



## Brazilian Feminist Network of Health, Sexual Rights and Reproductive Rights - RFS<sup>1</sup>

### Health, Sexual Rights and Reproductive Rights

The present Report exposes the fragility of the situation of women in the country related with the sexual rights and reproductive rights. It empathizes the mortality related with the insecure abortion, the maternal mortality, the adolescent pregnancy, the main causes of the women's deaths, gender violence and trafficking of women and girls for sexual exploitation. Demonstrates the persistence of many inequalities of gender, specifically, those concerning the difficulties of access to public policies, to public goods and social well-being. These inequalities are accentuated depending on ethnic, generational, regional or socioeconomic origin, which makes difficult the progress of women in Brazilian society.

This document is based on the Civil Society Shadow Report<sup>2</sup> to the 39<sup>th</sup> Session of the Committee of the Convention on the Elimination of All Forms of Discrimination against Women–CEDAW, occurred at July 2007. The Brazilian Feminist Network of Health, Sexual Rights and Reproductive Rights – RFS, is a national articulation linked to the Cairo 94, and advocates for the implementation of the UN Womens Rights documents. The RFS has hardly participated of these processes. Nowadays the Brazilian report to Cedaw is the main framework of the Brazilian women's movement. Here we have the main topics.

### UNSAFE ABORTION

1. In Brazil, according to the Penal Code<sup>3</sup> abortion is considered a crime against life, not being punished only in two circumstances (article 128): I – if there is no other method to save the life of the pregnant woman; II – if the pregnancy is the result of rape and the abortion is preceded by the consent of the pregnant woman, or, when she is incapable, by her legal representative<sup>4</sup> However, studies by the Alan Guttmacher Institute on estimates regarding the number of clandestine abortions indicate that there are 1,443,350 abortions annually.<sup>5</sup> This estimate attributes around 85% of the hospitalizations for abortion in the Unified Health System to complications derived from induced or clandestine abortions.<sup>6</sup> In the poorest regions of the country, the difficulty of access of women to information and family planning health services could be the cause of the high number of undesired pregnancies, which can result in the practice of unsafe abortions with

1 Reporteur: Telia Negrão, executive secretary of the Brazilian Feminist Network of Health, Sexual Rights and Reproductive Rights – RFS

2 This process was coordinated by a Organizing Committee composed of 23 national networks and coalitions of women involved in the work of documenting priorities and concerns relevant to women's citizenship and human rights. And was facilitated by a Managing Committee composed of Agende Actions in Gender, Citizenship and Development (Agende Ações em Gênero Cidadania e Desenvolvimento – AGENDE). The Brazilian Feminist Network of Health, Sexual Rights and Reproductive Rights – RFS had an important role in this process.

3 Law Decree No. 2848, of December 7, 1940 (Decreto Lei No. 2.848, 7 de dezembro de 1940).

4 Also see footnote 36

5 Ministry of Health, Technical Norms for Humanized Attention for Abortion, Ministry of Health, Brasília - DF, 2005, p. 7.

6 [www.redesaude.org.br](http://www.redesaude.org.br)

risk to life for the women. Abortion in these circumstances is among the principal causes of maternal mortality in the country. Prohibition results in persecutions and prisons of women who makes clandestine abortions, despite international advance in direction to the decriminalization. Young and adult women are submitted by humiliations and violent arrests. The cases are noticed by the Brazilian newspapers.

