively, enriched our work, showing how race/ethnicity and social class associate the issue of clandestine abortion with the vulnerability of social groups, making it also a social justice problem.

Introduction

This publication aims to offer an overview of the reality of unsafe abortion in Brazil, based on data collected on the magnitude of unsafe abortion and the impact of its illegality on women's health and on the quality of reproductive health care in five Brazilian states: Pernambuco, Bahia, and Paraíba, in the Northeastern region; Mato Grosso do Sul, in the Central-Western region; and Rio de Janeiro in the Southeastern region. The proposed research collected quantitative data, through which we estimated the number of abortions in these states based on hospitalizations for treatment of abortion in public healthcare facilities, data which were brought to life through researchers' observations, testimonies from healthcare providers and stories of women's experiences in healthcare facilities.

The work was carried out in the five states by developing dossiers on unsafe abortion with the objective of giving visibility to abortion care and denouncing human right violations, including access problems, poor quality of care, and biases and discrimination against women who have abortions. The information produced had the objective of contributing towards advocacy actions in these states and nationwide, to promote changes in the legal field and improve abortion care services provided by Brazil's Unique Health System (Sistema Único de Saúde, or SUS).

We sought to present evidence that abortion is a serious public health and social justice problem of great repercussions and with a complex chain of issues, including ethical and legal issues. The proposal aims to subsidize and discuss more in depth the political debate on the need to revise the current criminal law on abortion in Brazil. In addition, it aims to contribute towards qualifying abortion care, reducing stigma and stimulating providers, regardless of their moral and religious biases, to maintain an ethical position and uphold women's human rights. We also call to the public's attention its responsibility to uphold those rights.

The work was carried out by Ipas Brazil and Grupo Curumim, in partnership with women's organizations in the five states. This action is part of the series of strategies articulated nationwide through the coalition of Brazilian Initiatives for the Right to Safe, Legal Abortion, which were developed based on local actions in each state, in partnership with the National Front Against the Criminalization of Women and for the Legalization of Abortion (Frente Nacional Contra a Criminalização das Mulheres e pela Legalização do Aborto), the National

Feminist Network for Health and Sexual and Reproductive Rights (Rede Nacional Feminista de Saúde, Direitos Sexuais Reprodutivos – RFS), and Brazilian Women's Articulation (Articulação de Mulheres Brasileiras – AMB). The dossiers were developed in collaboration with Mário Monteiro, from the Institute of Social Medicine of the State University of Rio de Janeiro (UERJ), who systematized quantitative data about the magnitude of abortion in the five states, which are available through the SUS information system.

We hope that this research will contribute to strengthen the commitment of public administrators, parliamentarians, healthcare providers, communications professionals, legal professionals, and social movement advocates, and encourage the commitment of new individuals and social subjects by changing the worrisome reality of abortion in Brazil.

Objectives

- Contribute to give visibility to unsafe abortion as both a public health and women's human rights issue, addressing abortion care in the context of sexual and reproductive rights;
- Stimulate debates on the reality of unsafe abortion and the impact of its illegality on women's health and lives, and on the health services provided by Brazil's Unique Health System (SUS);
- Produce theoretical and empirical justification, in order to contribute towards the design and implementation of effective public policies, developing recommendations to subsidize the actions of parliamentarians and public administrators;
- Sensitize representatives of the legislative and executive branches, public administrators, healthcare providers, social control authorities, social movements and society in general, with respect to unsafe abortion issues;
- Subsidize advocacy actions to change Brazil's restrictive and punitive laws, strengthening the articulation and mobilization of different social sectors, including parliamentarians and public administrators.

Methodology

Dossiers were developed in each of the five states, using a similar methodology, protecting the particularities defined by each local group with respect to the different situations. Data were collected in the five states: in the capital and in large municipalities, such as Recife and Petrolina (PE); Salvador and Feira de Santana (BA); João Pessoa and Campina Grande (PB); Campo Grande and Corumbá (MS); Rio de Janeiro, Duque de Caxias and Nova Iguaçu (RJ), between 2008 and 2010 (see Annex 1). The criteria for selecting the municipalities were based on each state's capital and largest municipalities. The selection of maternity hospitals and general hospitals in each municipality was related to the existence of a high volume of abortion-related hospitalizations, as well as to greater access to data, the political open-mindedness of local administrators, and an understanding of the project's importance.

The methodology utilized three research mechanisms: consulting secondary sources of DATASUS and academic research studies; visits to maternity hospitals and general hospitals selected in each city; and direct, semi-structured interviews with women who underwent abortion procedures, healthcare providers, and administrators. In

Salvador, we accessed testimonies from relatives of women who died as a result of abortion, research reports developed by the Program of Gender and Health Studies of the Collective Health Institute of the Federal University of Bahia (MUSA/ISC/UFBA).

Secondary data were collected from studies and research published on the childbirth and abortion situation and from records of abortion-related hospitalizations and deaths, obtained by consulting the MOH's Health Information System (SIS/SUS -- DATASUS), especially the sub-systems: the Mortality Information System (SIM) and the Hospital Information System (SIH) in state and municipal ministries of health, as well as reports of State Committees for the Prevention and Control of Maternal Deaths.

In Mato Grosso do Sul, due to its location bordering with Bolivia and Paraguay, it was necessary to look at the specificities of the triple border configuration. Also in that state, we searched for information about the indigenous population, as this is the second state with the largest indigenous population in the country and the highest number of indigenous users of public services. The research team encountered greater difficulty to access data, as the agencies prohibited access alleging that the data requested were available in public data banks and accessible on the Internet (DATASUS) or stating that the bureaucratic system made it impossible to obtain these data. Ethnic-racial issues also marked researchers' perceptions in Bahia, who emphasized racial cutbacks, focusing on black women's health situation, as it was inevitable to avoid that reality as a consequence of racism.

Researcher Mário Monteiro, from the Institute of Social Medicine of the State University of Rio de Janeiro (IMS/UERJ) collaborated with the dossiers, analyzing quantitative data from the different states, which were available in DATASUS, and calculating estimates based on abortion-related hospitalizations, using the method proposed by the Alan Guttmacher Institute (AGI, 1994).

The research team visited the maternity hospitals to observe and analyze the provision of abortion care services and to conduct interviews with clients and healthcare providers. The methodology anticipated a visit to the maternity hospitals from representatives of the feminist movement and parliamentarians and/or advice as to how to compare data, promote advocacy actions, and sensitize administrators and parliamentarians. The visits were preceded by intense meetings to develop a publicity strategy to ensure dissemination about these visits, creating a political event. In the state of Paraíba, it was not possible to engage parliamentarians due to the local reality of the state and federal benches, which are not very open-minded and show little interest in topics related to women's health and reproductive rights.

In the state of Mato Grosso do Sul, only one state representative received the researchers in his office to hear their presentation of the research results. Unfortunately, it was not possible to hold a public hearing on the subject with the Legislative Assembly of that state. Dissemination of research data in the local media was done in connection with the trial of the healthcare providers accused of being involved in performing illegal abortions in a family planning clinic.

Qualitative data made it possible to show abortion clients' experiences in healthcare facilities, unveiling the plot of medical assistance and the stigma surrounding the different professional practices and presenting indicators of inhumane treatment based on statements made by the women and healthcare providers. In addition to interviews, on-site observations were carried out, which allowed a deeper understanding of women's journey in

health facilities and of the care they receive. In the state of Paraíba, they used data collected in previous studies, especially field diary entries resulting from ethnographic observations.

Unsafe Abortion in Brazil: Reflections on Social Injustice in Public Health

Legal restrictions on abortion in Brazil [1] make it difficult to understand the complexity of this topic, which involves legal, economic, social, psychological, ethical, gender and race issues, directly impacting women's lives and autonomy, as well as visualizing its actual magnitude. Despite the criminalization of abortion, women of reproductive age of all social classes, educational levels, races/ethnic groups, religions and age groups, resort to unsafe abortion (DINIZ & MEDEIROS, 2010).

However, the consequences of clandestine abortion vary depending on the woman's social position, producing greater risks to the lives of women who are poor, black, young, with low educational levels and little access to quality health care, for which reason abortion can be considered an issue of social injustice in Brazil (MONTEIRO & ADESSE, 2007). In Bahia, the maternal mortality indicators [2] confirm the perverse nature of the criminalization of abortion as a factor that supports social injustices, which are in turn fed by the association among discriminations based on gender, race, and socio-economic vulnerability. In Salvador, a municipality where 82% of the female population is black, unsafe abortion was the primary cause of maternal mortality throughout the 1990s, unlike the other Brazilian capitals, where the primary cause was hypertension (SIMONETTI et al, 2008).

AYoung women's greatest vulnerability is related to the fact that many adolescents and young women have neither material resources nor appropriate information. They suffer the effects of taboo, myths, and moral and religious beliefs surrounding sexuality, which cause embarrassment and make it difficult to seek family planning services and STI/AIDS prevention services. In addition, they usually have less power in relationships with men, especially when they are much younger, and they are more likely to suffer abandonment and social rejection due to an unintended pregnancy, abortion and its potential complications (MENEZES & AQUINO, 2001).

It is well known that criminalization does not lead to the elimination or reduction of induced abortions, besides significantly increasing the risks of sterility and maternal morbidity and mortality.

Based on data from the International Planned Parenthood Federation (2007), disseminated in a report titled "Death and Denial: Unsafe Abortion and Poverty," women who are most damaged by clandestine abortion live in the world's poorest countries, where maternal mortality rates attributable to unsafe abortion are greater than those in developed countries. According to the document, in Latin America there are approximately 17 million unsafe abortions, while Brazil is responsible for 9.5% of maternal deaths.

Research indicates the existence of a direct relationship between legal restrictions of abortion and the high number

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[1] Brazil's 1940 Penal Code considers abortion a crime, except when the pregnancy threatens the woman's life or when it is the result of rape. Currently, it is possible to request court authorization for cases of fetal malformation incompatible with extra-uterine life.

[2] Maternal morbidity and mortality indicators are used to evaluate a population's health conditions.

of maternal deaths and sequelae resulting from unsafe abortion, as the ban leads to unsafe abortion procedures. In South Africa, after the legalization of abortion in 1996, maternal death rates were reduced by 91% in just five years. In Romania, when abortion was banned, abortion-related deaths increased. [3] When legal restrictions were lifted, the country experienced a drastic reduction in the number of deaths resulting from abortion. Experiences reported in countries where abortion was legalized often reveal that the existence of unrestricted family planning policies and legal abortion services, together with ensuring sex education and information, promotes a significant reduction in abortion rates.

A research study conducted in Uganda, Africa, showed that treating unsafe abortion complications in hospitals can cost 10 times more than offering elective abortion procedures in primary health care facilities (BART JOHNSTON, GALLO AND BENSON, 2007).

The World Health Organization notes that 21% of maternal deaths (nearly 6,000 per year) in Latin America are caused by unsafe abortion complications, as a result of restrictive abortion laws (RFS, 2001). In Brazil, maternal mortality remains among the first 10 causes of mortality of females between 10 and 49 years of age (BRAZIL, 2009). In the last three decades, there was a significant decline in infant mortality and a reduction in women's fertility, resulting in a lower number of births, thus lower demand for obstetrical beds. However, maternal mortality remained at levels considered high (LAURENTI et al., 2003).

According to the Ministry of Health (BRAZIL, 2007), abortion is the country's fourth cause of maternal death due to hemorrhages and infection. A research study conducted by Laurenti et al. (2003) in every capital and in the Federal District, identified a correction factor of 1.4 to be applied to the maternal mortality ratio, showing a corrected value of 74 deaths per 100,000 live births in the country, due to underreporting, unlike what occurs in some countries where abortion is legal and the abortion-related maternal mortality ratio (MMR) is reduced or nonexistent. Between 1995 and 2000, statistics from several European countries showed MMRs of less than 10 deaths per 100,000 live births, with abortion performed in safe conditions and not considered a significant cause of death (ALEXANDER et al., 2003).

TIn the past few decades, there has been a trend towards a reduction in Brazil's abortion-related maternal mortality rate, despite underreporting of these deaths, which could be attributed to widespread use of misoprostol for medical abortion, a decline in fertility, and an increase in access to contraceptive methods. [4] Still, there has been a decrease in the mean age of women who have died and regional inequalities persist, as is evidenced by less reduction of MMRs in northeastern states. It is also in this region where abortion-related deaths gain more importance among the causes of maternal death (REDE FEMINISTA DE SAÚDE, 2003).

In 1994, the Alan Guttmacher Institute (1994) published the results of an important research study about unsafe abortion in Latin America, including Brazil, with national and international repercussions. The study was significant because it developed a methodology to estimate the number of abortions based on official data

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[3] In countries like South Africa and Romania, where abortion was legalized, women stop dying. (Sources: Dramatic decline in abortion mortality due to the Choice Termination of Pregnancy Act, South African Medical Journal, 2005; Commentary: The public health consequences of restricted induced abortion – Lessons from Romania, American Journal of Public Health, 1992).

[4] Especially the widespread distribution of oral contraceptives, injectables, and male condoms.

on hospitalizations in public healthcare facilities. By 1991, researchers estimated a total of 1,443,350 unsafe abortions in Brazil, and an annual rate of 3.65 abortions per 100 women between the ages of 15 and 49.

Besides being a probable cause of death, the clandestine nature of abortion makes the process more difficult, from the medical diagnosis to the appropriate recording of unsafe abortions in patients' medical charts (RFS, 2005). It is estimated that each year between 729,000 and 1.25 million unsafe abortions occur in Brazil, according to a research study on abortion, a serious public health and social justice problem (MONTEIRO and ADESSE, 2007), based on SUS's hospitalization data for 2005. In that same study, the authors estimated an average of 1,054,243 unsafe abortions annually in Brazil (MONTEIRO and ADESSE, 2007).

The National Abortion Research Study (PNA) [5] collected data on abortion in urban Brazil, in 2010, through random household sampling. The research combined two survey techniques—the ballot box technique and questionnaires filled out by interviewers—with a stratified sample of 2,002 literate women between the ages of 18 and 39. The PNA indicates that abortion is so common in Brazil that, by the age of 40, more than one out of every five women have already had an abortion. Typically, abortion is performed during the woman's reproductive years, that is, between 18 and 29 years of age, and is more common among women of lower educational levels, a fact that may be related to other social characteristics of women with low educational levels (DINIZ and MEDEIROS, 2010). Religion is not an important factor to differentiate between women with respect to performing abortion. Reflecting on the country's religious composition, the majority of women who had abortions were Catholic, followed by Protestants and Evangelists, and finally by women of other religions or without religion (DINIZ and MEDEIROS, 2010).

Half of the cases used medications [6] to induce the last abortion. Considering that most women have a low educational level, it is likely that the other half of the women, who did not use medications, undergo abortions in riskier conditions (DINIZ and MEDEIROS, 2010). This means that procedures performed without appropriate assistance, unsafely and in an environment that does not conform to minimum medical standards, with potential post-abortion complications, including hemorrhage, infection, infertility, and death. With the use of medications or riskier methods, some cases arrive at public maternity hospitals as incomplete abortions or infected abortions. The PNA calculated a high number of post-abortion hospitalizations, which took place in almost half of the cases.

A survey conducted by Araújo and Adesse (2007) demonstrated an increase in adolescent and adult women's use of misoprostol for medical abortion. This medication, indicated for gastric problems and more recently released by the National Agency of Health Vigilance (ANVISA [7]) for hospital use in obstetrics, has been reducing the number of infected abortions, which was confirmed by the providers interviewed or during visits to healthcare facilities in Bahia.

Data from DATASUS show that post-abortion sharp curettage (PASC) is the second most common obstetrical procedure performed in SUS in-patient facilities nationwide, with nearly 220,000 hospitalizations for abortion

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5 Conducted by the University of Brasilia (UNB) in partnership with the Institute of Bioethics, Human Rights and Gender (ANIS), financed by the National Health Fund.

6 Misoprostol, known as Cytotec®, is reported by the PNA authors as the most commonly used medication for termination of pregnancy.

7 See ANVISA's Decree No. 344/98.

care in 2007, with or without complications (BRAZIL, 2007). There appears to be a decrease in this number, as the Parliamentary Commission of Inquiry on Maternal Mortality (2001) reported 250,000 hospitalizations per year. Post-abortion sharp curettage was the most common surgery in Brazil's Unique Health System (SUS) from 1995-2007, according to a survey conducted by the Instituto do Coração (InCor) of the University of São Paulo[8] (TOLEDO, 2010).

Manual vacuum aspiration (MVA) is a procedure instituted by Brazil's Ministry of Health and recommended by the International Federation of Gynecology and Obstetrics (FIGO) and by the World Health Organization (WHO). Decree No. 569/2000 of the Ministry of Health established MVA as the most humane and effective procedure for treatment of incomplete abortion. Decree No. 48/2001 (included in the SUS table) defines it as the procedure that requires the shortest hospital stays (average time of 6 hours occupying an obstetrical bed) and with the least amount of risks for clients, at an average cost of R$129.57 for hospitalization in the states of Paraíba, Rio de Janeiro and Mato Grosso do Sul. In comparison, post-abortion sharp curettage is a medium-complex procedure, which requires anesthesia, involves greater risk of infection, longer hospital stays (an average of 36 hours), has an average cost of R$189.95, which burdens SUS and forces the women to remain at the facility for longer periods of time.

If adopted as a routine procedure, the MVA technique would ensure high efficacy for uterine evacuation, shorter hospital stays for women, fewer pain control resources, less incidence of complications, among other benefits. The impact of a PASC in a woman's life is greater in terms of risk for her health, time spent away from her family and her work, as well as the costs it represents for the health system. The costs for SUS can be estimated, taking into account the difference in value for each procedure, adding the amount of days the women remain at the facility while waiting to undergo the procedure, which burdens the system with the occupation of beds, food and medication costs, and the availability of healthcare professionals.

Leveraging Legal Frameworks to Ensure Women's Human Rights

The legalization of abortion and access to services in a dignified manner are included in the feminist movement's agenda as part of the struggle for women's comprehensive health care in the last three decades. In recent years, abortion care has been monitored by the feminist movement, researchers and administrators committed to improving abortion care in Brazil.

International agreements signed at UN conferences have contributed towards driving the adoption of sexual and reproductive health policies in the country and the debate on the need to revise punitive abortion law in Brazil, in the context of women's human rights. The 1984 Convention for the Elimination of All Forms of Discrimination against Women (CEDAW, 1998) was a framework for defending women's human rights, supporting the political action of women's movements at a time when many Latin American countries were achieving democratic regimes after military dictatorships. In 1993, the International Human Rights Conference in Vienna collaborated to establish women's rights as an indivisible part of human rights and ensure the commitment of the signatory

[8] http://www.ccr.org.br/a_noticias_detalhes.asp?cod_noticias=10790

countries. The Committee that oversees the Convention on the Elimination of All Forms of Discrimination against Women established in its General Recommendation No. 24: "When possible, legislation criminalizing abortion should be amended to remove punitive provisions imposed on women who undergo abortion" (CEDAW, 1998).

