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Simone Diniz

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REPRODUCTIVE HEALTH matters

ROUNDTABLE

# Materno-infantilism, feminism and maternal health policy in Brazil

Simone Diniz

Associate Professor, Department of Maternal and Infant Health, Faculty of Public Health, University of São Paulo; member, Coletivo Feminista Sexualidade e Saude, São Paulo, Brazil. *Correspondence*: sidinizg@gmail.com

**Abstract:** *In the last days of 2011, President of Brazil Dilma Rousseff issued a provisional measure (or draft law) entitled "National Surveillance and Monitoring Registration System for the Prevention of Maternal Mortality" (MP 557), as part of a new maternal health programme. It was supposed to address the pressing issue of maternal morbidity and mortality in Brazil, but instead it caused an explosive controversy because it used terms such as* nascituro *(unborn child) and proposed the compulsory registration of every pregnancy. After intense protests by feminist and human rights groups that this law was unconstitutional, violated women's right to privacy and threatened our already limited reproductive rights, the measure was revised in January 2012, omitting "the unborn child" but not the mandatory registration of pregnancy. Unfortunately, neither version of the draft law addresses the two main problems with maternal health in Brazil: the over-medicalisation of childbirth and its adverse effects, and the need for safe, legal abortion. The content of this measure itself reflects the conflictive nature of public policies on reproductive health in Brazil and how they are shaped by close links between different levels of government and political parties, and religious and professional sectors.*


**Keywords:** maternal health services, maternal mortality, humanised childbirth, unsafe abortion, pregnancy registration, advocacy and political process, law and policy, Brazil

Dilma Rousseff was part of the armed resistance to the Brazilian military dictatorship (1964–84). She was arrested and tortured, and imprisoned for three years in the early 1970s. Afterwards, she studied economics and became a public official, married twice and had a daughter, continued being politically active and finally joined the Workers' Party. Before she stood for election in 2010, in her public speeches Dilma Rousseff clearly expressed her belief in the need to decriminalise abortion. Indeed, this is the official position of the left-wing Workers' Party, and she felt perhaps no need to compromise her position on abortion, although she was never an activist on the subject. In spite of having little political visibility and no electoral experience, she was predicted to win the election on the first round, something even former president Lula himself never did.

Brazil is a lay country with the constitutional separation of church and state. During the campaign, as in every election, the Catholic and Evangelical churches united to put pressure on all candidates to accept their agendas in order to get "their" votes. Abortion is always a core issue in this, along with gay marriage.[1]

Although progressive sectors of the Catholic Church were very active in the defence of civil and political rights during the dictatorship, the predominance of conservative forces in recent decades has led the church to systematically oppose advances in human rights in relation to sexual and reproductive rights.[1] During the election campaign Dilma changed her discourse to what she thought was more acceptable: "no woman likes to have an abortion" and "we need to consider abortion as a public health issue". This was not enough: the anti-abortion religious sectors understood this as a clear pro-choice position.

At the peak of the campaign, the opposition candidate, José Serra, started championing a strong anti-abortion position to attract the religious vote, while his wife called Dilma a murderer of babies. Although Serra's Social Democratic Party (PSDB) had once supported the legalisation of abortion, and many of its feminist members had campaigned for reproductive rights, their strategy in

this election was to ally with religious fundamentalists and the right-wing to try to isolate Dilma as an atheist, Marxist, terrorist, and cold-hearted abortionist. The Catholic church printed millions of pamphlets against her, distributed in churches all over Brazil.

In the weeks preceding the election, the churches and most of the press – with a clear anti-Lula position – exploited the issue of abortion in the most distorted, irresponsible and aggressive way possible. Although public opinion polls showed that voters were more concerned with allegations of corruption against the Workers' Party than with abortion,[1] abortion was on the covers of all the weekly magazines up to the election. For the first time, Dilma's ever-rising popularity began to decrease, with a corresponding increase in support for the Green-Evangelical candidate Marina da Silva.

It seemed that the whole project of social justice developed by the Lula government was at risk if she did not portray herself as a religious devotee of Our Lady – as in pictures of her attending Catholic services – compromising her previous position. The birth of her first grandchild during the elections helped humanise her image. Finally, she made a formal agreement with religious leaders not to seek to reform the abortion law, although she made it clear she would not veto any initiative in Congress either. Then she started recovering lost ground, and won the election on the second round to become Brazil's first woman president.