2. The Federal Council of Medicine supports the procedure in cases of inviability of the fetus, especially anencephalic ones. However, even in these cases, women suffer humiliations and are submitted to inhuman treatment. In order to reduce the suffering of these women and to guarantee them the right to choose, there has been a struggle to include anencephaly among the cases that permits abortion by law. In fact, between July and October 2003, a preliminary ruling issued by a Minister of the Supreme Federal Court allowed the early inducement of labor in these cases. According to the World Health Organization (WHO), Brazil has the fourth highest number of anencephalic babies, behind only Mexico, Chile and Paraguay. It is estimated that close to 600 Brazilian women give birth every year to children with this problem. After close to four months in effect and having benefited 58 women<sup>7</sup>, the preliminary ruling was struck down on October 20, 2004. Since then, the legal action has been awaiting action by the Supreme Federal Court.
3. The second-most practiced obstetric procedure in public hospitals of the country is related to abortions in unsafe conditions. This is from the first to the fourth highest cause of maternal mortality in the country, and the fifth highest cause of hospitalization in the public health system. At the end of the 1990s, 250,000 cases per year of complications resulting from abortions were registered; thus, this is a grave public health problem, whose origin is found in precocious sexuality and low-quality family planning and health services, and aggravated by the prohibition of abortion in the country. The women's movement has been denouncing the lack of training and readiness of professionals and of health services, as well as the discrimination against women who come to health centers with abortions that have been initiated. The clandestinity in which the abortion are conducted, delays help to the victims and makes impossible the establishment of precise numbers of deaths and harms resulting from this practice. The technical regulations of the Ministry of Health on humane care for women and adolescents who are victims of violence and/or in situations of abortion (Normas Técnicas do Ministério da Saúde sobre a Atenção Humanizada às Mulheres e Adolescentes Vítimas de Violência e/ou em Situações de Abortamento), still face much resistance based on conservative cultural patterns, and require broader dissemination and effective application.
4. According to a WHO estimate, 31% of pregnancies end in abortion. Approximately 1.4 million spontaneous and unsafe abortions occur annually, at a rate of 3.7 abortions for every 100 women between 15 and 49 years old (Table 5). The cases of death due to abortions could be greater because the complications stemming from abortions often result in hemorrhages and infections, which are reported as such (without mention of abortion), which can camouflage the reality. In addition, there are affects of unsafe abortions on the health of women, such the loss of the uterus, ovaries or Fallopian tube, infertility, anemia and chronic pain.
5. According other study<sup>8</sup> there is evidence that the simple prohibition of abortion does not contribute at all to the reduction of the practice. There are restrictive countries that show high rates of abortion among women in reproductive age; however, in countries in which ample autonomy of the woman to decide on the pregnancy is assured, the rates of abortion are among the lowest in the world; in other words, criminalization of abortion does not inhibit its practice.

---

<sup>7</sup> Survey conducted by the Anis Institute for Bioethics, Human Rights, and Gender, Brasília (DF).

<sup>8</sup> Ipas Brasil 2007.

However, to force its clandestine practice in conditions of high risk to life and health of women raises the maternal morality rate.<sup>9</sup>

6. In terms of costs for these health care policies, in 2004 there were 1600 legal abortions contemplated in article 128 of the Brazilian Penal Code which deals with risk of life to the woman and pregnancy resulting from rape, in 51 specialized units of the Unified Health System (SUS) that were existent at the time, at the cost of R\$ 232,280. In the same year, there were 243,998 hospitalizations caused by post-abortion curettages stemming from spontaneous or unsafe abortions, at the cost of R\$ 35,040,978. These curettages constitute the second most practiced obstetric procedure by hospitalization units, surpassed only by normal births.
7. In 2005, beginning with the deliberations of the First National Conference on Policies for Women in the National Plan on Policies for Women, a Tripartite Commission was established for the revision of the punitive law that deals with voluntary interruption of pregnancy. This also complied with the determinations of international agreements, treaties and plans of action from international conferences in the field of human rights signed by the Brazilian government, in the sense of reviewing law that provide punitive measures against women who have been subjected to illegal abortions. The resulting draft law went to the National Congress; however, it was annexed to other existent proposals, and was not voted on within the required time. There are strong pressures by conservative sectors against the decriminalization of abortion and its legalization, especially in the Catholic Church, that is organized in a parliamentary block in the National Congress.<sup>10</sup> The second Conference (August, 2007), that has occurred after the 39a. Cedaw Session (NY, July, 2007) has ratified the position of the first Conference (2004): the Brazilian government may promote the decriminalization of the abortion.