In July 2007, CEDAW recommended to the Brazilian government that it "continue its efforts to enhance women's access to health care, in particular to sexual and reproductive health services" and that it "expedite the review of its legislation criminalizing abortion with a view to removing punitive provisions imposed on women who undergo abortion, in line with general recommendation 24 and the Beijing Declaration and Platform for Action." (CEDAW, 2007)

Recommendations from the 1994 International Conference on Population and Development (ICPD) in Cairo, and the 1995 Fourth World Conference on Women (WCW) in Beijing, and +5 versions consolidated the concepts of sexual and reproductive rights in an international context. International documents originating from these conferences—the Cairo Program of Action and the Beijing Platform for Action—are guidelines for governmental action in the area of sexual and reproductive health. Paragraph 8.25 of the ICPD report states "In circumstances in which abortion is not against the law, such abortion should be safe." (RFS, 2003). Paragraph 106k of the 1995 Beijing Platform for Action states that governments should "consider reviewing laws containing punitive measures against women who have undergone illegal abortions."

These conferences support the language in the Ministry of Health's National Policy on Sexual and Reproductive Rights (BRAZIL, 2005a) and the Technical Guidelines for Prevention and Treatment of Damage Resulting from Sexual Violence against Women and Adolescents (MINISTRY OF HEALTH, 1999 and 2005b), which instituted SUS's provision of legal abortion services, and the Technical Guidelines on Humane Abortion Treatment (MINISTRY OF HEALTH, 2005c).

Following up on a recommendation of the 2004 First Conference on Policies for Women, the Ministry of Policies for Women (SPM) established a Tripartite Commission made up of representatives of civil society, the government and the legislative branch, with the objective of presenting a proposal to review criminal law on abortion in Brazil. The Tripartite Commission developed a draft bill to decriminalize and legalize elective abortion in Brazil, which the President of the Republic should present before the National Congress.

Pressure from the National Conference of Brazilian Bishops (CNBB) led the Executive branch to back down. However, due to pressure from sectors fighting to change the law, Minister Nilcéa Freire (SPM) forwarded the Tripartite Commission's proposal to Representative Jandira Feghali. The representative was selected due to the fact that she assumed the task of reporting on the series of projects that proposed revising the Penal Code, pending since 2001. The representative presented a substitute of Bill 1135/91, based on the Tripartite Commission's proposal, favoring approval of all the proposals in favor of freedom of choice with respect to pregnancy termination and rejecting restrictive bills.

In 2008, Bill 1135/91, which incorporated the content of the Tripartite Commission's draft bill, was debated in public hearings, and suffered countless attacks from religious sectors, organized in benches of parliamentarians in the National Congress, who were able to defeat it in the Commission of Social Security and the Family (CSSF) and the Commission of the Constitution and Justice.

Conservative political forces act to prevent advances in laws and policies related to sexual and reproductive rights, placing obstacles to women's access to legal abortion and creating measures to control sexual and reproductive freedoms.

In May 2010, CSSF approved Bill 478/07, with provisions to protect the unborn. The bill addresses unborn human beings or conceived embryos, or in vitro fertilization, before it is transferred to the uterus, granting the embryo the same legal protection that is granted to human beings, particularly that of children and adolescents.

In Latin America in general, despite advances such as the decriminalization of abortion in Mexico's Federal District, most countries have adopted an intermediary position between a total ban and legalization, accepting abortion when the pregnancy threatens the mother's health and life, or in cases of rape.

The result of the legal ban on abortion is disastrous, as it forces women to resort to unsafe abortion methods in conditions that endanger their health and can lead to physical and psychological sequelae.

Overcoming all problems related to unsafe abortion in Brazil, such as women's injuries and deaths resulting from unsafe abortion, will only be possible with the revision of the criminal law that criminalizes abortion.

Inequalities among Brazil's Regions and the Consequences of Unsafe Abortion

Clandestine unsafe abortion affects women disproportionately, depending on their financial situation, geographic location, educational level, race and age (GALLI et al., 2005). In addition, the health system's structure level can generate variations in the rates of abortion and abortion-related maternal mortality in the different regions of Brazil, where the rates are higher in the North and Northeast regions (VALONGUEIRO, 2007).

The research study titled Magnitude of abortion in Brazil (MONTEIRO & ADESSE, 2007) notes the disproportionate impact of the criminalization of abortion among the most vulnerable women, who live in the poorest regions of the country. The study disaggregated the numbers of admissions reported in SUS's Hospital Information System, by Brazil's five macroregions and by age group.

The states in the Southeast (excluding Rio de Janeiro), South and Central-West region (excluding the Federal District) have rates lower than 20.4 abortions for each group of 1,000 women between the ages of 10 and 49. In the Northern states (excluding Rondônia) and in the Northeast (excluding Rio Grande do Norte and Paraíba), these rates are higher than 21.1 per 1,000 women (as well as in Rio de Janeiro) and reach more than 40 abortions per 1,000 women aged 10-49, in Acre and Amapá.

Map 1

Estimate of annual rates of induced abortion per 1,000 women aged 15-49

Source: Ministry of Health – SUS's Hospital Information System (SIH/SUS)

The highest rates can be seen in Amapá (47.7 per 1,000 women), Roraima (39.0 per 1,000 women), and Sergipe (30.4 per 1,000 women); the lowest rates in Rio Grande do Sul (13.2 per 1,000 women), Goiás (12.9 per 1,000 women), Rio Grande do Norte (12.5 per 1,000 women), and Paraná (11.3 per 1,000 women).

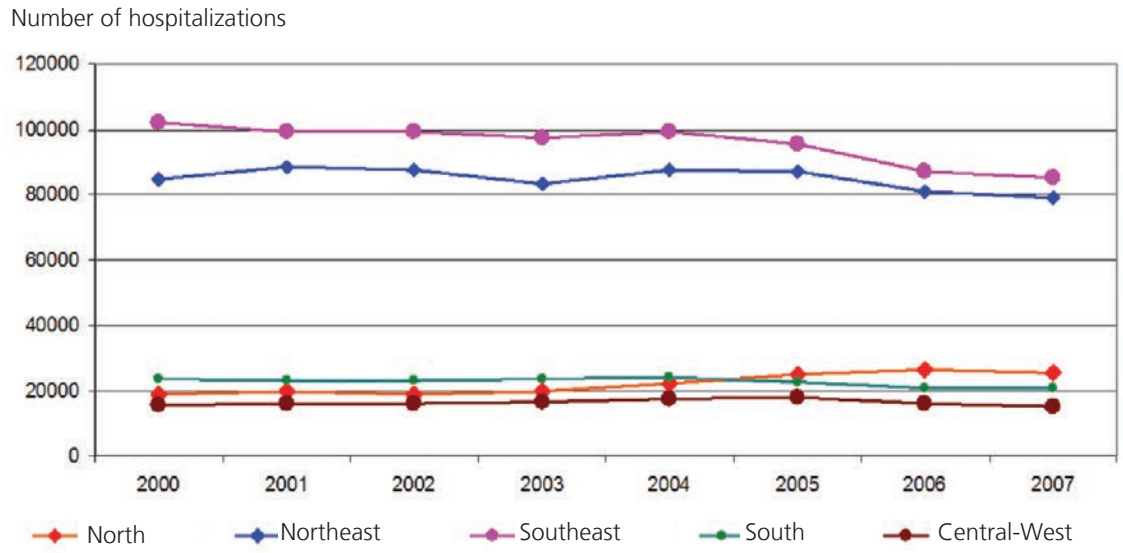
Of the states researched, the state of Bahia, in the Northeastern region, has the highest rate of induced abortion (24.3/1000); it is followed by Rio de Janeiro (20.9/1000), which is out of the norm for the Southeastern region; and then Pernambuco (19.6 /1000), Paraíba (19.6/1000), and Mato Grosso do Sul (13.8/1000).

In Brazil's two largest regions, the Southeast and the Northeast, there has been a trend towards a decrease in the number of abortion-related hospitalizations, which was well marked beginning in 2004. In the South and Central-West region, the historic series end practically with the same number of hospitalizations at the beginning of the series in 1998; however, in the North there was a clear increase between 2000 and 2007 (Graphic 1).

One of the causes of the reduction may be an increase in coverage of contraceptive methods between 1996 and 2006, which probably decreased the number of unwanted pregnancies, as shown in the National Demographic and Health Survey (MINISTRY OF HEALTH & CEBRAP; 2009a).

Graphic 1

Number of hospitalizations due to pregnancies ending in abortion
Brazil's Macroregions, 2000-2007



Despite the countless problems that persist in relation to the municipalities' family planning policy with respect to the supply and diversity of contraceptive methods and the promotion of educational actions that ensure information and provide guidance in choosing a method, it is undeniably clear that there were advances, especially with regard to quantitative data on free contraceptive methods distributed by the Ministry of Health.

As for the percentage of abortion-related hospitalizations of minors less than 20 years old, regional differences are confirmed with rates of 24.7% in Pará, 23.6% in Maranhão, 20.1% in Pernambuco, 15.7% in Santa Catarina, 14.8% in Rio Grande do Sul, and 14% in the Federal District, in 2007.

Among abortion-related complications, hemorrhagic shock was the most serious, and represents almost two thirds of hospitalizations due to complications of abortion in the Northeast, while in the South it is only 1%, which shows that shock can be avoided and its rate as an abortion complication can be reduced if abortion is performed in safe conditions or if effective treatment of unsafe abortion is provided.

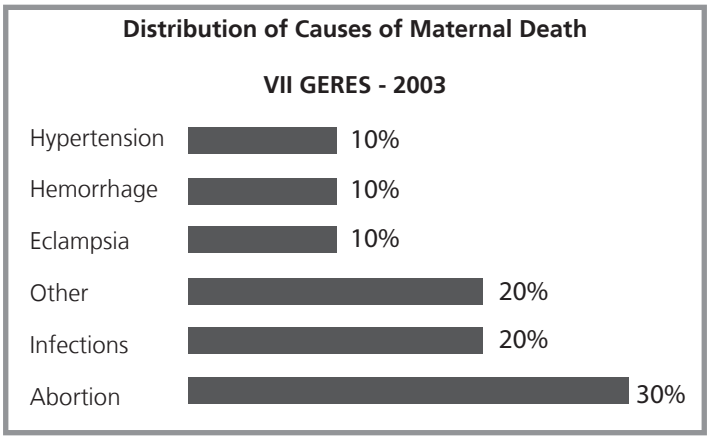
The GRAVAD research study (HEILBORN, 2006), carried out with 4,634 young women and men aged 18-24, in Salvador, Rio de Janeiro and Porto Alegre, analyzed young women's vulnerability to pregnancy, especially those resulting in abortion, according to the cities where they lived. The study revealed that young women from Bahia reported more frequently having had an abortion at some point in their lives (10.5%), as well as young men referring to their partner's pregnancy (19%). These numbers are greater than those reported by youth in Rio Grande do Sul (3% by young women and 7.2% by young men), and youth in Rio de Janeiro (7.2% by young women and 10.2% by young men). Pregnancy and abortion experiences cited by young women in Salvador were clearly associated to their social origin. It was these young women who reported lower use of contraceptives at the time of the pregnancy, and in the capital of Bahia, healthcare facilities were cited less often as a source of information about pregnancy and contraception.

Overview of the Abortion Reality by State Researched

Pernambuco - Recife and Petrolina

In Pernambuco [9], the research was conducted in Recife, state capital, and in the city of Petrolina, because it is where the VIII Regional Health Office (GERES) is based, in one of the state's microregions with the highest risks of induced abortion. In 2003, abortion was the first cause of maternal death in VIII GERES, as shown in Graphic 2.

Graphic 2



Source: Maternal mortality in Pernambuco – an estimate by macroregions.

In Recife and Petrolina, while there was a reduction in the number of maternal deaths resulting from abortion during the period studied (2003-2007), it is interesting to note that 100% of cases analyzed by the State and Municipal Maternal Mortality Review Committees were preventable, which denounces the gravity of violating the rights to life, health and to live free of preventable maternal death.

The Pernambuco Committee and the Municipal Committee of Recife made an effort to research underreporting to improve the quality of the data. Upon analyzing the events and procedures adopted, the committee was able to retrieve data that allow unveiling the true cause of death, discovering, among others, abortion.

From 2003-2007, approximately 85% of obstetric hospitalizations in Pernambuco were for delivery assistance, of which 19.7% were C-sections; abortion was responsible for 9.7% of the rest of the hospitalizations.

Table 1
AIH paid per year of competency, for normal childbirths, C-sections and abortions, by facility
Period: 2003/2007

Obstetric Procedure	Pernambuco	%	Petrolina	%	Recife	%
Total	698.858		25.751		108.338	
Normal childbirths	455.739	65,2	16.230	63,0	60.650	56,0
C-Sections	137.948	19,7	3.909	15,2	23.115	21,3
Abortions	67.943	9,7	3.890	15,1	14.080	13,0
Other obstetric interventions (Group 35)	2.386	0,4	106	0,4	639	0,6
Other obstetric interventions (Group 69)	34.842	5,0	1.616	6,3	9.854	9,1

Source: Ministry of Health – SUS's Hospital Information System (SUS (SIH/SUS), 2003-2007

[9] Data were condensed based on the Dossier on the reality of unsafe abortion in Pernambuco: the impact of the illegality of abortion on women's health in healthcare facilities in Recife and Petrolina, by Beatriz Galli, Ana Paula Viana, Mario F. G. Monteiro, and Núbia Melo.

According to data from the Office for Women's Health in Recife's City Hall, in 2007 there were 1,835 hospitalizations for abortion-related obstetric procedures in the three municipal maternity hospitals. SIH-DATASUS data indicate that during that same period 2,442 women were hospitalized to undergo abortion procedures in the city of Recife. Including hospitalizations in the supplementary network, one can deduce that more than 75% of obstetric hospitalizations for abortion procedures occur in the public municipal network.

Recife presents high risk of abortion among adolescents, compared to municipalities such as Porto Alegre, Brasília, and Belo Horizonte. The percentage found was 20.1% induced abortions among young women less than 20 years old, while in Rio Grande do Sul and the Federal District it did not reach 15%. In 2009, there was an increase in the maternal mortality rate resulting from abortion, and Recife's Municipal Maternal Mortality Review Committee verified the occurrence of five deaths of young women caused by unsafe abortion.

The induced abortion rate per 100 women aged 15-44 varies according to the state's region, with the highest rates in the state's interior.

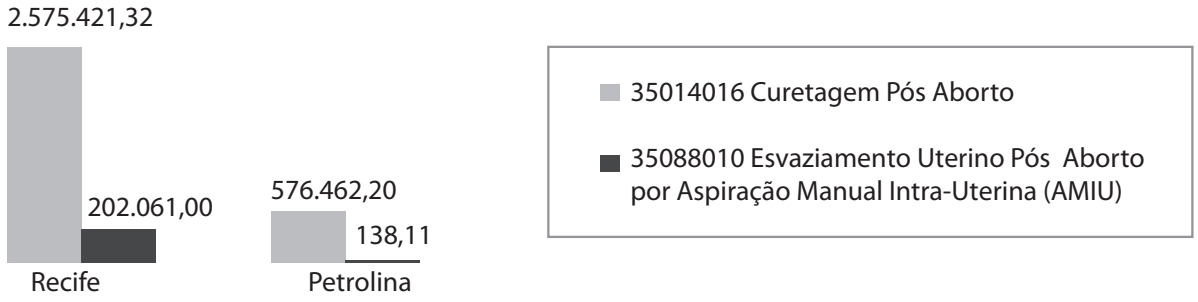
Between 2003 and 2007, in Recife and Petrolina, of the total number of hospitalizations for obstetric procedures, 77.3% and 78.2%, respectively, corresponded to hospitalizations for delivery assistance. The ratio of normal childbirths in Recife, close to 56%, was lower than that noted in Petrolina, 63%. In Petrolina and Recife, abortion contributed with 15.1% and 13%, respectively, percentages higher than the state average. Of the total number of hospitalizations for abortion, Petrolina contributed with almost 6% of hospitalizations for treatment of abortion complications in the state, and Recife contributed with approximately 21.0%. Still, nearly 30% of abortion-related hospitalizations in Recife's municipal network are of women who do not reside in this municipality.

With respect to the use of the manual vacuum aspiration (MVA) technique, nearly 10% of abortion procedures performed in Recife were MVA procedures; this percentage is higher than the regional and national average use of this method. This fact can be explained by the efforts of the Office of Women's Health of Recife's Municipal Ministry of Health to implement this procedure and train the medical teams of the municipal network in the effective adoption of this technique. Still, the number of post-abortion sharp curettage (PASC) procedures in Recife, remains absolutely greater than the number of post-abortion uterine evacuation procedures with MVA, as shown in Graphic 3 with relative costs of each procedure.

In Petrolina, from 200-2007, SIH/SUS data indicated only one (01) procedure performed with MVA, while 99.8% of abortion care procedures (4,095) were performed with PASC, although there were attempts to offer training in MVA use to healthcare providers at VIII GERES. This is an indication of resistance on the part of the medical community to adopt new technologies and knowledge for humane abortion care.

Graphic 3

Total Cost of Post-Abortion Sharp Curettage and Manual Vacuum Aspiration, 2003-2007



Paraíba - João Pessoa and Campina Grande

In Paraíba [10], the municipality of Campina Grande was included in the research study, together with the capital João Pessoa, as it is the state's second largest municipality and due to its high rate of abortion care provided to clients who are residents as well as to clients from other municipalities, which near the rates of the capital.

Spontaneous abortion appears as the second cause of hospitalization in Paraíba (Jan/2008 - June/2009), totaling 6,897 procedures performed (Table 2). Therapeutic or legal abortion is responsible for 36 cases, reported only in João Pessoa, as legal abortion care is only available in two of the state capital's maternity hospitals.