## *From materno-infantilism to a comprehensive women's health programme*

Since 1983 Brazil has had a Comprehensive Women's Health Programme (PAISM), a public health agenda developed by feminist groups and the public health movement, in the historical context of political democratisation in the 1980s.[2] These movements fought for and won the inclusion of the universal right to health care and the creation of a comprehensive and equitable public health system (SUS) in the 1988 Constitution.[3]

"Comprehensive" health is a complex concept, more used in Latin America than elsewhere. In the case of the PAISM, comprehensiveness included the notions of primary, secondary and tertiary care; the physical, emotional and social aspects of health, and of care for women from infancy until old age, not only for the reproductive years. This represented a rupture with "materno-infantilism"*– the focus on women as mothers in a sexist and authoritarian system of medical practice.[2,4] The first documents of the PAISM were very politicised, as were women's groups in its support, with a strong focus on the idea that "the technical is political".[4] The PAISM agenda was broad, ranging from sexuality education to menopause, mental health, de-medicalisation of childbirth, contraception and safe abortions. For decades, the mantra of the feminist movement in Brazil was the complete implementation of the PAISM. Many feminists have worked in the Health Ministry and in local government to make this possible, with less or more success.

Comprehensiveness is easier to define than to operationalise, especially in a system where "health care" is frequently translated into the poorly regulated public purchase of medical services from the private sector.[3] The focus on education about power relations, sexuality and fertility regulation that was so strong in the first years of PAISM gradually lost ground to the discourse of access to medical consumption.[5]

Indeed, access to the means of fertility regulation, such as surgical sterilisation and reversible contraceptive methods through both the public and private sectors is high: Brazil has a modern contraceptive prevalence of 80% among women in a relationship and a low fertility rate of 1.8, according to the most recent Demographic & Health Survey (2006).[6] Yet a 2011 nationwide survey[7] found a paradoxically high rate of unplanned pregnancy, 55% of all pregnancies. Unfortunately, the strong religious opposition to reproductive rights and the subservience of public policies to political manipulation have hindered an honest debate on abortion, which is illegal except in cases of rape and risk to the life of the woman[1,2] under legislation unchanged since 1940, regardless of considerable feminist activism.

The PAISM (re-defined as a "policy", not a "programme", in 2004) was eventually translated into lists of medical conditions needing tests, treatments, procedures and drugs, with varying levels

*This is a term used in Brazil in public health programmes to describe how women are seen mainly as bearing children and having reproductive cycles. It also refers to how women are infantilised, considered childish and in need of guardianship from health services instead of being treated as consenting adults (justifying the absence of informed choice), and how this relates to the medicalisation of women's bodies.[2,4,5]

of effectiveness and safety, in all aspects of women's health. Given the priority on productivity and the reality of limited resources for a chronically under-funded system, little was left of feminist concern for information for women and questioning of gender power relations, in both private and public spheres. Ensuring that women could make informed decisions about their reproductive choices became uncommon as an issue in health care provision.[5,8]

### *Universalisation of maternity care and deteriorating indicators?*

Presently, the two main problems with maternal health in Brazil are the over-medicalisation of childbirth and its adverse effects, and the lack of policies for safe, legal abortion.[2] Both issues depend on government decisions that are fraught with political conflict with the medical establishment and religious sectors.

The Brazilian effort to implement universality in health care for pregnant and childbearing women was quite successful, with antenatal care reaching 98.6% coverage, and institutionalised birth with a skilled provider 98%, in both cases 90% of these with a medical doctor.[6] Although this surely led to greater access to beneficial forms of care and to positive health outcomes, it also led to the uncontrolled use of interventions, mostly in order to speed up labour and delivery, thus maximising "productivity" and "efficiency" in obstetric wards.[5,8]

The appropriate use of obstetric interventions is a key component of maternity care and must be available without delay when needed. But the abuse through over-use of interventions for the convenience of health professionals in limited resource settings became the rule in Brazil. This organisational ethos shows limited consideration of potential adverse effects or patients' rights.[8] Hormonal augmentation of labour and induction of contractions is used in the vast majority of vaginal births, while caesarean section became the most common form of delivery in Brazil in 2011.[9,10] Although women's health groups have challenged this model of care and encouraged the adoption of a more evidence-based, humanised care,[2,11] we have had a limited influence on public policies and private practice, though we have gained considerable appeal and public attention.