#### 8. Facts:

Elivanir went to the hospital emergency room on 22 December 2005, complaining of strong pains in the womb. Through normal hospital procedures, she should have been treated as a case of premature labor (given that she was 5 to 6 months pregnant). The youth, however, was accused by hospital professionals and by the police on duty of having undergone abortion. She was threatened in the hospital, called a "murderer", and coerced into confessing to having had an abortion. She was arrested and handcuffed soon after having suffered an abortion, when in this moment she needed and should have been assisted with care and medical attention, as provided by the recommendations of the norms for humanizing treatment for women in cases of abortion. The faulty assistance provided to Elivanir characterized a situation of institutional violence, which disrespected various human rights contained in the Convention for the Elimination of All Forms of Discrimination Against the Woman, including the violation of Article 12(1) of the Convention that prohibits discrimination in access to health.<sup>11</sup>

### ADOLESCENT PREGNANCY

9. The magnitude of the adolescent pregnancy problem in Brazil shows the distance that exists between the sexual and reproductive rights provided in international documents (Cairo, 1994) and the real access to adequate conditions for their effective exercise. In addition, aspects of the economic, political, social and cultural order serve as obstacles for the full access to enjoyment of these rights. In 2002, a study showed that 33% of adolescents already had had sexual relations, 13% had children, and 16% had become pregnant.<sup>12</sup> And 29% of the pregnancies were not carried to completion. Close to 26% of babies born alive had mothers whose age group was between 15 and 19 years old.<sup>13</sup>

**Table 4 – Adolescent Pregnancy in Brazil**

Close to 26% of children who were in born in 2004 were children of adolescents (a)

<sup>9</sup> Information provided by attorney Maria Beatriz Galli (IPAS Brazil) to the Managing Committee (Comitê Gestor) of the Civil Society Report to CEDAW 2005, at [www.ipas.org.br](http://www.ipas.org.br).

<sup>10</sup> Brazilian Feminist Network for Health, Sexual Rights and Reproductive Rights, Elections without Stepping Backwards (Eleições sem Retrocesso), Public Note, Set, 2005, at [www.redesaude.org.br](http://www.redesaude.org.br).

<sup>11</sup> Press release sent to the media by the Women's Forum of Ceará and by the Concerted Action of Brazilian Women, 2005.

<sup>12</sup> Research conducted by UNICEF, 2002.

<sup>13</sup> Ministry of Health (2004).

From 2001 to 2003, 82,000 babies were born whose mothers were between 10 and 14 years old (a)
Pregnancy among youths of 15 to 19 years of age increased 2% per year over the last decade (d)
25% of these youths left school (b)
25% reported pregnancy as the reason for leaving school (b)
Early pregnancy is the greatest cause of school evasion for youths 15 to 17 years old (c)
42% of girls who gave birth had already left school (c)
25% abandoned school temporarily, and 17.3% had left permanently (c)

Sources: (a) Ministry of Health (MS), (b) UNESCO, (c) Aquino et al (2003), (d) Countdown 2015 (2004).<sup>14</sup>

9. A study coordinated by three federal universities in 2006, which involved 4,600 people in the cities of Porto Alegre (South), Rio de Janeiro (Southeast), and Salvador (Northeast), indicates that 17% of youths between 18 and 24 years of age provoked abortion in their first pregnancy. Youths with intermediate or higher education undergo more abortions than youths with basic education (29.5% compared to 19%).
10. Regulated by law in Brazil since 2000, the distribution of emergency contraceptives was started only in 2002, and is still distant from the daily reality of youths and of women, which contributes to unsafe abortions and as a result, high maternal mortality. The distribution of emergency contraceptives is still incipient because of lack of continuity, disjointedness of policies, lack of training of professionals, and prejudicial attitudes in the health system. Though distributed in 2000 of 5561 municipalities, routine distribution is significant only for 59 service units that specialize in care for women who are victims of sexual violence.

## MATERNAL MORTALITY

11. The study “Attendance provide of the sexual violence in Brazil”, coordinated by the Cemicamp (Unicamp University) and FEBRASGO (Federation of Brazilian Gynecology and Obstetrics Societies) in 2007 has involved 1399 health services. Even though the existence, the study showed that only 40% in the Centerwest and Southeast regions, and less than 25% in the other (North and Northeast) had a attendance protocol, according the national normative of the Brazilian Health Minister. Despite the fact that emergency contraceptives have been offered to the population for five years through sale in pharmacies as well as through the policy of distribution to municipalities by the Ministry of Health, there is still no systemization of an order mandating its supply and marketing to the public, especially to women. The provision by the federal government of emergency contraceptives does not signify that they arrive to women in municipalities.
12. General Recommendation No. 24 of the CEDAW Committee establishes that neglecting 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.”<sup>15</sup> The existence of a punitive law places women in risk of death by unsafe abortion in Brazil. The CEDAW Committee, upon analyzing the National Report presented by Brazil in its 29th Session (30 June to 18 July of 2003), recommended to the State of Brazil in its Concluding Comments (paragraph 127) that: “further measures be taken to guarantee effective access of women to health-care information and services, particularly regarding sexual and reproductive health, including young women, women from disadvantaged groups and rural women. Those measures