Table 2
Abortion Diagnosis in Paraíba. Period: January 2008 to June 2009

Diagnosis	TOTAL
Spontaneous abortion	6.897
Therapeutic abortion	36
Other pregnancies ending in abortion	769
Total	7.702

Source: Ministry of Health – SUS Hospital Information System (SIH/SUS)

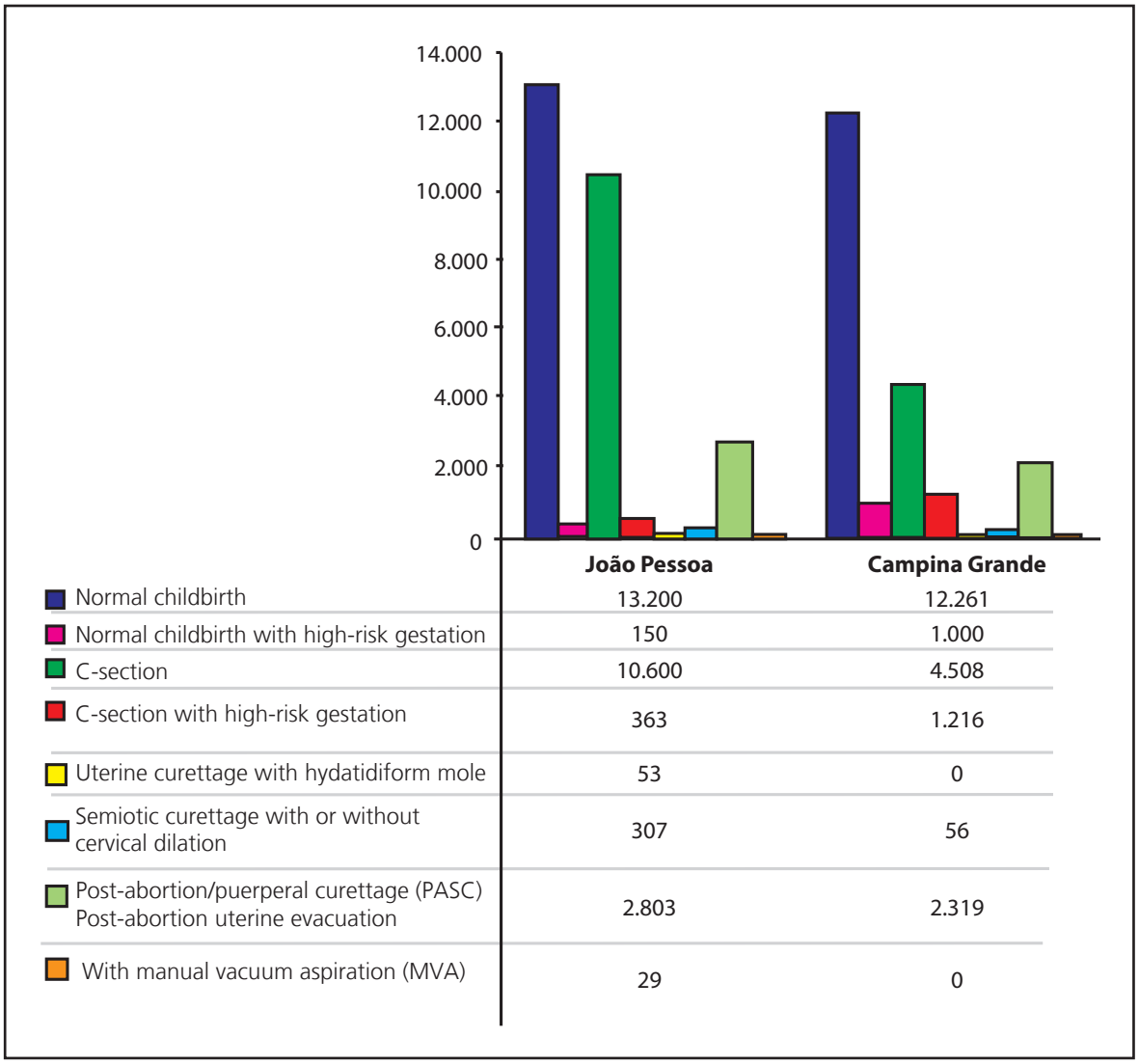
After childbirths, post-abortion sharp curettage is the second most common obstetric procedure in the in-patient facilities of the public health network. Of the 7,498 PASCs performed in the state, 73.85% occurred in the two cities studied.

In the municipalities researched, 5,122 PASCs were performed--2,803 in João Pessoa and 2,319 in Campina Grande. It is important to note the proximity of the numbers in Campina Grande in relation to those in the capital. The first municipality has a smaller population (383,764 inhabitants) than João Pessoa (702,235 inhabitants), which indicates that services in Campina Grande, characterized as a hub city, are highly sought by clients from the interior. In João Pessoa, 44% of PASC procedures correspond to hospitalizations of clients who do not reside in the capital, and in Campina Grande it is 52%.

[10] Data extracted from the Dossier on the reality of unsafe abortion in Paraíba: the impact of the illegality of abortion on women's health in healthcare facilities in João Pessoa and Campina Grande, by Socorro Borges, Cristina Lima, and Gilberta S. Soares.

Graphic 4 demonstrates that, in the series of obstetric procedures for sharp curettage (post-abortion/puerperal sharp curettage, semiotic curettage with or without cervical dilatation, uterine curettage for hydatidiform mole), or post-abortion uterine evacuation with MVA were performed only in João Pessoa. Of the 29 procedures, 19 were performed on women who reside in the municipality, that is, women from the entire state depend on the capital's facilities to have access to the cheapest and safest procedure. The 29 procedures performed with the MVA technique may be included in the 36 diagnoses of therapeutic abortions, concluding that they were probably used for legal abortion care, and the other seven women underwent the traditional procedure.

Graphic 4
Hospitalizations by Obstetric Procedure and Site
Period: January 2008 to July 2009



	João Pessoa	Campina Grande
Normal childbirth	13.200	12.261
Normal childbirth with high-risk gestation	150	1.000
C-section	10.600	4.508
C-section with high-risk gestation	363	1.216
Uterine curettage with hydatidiform mole	53	0
Semiotic curettage with or without cervical dilation	307	56
Post-abortion/puerperal curettage (PASC) Post-abortion uterine evacuation	2.803	2.319
With manual vacuum aspiration (MVA)	29	0

Source: Ministry of Health – SUS Hospital Information System (SIH/SUS)

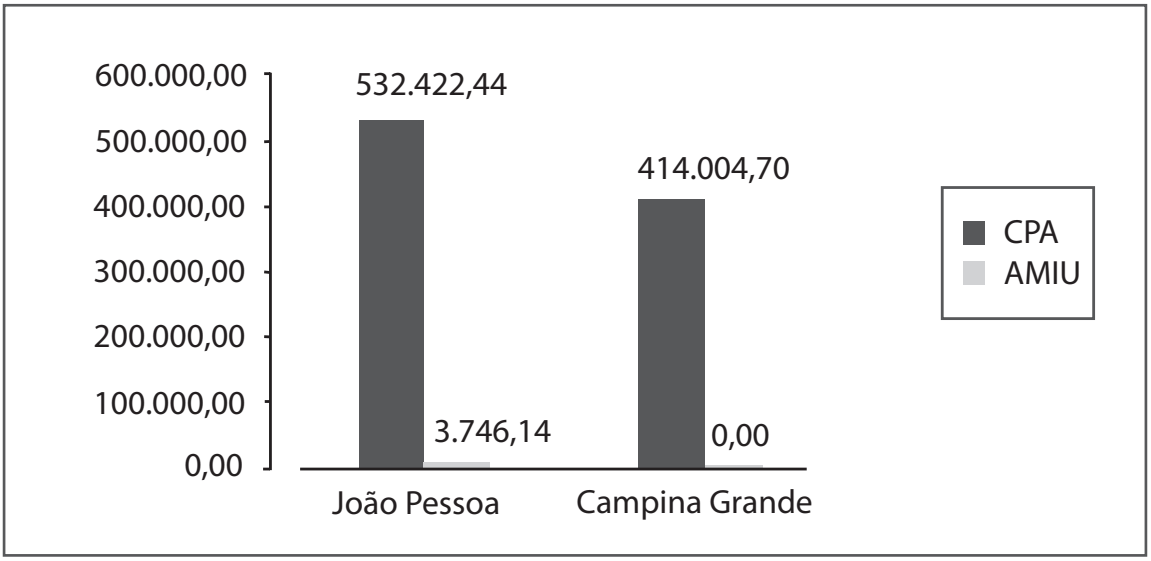
Considering hospitalizations for obstetric procedures, it can be noted that the ratio of PASC in João Pessoa and Campina Grande corresponds to 10% and 11% of the total number of procedures performed, respectively, while the MVA technique is responsible for only 0.9% of the procedures. A 2003 research study conducted by Cunhã – Coletivo Feminista (RABAY & SOARES; 2008) found the percentage of abortion-related hospitalizations in João Pessoa was 13.4%.

The number of PASC procedures performed in João Pessoa is still absolutely higher in comparison with the MVA

technique, even though the municipality has two legal abortion facilities and has invested in training healthcare professionals in the use of MVA. In Campina Grande, there were no MVA procedures (Graphic 5). As in the state of Pernambuco, women in the interior of the state of Paraíba do not have access to the safer and less invasive technique.

Graphic 5
Total Costs of Post-Abortion/Puerperal Sharp Curettage (PASC) and Post-Abortion Uterine Evacuation with Manual Vacuum Aspiration (MVA)

Period: January 2008 to July 2009.



Source: Ministry of Health – SUS Hospital Information System (SIH/SUS)

At the facilities researched, the study found that clients' stay ranged from 72 hours to 96 hours for PASC, which was higher than the time ranging from 12 to 24 hours estimated in previous studies (RABAY & SOARES, 2008). Clients from other cities are referred to maternity hospitals in João Pessoa and Campina Grande. From 1998 to 2008, there was a 176% rise in the number of hospitalizations for abortion reported in SUS in the state of Paraíba, increasing from 1,772 in 1998 to 4,896 in 2008. In 2008, the I Regional Health Nucleus (NRS) (hub city of João Pessoa) and the III NRS (hub city of Campina Grande) reported 74% of hospitalizations as a result of abortion. This percentage was 64% in 1998.

Induced abortion numbers are concentrated in João Pessoa and Campina Grande, and the I and III NRS present higher risks of induced abortion. The average rate is 19.6 induced abortions per 1,000 women aged 15-49 in Paraíba, 24.0 per 1,000 women in the I NRS and 25.1 per 1,000 women in the III NRS. Still, eight municipalities present high rates ranging from 40 per 1,000 women to 51.3 per 1,000 women; one municipality belongs to the I NRS and the rest to the III NRS.

Based on the number of abortion-related hospitalizations reported by SUS in 2008, the number of induced abortions in the state of Paraíba was estimated at 20,655—9,336 in the I NRS (Campina Grande) and 5,944 in the III NRS (João Pessoa).

During the period from January 2008 to July 2009, consistent with national trends, there was a predominance of

young women aged 20-29 in spontaneous abortion diagnoses (Table 3). The study points out the high number of hospitalizations due to spontaneous abortions among girls and adolescents aged 10-14 (115) and those aged 15-19 (1,207), which may suggest that there are cases of abortion resulting from pregnancy cause by sexual violence, which are reported as spontaneous abortions, and that healthcare facilities are not prepared to deal with adolescent sexuality.

Table 3
Diagnosis of Spontaneous Abortion by Age Group and Race/Color
Period: January 2008 to July 2009

	Race/color	10 -14 years old	15 - 19 years old	20 - 29 years old	30 - 39 years old	40 - 49 years old	50 - 59 years old	60 - 69 years old	70 - 79 years old	TOTAL
Specific cause: spontaneous abortion	White	7	75	216	103	22	-	-	-	423
	Black	4	16	52	28	15	1	-	-	116
	Mulatta	56	534	1.477	653	131	2	-	-	2.853
	Yellow	-	5	4	6	-	-	-	-	15
	Indigenous	2	1	6	1	1	-	-	-	11
	No data	46	576	1.675	907	254	15	3	3	3.479
	Total	115	1.207	3.430	1698	423	18	3	3	6.897

Source: Ministry of Health – SUS Hospital Information System (SIH/SUS)

It was noted that in Paraíba's public health facilities abortion care services were provided primarily to black women and mulattas. Of the total number of spontaneous abortions, 43% correspond to clients who are black or mulattas. It is interesting to note the lack of identification of color for a significant number of clients (3,479), which reveals health professionals' failure to indicate their clients' color and their lack of awareness of the importance that providing this information in patient charts has for developing public policies and fighting racism in this country.

Bahia - Salvador and Feira de Santana

In the state of Bahia [11], research was conducted in the municipalities of Salvador and Feira de Santana. Salvador has a high rate of abortions associated to socio-economic conditions and racial issues, seeing that 82% of the city's female population is black. The municipality of Feira de Santana serves as a referral center for the health macro-region of the 2nd Regional Health Office, made up of 22 municipalities. However, based on information provided by municipal administrators during the researchers' visit, clients from nearly 60 surrounding municipalities arrive here in search of care. According to Souza (1998), 28% of the females treated for abortion complications in the hospitals researched in Feira de Santana were residents in other municipalities.

[11] Data gathered based on the dossier "The reality of unsafe abortion in Bahia: the illegality of abortion practice and its effects on women's health in Salvador and Feira de Santana," by Cecilia Simonetti, Maria Helena Souza, and Maria José de Oliveira Araújo.

Sharp curettage is the second most common procedure in the SUS network in Salvador. In 2007, 8,387 sharp curettage procedures were performed, which can be translated as approximately 699 per month, 23 per day, and one per hour. For every four hospitalizations for childbirth there is one hospitalization for post-abortion sharp curettage in this city, an average which is quite lower than the national average of 6.7 childbirths per 1 abortion (MENEZES and MARINHO, 2008).

Data from the Ministry of Health/DATASUS on abortion-related hospitalizations of women who are residents of Salvador reveal that from 2000-2007 nearly one fifth of hospitalizations were due to "non-specified" abortions (Table 4), possibly resulting from provoked events. One cannot rule out the possibility that diagnoses recorded as spontaneous abortions or other abnormal products of conception were classified incorrectly to hide induced abortions. Data on abortion-related hospitalizations in the capital have remained practically at the same level in the last few decades.

The number of therapeutic and legal abortions has been increasing discretely, with a significant rise in 2007 (Table 4). Still, Bahia's Institute of Perinatology (IPERBA), which is the only public hospital in the state of Bahia that provides care to women who are victims of sexual violence and legal abortion services, reported only 38 cases from 2006-2007, and a total of 12 procedures for the termination of pregnancies resulting from rape.

Table 4
Hospitalizations of Women (aged 10-49) for Abortion
Salvador, 2000-2007

Type of Abortion*	2000	2001	2002	2003	2004	2005	2006	2007**
Ectopic pregnancy	196	223	116	190	256	293	300	317
Hydatidiform mole	26	18	25	14	35	24	45	56
Other abnormal products of conception	2.762	2.223	2.497	2.433	2.612	1.592	1.493	1.567
Spontaneous abortion	4.430	4.866	4.870	4.805	5.145	6.084	5.299	5.538
Therapeutic and legal abortion	8	0	1	3	6	18	9	56
Other types of abortion	38	78	14	51	57	74	39	64
Non-specified abortion	1.637	1.631	1.310	874	1.152	1.659	1.269	723
Unsuccessful abortion	73	58	22	114	69	31	33	31
Complications resulting from abortion, ectopic pregnancy, hydatidiform mole	391	678	165	7	25	35	26	37
Total	9.561	9.775	9.020	8.491	9.357	9.810	8.513	8.389

Source: MS/Datasus/SIH-SUS.
* International Classification of Diseases – ICD 10.
** Partial data

A high percentage of abortion-related hospitalizations was found in one of the main public maternity hospitals in Salvador, in a 2002 study in which the number of abortion-related hospitalizations exceeded the number of normal childbirths and C-sections. Of the women studied, 71.7% induced abortion for different reasons,

including lack of financial resources in 58.1% of cases (LOPES et al, 2003).

According to data from the Municipal Health Secretariat (GT Rede Saúde da Mulher, 2007), pregnancy, childbirth, and puerperium were the most common causes of hospitalization in Salvador in 2006, corresponding to 39,120, that is, 44% of all SUS hospitalizations. Of these hospitalizations, 42.62% corresponded to childbirths, 16.40% to other pregnancy complications, 13.55% to spontaneous abortions, and 8.2 % to other pregnancies that ended in abortion. If we add abortions considered spontaneous to those classified as other pregnancies ending in abortion, we have a total of 8,511 hospitalizations for these causes, that is, 22% of the total number of pregnancies resulting in abortion.

The dossier titled The Reality of Unsafe Abortion in Bahia (SIMONETTI et al, 2008) notes that clients with serious problems related to pregnancy, childbirth, and abortion are referred to the general hospital, in the periphery district, which receives women from the capital and neighboring municipalities, as a significant number of maternal deaths occur in this hospital.

Table 5 shows slight annual variations in the number of hospitalizations due to abortion among women who live in this municipality. Thus, the childbirth/abortion ratio remains unaltered at approximately one abortion-related hospitalization for every four deliveries.

Table 5
Hospitalizations of Women Aged 10-49 Residents of Salvador, for Obstetric Procedures* and Childbirth/Abortion Ratio. Salvador, 2000-2007

Nº	Normal Childbirths and C-sections	Abortions	Other Obstetric Interventions	Total	Child-birth/ Abortion Ratio
2000	38.036	9.433	154	47.623	4
2001	35.126	9.684	130	44.940	4
2002	33.143	8.824	111	42.078	4
2003	32.018	9.090	85	41.193	4
2004	31.725	9.116	99	40.940	3
2005	31.075	9.599	200	40.874	3
2006	28.115	8.374	222	36.711	3
2007	30.848	8.381	198	39.427	4

Source: MS/Datasus/ SIH
*Normal childbirths + C-sections

Throughout the 1990s, abortion was the first cause of maternal death in Salvador, unlike the rest of the Brazilian capitals, where hypertension was the first cause. Menezes and Aquino's study (2001) of maternal death in Salvador analyzed all cases of death of women in reproductive age, between 10 and 49 years old, who were residents of this municipality in 1998. Maternal death was defined as that occurring up to one year after childbirth or abortion. The data found determined a ratio of 96.7 deaths per 100,000 live births, placing Salvador as a city with high rates of maternal mortality, according to the standards of the World Health Organization (WHO).

The study revealed the difference in the risk of dying from maternal causes among the different districts in the city, with the highest rates found in the poorest districts, as it is maintained throughout the years. Abortion-related deaths occurred among young women, with an average and median, respectively, of 23 and 21 years old.

Abortion was performed with Cytotec®, either alone or combined with teas. All the women were either mulattas or black, and most of them even had basic educational level. A few of them were single, but many lived in union and left their partners and small children behind.

Other studies confirm the association among maternal death, class and race, identifying that from 2000-2004, most women who died from maternal causes, including abortion, were either black or mulattas, in a health district in the periphery of Salvador and in the city of Feira de Santana, where sickle cell anemia stood out as an indirect cause (SIMONETI et al., 2009).

Current data on maternal death in districts on the periphery of the city confirm social inequalities among white and black women. In Cabula/Beirú Health District 25, the vast majority of women who died from maternal causes, including abortion, from 2000-2004, were black women, revealing existing inequities with respect to the health of the black population. (Table 6).

Table 6
Maternal Death by Group of Causes, Race/Color in Cabula/Beirú Health District – 2000-2004

Direct Obstetric			Indirect Obstetric			Abortion		
White	Black	UNK*	White	Black	UNK	White	Black	UNK
01	10	0	0	01	0	0	03	01

Source: Cabula/Beirú Health District.
* Unknown

In Bahia, the situation repeats itself in relation to the other states with respect to the low use of the MVA technique, which is practically nonexistent. At one of the hospitals visited, only one MVA procedure was performed in 2005. However, three of the institutions visited trained their staff on the MVA procedure; two justified not having used the technique because they still had not acquired the MVA kit [12].