Although the adverse effects for pregnant women of inappropriate procedures in childbirth have been demonstrated extensively with the best scientific evidence,[12] professional culture tends to underreport and underestimate their importance, and this is reflected in the health information system's data, where information on adverse effects and safety incidents is often missing.[5,8] Women who have been subjected to liberal augmentation, induction, forceps, unnecessary episiotomies and caesarean sections experience increased maternal morbidity (haemorrhage, infections, mental health problems, and sexual problems) and higher mortality.[12] The adverse effects for the newborn include an increase in pre-term deliveries with low birthweight, acute respiratory and metabolic complications, more admissions to intensive care units, and more recently, the identification of longer-term, increased risk of chronic diseases associated with interventions.[13]

The consequences of these negative outcomes are evident in the indicators, despite huge improvements in access to health care. They include a consistent increase in the rate of pre-term and low birthweight babies,[2] and severe morbidity (near-miss cases) four times higher than those in developed countries.[14] As the number of maternal deaths is small, it is difficult to identify trends, and time trends can be distorted by improvements in vital statistics. However, in the information system (Datasus), there is no improvement in the number of maternal deaths from 2001 to 2010[2,14] – all of which are embarrassing for Brazil and threaten the notion that "the more intervention the better".

On the subject of universal access and equity, in August 2011, the UN Committee on the Elimination of Discrimination against Women (CEDAW) found that Brazil failed to prevent the death of Alyne da Silva, a 28-year-old Brazilian woman of African descent, who received grossly inadequate treatment at a local health centre in one of Rio de Janeiro's poorest districts, and later in the hospital she was referred to, which led to her death. The Committee's landmark decision, the first maternal mortality case decided by a UN treaty body, "specifically required that a State provide adequate and quality maternal health care services as part of its non-discrimination obligations. The Committee recommended that Brazil ensure women's right to safe motherhood and affordable access for all women to emergency obstetric care and reaffirmed that state policies should be action-oriented as well as adequately funded."[15]

Something had to be done, and proposals for a complete change in maternity care to evidence-based, safe, effective, humane and integrated health

care are again emerging.[16,18] This includes support for training of midwives and nurse-midwives to take increased responsibility for birthing care, and the expansion of midwife-led birth centres. These are the same public health proposals we developed in the 1990s, and they continue to be strongly opposed by the medical establishment.[3,8,17]

In terms of specialist obstetric care, the necessary resources and drugs to prevent and treat the main causes of maternal deaths are normally available in health services, and virtually all women deliver in hospitals. If the quality of obstetric care is central to the issue of maternal mortality in Brazil, then we need to modify the behaviour of health professionals so that they adhere to evidence-based practice,[14] which is one of the critical issues not being addressed, alongside how certain women are poorly treated and neglected, as in the Alyne case.[15]

However, this progressive, woman-centred, evidence-based proposal was again de-politicised and reduced by the circumstances of Dilma's election and government agreements, to a return of materno-infantilism, explicitly rupturing with the PAISM quest for comprehensiveness in women's health care. Because maternal and child health, if presented in a certain way, has an uncontroversial appeal, Dilma's supporters created the "Stork Network" during the election and presented it as an electoral novelty. The social movements for changing childbirth gave the future government the benefit of the doubt, since the electoral situation was so complicated.

## *Materno-infantilism rides again*

The group that was invited to take charge of the Women's Health Technical Area in the Health Ministry after the elections was familiar with the evidence- and rights-based, humanised approach to care in childbirth, and with the very successful changes in this direction made by the City Government of Belo Horizonte and the city's Sofia Feldman Hospital, an innovative maternity referral hospital.[18] A group of supporters, including providers, academics, policy-makers and women's health activists, were mobilised to contribute to the Stork Network, including myself. The hope for concrete changes was high, especially with the proposal to improve Datasus, the current health information system, so that it would: 1) be capable of making the outcomes of excessive intervention in childbirth visible, and 2) include information such as presence of a birth companion, bodily integrity, perineal outcomes and rates of episiotomy, inductions and augmentations, fundal pressure, and other interventions presently not reported in the Datasus.