<sup>14</sup> Aquino, E. M., Barbosa, R.M., Hielborn, M.L., and Berquó, E., “Gender, sexuality and reproductive health: the constitution of a new field in reproductive health”, *Journal of Public Health* (“Cadernos de Saúde Pública”), v. 19, no. 2, 2003.

<sup>15</sup> Report on Human Rights and Maternal Mortality, “Women and the Right to Live Free from Preventable Maternal Mortality” (“As Mulheres e o Direito de Viver Livre de Morte Materna Evitável”), Advocaci, Rio de Janeiro, 2005.

are essential to reduce maternal mortality and to prevent recourse to abortion and protect women from its negative health effects.”

13. Even though maternal mortality is not among the greatest causes of death for women in Brazil (Table 6), approximately 2000 Brazilian women die each year for causes that were preventable in 92% of the cases. The Brazilian maternal mortality ratios are on levels considered unacceptable, possibly reaching 92 deaths per 100,000 live births.<sup>16</sup> As pregnancy is an event related to sexual life and not to illness, the persistence of high levels of maternal mortality is an indication of the status of women in the society. It denotes inequality of gender, of access to goods and services, in particularly health, and of the quality of services offered and of the quality of health professionals. It also indicates inequality of race and ethnicity. That is, racism burdens our access to health; according to the study Portraits of Inequality conducted by the Institute for Applied Economic Research (IPEA) and UNIFEM, 44.5% of black women have never a clinical breast exam, while white women without access to this exam totaled 27.3%.<sup>17</sup> Finally, it indicates the insufficiency of measures that aim at prevention and payment of reparations for the deaths, demonstrating the low value of life and the citizenship of women, in other words, the violation of human rights. In Brazil, deaths that occur in pregnancy and childbirth are still seen as accidents or inevitable occurrences related to the “sacred” maternal mission. Dying in childbirth has become commonplace, which suggests the necessity for change in cultural patterns that conceal this problem.

**Table 6 – Causes of death for Brazilian women in order of prevalence**

1st - Cerebral Vascular Accident (CVA)	6th - Neoplasm of digestive organs
2nd – AIDS	7th – Hypertension
3rd – Homicide	8th – Isquemic heart disease
4th - Breast cancer	9th – Diabetes
5th – Traffic accident	10th – Cervical cancer

Source: Ministry of Health, 2005

14. Among the principal causes of maternal death are hypertension (13.3%), hemorrhage (7.6%), postpartum infection (3.9%), and abortion (2.7%). The maternal mortality coefficient places Brazil next to the poorest countries in Latin America. In 2002, the maternal mortality ratio obtained from death certificates was on the order of 53.4 maternal deaths per 100,000 live births (SIM/SINASC) due to complications arising during pregnancy, childbirth or puerperium. Upon utilizing the correlation factor of 1.4 developed in the subsequent study, in 2001, the maternal mortality ratio reached 74.5 deaths per 100,000 live births, when in developed countries the adjusted ratios were 6 to 20 deaths per 100,000 live births.<sup>18</sup>
15. In Brazil, insufficient information makes accurate monitoring of trends and causes of maternal mortality difficult. This results from incorrect reporting on death certificates, and from omission of the fact that the cause of death was related to complications during pregnancy, childbirth or puerperium. The absence of registers – under-reporting – is verified in the North, Northeast and Central East regions, and indicates regional inequalities and is related to low levels of human development (IDH). A study published by the Feminist Health Network demonstrates that poor quality of healthcare in the country is the principal cause of high rates of maternal mortality. According to academics on the topic, for each death due to problems of poor medical care, there is another that is not reported. Thus, to understand the real dimensions of the magnitude of maternal mortality, the registered rates should be multiplied by two.<sup>19</sup>

<sup>16</sup> Tanaka, A.C. & Mitsuki, L., Study on the magnitude of maternal mortality in 15 Brazilian cities, São Paulo, UNICEF, 1999.