Mato Grosso do Sul - Campo Grande and Corumbá

The dossier [13] was developed with data from the capital Campo Grande and from the municipality of Corumbá. Campo Grande is characterized by growing urbanization, circulation of capital, and a significant number of the population originating from the rural exodus and other Brazilian states (IBGE, 2007). It is in this scenario marked by agrarian and large estate characteristics, which favor males, that countless women have their human rights violated, including their right to quality reproductive health care. A differential factor of that state in relation to the other states is the strong presence of an indigenous population, which constitutes Brazil's second largest indigenous population.

In Mato Grosso do Sul, women face a hostile environment when trying to exercise their sexual and reproductive rights. Legal abortion services, in cases of rape or threat to the mother's life, are not available in the state (CATHOLICS FOR FREE CHOICE, 2006). Access to health care is insufficient.

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12 The kit is made up of Karman cannulae, with diameters of 4-12cm, which connect to a vacuum syringe.
13 Data collected from the Dossier on Unsafe Abortion for Advocacy: The Impact of the Illegality of Abortion on Women's Health and on the Quality of Reproductive Health Care in Campo Grande and Corumbá, Mato Grosso do Sul by Alexandra Lopes da Costa, Nathalia Eberhardt Ziolkowski, Beatriz Galli, and Paula Viana

On April 13, 2007, police in Mato Grosso do Sul raided a family planning clinic in Campo Grande and seized the medical records of nearly 10,000 women. The women were threatened with being prosecuted, and there were many violations, including omitting public institutions, such as professional councils and health secretariat administrators, public display of patient charts, and trying the women without legal counsel, randomly applying alternative penalties. Those events intensified the state's intimidating climate against those who wish to speak openly about women's reproductive rights (IPAS, 2008).

The dossier developed highlighted the difficulty in obtaining information due to the lack of data and current profiles on maternal morbidity and mortality and on the magnitude of unsafe abortion in the state. A thesis developed in 2007 by physician Ana Lúcia Gastaud, titled A mortalidade materna e a mortalidade infantil em Mato Grosso do Sul, Brasil, de 2000 a 2002 (Maternal Mortality and Infant Mortality in Mato Grosso do Sul, Brazil, 2000-2002) confirmed the inadequacy of records in the epidemiologic monitoring systems in most of the municipalities of Mato Grosso do Sul, often missing data or containing contradictory information.

With respect to rural women's reproductive health, maternal mortality rates due to unsafe abortion in rural areas are more underreported than in urban areas. Another critical point for rural women is the lack of recognition of the status of female workers in the setting where they live, which makes them more vulnerable with respect to access to social policies.

Despite efforts from human right organizations and universities, which throughout the years have been researching and discussing public policies to ensure the human rights of indigenous peoples in Mato Grosso do Sul, few studies address maternal mortality and abortion among the different indigenous ethnic groups in the state. According to the Special Indigenous Health District (MS), which belongs to the National Health Foundation (FUNASA) [14], data on maternal mortality, especially resulting from abortion, are scarce among the various indigenous ethnic groups in the region.

The lack of knowledge also applies to traditional beliefs and knowledge of indigenous women with respect to methods used to prevent and terminate pregnancy. According to FUNASA administrators and professionals, little is known about the difficulties experienced by indigenous women in that aspect of life. The lack of action on the part of the State and the lack of information in a language that is accessible to the indigenous population on issues related to pregnancy, contraception, maternal mortality, and abortion, quite possibly place indigenous women in the most vulnerable group with respect to access to reproductive health policies.

The difficulty in having information produced by the State and municipalities proves to be a barrier for the design of public policies and health care practices that are more appropriate for women's needs, with access to family planning information and methods, to emergency contraception, to safe abortion care, and to the right to humane care. In relation to indigenous women, "it is important to offer information, not impose policies, but it is critical to offer it" (COSTA & ZIOLKOWSKI, 2010, p. 25).

Gastaud (2007) noted that eclampsia was the main cause of maternal death in the state during the study period, followed by deaths resulting from abortion and problems during labor. Data from the Special Indigenous

[14] Available at http://www.ensp.fiocruz.br/portal-ensp/ceensp/detalhes-noticias. php?Matid=13495

Health District (DSEI-MS / FUNASA), agency responsible for offering public health care to the state's indigenous population, indicated three maternal deaths of indigenous women in 2008.

DATASUS data show a high incidence of obstetric procedures for abortions with non-specified cause. Based on the data bank, from 2005-2007, 3,059 abortion procedures were recorded in Campo Grande. It is the highest incidence in Mato Grosso do Sul, representing almost 37% of all cases of assistance provided to women undergoing abortion in the state during this period. According to a research study conducted by Monteiro and Adesse (2008), it is estimated that Corumbá had 759 induced abortions, for which this municipality has the third highest incidence of the 78 cities in Mato Grosso do Sul.

The state's induced abortion rate is 13.8 for every 1,000 women aged 15-49. Campo Grande's rate is 15.9. However, nine municipalities had estimated annual rates of more than 20 induced abortions among women aged 15-49, including Corumbá, with a rate of 24.4, for which this municipality had the third highest rate of the 78 cities in Mato Grosso do Sul, as shown in Table 7.

Table 7

Estimates of the Number of Induced Abortions by Municipality and Abortion Rate per 1,000 Women in 2008

Induced Abortions by Municipality in Mato Grosso do Sul in 2008	Female Population Aged 15-49	Induced Abortions	Rates per 1,000 women
Mato Grosso do Sul	755.323	10.450	13,8
Campo Grande	252.283	4.020	15,9
Corumbá	31.067	759	24,4

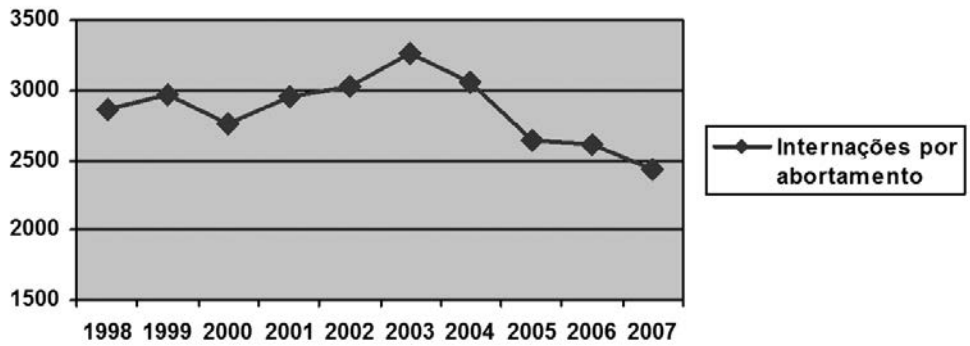
Source: Monteiro and Adesse, 2009

Monteiro and Adesse (2008) estimated the number of induced abortions in Mato Grosso do Sul, based on the number of hospitalizations for abortion, and concluded that, from 1998-2007, there was an 18% decrease in the number of induced abortions in the state, probably associated with the increase in the female population's educational level and an increase in the adoption of contraceptive methods, which led to reduced fertility (Graphic 9).

Graphic 9

Hospitalizations for Abortion in Mato Grosso do Sul, 1998-2007

Morb. List ICD-10: Spontaneous Abortion, Therapeutic Abortion, Other Pregnancies Ending in Abortion



In 2008, there were no big changes with respect to the number of abortion-related hospitalizations or the estimate of induced abortions. There were 2,480 abortion-related hospitalizations in the state (Table 8), generating an estimate of 10,450 induced abortions.

Table 8

Number of Abortion-Related Hospitalizations - 2008

State	Women aged 10-14	Women aged 15-19	Women aged 20-29	Women aged 30-39	Women aged 40-49	Total
Mato Grosso do Sul	57	442	1232	658	88	2480

Source: Monteiro and Adesse, 2009

Table 9

Percentage of Abortion-Related Hospitalizations by Group - 2008

State	10 - 14	15 - 19	20 - 29	30 - 39	40- 49
Mato Grosso do Sul	2,3%	17,8%	49,7%	26,5%	3,5%
BRAZIL	1,4%	16,9%	49,9%	25,9%	5,8%

Source: Monteiro and Adesse, 2009.

As for the method used for treatment of abortion, PASC is the most common procedure in Mato Grosso do Sul. However, the facilities visited in Campo Grande and Corumbá confirmed that they use MVA. During the period from June 2007 to June 2009, one of the hospitals visited performed 416 uterine curettages as a result of abortion—257 for incomplete abortion, 75 for missed abortion, and 84 for spontaneous, inevitable, and embryonic abortion or other related causes.

Despite reports of hospital use of Misoprostol for deliveries and abortions, in accordance with the technical guidelines of the Ministry of Health, members of the nursing team at one of the facilities reported that it is very difficult to acquire Misoprostol. In the city of Corumbá, the situation is different. According to reports from specialists and public administrators in the municipality, Misoprostol is easy to access in this region. Some people attribute this fact to greater access to this medication through the border with Paraguay.

For health professionals in Campo Grande, the ease in acquiring this medication may be one of the factors that caused a decrease in abortion-related mortality, as it is a medication that does not present as many health risks as other methods used to induce abortion. However, they stated that the main problem is that the women don't know how to use it correctly. [15]

That information could not be verified due to lack of data, considering that this ativity has been illegal in Brazil since 1991, when the Ministry of Health banned its sale. In 1998, the MOH issued Decree nº. 344, which banned access to this mediction and allowed only hospital use of Misoprostol and its sale to hospitals registered in Anvisa [16]. Campo Grande has the only legal abortion care facility in the state; however, the population is not informed of this, according to testimonies of health professionals during visits to healthcare facilities.

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15 Abortion Tourism along the border between Brazil and Paraguay: http://www.portalms.com.br/noticias/detalhe.asp?cod=24120 e http://www.crfpa.org.br/Noticias/Novembro%202008/2111not1451.htm

16 Available at: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0100-72032008000600001

Rio Janeiro - Rio de Janeiro, Nova Iguaçu and Duque de Caxias

In Rio de Janeiro [17] , data were collected in the capital and in the municipalities of Nova Iguaçu and Duque de Caxias, located in the Baixada Fluminense. The last two cities were chosen to represent the reality of the Baixada Fluminense, which is experiencing problems with the infrastructure of maternity hospitals, and lack of access to obstetric care and family planning services. Based on an interview with an administrator, the maternity hospitals in the Baixada Fluminense are not in good functioning condition and do not provide quality services. Unwanted pregnancy is a serious problem that needs to be addressed, primarily among young women aged 10-19. PSF coverage is 25-30% in this municipality with 900,000 inhabitants. There is no adequate access to family planning services (GALLI, VIANA & SHIRAIWA, 2010). Health administrators and professionals emphasized the importance of knowing the abortion methods used in the Baixada Fluminense and their consequences.

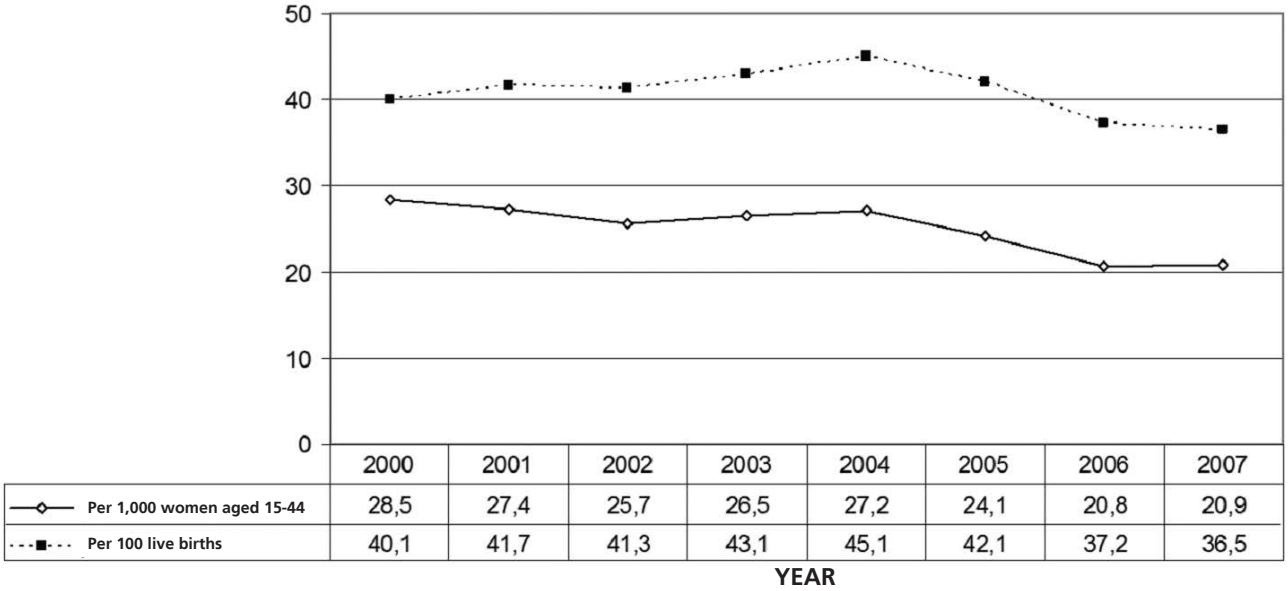
According to data of the Maternal Mortality Committee in Rio de Janeiro, from 2002-2007, the main direct causes of maternal death were hypertension, hemorrhage and abortion, consistent with the main direct causes of obstetric death in Brazil, based on an MOH Study of Mortality of Women Aged 10-49, with emphasis on Maternal Mortality (2006).

There was a continuous decrease in the estimate of induced abortions per 1,000 women aged 15-44 from 2000-2007 in Rio de Janeiro, as the 2000 estimate of 28.5 was reduced to 20.9 in 2007 (Graphic 10).

Graphic 10

Estimates of Induced Abortion Rates per 1,000 Women Aged 15-44 and of Rates per 100 Live Births

State of Rio de Janeiro – 2000-2007



	2000	2001	2002	2003	2004	2005	2006	2007
Per 1,000 women aged 15-44	28,5	27,4	25,7	26,5	27,2	24,1	20,8	20,9
Per 100 live births	40,1	41,7	41,3	43,1	45,1	42,1	37,2	36,5

[17] Data collected from the Dossier on Unsafe Abortion for Advocacy: The Impact of the Illegality of Abortion on Women's Health and on the Quality of Reproductive Health Care in the State of Rio de Janeiro, by Beatriz Galli, Paula Viana, and Tizuko Shiraiwa.

From 1999 to 2007, an estimated 800,000 abortions were induced in the state of Rio de Janeiro, and the largest age groups included in this estimate were: women aged 20-24 (32.1%), women aged 25-29 (24.7%), and women aged 15-19 (20.5%). This means that 3 of every 4 induced abortions were performed on women aged 15-29. During this period, the number of induced abortions decreased in all age groups, resulting in a reduction of 24% (Table 10).

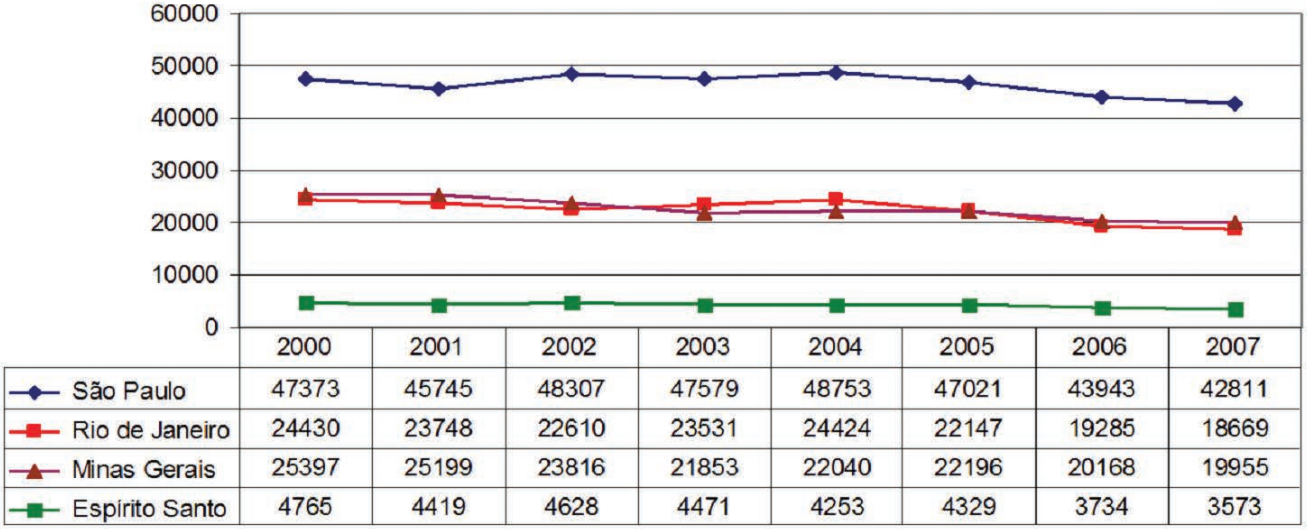
Table 10

ESTIMATES OF THE NUMBER OF INDUCED ABORTIONS IN THE STATE OF RIO DE JANEIRO – 1999-2007 ANEIRO - 1999 A 2007										
Age Group	1999	2000	2001	2002	2003	2004	2005	2006	2007	1999 A 2007
10 -14	1266	1413	1396	1253	1333	1207	966	1055	1097	11969
15 - 19	20955	19866	19524	17875	17989	18208	16850	14091	13787	176951
20 - 24	30118	30126	30286	29160	29907	31033	27460	23410	21077	277923
25 - 29	22520	22583	21499	20798	22705	24275	21938	19322	19098	213891
30 - 34	14981	14989	14048	13812	14095	14538	13770	12007	11888	137443
35 - 39	10020	10028	9163	8577	8767	9437	8497	7733	8155	88277
40 - 44	3902	4058	4269	3911	4476	4341	3953	3742	3658	39530
45 - 49	700	667	561	523	570	473	527	468	456	5413
Total	104667	103937	100988	96006	100018	103650	94028	81915	79287	864498

In the Southeast, from 2000-2007, all of the nation's facilities experienced a reduction in the number of abortion-related hospitalizations, which was associated with an increase in the range and number of contraceptives provided in the public network (Graphic 11).