Those hopes for change in maternity care were jeopardised by the government's political compromise with both religious and professional interest groups. The name chosen by Dilma's campaign team for this programme, Stork Network, was a very unhappy one. Indeed it sounded as if it were part of ongoing efforts to disqualify women's movements in the electoral arena: infantilising and de-sexualising women, disregarding the whole debate about the need to re-politicise reproduction and sexuality in policy-making and the use of technology from the perspectives of feminist women's health activists and the movement for the humanisation of childbirth.[5,8,11]

The development of the draft proposal for the Stork Network took several months and a final version was never widely circulated. Although it discreetly included contraception and the implementation of harm reduction for unsafe abortions, it was perceived as an attempt to put maternal health at the centre of the policy, with some not very visible, even cosmetic, secondary mention of fertility regulation. Some meetings were called to discuss the proposal and receive comments from civil society, but apparently civil society and feminist groups were never able to debate the proposal or participate openly. All this contributed to the reasonable conclusion by social movements that the proposal was neglecting the concept of comprehensiveness and represented a politically expedient return to materno-infantilism to please conservative forces.

When the proposal was finally presented publicly by President Dilma Rousseff, it was in the form of Provisional Measure (MP) 557, on 27 December 2011. If fell like a bomb to intense criticism from feminist and human rights groups, academic institutions and even ABRASCO, the national public health association.

Among the many controversial aspects it contained, such as giving women US$30 to help them access maternity services, in a country where almost 99% of births take place in hospitals, two issues caused most outrage. One was the use of the term *nascituro* (unborn child) and the other was compulsory registration of pregnant women at the point of confirmation of pregnancy. Another problem, which received less attention, was the

virtual disappearance of the evidence-based, rights-based approach that was hoped for, both in health care provision and in the health information system.

## *Provisional Measure (MP) 557*

### The first version

*"The services of public and private health are required to ensure pregnant women and their* **unborn children** *the right to safe and humane antenatal, labour, birth and post-partum care."*

*… II. Register in the computerised data of* **all pregnant women**, *and post-partum women in the services of the health facility;*

*"III. Include in the computerised system for pregnant and post-partum* **women at risk** *seen in health services, the diagnosis and treatment plan defined and executed, and other information determined by the National Steering Committee."* (my emphasis)

The Health Minister himself, as did other senior Ministry officers, had to give many interviews to explain – with very limited success – what the "unborn child" and the compulsory registration of pregnancies had to do with Brazil's maternal health problems. At first, they tried to minimise the importance of the inclusion of the infamous anti-abortion wording of the "unborn child", and said that they had no intention of joining the anti-reproductive rights discourse. They argued that for many people, use of the term "unborn child" can be interpreted in a neutral way.

But this is not neutral language and no naïvety is acceptable from policy-makers. The term "unborn child" and its legal implications are inescapable, seeking to confer rights on the embryo/fetus, suggesting implicitly that the already very limited legal grounds for abortion in Brazil should be revoked.[19] The term is even contrary to existing constitutional rights, as the Constitution states clearly that human rights start at birth. This historically is a core issue of Brazilian feminism.

The second serious problem was why the registration of *all* pregnancies was required. There is already registration of pregnant women in Brazil when they begin antenatal care (*Sisprenatal*). If the aim of registration is for pregnant women at risk, that is, those who have both initiated antenatal care, which not all women will, and those who have received a diagnosis of risk, who are a minority, why is it necessary to change the way it is now and create a *law* to register *all* pregnant women at the time of confirmation of pregnancy?