<sup>17</sup> See the link “Diálogos sobre racismo” on the site, [www.patriciagalvao.org.br](http://www.patriciagalvao.org.br), accessed October 14, 2006.

<sup>18</sup> Research coordinated by Dr. R. Ruy Laurenti, Jorge Mello, M.A.H.P.D., S.L. Gotlieb, et al., Study on maternal mortality of women 10 to 49 years old in Brazil, Ministry of Health, OPAS, Public Health School of USP, 2002.

<sup>19</sup> Feminist Health Network, Preventable and Avoidable Deaths (Dossier), Belo Horizonte, 2005.

16. The study also concluded that hypertension, a major cause of maternal mortality, indicates problems in the quality of prenatal care and care during childbirth. Hemorrhages are also directly associated with low-quality of medical care for the pregnant woman during childbirth. To this is added the lack of blood in hospitals, which has further raised the rates of maternal mortality in Brazil.<sup>20</sup>
17. Brazilian women need to receive higher quality pre-natal care, as they are dying due to lack of simple care like monitoring of blood pressure. The number of consultations recommended by the World Health Organization (WHO) to detect cases of hypertensive illness, specifically for pregnancy (preeclampsia and eclampsia), as well as diabetes and hypertension, and to prevent infections, still has not been achieved.
18. The National Pact to Reduce Maternal and Neonatal Death, drafted in 2004 in partnership with women's movements, established strategies for the compliance of the Millenium Development Goals: reduction of maternal and neonatal mortality by 15% by the end of 2006. The creation of Committees on Maternal Death, training for professionals with basis in scientific evidence, and minimum measures for humanization of care were prioritized. The medium and long term goals strive for rates acceptable to the World Health Organization, whose objective is to bring together social actors that mobilize for the increase in quality of healthcare to women and newborns. However, their efforts are still insufficient to alter patterns of care at the local level. There is resistance in many states and municipalities to complying with the Pact, as well as to making agreements and implementing health actions provided in the national policies; this reveals a culture of devaluation of the health and life of women.

## HIV

19. Currently women represent close to half of the 37.2 million adults in the world infected by the HIV virus. Brazil has also reflected this increase. Data from the Ministry of Health showed that until 1996, the ratio was three infected men for each woman, but beginning 2004, this difference ceased to exist for youths between 15 and 19 years old. Of cases reported up to June 2006, 67.2% were men (290,917 cases) and 32.8% were women (142,138 cases), and in 2003, the rate of incidence was 25.4 per 100,000 inhabitants for men, and 16.1 for 100,000 inhabitants for women.<sup>21</sup> The ratio of the sexes has been decreasing systematically, from 15.1 men per woman in 1986, to 1.5 men per woman in 2005. It is admitted today that the increase of the epidemic in women is due to errors and prejudices in the understanding of the illness that oriented AIDS programs of the entire world in the 1980's and 1990's. There is a greater increase of the disease in the low-income population, with even greater increase for women than men in this group. A progressive increase since 1980 in the number of Brazilian municipalities with at least one case of AIDS among women has also been verified, which indicates "ruralization" has been accompanied by the process of feminization of the epidemic.<sup>22</sup> The transmission of AIDS for women takes place basically through sexual contact with infected partners. Close to 40% of AIDS cases for women involves multiple sexual partners; 60% involves partners who, for their part, have multiple sexual partners, as well as partners who used injectable drugs and partners who are HIV positive.
20. Sectors of women in situations of greater vulnerability or disadvantage have been the most victimized in the epidemic. Note the case of prisoners: even though female prisoners constitute 5% of the Brazilian prison population, they are the greater part of the infected and sick. A study by the organization Feminine Plural Collective of Porto Alegre, supported by UNESCO and by the Interdisciplinary Study Group on Research on Women of the UFRGS<sup>23</sup> indicated that only

<sup>20</sup> Tanaka, A.C., Dossier on Maternal Mortality, National Feminist Network on Health, Sexual Rights and Reproductive Rights, São Paulo, 2001.