Graphic 11

Number of Hospitalizations Due to Pregnancies Ending in Abortion
Healthcare Facilities in the Southeast, 2000-2007



	2000	2001	2002	2003	2004	2005	2006	2007
São Paulo	47373	45745	48307	47579	48753	47021	43943	42811
Rio de Janeiro	24430	23748	22610	23531	24424	22147	19285	18669
Minas Gerais	25397	25199	23816	21853	22040	22196	20168	19955
Espírito Santo	4765	4419	4628	4471	4253	4329	3734	3573

In 2006, in Rio de Janeiro, according to SIH-SUS data, the primary cause of hospitalization of women of reproductive age was obstetric causes, with a peak in the 20-24 age group, followed by mental and behavioral disorders, which was the first cause in the 40-49 age group. Abortion is the third cause of hospitalization of women aged 10-49. (Table 11)

Table 11
Main Causes of Hospitalization of Women Aged 10-49

Age Group Cause	<11	12-19	20-29	30-39	40-49	Total	%
All causes of hospitalization	2783	45.946	107.383	64.824	49.853	270.789	100
Childbirth	1	26.858	58.812	20.099	2.143	107.913	39,85
Mental and behavioral disorders	11	310	2869	7466	9.791	20.427	7,54
Abortion	0	3.482	9513	4.294	943	18.232	6,73
Total of the first three causes	12	30.650	71.194	31.849	12.877	146.572	54,12

Source: AIH, 2006 State of Rio de Janeiro DATASUS

Hospitalizations for abortion-related procedures correspond to more than 12% of hospitalizations related to pregnancy, childbirth and puerperium in 2006, totaling 18,491 hospitalizations, and the age distribution presents a profile similar to that of women who are hospitalized for deliveries (100,426 hospitalizations).
The situation in Rio de Janeiro with respect to the use of the MVA technique is no different from most of the states studied, as the procedure was offered only to 2.33% of the women hospitalized in SUS hospitals (Table 12).

Table 12
Hospitalizations for Procedures Related to Pregnancy, Childbirth, Puerperium, and Abortion in the State of Rio de Janeiro, 1996 (DATASUS)

Procedure Performed	12-19	20-24	25-29	30-34	35-39	40-49	Total
Curetagem Pós-Aborto	3.456	5.223	4.217	2.567	1.682	937	18.082
Post Abortion Uterine Evacuation with MVA	70	110	94	82	43	34	433
Total Number of Abortion Procedures	3.526	5.333	4.311	2.649	1.725	971	18.515
Childbirth with Eclampsia	0ao	1	1	2	0	0	4
Assisted Deliveries	199	202	129	52	17	9	608
Normal Childbirth	16.549	20.572	14.596	7.904	3.652	1.146	64.420
Normal Childbirth in High-Risk Women	595	680	584	417	272	125	2.673
Normal Childbirth Exclusively for Hosp Amigos Crianca	5.984	7.090	4.698	2.406	1.136	389	21.703
Normal Childbirth without Dystocia Performed by Nurse-Midwife	431	600	423	200	107	30	1.791
C-Section w/Tubal Ligation in Patients w/Successive C-Section	4	75	162	149	55	22	467
C-Section with Tubal Ligation in Patients w/Successive C-Section	7	108	223	181	122	62	703
C-Section in High-Risk Women	426	547	516	418	269	124	2.300
C-Sections Exclusively in Hosp, Amigos da Criança	1.193	1.683	1.414	848	468	151	5.757
Total Number of Deliveries	25.388	31.558	22.746	12.577	6.098	2.058	100.426

A Snapshot of Everyday Care

Gaps in the Referral and Counter-referral Systems

Overcrowding in referral maternity hospitals is a reality in several states, overloading capitals and large municipalities, as exemplified in Recife and Petrolina, João Pessoa and Campina Grande, and Salvador and Feira de Santana. As foreseen by SUS, following the principle of hierarchization of the complexity of health care, capitals and large cities with highly complex maternity hospitals must function as referral centers for treatment of clients of smaller municipalities and for more complicated cases.

However, due to the collapse of the health network in the interior of the states, which does not even meet the population's primary needs, often that which could be resolved in the municipality is not resolved, resulting in appropriate transfers to the capitals and large municipalities. This generates a larger caseload than was previously agreed to by municipal administrators under the coordination of a state administrator in the Bipartite Inter-Managerial Commission (CIB). Municipalities with referral maternity hospitals are overloaded with a large caseload, which extrapolate planning, revealing problems in agreements with the CIB. These problems are related to partisan political issues and to administrators' lack of commitment, which interferes with upholding agreements in the states.

The fact that some maternity hospitals are not computerized contributes to the problems in the referral/counter-referral systems between maternity hospitals and municipal primary care facilities, between the latter and the referring municipalities, in addition to making it impossible to implement a single patient chart, which makes it difficult to have an integrated system.

In the Northeast, due to the geographical proximity among states, it is common for referral maternity hospitals to treat both women from municipalities of that same state and from neighboring states, resulting in problems such as overcrowding of beds and overload of healthcare professionals, and compromising quality of care. The municipality of Petrolina (PE) serves an average of 57 municipalities in that same state, in addition to clients from Bahia, Ceará and Piauí for abortion cases. According to the Petrolina dossier, health professionals' refusal to perform sharp curettage procedures and the lack of anesthesiologists in municipal hospitals are reasons to refer patients to that service (VIANA, et al., 2008).

Women experiencing abortion who are residents of small or medium-sized municipalities often are transferred to maternity hospitals in capital cities because hospitals don't have appropriate care conditions, or due to health professionals' boycott of abortion care. It is also possible to suppose that the clandestine nature of abortion forces women to resort to other cities to resolve the problem in a safe, protected manner, as a strategy to preserve their anonymity. Overcrowding in maternity hospitals contributes towards inhumane care, with few resolutive conditions and of poor quality, for which the needs of the population are not met adequately.

Data demonstrate that nearly 30% and 28% of obstetric hospitalizations occurring in the municipal network of Recife and Feira de Santana, respectively, for treatment of abortion complications, are of women who reside outside the municipalities. In João Pessoa and Campina Grande, the percentage of non-residents who receive care is high--44% in the former and 52% in the latter. The municipalities of Feira de Santana (BA), Petrolina (PE), Campina Grande (PB), Corumbá (MS), and Duque Caxias (RJ) are site to health macro-regions, as they

serve as referral centers for abortion care for other municipalities of the state. In addition, the municipalities of Feira de Santana (BA) and Campina Grande (PB) are geographically located where there is a confluence of municipalities, yet one more reason to receive residents of other municipalities. Campina Grande's volume of annual hospitalizations for abortion is very close to that of the capital of the state, which has a larger population.

About the Infrastructure

The above-mentioned issues related to the system's organization contribute towards existing infrastructure problems found in healthcare facilities. However, problems with inter-municipal agreements are not entirely responsible for the lack of maintenance of the facilities and equipment, or even the lack of sheets, pillows and towels, identified in Petrolina and João Pessoa. In Recife, the study identified problems related to the infrastructure and limited human resources.

> *We found a 24-year-old woman, who was in a lot of pain, lying on a plastic bed without a pillow and with only one sheet. Her serum was obstructed with blood, and she was losing fluids, a situation of abandonment, isolation, solitude and inhumanity. The young woman even remained in the same ward where there was a woman accompanied by her newborn. (PE Dossier)*

Infrastructure problems have repercussions on the quality of care, in addition to compromising health professionals' work, which causes stress in their daily activities. Some administrators noted that overcrowding results in an overload for health professionals, compromising quality of care, in addition to the number of professionals, which is far short of what is needed:

> *This is a serious human resource problem; health professionals do not have time to talk to and visit with patients, as they are overworked. Ideally, the Barros Lima Maternity Hospital should have five physicians on duty, but it has difficulty maintaining the required team due to vacations, long paid leave, and resignations. Actually, there is an average of three physicians on duty (Health Administrator, PE Dossier).*

Another important issue is the fact that women who abort remain in the same spaces as women who give birth. In general, the maternity hospitals researched do not have specific wards for women who present with abortion, with the exception of the Cândida Vargas Maternity Hospital, in João Pessoa. This means that they have to wait in the pre-delivery area to undergo the sharp curettage procedure, and then they stay in the delivery wards with the women who gave birth and their babies. The research team who developed the PE dossier pointed out that they found many abortion clients in the pre-delivery areas alongside women who were in labor, or in the wards with mothers and newborns breastfeeding or lying in bed.

Despite the argument that separate spaces could contribute towards stigmatizing the women who abort, the fact is that there are no adequate spaces for abortion care, which contributes towards exposing the women, lack of privacy, judgment, and inhumane care. It is important to consider that abortion means something different to each woman, and that staying with women who just gave birth and their babies can be constraining and cause emotional discomfort, resulting in feelings of guilt, loss, frustration and disgust. Still, many clients value being

with other women, regardless of the procedure they underwent.

> *This room is for observation and does not have a bathroom; we use the one in the postpartum ward, where there are women breastfeeding their newborns. Thus, we end up sad. My belly has a dead baby; I think they should do something about this. At times I forget that I lost my baby; I sleep and when I awake I have to face reality (Client, RJ dossier).*

At a facility in Rio de Janeiro, the women stay in an area for hypodermic patients [18] . One nurse stated: "*The area is very inadequate for abortion patients; there is no privacy, no shower stall and no bathroom; they are exposed. After the sharp curettage procedure, they return to the hypodermic patient area, where instead of a bed, they are only offered a reclinable chair until discharge. When that area is full, patients are redistributed to other spaces."* (Nurse, RJ) *"Today this area is very full; it is not appropriate to be with so many people; this is not a ward, and those who arrive here to provide treatment have to wait standing up because there is no place to sit down"* (Health Professional, RJ Dossier).

The lack of an appropriate space denounces the lack of priority and infrastructure for abortion care. These situations reveal that there are different ways to punish and discriminate against women who have abortions. Many health professionals believe it is appropriate to have separate areas for delivery and abortion cases, due to the fact that sharing the same space is constraining for the women undergoing abortion.

There are also difficulties to perform the ultrasound exam, which contributes towards prolonging the waiting time as well as the time spent providing care. Often the ultrasound is not available or is only available during business hours, or it is available only in other municipalities. It is very common to not have ultrasound available during the night shift or on weekends and holidays, which forces patients to wait to undergo the procedure. Although the ultrasound is not indispensable for diagnosis in every case, some health professionals consider performing an ultrasound an obligatory step as a prerequisite for the sharp curettage procedure, placing too much importance on the ultrasound to resolve cases. However, for some professionals the clinic is determining, and ultrasound is necessary only when there are doubts.

The Technical Guidelines for Humane Abortion Care do not require an ultrasound exam, stating that: "the ultrasound confirms the diagnostic hypothesis, although it is not indispensable" for cases of inevitable/incomplete abortion (MINISTRY OF HEALTH, 2005:23).

A social worker in João Pessoa confirmed that the ultrasound is performed especially in cases where induced abortion is suspected. Requiring this exam could be viewed as an instrument to control women's bodies and a resource to exercise medical power over women's decisions, perhaps interfering when possible. The wait is a way to punish the women. (RABAY AND SOARES, 2008).

However, the difficulty to access the ultrasound exam could also produce an error in the abortion diagnosis. The PE dossier highlighted the problem of a delayed diagnosis and recurrence of diagnosis errors in Petrolina, where

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[18] Space used for observation, rest and stabilization of vital signs.

the facility does not have access to ultrasound and has to refer patients to a polyclinic, which only performs ultrasounds in the afternoon.

> *Ultrasounds that diagnose missed abortion and anembryonic gestation, which lead to the immediate hospitalization of the women. When Dr. Malam is able to repeat the exam, he verifies the error and that the embryo is normal. After several days in the hospital, the woman is discharged without any health problem (health professional, PE dossier).*

Technical Guidelines and Abortion Method: What is the Status of MVA Use?

Health professionals have little knowledge about the Technical Guidelines for Humane Abortion Care (MINISTRY OF HEALTH, 2005c), which established abortion care regulations in Brazil. In addition, on a daily basis, there is failure to comply with programs, protocols, manuals, and especially with the Technical Guidelines. When dealing with abortion, usually health professionals refuse to treat the women or find it difficult to adopt the recommendations of the Technical Guidelines and of maternity hospital administrators, just like with the use of the manual vacuum aspiration (MVA) technique.

As for the procedure method, there is an almost absolute predominance of post-abortion sharp curettage (PASC) vs. the MVA technique, despite the differences that can result in better quality of care. The Technical Guidelines for Humane Abortion Care (MINISTRY OF HEALTH, 2005c) notes the use of MVA as a cheaper, faster, and safer method than PASC.

The municipality of Recife was where the technique was used most, reaching a percentage of 10% in relation to procedures for treatment of induced abortion in comparison to the other capitals that presented percentages of 2.33% (Rio de Janeiro) and 1% (João Pessoa and Salvador) and some municipalities that did not report procedures with MVA. In Petrolina (PE), between 2003 and 2007, PASC was chosen as the method for 98% of the procedures. The same phenomenon was detected in municipalities such as Rio de Janeiro, Duque de Caxias, Nova Iguaçu, João Pessoa, Campina Grande, Salvador, Feira de Santana, Campo Grande, and Corumbá.

Explanations were raised for not performing the procedure, given that on-site training was offered so that providers could learn to master this technique. Some healthcare professionals interviewed in Bahia noted that a quick, two-day training is not sufficient to break or reduce providers' resistance. Despite being low, the number of MVA procedures increased after the second training. According to one of the providers interviewed, "to increase the acceptance of MVA, we need to invest more in making providers more sensitive to women who undergo abortion; it is not sufficient to just have the kit". (BA Dossier).

Post-Abortion Family Planning

That seems to be one of the biggest gaps in abortion care. Post-abortion family planning is not implemented as a routine service. Users often return home without having received preventive care; they leave the facility without being counseled to use a contraceptive method and without a referral to a basic care facility for the prevention of unintended pregnancy. There are cases where counseling is provided, but informally or rushed without attaining the necessary effectiveness. There are also stories of users who request counseling but don't receive it. *"There is no post-abortion family planning. The women leave the hospital without a referral. They ask for counseling, but there is nowhere where they can be referred. The hospital is highly complex; it is not a basic care facility*" (RJ

Dossier). That flagrant omission is reflected as punishment of the women who return to the facilities with repeat abortions, as they are judged as irresponsible. It is evident that the lack of a referral and counter-referral system is harmful to women's reproductive health.

In João Pessoa, monitoring of abortion care, conducted by Cunhã Coletivo Feminista in four public maternity hospitals in the Great João Pessoa (2009), reveals an average of 1.4 abortions for each woman, indicating the practice of repeat abortion. Of a sample of 56 women who accessed the services, 16 had already experienced one or more abortions (CUNHÃ, 2009).

In Mato Grosso do Sul, an administrator recognized that family planning services need improvement. In Bahia, one of the facilities researched registers clients for family planning service, and they are discharged with a follow-up visit scheduled. However, they are aware that it is difficult for women to return to the facilities post-abortion or post-partum, because they have to take care of their small children, babies and housework in precarious economic contexts.

Given the lack of quality family planning services, many providers opt for and offer their clients tubal ligation as a family planning method. In all of the facilities researched, there was hardly any reference to indication for and provision of emergency contraception.

Post-abortion family planning is indispensable for the prevention of unintended pregnancies, as it also prevents resorting to repeat abortions. That gap is reflected as negligence on the part of the State, especially in the context of accountability and criminalization of the women who resort to abortion.

Wait, hunger, lack of information, lack of privacy, discomfort... inhumane care

> *I was not treated badly here, but that room is very cold and the conditions are horrible. If I had not brought a bedspread from home, I would be freezing in that uncomfortable chair. I've been here since yesterday, 24 hours thus far, 12 hours and 45minutes without eating; I think that I'm waiting for a curettage procedure, which I believe will be performed this afternoon, but here no one informs you of anything... (Client, RJ Dossier).*

As shown previously, abortion is a significant part of the demand of women who seek reproductive health services. Quality care is a client's right, especially when she is physically and emotionally vulnerable, regardless of whether she is experiencing childbirth, spontaneous abortion or induced abortion.

However, the women's stories reveal a violation of the right to health care and information, and the right to autonomy in relation to the decision to end a pregnancy. Testimonies from women undergoing abortion note frequent inhumane care in hospitals, characterized by long waits, fasting, lack of information, violation of privacy, and attitudes of recrimination, blame and punishment of patients. In Salvador and Campo Grande, there were even reports of sharp curettage procedures performed without anesthesia, a very common practice in poor treatment of abortion patients, which was seen in previous reports and which has been fought throughout the years.

The wait could be related to factors inherent in patients' clinical status, such as cervical dilation. However, experience has shown that it is also determined by issues such as the lack of ultrasound and to giving priority to providers' alleged power to judge and punish their clients.

Women undergoing abortion do not receive preferential treatment, and there is an informal order that prioritizes care to pregnant women who are in labor. That standard was found in all the facilities researched, which clearly lengthens clients' hospital stay. When they present at the maternity hospital experiencing abortion, generally bleeding, they wait two or three hours at the reception or in triage, even if they are in pain or hemorrhaging.

> *... We arrived early; I remember that there were only two people ahead of me, but they were taking a long time to treat me. Other people started arriving and they went right in front of me; I think it's because they knew that I had induced an abortion. I think that when women induce an abortion, they punish them harshly, leaving her lying in a corner. I was with my sister and my mother; we waited in the waiting area, but they did not take me in; they didn't even bring a bed; I remained seated. I had a very big Tampon, but even so, when I got up from the chair, I saw that my clothes were drenched in blood. The receptionist called the doctors. I think that if they had not seen all that blood, it would have taken longer. I know that I got there at 7 a.m. and they took me in around 10:00. (Client, BA Dossier)*

> *Sometimes even with hemorrhage... there was a case of a woman who smelled awful when she was finally able to be seen; she spent more than a day waiting in triage, with missed abortion, with sepsis, even so, she was the last one to be seen that day. "That's how it is; when it's an abortion, they don't even want to know whether it was spontaneous or induced; the woman is left for last in admissions" (Health Professional in Petrolina, PE Dossier).*

It is worth noting that at a maternity hospital in Campina Grande, it was surprising to see that women were discharged from the hospital immediately after the sharp curettage procedure. That is considered carelessness and negligence, especially in contexts of poverty, in which women need to return to work immediately after leaving the hospital, and sometimes they have neither a companion nor transportation to return home.

Lack of priority is also related to lack of space to treat abortion patients in overcrowded maternity hospitals: "If there are three good rooms and a bad one, the woman who presents with abortion complications will be put in the worst room" (Health Professional, RJ Dossier). Clearly, women undergoing abortion receive different treatment than those who are about to give birth; it is evident that women who abort are undervalued and marginalized, and face institutional violence.

The wait is generally accompanied by discomfort, bleeding, pain, fear and hunger, as clients who are waiting are usually subjected to fasting. Hunger is very discomforting for the women, as many of them experience hunger in their daily lives given their low-income situation. During the waiting periods, expectations are maximized by the lack of adequate information denied to clients by healthcare providers, which violates their right to choose.

It took a long time to perform that sharp curettage. It took my boyfriend's aunt arguing and saying something... Then it was my mom who went to talk to them. They told her: "stay calm, you have to stay calm". She said: "how can I stay calm when my daughter has already been fasting for four days. What kind of fast is that? Is it Holy Week fasting? Is my daughter going to die by chance?" Then, they answered: "in three hours". Three hours turned into after the visit. Six hours had gone by when they finally performed it, and that was because my mother went to complain again. (Client in João Pessoa, PB Dossier).