The fact is that this text was very similar to the text in an anti-abortion bill tabled in Congress in 2007[20] by federal representative Walter Brito Neto (PL 2504), identified as an evangelical parliamentarian. His bill also mandates registration of pregnant women at the time of confirmation of pregnancy "in all health facilities, clinics or hospitals, public and private," and describes this as "a major breakthrough for the development of policies for health care… related to the care of mother and newborn, enabling better care and provision of health services." This, so far, sounds like Dilma's bill. But then it makes clear what for this registration is actually for:

*"… to facilitate the production of evidence in cases of illegal abortion because the pregnancy registry will make possible the gathering of data to identify the active agent of abortion."*[20]

This proposal is clearly for an information system designed not to improve women's health care or safety, but quite the opposite, one that aims to increase women's vulnerability and further limit their rights to privacy and reproductive choice.

### The second version: response to the outcry

Fortunately, the term "unborn child", was deleted in the revised version of Provisional Measure 557. This was much celebrated, as Dilma herself admitted publicly that it was a mistake when questioned by the *Rede Nacional Feminista de Saúde, Direitos Sexuais e Direitos Reprodutivos* (Feminist Sexual and Reproductive Rights Network).[21]

A few days after the publication of the revised version, but not necessarily related to it, Dilma appointed a feminist activist, Eleonora Menicucci, to the Ministry for Women's Policies. Menicucci, a professor of sociology who was jailed by the dictatorship together with Dilma, historically has very vocal and strong views about sexual and reproductive health and rights, especially the need to legalise abortions, which she expressed clearly at the time of her appointment. That reignited hopes for change in the Dilma government, as well as the fury of anti-abortionist groups, who were shouting for Menicucci's resignation even before she started her new job.

Although the mandatory registration of pregnancies,[22] got less attention at first, on 22 March the Brazilian women's group Articulação de Mulheres Brasileiras wrote a public letter to Minister Menicucci:

*"We believe that the retreat of the government was insufficient. We regret that Provisional Measure*

*557 was not withdrawn from Congress… This initiative is a fallacy; the demand for it was articulated by conservative groups behind the scenes… Even with the appointment of Minister Eleonora Menicucci and the removal of any reference to "the unborn child", the measure is still a threat to women's rights."*[23]

Together with "the unborn child" and mandatory registration issues, a third failure remains: the failure to address the needed changes in over-medicalised maternity care and the high rates of unsafe, illegal abortions.

**Surveillance of services, not only surveillance of women**

Intended to be a landmark maternal health policy, the Provisional Measure contains an incredibly long and bureaucratic list of public health system (SUS) and Ministry departments that should be involved and who should be responsible for what. No mention is made of the rising caesarean and pre-term birth rates, the need to change care models or the information system to register and monitor the appropriateness of the use of interventions, or the need for safe abortions. On the abortion front, however, although this is not mentioned in the measure, the Women's Health Area of the Ministry of Health is organising meetings to debate the proposal for harm reduction in illegal abortions, inspired by the Uruguay experience. Hopefully, the appointment of Menicucci will foster cooperation between the Health and Women's Policies Ministries.

The other good news on the abortion front is the approval by Brazil's Supreme Court on 12 April 2012 of the legalisation of abortion in cases of anencephaly, a disorder that leads to a malformation or absence of large parts of the fetal brain and is not compatible with survival. This was not a problem for wealthier women, who in such cases resorted to a private provider, with or without legal authorisation, but it will improve access for the 70% using the public health system. Brazil currently has 65 public hospitals that are authorised to perform these abortions, and according to the Ministry of Health, by the end of the year there will be 30 more, totalling 95 locations across the country. It was the first time that the Court used wording like this about women's reproductive rights. This judgement has also an important symbolic effect, as most of the population support abortion in this case.[24]

The only mention of promoting any change towards humanised maternity care in the first version of the Provisional Measure was the inclusion of companions at birth, with the usual ambivalent wording which, in practice, will give doctors the authority to violate the 2005 law that gave women the right to companionship at birth (No.11.108/05). In the Provisional Measure, there are no sanctions if providers and maternity services refuse to allow a companion, justifying their disregard of the law based on their "medical autonomy". Having a companion at birth should be considered an indicator of safety, quality of care, and respect for women's rights and privacy in pregnancy and delivery.[5,18] There are no systematic data on companions at birth in the health information system, however, and the last national data available are from 2001–2005, from the Demographic & Health Survey,[6] before the law was passed, which showed that only 16% of women had companions (32% in the private sector, 9% in the public sector). This rate is believed to be improving, giving the intense activism on this issue, both by consumers' movements and policy-makers, but without reliable data it is not possible to monitor what is happening.