<sup>21</sup> Women and AIDS. The Global Coalition on Women and AIDS, UNAIDS, 2006.

<sup>22</sup> National Plan to Confront the Feminization of the HIV/AIDS Epidemic and other STDs ("Plano Nacional de Enfrentamento da Feminização da Epidemia do HIV/AIDS e outras DSTs"), Ministry of Health, SPM, 2007.

<sup>23</sup> Feminine Plural Collective, Health, Life and Sexuality of Women in Semi-Open Detention, Aparecida Fernandes and Telia Negrão (organizers), Porto Alegre, 2005.

half of the population studied uses condoms in sexual relations. Also, more than half had not undergone an HIV/AIDS exam for over a year, and up to 2 years. The level of adherence to treatment is low because of lack of prospects for the future.

21. The transmission of HIV from infected mother to baby during pregnancy, childbirth, or breastfeeding (vertical transmission) has also been a problem in Brazil. Close to 9000 children up to 12 years of age who were infected during pregnancy or birth have already been registered with AIDS. But with the diagnosis of HIV infection during pre-natal care, the adoption of adequate measures of treatment for the mother, assisted birth, suspension of breastfeeding, and treatment of the child for 4 weeks, this type of transmission can be reduced to less than 3% of children.
22. Sexual orientation of Brazilian women has also been revealed as a factor in discrimination in health access. Four studies compiled in the Dossier on the Health of Lesbian Women<sup>24</sup> showed that: 13% to 70% of lesbians interviewed did not even have annual access to health services; and 3% to 7% never went to the gynecologist. Among women that accessed services, half never disclosed sexual orientation. Among those that disclosed sexual orientation, more than half perceived negative or discriminatory reactions on the part of the professional, indicating lack of training and prejudice, and a violation of rights. The National Policy for Holistic Health Assistance to Women (Política Nacional de Atenção Integral à Saúde da Mulher - PNAISM) includes specific attention to health for lesbian women, but the practice in health services continue to be prejudiced.

## **TRAFFICKING OF GIRLS AND WOMEN AND SEXUAL EXPLOITATION**

23. Intra-family sexual violence (sexual abuse, rape, seduction, negligence, abandonment, ill treatment, physical and psychological violence), violence outside the home (in the street, schools, shelters, etc) and sexual violence for commercial ends persist as a grave social problem in Brazil, affecting up to 500,000 to 800,000 girls. Though there are conflicting reports on the number of girls affected, during the conference promoted by the UN on economic exploitation of children, held in Geneva in 1993, the International Catholic Child Bureau estimated the number of girls exploited in prostitution rings to be 800,000.
24. Sexual exploitation takes place through various modalities: traditional prostitution carried out in brothels or on the edge of highways, port areas, and exploitation of mines; traffic for sexual ends and sexual tourism between Brazil and foreign countries; pornography through traditional print media and through Internet, which includes pedophilia and the stimulation of sexualization of children. Violence against girls, in its diverse forms, has more dramatic affects according to the social class and racial group to which the girls belong.
25. In the years 2003 and 2004, this phenomenon was put on the political agenda when the Joint Legislative Inquiry Committee of the National Congress (Comissão Parlamentar Mista de Inquérito – CPMI) was established. The Committee heard 285 persons, analyzed 958 documents, and received 832 complaints from throughout the country. Its findings indicated that the diverse networks of exploitation that had been denounced had links with governmental organs, particularly with the police; they showed the necessity to dismantle powerful schemes of exploitation, integrated by influential people in the economic and political sphere. Upon finalizing its work, the Commission requested the filing of charges against 200 persons, among who were politicians, judges, businesspeople, athletes, religious leaders, and police officers. The Inquiry Committee offered a host of proposals for public policy and legislative reform directed toward the incorporation of a new focus for the approach to the problem; it suggested that the moral approach (which was predominant at the time), be replaced by that of law, as a way of treating these violations as sexual crimes. The Committee indicated reform of the Penal Code as an important action to combat the sexual exploitation of girls and women, as in Brazil, sexual

---

<sup>24</sup> Feminist Health Network, 2006.

crimes still has not been considered “crimes against human rights”, but as “crimes against custom”. With regard to girls, the Statute of the Child and Adolescent (1990) is an important instrument of defense, however, it does not consider dimensions of gender and other manifestations of social diversity.