Often women report discomfort when their privacy is violated. This takes place in different ways: high demand of maternity hospitals produces overcrowding in wards, for which the demand for beds is higher than the capacity of the wards; providers' indiscretion; the fact that wards are accessed by other people, such as vigilantes; small gowns; and excess of students in teaching hospitals, which is always a reason reported by the women for feeling constrained.

You are thrown into a corner and they give you bad looks. So as not to say that they did not pay any attention to me, that happened a day after, when a group of academicians was "invited" by a physician to see my situation. There were about six of them, and they all touched me to feel something the physician was showing them. Today, I can't believe that I allowed them to do that to me! They would simply come in, insert their hand, and they did not even say a word to me. It's as if I were a thing, an object. (Client, MS Dossier).

I was in the waiting area waiting to undergo sharp curettage; they threw you in there as if it were some kind of punishment. I thought I was being punished. And I was there the whole day, Mother's Day.... The doctor came, examined me, and said nothing, absolutely nothing. I remained there in the hospital gown. And then the interns came, lifted the gown and inserted their fingers, without saying a word. One right after the other would approach me, and I felt awful... (Client, Bahia Dossier).

Waiting, hunger, pain, and feeling exposed are eased with information. Lack of communication between providers and clients is a given in healthcare facilities. Often women are not informed about the procedures to which they will be subjected, and they only find out about it when they talk to other clients who have already gone through the same process. Many women do not understand the procedure they are about to undergo, why they need to extend their fasting, why they have to wait. We found clients in different states, who even thought of leaving the maternity hospital due to long waits and lack of information.

The Technical Guidelines for Humane Abortion Care (BRAZIL, 2005c) recommend counseling the woman so she can undergo the process proactively, make decisions, and take care of herself. Misinformation prevents establishing a relationship of trust between providers and clients, and compromises the continuity and effectiveness of healthcare actions.

Lack of communication is the result of the type of relationship that providers think they should establish with their clients, seen as patients. Technicism marks that behavior, where the provider's technical knowledge causes

distancing in the provider-client relation, based on a relationship of superiority/inferiority. Some providers refer to women as a curettage, which reduces the woman who is undergoing abortion to a procedure or object. The testimony of a health professional reveals the way in which his colleagues act with respect to abortion:

> *"They do not agree to anesthetize the women to perform the sharp curettage procedures at night; they leave everything for the morning shift. They don't get up. If another woman comes in for a sharp curettage, she could be bleeding, hemorrhaging, and they would say a joke like: 'gather all the curettage clients and they'll be next'." (Health Professional in Petrolina, PE dossier).*

When there is no dialogue, the client feels like an object treated with total disregard. "It is difficult to identify the providers who treat us; they don't say their names, and it is very difficult to read their names on their gowns when you are in pain" (Client, PB dossier). Once again, testimonies show women's low socio-economic status and low educational level, which increase the vulnerability to which they are subjected in healthcare facilities.

The way students/interns are led by professors and the way they approach clients is seen as learning the provider-client relationship model predominant in the health sector, which leads to adopting practices of constraint, punishment, and lack of dialogue. The attitude of technicism and the position of superiority and judgment create barriers that prevent providers from getting closer to their clients, compromising trust and dialogue, which are important for making clients feel at ease.

The care provided lacks active listening on the part of health professionals. Active listening involves hearing and addressing clients' needs, difficulties, doubts and sorrows. It should also consider social and cultural insertion, family history, the woman's relationship with her partner and her desire to have or not have children. It also involves the issue of rights and citizenship, rescuing the client's status as a historical subject and not merely a recipient of medical behaviors.

Criminalization of Women and the Presence of Religious Values in Health Care

Dehumanization is related to the clandestine nature of abortion in the country. Increasing criminalization of women who have abortions has increased cases of imprisonment of women both in the communities and in hospitals. In one of the dossier's it was reported that at one of the hospitals in Rio de Janeiro, *"the head of obstetrics called the police, because a woman had helped another woman induce an abortion, since the 'abortionist' had fainted when she saw the fetus. That woman was imprisoned, and the physician was a prosecution witness"* (RJ Dossier). Accusation cases coexisted with the practice of healthcare providers in public Brazilian facilities, constituting disrespect of women's human rights with respect to safeguarding the secrecy of abortion care and the patient's chart, running counter to that advocated by the Technical Guidelines for Humane Abortion Care [19]. In addition to providers reporting abortion cases, there are other forms of criminalization through legitimization of ill treatment, punishment, prejudiced attitudes, moral judgments, and accusations suffered by women who undergo abortion.

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[19] In the face of natural or induced abortion, the physician or any other health professional cannot report this act to legal and judicial authorities, or to the Public Ministry, due to his duty of medical secrecy; revealing the secret is anti-ethical and criminal, especially because it can result in a criminal procedure against the woman.

The way providers refer to the women is loaded with judgment and prejudice: *"there are the clients; there is a portion of the unmanageable population with whom no physician is able to have a conversation; they are drug addicts, who live any which way, who don't care about what we tell them". "Their lifestyle has no ties to anything; those women who have abortions... and later regret it"* (Health Professional in Salvador, BA Dossier). Visits to facilities, observations of services, interviews with clients, testimonies and expressions used by the healthcare providers interviewed often indicated the urgency of overcoming the various forms of discrimination that affect women who undergo abortion.

Biased, inadequate approaches instituted by providers result in inhumane care marked by institutional violence. Women who abort are judged as irresponsible and non-committal, as providers do not practice active listening to learn women's reasons for becoming pregnant and having an abortion, or to learn about the difficulties they face to prevent unwanted pregnancy.

It was also verified that providers have an investigative and judgmental tone with respect to women's attitudes, without knowing the meaning of humane care.

> *"In another institution, a provider stated that he initially wanted to be a gynecologist, but at the end of the course he chose to be an anesthesiologist. "Do you know why? Because sedare dolore divinum est "[20]. Later, that same provider returned to the facility where we were, holding a woman in his arm. With a gesture that indicated his lack of respect towards her, he showed her to us at the same time that he asked her in an aggressive tone: 'Was it spontaneous or induced? Tell me my child, how many pills did you put in your vagina? How many did you take? Are you one of those who kill the cobra and show the stick?" He then ordered the nurse to take her to the surgical center and added: "Leave her there feeling a bit cold". (BA Dossier)*

Endowed with authority, the physician confers upon himself the power to interrogate his client in an investigative manner to find out whether she induced the abortion. The testimony of a client summarizes this well.

> *"I had no companion. I only had an accuser. That's all." For many providers, treating the woman poorly is a way of making her pay for having had an abortion. "And we know that prejudice is such that even women who present at hospitals with spontaneous abortions are also treated poorly, because there is always the suspicion that the woman did something to induce that abortion" (Researcher, MS Dossier).*

In fact, providers' attitudes are characterized by religious moral values, which makes it difficult for them to treat abortion cases. Many healthcare providers are Catholic or Evangelical, and have problems performing abortions, because they transfer their religious beliefs to their practice. They often explain their unwillingness as the position to defend life. Still, with positions opposed to preserving women's lives, providers judge the women, adopt punitive and discriminatory attitudes, boycott abortion care, or refuse to perform legal abortion procedures. A health professional in Rio de Janeiro noted the difficulties in providing legal abortion services:

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[20] "Pain sedation is a divine act".

"Even so, I perceive resistance from obstetricians and anesthesiologists to perform the procedure due to personal issues. The maternity hospital plays its part, but providers whose position is to preserve life end up judging the women and refusing to perform the procedure" (RJ Dossier)

Delving deeper into issues related to providers' practice is fundamental for designing and implementing public policies to create an enabling environment for abortion care, reducing stigma and stimulating providers, regardless of their moral and religious biases, to adopt an ethical position that ensures respect to women's human rights.

Despite their religious affiliations and biases, some providers try to ensure abortion care:

With respect to the religious issue, there is a huge bias. I am an Adventist, but I understand that the problem is between the woman and God. Now I work with 17 providers (undergoing professional training) and sometimes I see one of them asking whether the abortion was induced. I tell them that they are not there to ask those questions, that their duty is to provide care and check vital signs... (Health Professional, PE dossier).

Still, maternity hospital settings are marked by religious symbolism in the vast majority of the facilities researched, which infringe upon the secular nature of health care and of public policies. Predominant are Catholic symbols, including crucifixes, images of saints, paintings with psalms in hallways, images of the Virgin Mary in reception areas, and even chapels inside the maternity hospitals, as well as televisions transmitting Catholic and Evangelical programs in the wards. Religious presence in health facilities has been instituted in a naturalized manner, collaborating to legitimize providers' abusive practices and to blame the women. It also implies disrespect to women affiliated to other religions, such as African cults, or those who have no religion. The testimony of an administrator at a maternity hospital in Pernambuco confirms the institutionalization of disrespect to secularism: *"Here in the hospital there is an Evangelical project whose members pray with and read the bible to the patients every day, and a Charismatic group of the Catholic Church comes every weekend... it is a routine, a comfort"* (PE Dossier).

How about the women, what do they feel?

In the face of that scenario, the women are left in a threatening situation when they seek treatment of abortion, be it induced or spontaneous, in health facilities, and the feeling of insecurity and loneliness is common in maternity wards. *"I was afraid. I was very scared that something awful would happen to me. I only ended up in the hospital because I was hemorrhaging. I bled all night; I was very weak and the hemorrhage only seemed to increase"* (Client, MS Dossier).

Due to the clandestine nature of abortion and countless acts of institutional violence, the women either do not seek this service or do so late. When they present at the facility, they often refer to it as spontaneous bleeding, without mentioning having induced an abortion, as a strategy to protect themselves against providers' judgments and discrimination, as well as against the growing threat of being reported or imprisoned, which conservative groups have promoted in opposition to women's struggle to increase their rights.

Clients' attitudes are often confronted by healthcare providers and medical students with approaches that aim to force them to confess. Even when it is pointed out that providers do not have the right to judge, their statements

are indicative of the way they treat the women, turning their social status and vulnerability into something banal: *"However, we know the folklore of the stories of patients who present at public hospitals after having induced an abortion"* (Health administrator, RJ Dossier).

The feeling of loneliness expressed by the women is associated to the absence of the pregnancy "partner", the absence of dialogue with providers, the fact that they are in a clandestine situation, and to providers' rudeness and abuse of authority, as well as all types of ill treatment suffered during their stay in the maternity hospital. There is also the fact that women who have abortions do not have the right to a companion, which is often justified by the lack of space, but is more a reflection of the criminalization of the practice of abortion in health facilities.

When they are treated with disregard, are not welcomed and their needs are not met, the women evaluate healthcare providers and services negatively, as opposed to their positive evaluation when they receive humane care.

However, they minimize violations through problem resolution, after receiving care, they report a feeling of relief.

> *"I felt relief after receiving care. Great relief after everything turned out okay. It was the best thing that happened. Logically, it is not good to experience suffering, fear, and sorrow. But I have no regret..." (Client, PB Dossier).*

Final Considerations

The study conducted in five states, with high incidence of unsafe abortion, in three Brazilian regions, produced data that reflect the national reality, with a few exceptions. The Technical Guidelines for Humane Abortion Care (BRAZIL, 2005C) note the use of MVA as a cheaper, faster and safer method than sharp curettage. However, in all the states studied –Pernambuco, Paraíba, Bahia, Mato Grosso do Sul, and Rio de Janeiro- post-abortion sharp curettage (PASC) was the preferred method in 98% of procedures to complete the abortion process. Recife had the highest rate of MVA use, reaching 10% in comparison with the use of PASC.

In the same states, testimonies of women presenting at hospitals to seek abortion care reveal frequent inhumane treatment, long waits accompanied by fasting and bleeding, sharp curettage procedures performed without anesthesia, and attitudes reproaching and blaming the women who undergo induced abortion.
The study also found serious failures in post-abortion family planning services. In general, family planning services are not provided immediately post-abortion and women are not referred to other facilities for this service. When it is provided, it is done so informally. In Mato Grosso do Sul, they reported serious failures with coverage, quality of care and maintaining stocks of contraceptive methods, which affect rural areas and poor sectors of the population, especially the indigenous population.

That scenario points out that one of the essential instruments for reverting that reality is for providers to incorporate in their daily practice the recommendations of the Technical Guidelines for Humane Abortion Care (BRAZIL, 2005c). However, there is much to be done in reference to providers' moral values and biases, as it is

not possible to practice the recommendations of making patients feel welcomed, respecting their decisions, and providing humane care, if providers do not have a secular position that accepts the woman's decision to undergo abortion, without judging her behavior.

The collection of dossiers raised a series of recommendations directed at parliamentarians, administrators, and professional training entities, with the aim of collaborating to transform the reality generated by Brazil's restrictive abortion law as a barrier to access to health care as one of women's human rights.

Recommendations for Competent Authorities

The recommendations below are the result of the conclusions reached based on the data collected to develop the five dossiers, and of the debate held among administrators, health professionals, and leaders of the women's movement based on that work. They aim to collaborate towards improving the quality of abortion care nationwide, based on the experience of the states studied and to reflect on the need to decriminalize and legalize abortion in Brazil.

- Whereas the illegal practice of abortion does not reduce its incidence, and whereas the current legislation has a negative impact on women's lives, on the quality of care, and on Brazil's Unique Health System (Sistema Único de Saúde);
- Whereas in the country's poorest regions and in the periphery of urban centers, women's difficulty in accessing health and family planning information and services may be the cause of the high number of unwanted pregnancies, which can lead to the practice of unsafe abortions that threaten women's lives;
- Whereas the majority of women who access health services for treatment of unsafe abortion are black, young, poor, unemployed, with low educational levels, and already have children;
- Whereas abortion is the fourth cause of maternal death in our country, a cause which has been overcome in countries where abortion has been legalized;
- Whereas the abortion procedure performed by trained health professionals in safe hygienic conditions does not represent risks for women's lives and health. In Northern countries, the likelihood of a woman dying from abortion complications is one in 100,000 procedures, that is, lower than the risk of dying from pregnancy-related causes or in childbirth (THE ALAN GUTTMACHER INSTITUTE, 1999);
- Whereas the UN Human Rights Committee established that "*respect to women's lives includes the duty of State Parties to adopt measures to prevent women from resorting to unsafe clandestine abortions, which put their lives and health at risk, especially poor women and Afro-descendants";*
- Whereas the UN Committee on the Elimination of Discrimination against Women (CEDAW), in its General Recommendation No. 24 expressed that failure to guarantee access to health services that only women need is a form of discrimination against women: *"Other barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures";* and requires that *"when possible, legislation criminalizing abortion should be amended to remove punitive provisions imposed on women who undergo abortion";*
- Whereas access to safe abortion services is directly related to greater or lesser purchase power of the women who seek those services. Women of more privileged classes have access to private clinics and to better trained providers than women with a lower socio-economic status. The International Covenant on Civil and Political

Rights (Article 2) and the International Covenant of Economic, Social and Cultural Rights (Article 2), both ratified by the Brazilian government, establish the duty of State Parties to ensure the exercise of human rights without discrimination of any kind, including socio-economic;

And, finally, whereas the criminalization of abortion results in the clandestine nature of its practice and in unsafe abortions, we list below the following recommendations:

- Increase coverage and qualify obstetric care in all of the municipalities, according to the administrative complexity of the SUS;
- Organize obstetric and neonatal care networks that ensure service to high-risk pregnant women in emergency situations, respecting the referral and counter-referral mechanisms;
- Increase coverage and qualify the network of care to women and adolescents who are victims of sexual violence, ensuring abortion services in cases where it is legal;
- Qualify and humanize care provided to women who undergo abortion in hospitals;
- Disseminate the Ministry of Health's Technical Guidelines for Humane Abortion Care, and monitor and evaluate their implementation in health facilities;
- Increase the use of the manual vacuum aspiration (MVA) method in facilities that are already using it and implement the procedure as routine practice in Brazilian maternity hospitals, aiming to prove its benefit for clients and facilities alike;
- Create mechanisms and routines that aim to decrease the hospital stay of women who undergo abortion;
- Respect women's privacy during abortion care;
- Make ultrasound available in the municipalities in order to reduce women's waiting time to undergo the procedure, thus preventing long waits, fasting and transfers;
- Facilitate the purchase of medications, specifically Misoprostol, through new decrees and resolutions that ensure that smaller maternity hospitals and hospitals in the interior can obtain them;
- Prioritize improvement of family planning services in the municipalities, through the implementation of Family Planning actions and monitoring of those actions;
- Ensure post-abortion family planning services in maternity hospitals, referring clients for basic care;
- Ensure psychosocial care of women who undergo abortion in public maternity hospitals;
- Develop an ongoing education process with healthcare providers, with a gender perspective, on sexual and reproductive rights, focused on the client-provider relationship, issues related to unsafe abortion and legal abortion, aiming to humanize care;
- Engage the feminist movement in developing abortion-related, ongoing education processes to be implemented with health professionals;
- Stimulate research that can envision abortion and contraception issues based on women's perspectives interfaced with the environment in which they live and their specific cultural background;
- Support sexual and reproductive right campaigns, targeting the most vulnerable populations, especially women who reside in municipalities in the interior, young women, and adolescents.

Final Recommendation

Based on the proven impact of the current abortion legislation on women's health, on the quality of care, and on Brazil's Unique Health System (SUS), and based on the facts and data presented in this report, we recommend that the representatives of the National Congress support and approve bills presented before this House of Representatives related to the revision of the current restrictive abortion law, supporting abortion decriminalization and regulation through SUS, adopting as reference the tenor of the proposal developed by the Tripartite Commission in August 2005 for the Revision of Punitive Legislation on Elective Abortion.