The hopes of affirmation of women's right to a companion at birth were frustrated when the second version of the Provisional Measure excluded the mention of a companion altogether, as the wording had been mixed up confusedly with "the unborn child".

Brazil continues to need its health system to be accountable for respecting women's rights, as well as for its health interventions and outcomes, with an information system that can be used to measure both the benefits and harms of health care interventions. Without this, we tend to prioritise consumption of medical care uncritically over concrete improvements in health and health rights. The negative health effects of over-medicalised childbirth and unsafe, illegal abortions are only examples of how ideologically motivated interference in public health policy can be detrimental both to women's health and the content and use of public health information systems.

According to Cfemea, the Brazilian Congress Feminist Watch, Provisional Measure 557 is not on the Congressional agenda for a vote until late May 2012. More confrontation is expected.

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**Résumé**

Les derniers jours de 2011, la Présidente brésilienne Dilma Rousseff a promulgué une mesure provisoire (ou projet de loi) intitulée « Système national d'enregistrement, de surveillance et de suivi pour la prévention de la mortalité maternelle » (MP 557), dans un nouveau programme de santé maternelle. Ce système était supposé



**Resumen**

En los últimos días del año 2011, la Presidenta de Brasil Dilma Rousseff emitió una medida provisional (o anteproyecto de ley) titulada "Sistema Nacional de Vigilancia y Monitoreo de Registros para la Prevención de la Mortalidad Materna" (MP 557), dentro de un nuevo programa de salud materna. Se suponía que tratara el urgente

agir sur la question urgente de la mortalité et morbidité maternelles au Brésil, mais il a en fait déclenché une controverse explosive parce que le texte utilisait des mots comme *nascituro* (enfant à naître) et proposait l'enregistrement obligatoire de toutes les grossesses. Après d'intenses protestations des groupes féministes et des droits de l'homme affirmant que cette loi était inconstitutionnelle, violait le droit des femmes à la confidentialité et menaçait leurs droits génésiques déjà limités, elle a été révisée en janvier 2012, en omettant « l'enfant à naître » mais non l'enregistrement obligatoire des grossesses. Malheureusement, nulle version du projet de loi n'aborde les deux principaux problèmes de santé maternelle au Brésil : la surmédicalisation de l'accouchement avec ses conséquences néfastes et la nécessité d'un avortement légal et sûr. Le contenu lui-même de cette mesure reflète la nature conflictuelle des politiques publiques de santé génésique au Brésil et la manière dont elles sont façonnées par les liens étroits entre différents niveaux de gouvernement et de partis politiques, et les secteurs religieux et professionnels.

asunto de morbilidad y mortalidad maternas en Brasil, pero en vez causó una explosiva polémica al utilizar términos como *nascituro* (nonato) y al proponer el registro obligatorio de todo embarazo. Tras intensas protestas de grupos feministas y de derechos humanos, que señalaron que esta ley es inconstitucional, viola el derecho de las mujeres a la privacidad y pone en peligro nuestros derechos reproductivos de por sí ya limitados, la medida fue modificada en enero de 2012: se omitió el término *nascituro* pero no el registro obligatorio de todo embarazo. Desafortunadamente, ninguna versión del anteproyecto de ley trata los dos principales problemas de la salud materna en Brasil: la medicalización en exceso durante el parto y sus efectos adversos y la necesidad de servicios de aborto seguro y legal. El contenido de esta medida refleja la naturaleza conflictiva de las políticas públicas en la salud reproductiva en Brasil y cómo éstas son definidas por vínculos estrechos entre los diferentes niveles del gobierno y los partidos políticos, y los sectores religiosos y profesionales.

COURTESY OF PROF MELANIA M R AMORIM / DR LEILA KATZ, INSTITUTO DE MEDICINA INTEGRAL PROF. FERNANDO FIGUEIRA

Young woman, 14 years old, primiparous, had repeated seizures (eclampsia) in a rural zone and was transferred, without receiving magnesium sulphate, to the referral hospital, where she died, Recife, Brazil, 2008