*Table 2 – Sexual Exploitation in Brazil*

<b>500,000 to 800,000 girls living in exploitation</b>
241 routes for trafficking of human beings
257 police investigations on trafficking of women
<b>200 persons already charged</b>

Source: Dossier on Gender Violence against Girls, 2005.

26. Sex trafficking in Brazil predominantly affects black and “dark” women and girls between the ages 15 and 27, generally from poorer classes, with low levels of education, who live on the margins of urban areas with lack of sanitation and transportation (among other community social goods), who live with some type of relative, has children, and engages in low-wage work activities. In 2002 the existence of 241 routes of humans trafficking with national and international reach were registered. A study conducted in that period identified 257 investigations on trafficking of women, and showed the governmental system of registration of the crime as being extremely deficient, with police authorities having little training to assist victims of sexual trafficking; thus the information transmitted by organized crime tended to circulate in a more rapid and efficient fashion than in the federal system to defend the victim. The study noted the difficulties in dismantling trafficking networks, and supported the development of strategies to confront the problem in Brazil, above all through the creation of local networks and the mobilization of the Brazilian population to act against the problem by filing complaints on cases of trafficking, giving visibility to the problem.<sup>25</sup>
27. More recent data<sup>26</sup> shows that sexual exploitation of children and adolescents in Brazil is a practice that exists in 937 municipalities. Of the cities identified, 298 (31.8%) were in the Northeast; 241 (25.7%) in the Southeast, 162 (17.3%) in the South; 127 (13.6%) were in the Central-East; and 109 (11.6%) in the North of the country. In the state of Ceará (Northeast), 41 municipalities were identified where sexual exploitation of children and adolescents occur.
28. Facts:

1. To this day we can have cases of sexual exploitation of domestic workers; but how does a society which ignores the principles of the highest law of the country in order to not comply with them or enforce compliance justify itself? A society that shields itself from complying with the laws regarding domestic work by exploiting the work of children. We need to lend a hand and fight to eradicate this evil that devastates the country, where girls and boys are yanked from their cribs in their homes to live in a “family” home. There are close to 502,000 children and adolescents in Brazil, aged 5-17, in domestic work. Of this total, 230,000 are not yet 16 years old, thus, are under the age permitted by law to work. (Maria Isabel Castro Costa, Domestic Workers Union of the State of Maranhão, São Luís, MA).
2. Data presented by Brazilian Institute for Geography and Statistics on the realities of childhood and adolescence show that Brazil is not a poor country, but an unjust country. Even today, family income, ethnicity, sex, location of residence, and whether the person has disabilities, determine the access of boys and girls to health services, nutrition, infant education, and primary and intermediate school. It also affects whether he or she will have his/her work exploited before the age of 16, and even the risk of being infected by HIV/AIDS. This “determinism” is a grave violation of human rights for these children and adolescents. (Ilma Fátima de Jesus, Unified Black Movement (MNU), São Luís, Maranhão).
3. In the year 2004, the NGO Plural Women’s Collective, moved to action by the disappearance of many children and adolescents in the “gaúcho” state (Rio Grande do Sul), and by the reports of violent deaths produced by a serial killer, implemented a project named “Disappeared Girls and Boys – The Right to be Found.” Its objective was to investigate the reasons for these disappearances and the gender relations embedded in them, seeking the foundation of a new public policy. As part of its contribution, it took to reading bulletins of the period 2002 -2004 from the archives of the disappeared persons service of the Department of the Child and Adolescent (DECA/RS). It found, after reading nearly 3000 bulletins, that the majority were black girls of lower social classes, who had run away from ill treatment and sexual abuse. With regard to gender, the data available

<sup>25</sup> Study on Trafficking of Women, Children and Adolescents for Commercial Sex Exploitation in Brazil (Pestraf, 2002), conducted by the Resource, Study and Action Center on Children and Adolescents (Centro de Referência, Estudos e Ações sobre Crianças e Adolescentes - Cecria).