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Annex 1

Table 1: Maternity Hospitals Researched and Parliamentarians' Actions in the States/ Municipalities Studied

State	Capital / municipality	Maternity Hospital	Parliamentarians and their actions with respect to the project
Pernambuco	**Recife**	Maternity Hospital Prof. Barros Lima	State Deputy Teresa Leitão (PT) – Articulation for launch before the Legislative Assembly Federal Deputy Paulo Rubem (PT) – Articulation for launch before the Federal House of Representatives They participated in visits to maternity hospitals, in press collectives, and in the state launch.
	Petrolina	Maternity Ward in Hospital Dom Malan,	
Bahia	**Salvador**	Maternity Hospital Tsyla Balbino Institute of Perinatology of Bahia – Iperba	Councilors present at the state launch: Vânia Galvão (PT) Olívia Santana (PCdoB) Aladilce Souza(PCdoB) Marta Rodrigues (PT) State Deputy Present at the state launch Daniel Almeida (PCdoB) Federal deputies present at the state launch Zezéu Ribeiro (PT) Lídice da Mata (PSB) Alice Portugal (PCdB) Neuza Cadore (PT)
	Feira de Santana	Maternity Hospital Prof. José Maria de Magalhães Neto	
Paraíba	**João Pessoa**	Cândida Vargas Institute	There was no parliamentary action
	Campina Grande	Maternity Hospital Elpídio de Almeida	
Mato Grosso do Sul	**Campo Grande**	Maternity Hospital Cândido Mariano	State Deputy Paulo Duarte (PT) – Articulation before the Legislative Assembly State Deputy Marcus Trad (PMDB) They received in their cabinets the committee of researchers and of the women's movement.
	Corumbá	University Hospital Maria Aparecida Pedrossian	

Rio de Janeiro	**Rio de Janeiro**	Maternity Hospital Pró-Matre	State Deputy Inés Pandeló (PT) – asses. Accompanied us during the visits and participated in the public hearing. State Deputy Paulo Ramos (PDT) – Accompanied us during the visits and participated in the public hearing. State Deputy Marcelo Freixo (PSOL) – Articulation before the Legislative Assembly, convened and coordinated the public hearing and accompanied us on visits to maternity hospitals.
	Nova Iguaçu	General Hospital of Nova Iguaçu/ Hospital da Posse	
	Duque de Caxias	Municipal Hospital Dr. Moacyr do Carmo	

Annex 2

COMMUNICATIONS REPORT

Communications, by its political nature, is an indispensable element in intervention strategies advocating for women's rights. Therefore, from the development phase to the dissemination of the dossiers, we used specific communication tools, which took into consideration local contexts, individuals and institutions involved, and the relevance of mass communication vehicles (public, private, community-based, etc.) to continuing or eliminating social stigmas. Newspaper coverage revealed, even in unsaid, dominant or even latent political and social trends. Still, astonishing data showing women's vulnerability in the face of a taboo topic such as abortion managed to penetrate the filter of media injunctions, in addition to leaving a good hook, using journalistic jargon, for other subjects on elective abortion, which succeeded the media hits mentioned below.

MEDIA HITS IN THE STATES:

HITS IN PERNAMBUCO

Period: 10/06/2008 to 12/08 /2008

Person Responsible: Nataly Queiroz – Communications Advisor

Number of Hits: Printed – 10 entries
Television – 03 hits
Radio – 11 hits
Web – 19 hits

PRINTED				
Vehícle	**Publisher**	**Date**	**Topic**	**Source**
Gazeta do São Francisco	Geral	10/06/2008	Dossier/visit to Dom Malan	Advisors
Folha de Pernambuco	Grande Recife	10/06/2008	Dossier/visit to Barros Lima	Paula Viana
Jornal do Comércio	Cidades	11/06/2008	Dossier/visit to Dom Malan	Advisors
Gazeta do São Francisco	Geral	11/06/2008	Dossier/visit to Dom Malan	Paula Viana
Folha de Pernambuco	Grande Recife	22/06/2008	Dossier / Abortion in Brazil	Núbia Melo
Folha de Pernambuco	Editorial	24/06/2008	In favor of abortion decriminalization	
Diário de Pernambuco	Brasil	03/07/2008	Entrega dossiê Câmara	Beatriz Galli
Diário de Pernambuco	Vida Urbana	03/07/2008	Research/ Dossier	Advisors
Jornal de Uberaba (MG)	Caderno B / Saúde	04/07/2008	Dossier	Beatriz Galli
Diário de Pernambuco	Vida Urbana	12/08/2008	ALEPE Hearing/ Dossier	Advisors
TELEVISION				
Broadcasting Station	**Program**	**Date**	**Topic**	**Source**
TV Grande Rio (Globo)	Noticiário Grande Rio	10/06/2008	Dossier/visit to Dom Malan	Paula Viana
TVU	Nosso Jornal	11/06/2008	Dossier /Audit	Paula/Núbia
TV Jornal	TV Jornal Notícias	03/07/2008	Submit dossier to House of Representatives	Núbia Melo
RADIO				
Broadcasting Station	**Program**	**Date**	**Topic**	**Source**
Rádio Folha	Folha Notícias	09/06/2008	Dossier /Visit to Barros Lima	Paula Viana
CBN	CBN Recife	09/06/2008	Dossier /Visit to Barros Lima	Paula Viana
Rádio Folha	Folha Notícias	11/06/2008	Dossier /Audit	Núbia Melo
Rádio Universitária FM	Redator Comunitário	12/06/2008	Dossier /Audit	Paula Viana
Rádio Palmares	Rádio Mulher	16/06/2008	Dossier /Audit	Paula Viana
CBN	CBN Recife	26/06/2008	Alepe hearing/ Dossier	Núbia Melo
CBN	CBN Recife	03/07/2008	Entrega dossiê Câmara	Núbia Melo
Rádio Clube	Super Tarde	07/07/2008	Projeto/dossier	Paula Viana
Rádio Jornal	Super Manhã	12/08/2008	Alepe hearing/ Dossier	Paula Viana
CBN	CBN Recife	12/08/2008	Alepe hearing/ Dossier	Paula Viana
Rádio Folha	Folha Notícias	12/08/2008	Alepe hearing/ Dossier	Paula Viana
WEB				
Portal	**Section**	**Date**	**Topic**	**Source**
Pernambuco.com	Últimas	09/06/2008	Visita Barros Lima	Advisors
Folha Digital	Notícias	09/06/2008	Visita Barros Lima	Advisors
JC Online	Cidadania	25/06/2008	Audiência Alepe	Advisors
Pernambuco.com	Últimas	25/06/2008	Audiência Alepe	Advisors
Folha Digital	Notícias	25/06/2008	Audiência Alepe	Advisors
Hotlink	Local	25/06/2008	Audiência Alepe	Advisors
JC Online	Últimas	02/07/2008	Submit dossier to House of Representatives	Agência Estado
Pernambuco.com	Últimas	02/07/2008	Submit dossier to House of Representatives	Agência Brasil
Agência Brasil	Notícias	02/07/2008	Submit dossier to House of Representatives	Beatriz Galli
Fórum PLP's do Distrito Federal		02/072008	Submit dossier to House of Representatives	Agência Brasil
Agência Brasil	Notícias	02/07/2008	Projeto/Aborto no Brasil	Beatriz Galli
UOL	Últimas	02/07/2008	Submit dossier to House of Representatives	Agência Brasil
Hotlink	Brasil	02/07/2008	Submit dossier to House of Representatives	UOL
Adital	Brasil	02/07/2008	Submit dossier to House of Representatives	Paula Viana
Agência Estado	Últimas	02/07/2008	Submit dossier to House of Representatives	Beatriz Galli
Agência NE	Notícias	06/07/2008	Dossier /audti	Dados dossiê
Rits	Rets	11/07/2008	Dossier	Dados dossiê
Pernambuco.com	Últimas	12/08/2008	Alepe hearing	Advisors
Pauta Social	Pautas	11/08/2008	Alepe hearing	Advisors
JC Online	Últimas	12/08/2008	Alepe hearing	Advisors
Pernambuco.com	Últimas	02/07/2008	Submit dossier to House of Representatives	Agência Brasil
Agência Brasil	Notícias	02/07/2008	Submit dossier to House of Representatives	Beatriz Galli
Fórum PLP's do Distrito Federal		02/072008	Submit dossier to House of Representatives	Agência Brasil
Agência Brasil	Notícias	02/07/2008	Submit dossier to House of Representatives	Beatriz Galli
WEB				
Portal	**Seção**	**Date**	**Topic**	**Source**
UOL	Últimas	02/07/2008	Submit dossier to House of Representatives	Agência Brasil
Hotlink	Brasil	02/07/2008	Submit dossier to House of Representatives	UOL
Adital	Brasil	02/07/2008	Submit dossier to House of Representatives	Paula Viana
Agência Estado	Últimas	02/07/2008	Submit dossier to House of Representatives	Beatriz Galli
Agência NE	Notícias	06/07/2008	Dossiê /balanço	Dados dossiê
Rits	Rets	11/07/2008	Dossier	Dados dossiê
Pernambuco.com	Últimas	12/08/2008	Alepe hearing	Advisors
Pauta Social	Pautas	11/08/2008	Alepe hearing	Advisors
JC Online	Últimas	12/08/2008	Alepe hearing	Advisors

HITS IN BAHIA

Period: 13/11/2008 to 12/02/2009

Person Responsible: Linda Bezerra and Perla Mayane Santos Ribeiro – Communications Advisors

Nataly Queiroz – Communications Consultant

Number of hits: Web – 15 hits

WEB				
Portal	**Section**	**Date**	**Topic**	**Source**
Grupo Curumim	Post	13/11/2008	Dossiê / Lançamento	Da Assessoria
Blog Bahia de Fato	Post	03/12/2009	Dossiê / Lançamento	Da Assessoria
Blog Política Livre	Post	03/12/2009	Dossiê / Lançamento	Da Assessoria
Adital	Notícia	05/12/2008	Dossiê / Lançamento	Lena Souza / Télia Negrão/ Assessoria
Fórum de Entidades Nacionais de Direitos Humanos	Direitos das Mulheres	06/10/2008	Dossiê / Lançamento	Agência Adital
Blog Bahia de Fato	Post	06/10/2008	Dossiê / Dados	Agência Adital
Blog Bahia de Fato	Post	06/10/2008	Dossiê / Repercussão junto a deputada Lídice da Mata	
Rádioagência NP	Nordeste	06/12/2008	Dossiê / Lançamento	Greice Menezes / Assessoria
Fórum PLP's do Distrito Federal	Direitos Humanos	06/2/2008	Dossiê / Lançamento	Agência Adital
Blog Multi-eu	Post	07/12/2008	Dossiê	Agência Adital
Ipas Brasil	Revista de Saúde Sexual e Reprodutiva	Dez/2008	Dossiê	Da assessoria
Observatório de Gênero	Publicações	Dez/2008	Dossiê	Da assessoria
CCR	Notícias		Dossiê / Lançamento	Da assessoria
Rede Feminista de Saúde	Comunica Rede	19/12/2008	Dossiê	Da assessoria
Blog Infância Urgente	Post	12/02/2009	Dossiê / Dados	Dossiê

HITS IN MATO GROSSO DO SUL

Period: 10/06/2009 to 07/04/2010

Person Responsible: Ivanise Andrade – Communications Advisor

Nataly Queiroz –Communications Consultant

Number of hits: Printed – 05 hits

Television – 01 hits

Web – 20 hits

PRINTED				
Vehicle	Publisher	Date	Topic	Source
O Estado de MS	Cidades	12/06/2009	Elaboração Dossiê	Da Assessoria
O Estado de MS	Cidades	19/06/2009	Elaboração Dossiê	Paula Viana / Beatriz Galli
Folha do Povo		19/06/2009	Dados Dossiê	Paula Viana
O Estado de MS	Cidades	07/04/2010	Dados aborto	JC
O Estado de MS	Cidades	09/04/2010	Dados aborto / Caso Neide Mota	Paula Viana / Beatriz Galli
TELEVISION				
Emissora	Program	Date	Topic	Source
TV MS Record	Jornal MS Record 2ª Edição	17/06/2009	Dossiê	
WEB				
Portal	Section	Date	Topic	Source
Capital do Pantanal	Geral	11/06/2009	Elaboração Dossiê MS	Nota / Assessoria Dossiê
Campo Grande News	Geral	11/06/2009	Elaboração Dossiê MS	Nota / Assessoria Dossiê
Ativa FM	Geral	12/06/2009	Elaboração de Dossiê MS	Nota / Assessoria Dossiê
Campo Grande News	Geral	18/06/2009	Dados preliminares Dossiê MS	Paula Viana
Folha de Dourados	Estado	18/06/2009	Dados preliminares Dossiê MS	Paula Viana
Blog Cravo e Canela	Post	18/06/2009	Dados preliminares Dossiê MS	Paula Viana
BBC News	Notícias	18/06/2009	Dados preliminares Dossiê MS	Paula Viana
Fátima News	Notícias	18/06/2009	Dados preliminares Dossiê MS	Paula Viana
CCR	Cobertura Temática	18/06/2009	Dados preliminares Dossiê MS	Paula Viana
Jornal Hojems	Geral	18/06/2009	Dados preliminares Dossiê MS	Paula Viana
Rádio Grande FM	Mato Grosso do Sul	19/06/2009	Dados preliminares Dossiê MS	Paula Viana
Pantanal Notícias	Notícias	19/06/2009	Dados preliminares Dossiê MS	Paula Viana
Câmara Municipal de Pedro Gomes	Notícias	19/06/2009	Dados preliminares Dossiê MS	Paula Viana
Costa Rica News	Destaque	19/06/2009	Dados preliminares Dossiê MS	Paula Viana
WEB				
Portal	Section	Date	Topic	Source
Conesul News	Geral	19/06/2009	Dados preliminares Dossiê MS	Paula Viana
A Tribuna News	Últimas Notícias	19/06/2009	Dados preliminares Dossiê MS	Paula Viana
Idest	Notícias	19/06/2009	Dados preliminares Dossiê MS	Paula Viana
CCR	Frase da Semana	19/06/2009	Dados preliminares Dossiê MS	Paula Viana
Campo Grande News	Geral	05/04/2010	Ongs denunciam abortos em MS	-
Campo Grande News	Geral	07/04/2010	Julgamento médica e denúncia Ongs	-

Articles published in newspapers

Jornal O Estado de MS, 12/06/2009

LEVANTAMENTO

MS registra 10,5 mil abortos induzidos

Ongs vão elaborar dossiê sobre o procedimento no Estado; número é referente a 2008

Gesiel Rocha

Mato Grosso do Sul é um dos Estados brasileiros com os maiores índices de abortamento inseguro, segundo informações divulgadas pelas organizações não-governamentais Grupo Curumim, de Pernambuco, e IPAS, do Rio de Janeiro. As instituições se baseiam em um estudo feito pelos pesquisadores Mário Monteiro e Leila Adesse, do Instituto de Medicina Social do Rio de Janeiro, e divulgado no início deste ano. Conforme a pesquisa, em 2008 foram realizadas 2.480 internações no Estado em consequência de abortos, gerando uma estimativa de 10,5 mil abortamentos induzidos. Tal estimativa é baseada na proporção de abortamentos que necessitam de internação.

Tomando como base os índices verificados, pesquisadoras do Grupo Curumim e do IPAS vêm a Campo Grande nos dias 17 e 18 de junho para investigar a situação do atendimento às gestantes e, em particular, às mulheres em situação de abortamento. Juntamente com pesquisadoras ligadas ao Movimento de Mulheres do Estado, elas vão visitar serviços públicos de saúde e conversar com gestores, parlamentares e profissionais. Os dados coletados vão compor um dossiê sobre a realidade do abortamento inseguro em Mato Grosso do Sul, que será anexado a dossiês de outros Estados para compor um estudo inédito a ser entregue ao Congresso Nacional no início de julho.

> Levantamento feito em 2008 aponta 2.480 internações realizadas no Estado por conta de abortos

DIREITOS HUMANOS

Além do alto número de abortamentos induzidos, as instituições que vão realizar o levantamento afirmam que a situação dos direitos humanos no Estado é bastante precária. As ongs citam o caso das mulheres indígenas, que compõem o grupo mais vulnerável ao risco de morte e morbidade materna por aborto inseguro.

"Milhares de mulheres estão sendo criminalizadas por terem supostamente recorrido ao abortamento clandestino, o que revela que o Poder Público não vem atendendo, pelo menos não com a qualidade necessária, as mulheres que necessitam desse tratamento", afirmou a assessoria das instituições.

Na avaliação das coordenadoras nacionais da pesquisa, Paula Viana, do Grupo Curumim, e Beatriz Galli, do IPAS, o número de internações e as complicações delas seriam menores se a criminalização não inibisse as instituições de saúde de oferecer atenção médico-hospitalar segura para as mulheres que decidissem induzir o aborto.

SAÚDE PÚBLICA

As informações coletadas em todo o País vão subsidiar o debate entre profissionais de saúde, gestores e parlamentares sobre a necessidade da revisão da legislação penal atual sobre o aborto. A ideia é que o tema seja tratado no âmbito da saúde pública e não mais na esfera criminal.

Dados preliminares obtidos pelas pesquisadoras revelam que a ilegalidade da interrupção voluntária da gravidez gera impacto direto na qualidade do atendimento oferecido e pode mascarar a realidade. A intervenção mais utilizada, por exemplo, para assistir mulheres que abortaram ainda seria o mais caro e arriscado (Curetagem pós-parto), na contramão da política nacional, que indica o uso de Aspiração Manual Intra-uterina (AMIU).

E-mail para esta editoria: cidades@oestadoms.com.br

Caso Neide Mota teve repercussão nacional

• Em abril de 2007, Mato Grosso do Sul tornou-se notícia nacional quando a médica anestesiologista Neide Mota Machado, dona da Clínica de Planejamento Familiar, e mais oito funcionários do estabelecimento foram denunciados por crime de aborto e formação de quadrilha. Neide chegou a ser presa após ficar foragida durante dois meses e 19 dias, mas foi liberada por força de habeas-corpus. A médica responde a processo em liberdade, por ter praticado abortos na própria clínica por pelo menos 20 anos.

Pelo menos 10 mil fichas de mulheres que teriam se submetido ao procedimento criminoso foram apreendidas na clínica. A polícia chegou a ouvir muitas das pacientes e o Ministério Público Estadual (MPE) pediu que mais de oito mil delas fossem excluídas da investigação. Casos que ocorreram entre 2001 e 2002 foram localizados por meio das fichas apreendidas pela polícia.

Em agosto de 2008, o juiz da 2ª Vara do Tribunal do Júri, Aluízio Pereira dos Santos, aceitou a denúncia do MPE e pronunciou os envolvidos para que sejam levados a júri popular. No entanto, todos os réus pronunciados entraram com recurso no Tribunal de Justiça (TJ) de Mato Grosso do Sul, recorrendo da sentença do magistrado de primeiro grau. **(GR)**

Jornal O Estado MS, 19/06/2009

ABORTO

Pesquisadoras preparam dossiê sobre saúde materna no Estado

Luisa Amorim

• As pesquisadoras Paula Viana, coordenadora do grupo Curumim em Recife (PE) e Beatriz Galli, assessora de Direitos Humanos do Grupo IPAS, do Rio de Janeiro (RJ), estiveram em Campo Grande nesta semana para elaboração de um dossiê sobre a saúde materna em Mato Grosso do Sul. A principal motivação para a elaboração do documento é o elevado número de abortamentos inseguros subnotificados no Estado. Elas apontam que, em 2008 foram realizadas 2.480 internações no Estado em consequência de abortos, gerando uma estimativa de 10,5 mil abortamentos induzidos.

O documento, que deverá ser entregue ao Congresso Nacional, "é uma forma de dar um direcionamento correto às políticas públicas para a mulher, que se enquadrem à realidade do Estado", afirmam as pesquisadoras. O levantamento foi baseado em dados coletados no Sistema Único de Saúde (SUS) e em visitas a duas maternidades da Capital.

LEVANTAMENTO

Beatriz Galli afirma que a decisão de pesquisar a situação de Mato Grosso do Sul - o mesmo levantamento já foi feito no Estado de Pernambuco e na Bahia - foi baseada no alto volume de abortos do Estado. "O aborto deve deixar de ser criminalizado. Um grande exemplo é a história das mulheres que foram condenadas e apareceram nas principais manchetes do Brasil", afirma Beatriz. De acordo com ela, outro fator preocupante é não existir um serviço de planejamento familiar, principalmente no Interior.

"O número de estupros notificados em Mato Grosso do Sul é muito alto. Como essas mulheres foram atendidas? Alguma dessas situações de violência resultou em uma gravidez? Elas receberam atenção qualificada relacionada à prevenção da gravidez e de Doenças Sexualmente Transmissíveis?", questiona Beatriz.

Ainda segundo dados da pesquisa, o grupo mais vulnerável do Estado são as mulheres indígenas. "Estamos conversando com as equipes, levantando dados e mostrando que esse tipo de problema deve ser mais debatido na sociedade. As mulheres com menor grau de escolaridade, mais jovens e indígenas ou afrodescendentes são as mais susceptíveis a mortes maternas", afirma Paula.

Folha do Povo, 19/06/2009

• EM 2008

Estado teve cerca de 10 mil abortos

Uma pesquisa desenvolvida pelo Instituto Social de Medicina da UERJ (Universidade Estadual do Rio de Janeiro) demonstrou que Mato Grosso do Sul teve aproximadamente 10 mil abortos no ano de 2008. Com base nos dados levantados pela pesquisa, o Grupo Curumim, entidade civil feminista de Pernambuco, desenvolveu outra pesquisa no Estado, sobre a saúde reprodutiva da mulher com ênfase na realidade do aborto praticado de forma clandestina.

Os dados apurados pela UERJ, através do pesquisador Mário Monteiro, foram baseados nos cálculos obtidos nas informações do Ministério da Saúde, ou seja, dos 2.450 abortos registrados no Estado, o pesquisador calculou dados sobre a população de mulheres em idade fértil no Estado, mais os índices de violência sexual, e similares chegaram a 10.450 casos.

Esses números chamaram a atenção dos pesquisadores do Grupo Curumim, que uniu forças com a ONG Ipas, do Rio de Janeiro, para aprofundar o resultado da pesquisa e questionar sobre a saúde pública da mulher em Mato Grosso do Sul.

O grupo, para conseguir levantar os dados, esteve em hospitais e maternidades do Estado, para confrontar as informações oficiais do Ministério da Saúde e reunir números com os profissionais que estão atuando na área.

Ontem, 18, foram publicadas as primeiras informações da pesquisa, que está prevista para ser concluída no final do mês. O resultado final será divulgado em Brasília (DF) nos dias 1º e 2 de julho.

■ Entidades trabalham com rede de apoio para grávidas

Paula Viana, 46 anos, enfermeira e pesquisadora do grupo, disse que os 250 casos de estupro no Estado no ano de 2003, mostrados pelo Relatório Nacional de Direitos Humanos do Núcleo de Estudos da Violência da USP (Universidade de São Paulo) em 2007, chamou a atenção das entidades que atuam nessa área.

Como muitos casos de abortos induzidos são feitos de forma clandestina, e difícil precisar a quantidade de abortos no Estado, e muitos profissionais contam que na maioria são feitos de forma rudimentar, introduzem objetos na vagina e também ingerem chás fortes, o que coloca em risco a vida dessas mulheres.

"Os dados utilizados nesse tipo de pesquisa sempre se baseiam em estimativas feitas a partir do sistema de informação do Ministério da Saúde, porque se tem pouco conhecimento sobre a situação real das mulheres", relata a pesquisadora.

A pesquisa da UERJ, aponta que os municípios de Anastácio, Aquidauana, Caarapó, Corumbá, Ladário, Naviraí, Ponta Porã, São Gabriel do Oeste e Sonora são os que apresentam as maiores taxas estimadas de aborto no ano de 2008.

O índice é de 20 abortos induzidos por ano, para cada mil mulheres de 15 a 49 anos. Outro dado apontado é que entre mulheres com idade inferior a 20 anos, o índice atinge 20%, considerado um dos mais altos do País.

A violência sexual contra as mulheres é apontada como uma necessidade que precisa de cuidados específicos, como distribuição de contraceptivo e preservativos para a prevenção de gravidez e DST (Doenças Sexualmente Transmissíveis).

Geralmente quando as mulheres não tem acesso aos contraceptivos acabam por recorrer aos abortos ilegais que põem em risco a própria vida.

O aborto induzido é definido como crime, pela legislação brasileira, sendo que só é permitida a prática quando a gravidez põe em risco a vida da gestante, ou nos casos de estupro, situação que ainda gera polêmica entre grupos religiosos e segmentos conservadores da sociedade.

"Queremos que o aborto deixe de ser pensado como área criminal, e seja tratado como um problema de saúde pública", completa a pesquisadora.

A Arquidiocese de Campo Grande mantém um grupo de apoio para ajudar as mulheres que desejam o aborto, através do telefone 3321-0139. Na Paróquia São José, por dia, são atendidas em média 10 ligações; a equipe é formada por voluntários, psicólogo e médico.

Segundo informações obtidas com uma atendente, a maioria das mulheres que procuram o atendimento é de adolescentes, e as que optam por fazer o aborto se dizem arrependidas. O grupo de apoio no momento está necessitando de voluntários, que irão dar atendimento uma vez por semana pelo período de quatro horas. **(LC)**

Jornal O Estado de MS, 07/04/2010

Caso Neide Mota

Ex-funcionárias de clínica de aborto vão a júri amanhã

Quatro ex-funcionárias da Clínica de Planejamento Familiar, localizada na área central de Campo Grande, vão a julgamento popular às 8 horas de amanhã. O júri havia sido marcado para março, mas por conta de documentação ele deve ocorrer nesta semana e será ministrado pelo juiz, Aluízio Pereira dos Santos, da 2ª Vara do Tribunal do Júri.

A psicóloga Simone Aparecida Cantaguessei de Souza e as enfermeiras Libertina de Jesus Centurion, Maria Nelma de Souza e Rosângela de Almeida trabalhavam na clínica que pertencia a ex-médica Neide Mota Machado, realizando abortos clandestinos, conforme denúncia feita ao MPE (Ministério Público Estadual). Após o caso tomar repercussão, a unidade foi fechada em março de 2007.

Se forem condenadas, elas podem cumprir pena de 26 a 104 anos de reclusão em regime fechado por ter auxiliado Neide na realização de aproximadamente 9 mil abortos, porém, por conta do tempo em que ocorreram os fatos, alguns crimes já prescreveram. No documento principal há pelo menos 1,2 mil abortos.

As ONGs Ipas Brasil, do Rio de Janeiro, e Grupo Curumim, de Recife, vão esperar a conclusão do júri para reforçar as denúncias aos órgãos internacionais de que o direito à privacidade das mulheres não está sendo respeitado. Essas entidades questionam o que consideram como "tratamento equivocado" sobre a questão. Elas defendem um debate sobre a saúde sexual e reprodutiva das mulheres, por isso vão denunciar o que consideram "criminalização de profissionais da saúde".

As entidades pretendem denunciar o caso para a comunidade internacional alegando descumprimento pelo governo de compromissos internacionais em matéria de saúde sexual e reprodutiva. (JC com Bruno Desidério)

HITS IN PARAÍBA

Period: 17/10/2009 to 21/10/2009

Person Responsible: Cristina Lima, Jô Vital, and Iayna Rabay - Communications Advisor

Nataly Queiroz – Communications Consultant

Number of hits: Printed – 03 hits

Television – 03 hits

Radio – 02 hits

Web – 14 hits

PRINTED				
Vehicle	**Publisher**	**Date**	**Topic**	**Source**
Correio da Paraíba	Cidades	20/10/2009	Número de aborto na Paraíba	
Correio da Paraíba	Cidades	21/10/2009	Dossiê PB	
O Norte	Dia-a-Dia	10/09/2010	Dados Dossiê	Maria Lúcia / Gerlane Bandeira
TELEVISION				
Broadcasting Station	**Program**	**Date**	**Topic**	**Source**
TV Paraíba	JPB 1ª Edição	20/10/2009	Projeto Abortamento inseguro na Paraíba	
TV Correio	Jornal da Correio – 2ª Edição	20/10/2009	Riscos da curetagem para as mulheres	
TV Cabo Branco	Bom Dia Paraíba	21/10/2009	Abortamento inseguro na Paraíba	Paula Viana
RADIO				
Broadcasting Station	**Program**	**Dae**	**Topic**	**Source**
Rádio Tabajara AM	Paraíba Agora	20/10/2009	Impacto do aborto ilegal na Paraíba	Lucia Lira/ Paula Viana
Rádio 101 FM	Paraíba Agora	21/10/2009	Impacto do aborto inseguro na Paraíba	Ana Paula Sciammarella / Socorro Borges
WEB				
Portal	**Section**	**Date**	**Topic**	**Source**
Paraíba 1	Cidades	17/10/2009	Dossiê	Assessoria
Blog Diálogo Jovem	Post	17/10/2009	Dossiê	Portal Paraíba 1
Patos Online		20/10/2009	Dados Aborto	Assessoria
Ipas	Publications	01/03/2010	Dossiê	Assessoria
Portal Correio	Cidades	01/07/2010	Dossiê Aborto PB	Nota / Da assessoria
PB Agora	Cidades	01/07/2010	Dossiê Aborto PB	Nota / Da assessoria
Rádio Liberdade Fm	Paraíba	01/07/2010	Dossiê Aborto PB	Nota / Da assessoria
WEB				
Portal	**Section**	**Date**	**Topic**	**Source**
Portal Patos Absoluto	Cidades		Dossiê Aborto PB	Nota / Da assessoria
Paraíba Agora	Notícias	01/07/2010	Dossiê Aborto PB	Nota / Da assessoria
CZ Agora	Post	01/07/2010	Dossiê Aborto PB	Nota / Da Assessoria
CCR	Notícias	02/07/2010	Dossiê Aborto PB	Correio da Paraíba / Assessoria
Focando a Notícia	Saúde	02/07/2010	Dossiê Aborto PB	Nota / Da assessoria
Criança.PB	Notícias	02/07/2010	Dossiê Aborto PB	Nota / Da assessoria
Salvem as nossas crianças	Notícias	03/07/2010	Dossiês Aborto PB	Criança.PB / Assessoria

DOSSIÊ REVELA IMPACTO NOS SERVIÇOS DE S

PB já fez 3.266 aborto

João Pessoa é a única cidade do Estado que realiza aspiração manual intra-ut

FLÁVIO ASEVÊDO

Apenas a Capital do Estado realiza o procedimento Aspiração Manual Intra-Uterina (AMIU). Este será apenas um dos dados destacados hoje no Instituto de Saúde Elpídio de Almeida (Isea) durante a divulgação do "Dossiê sobre a Realidade do Aborto Inseguro na Paraíba: O Impacto da Ilegalidade do Abortamento na Saúde das Mulheres e nos Serviços de Saúde de João Pessoa e Campina Grande". Nas demais cidades, o pós-aborto ainda é feito através da curetagem, que exige internação, e anestesia geral, aumentando os riscos de infecção hospitalar.

De janeiro a agosto deste ano, 3.266 mulheres fizeram abortos na Paraíba. A Capital João Pessoa lidera o ranking de abortos por local de internação, com 39,8% (1301 abortos), seguida de Campina Grande, com 29,6% (969 abortos). Um único óbito foi registrado, no município de Patos, que teve 193 abortos no período.

Os abortos ocorreram de forma espontânea, por razões médicas ou em outras gestações que terminaram com a morte do feto. As informações são do Sistema de Informações Hospitalares do Sistema Único de Saúde (DataSus). A divulgação do dossiê ocorrerá às 11h, durante uma visita das pesquisadoras ao Isea. Amanhã, elas estão em João Pessoa, no Instituto Cândida Vargas, às 10h.

Divulgação

Informações do DataSus serão apresentadas hoje em Campina Grande e amanhã na Capital

Apesar de João Pessoa ser a única cidade do Estado em que é realizado o AMIU, o procedimento ainda é pouco realizado. Entre janeiro de 2008 e junho de 2009, a Capital realizou apenas 29 AMIU, enquanto que foram feitas 2.319 curetagens no mesmo período. A pesquisa foi desenvolvida por representantes do movimento de mulheres, pesquisadoras do Coletivo Feminista, Grupo Curumim e órgãos de Pernambuco, Brasília e Rio de Janeiro.

CORREIO DA PARAÍBA — Cidades — Paraíba • Quarta-feira, 21 de outubro de 2009

Dossiê revela 115 abortos de meninas

Levantamento sobre impacto da ilegalidade do aborto mostra que garotas entre 10 e 14 anos já interromperam gestação

A divulgação, ontem, do "Dossiê sobre a Realidade do Aborto Inseguro na Paraíba: O Impacto da Ilegalidade do Abortamento na Saúde das Mulheres e nos Serviços de Saúde de João Pessoa e Campina Grande" revelou um dado preocupante para as autoridades de saúde e de defesa da Criança e do Adolescente. De acordo com o Dossiê, 115 meninas entre 10 e 14 anos foram internadas e fizeram aborto entre janeiro de 2008 e junho de 2009 na Paraíba.

Outro dado revelado foi que as mulheres negras e pobres são responsáveis por quase metade dos abortos realizados na Paraíba no mesmo período. Do total de mulheres que fizeram o aborto espontâneo, 6.897, pouco mais de 43%, ou seja, 2.969 delas, afirmaram ser negras. Os outros 57% estão distribuídos entre brancas pobres e ricas, índias e pardas.

Em um ano e meio, foram realizadas 44.368 internações para procedimentos obstetrícios, dos quais, 17,35% são para o abortamento. Os gastos públicos com a curetagem pós-aborto foi de quase R$ 1 milhão (R$ 946.427,14). Além dos abortos espontâneos, foram realizados 36 abortos por razões médicas e 779, resultado de outras gravidezes.

A intenção da divulgação do dossiê, segundo a pesquisadora da Articulação de Mulheres Brasileiras, Maria Lúcia Lopes de Oliveira, é diminuir a prática do aborto inseguro e garantir o direito ao aborto nos casos em que ele já é legalizado, além de permitir que o desejo das grávidas ao aborto seja assegurado em qualquer caso.

"Quando as mulheres procuram os serviços de saúde para realizar o aborto, muitas vezes são humilhadas e maltratadas. O aborto já é legal em casos de violência sexual e de risco de morte para a mãe, mas queremos que o atendimento seja humanizado e não criminalizado", disse. Ela afirmou que qualquer mulher grávida, ao recorrer aos hospitais para abortar, tem que ser bem assistidas e orientadas. "Se ela quiser levar adiante a decisão pelo aborto, deve ter se desejo respeitado", completou a pesquisadora.

Maternidade Frei Damião faz o aborto autorizado por Lei

Falta informação

"As mulheres que procuram o serviço público para abortar são na maioria pobres e negras, com idades entre 20 e 29 anos. Falta orientação, desde o pré-natal, na atenção básica e não tem planejamento familiar. Elas desconhecem ou não têm acesso aos métodos contraceptivos, como a pílula ou camisinha", falou Maria Lúcia.

Estatística:

10 a 14 anos -	115 casos
15 a 19 anos -	1.207
20 a 29 anos -	3.430
30 a 39 -	1.698
40 a 49 -	423
50 a 59 -	18
60 a 69 -	3
70 a 79 -	3

Obs. Pesquisadora acredita que houve um equívoco na hora do preenchimento do formulário junto ao Sistema Único de Saúde, em relação ao registro de mulheres grávidas entre 60 e 79 anos, na terceira idade.

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HITS IN RIO DE JANEIRO

Period: April and May 2010

Person Responsible: Evanize Sydow (Ipas Brazil) – Communications Advisor

Nataly Queiroz – Communications Consultant

Number of hits: Printed – 02 hits

Radio – 01 hit

Web – 25 hits

PRINTED				
Veículo	**Editoria**	**Date**	**Topic**	**Source**
Jornal do Brasil		04/05/2010	Dossiê	
Estado de S. Paulo		04/05/2010	Dossiê	
RADIO				
Broadcasting Station	**Program**	**Date**	**Topic**	**Source**
Rádio MEC		30/04/2010	Dossiê	Beatriz Galli
WEB				
Portal	**Section**	**Date**	**Topic**	**Source**
Blog Eu Decido	Post	04/04/2010	Dossiê / Lançamento	Da Assessoria
Consultor Jurídico	Notas Curtas	29/04/2010	Dossiê / Lançamento	Da Assessoria
Ariquemes On line	Coluna	29/04/2010	Dossiê / Lançamento	Conjur
Terra	Brasil	30/04/2010	Dossiê / Lançamento	Da Assessoria
JB On line	Brasil	30/04/2010	Dossiê / Lançamento	Da Assessoria
O Dia	Rio	30/04/2010	Dossiê / Lançamento	Da Assessoria
Rádio 102 Fm	Cidades	30/04/2010	Dossiê / Lançamento	Da Assessoria
Rádio Cidade FM	Notícia	30/04/2010	Dossiê / Lançamento	Da Assessoria
Rio News	Post	30/04/2010	Dossiê / Lançamento	Da Assessoria
Adital	Notícias	30/04/2010	Dossiê / Lançamento	Tizuko Shiraiwa
Ciranda	Notícias	30/04/2010	Dossiê / Lançamento	Adital
Jornal da Mulher	Aconteceu	Abril/10	Dossiê	Da Assessoria
De igual a igual	Notícias	02/05/2010	Dossiê / Lançamento	Adital
Fórum PLP1z do Distrito Federaç	Notícias	02/05/2010	Dossiê / Lançamento	Adital
IPS	IPS Brasil	03/05/2010	Dados Dossiê	Kauara Rodrigues
Portal No Minuto	Cidades	03/05/2010	Dossiê	Tizuko Shiraiwa
Adital	Notícias de Pulsar	03/05/2010	Dossiê	Tizuko Shiraiwa
Agência Pressenza			Dossiê	Ciranda / Terezinha/Vicente
Jus Brasil	Notícias	03/05/2010	Dossiê / Assembléias	Da Assessoria
Coordenação Nacional das Mulheres	Notícias	03/05/2010	Dossiê / Dados	Da Assessoria
Últimas Notícias	Notícias	03/05/2010	Dossiê / Lançamento	Adital
Criança.PB	Notícias	03/05/2010	Dossiês / Lançamento	Adital
Agência Aids	Clipping	04/05/2010	Dossiê	Da Assessoria
SBC Notícias		04/05/2010	Dossiê / Dados	Beatriz Galli
CCR	Notícia do Dia	04/05/2010	Dossiê / Lançamento	Adital

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http://jornadaspeloabortolegal.wordpress.com

ARTICULAÇÃO DE MULHERES BRASILEIRAS

http://www.articulacaodemulheres.org.br

REDE Feminista DE SAÚDE
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http://www.redesaude.org.br/

Cunhã Coletivo Feminista

http://www.cunhanfeminista.org.br/

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http://www.cfemea.org.br/

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