<sup>26</sup> Study conducted by the Ministry of Social Development, National Plan for Confronting Sexual Violence Against Children and Adolescents, Sentinela Program, 2005.

through the police of Rio Grande do Sul showed that of every four children and adolescents who disappeared, two to three were girls, with the number of girls increasing with greater age. By 12 years old, girls were more than 75% of the total disappeared.<sup>27</sup>

## VIOLENCE AND DISCRIMINATION

29. In Brazil, the definition of violence against women in the Convention of Belém do Pará has been adopted. This definition considers as violence, any act or conduct based on gender, which causes death, physical, sexual or psychological harm or suffering to women, in the public sphere as well as in the private sphere. The “Maria da Penha” Law (Law 11340/2006) on domestic and family violence specifically against women, focused for the first time on identification and treatment of the problem, even though the Federal Constitution of 1988 contemplated and recognized the existence of domestic violence, in a general manner, in the families sphere. It should be understood, however, is that violence practiced against women in all income levels in Brazil goes beyond the domestic sphere, therefore, it also occurs in the public sphere, by action or omission. And, the greater the level of vulnerability of women, the great the incidence of gender violence. Public opinion surveys<sup>28</sup> on violence against women show that Brazilians believe: the woman should not put up with aggressions by the companion (86%); there is no situation which justifies the aggression of a man against a woman (82%); and that domestic violence is a very grave problem (91%). Still, these views do not correspond with the incidence of violence registered in Brazil that has already been cited.<sup>29</sup> Even though public opinion expresses serious concern and absolute rejection of violence, the statistics reflect social and institutional practices that are constants in the systematic pattern of discrimination and impunity.

### 30. Facts:

A document sent to the Presidency of the Republic in January 2007 denounced the constant impunity involved in the violation of rights of indigenous peoples in Brazil, asserting that it is a strong stimulus for the occurrence of new and ever-increasingly grave violations of indigenous rights. The text also refers to the impunity that accompanies cases of gender violence and of racism, highlighting the murders of 20-year-old Marina Macedo, of Baniwa ethnicity, who was found strangled and with signs of rape on the morning of January 7, 2007, in the municipality of São Gabriel da Cachoeira (a 858 kilometers from Manaus, Amazonas); and the case of 70-year-old Kurutê Lopes, of Guarani-Kaiowá ethnicity, who was shot to death a day before. The document called for the effective punishment of the persons responsible for these crimes. GRUMIN Network of Indigenous Women (Rede GRUMIN de Mulheres Indígenas <http://redegrumindemulhereindigenas.blogspot.com/>)

31. The Special Police Departments for Assistance to Women (DEAMs) constitute the principle mechanism to denounce violence against women since 1985, when they began to be established through demands by women and the feminist movement. However, the 339 DEAMS existing today in the country offers assistance to only 10% of the total of 5,561 Brazilian municipalities. Disproportionality also occurs by region, with the greatest concentration being in the Southeast region of the country, especially in the state of São Paulo. Thus, while the coverage of women in situation of violence is reported as 13% of municipalities (220 municipalities) in the Southeast of the country, in the Northeast region it is 3% (50 municipalities). The lack of training of police agents in dealing with gender violence and the insufficiencies of human and financial resources and adequate infrastructure also are factors that make difficult the capacity of this mechanism to fulfill its role of investigating and classifying crimes committed against women.

32. Signs of progress, as well as insufficiency, are assistance services to victims of sexual violence. In all of Brazil, there are only 37 hospitals that offer assistance by providing emergency contraceptives, prophylaxis (SP) for the prevention of STDs, HIV and AIDS, and abortion provided by law. Five states do not have these services: Roraima, Amapá and Tocantins (North), Piauí (Northeast) and Mato Grosso do Sul (Center-Oest). In Ceará (Northeast) and in Goiás (Center-Oest) these services exist, but there is no registry of legal abortion services. The demanding of the Bulletin

<sup>27</sup> Dossier on Gender Violence Against Girls, Feminist Health Network, 2005.

<sup>28</sup> Study conducted by the Patrícia Galvão Institute, based on the Ibope Opinion Survey “What society thinks about the problems of violence against women” (2004).

<sup>29</sup> See in particular paragraphs 3 and 4 of this Shadow Report.

of Occurrence is prevalent, even though it was expressly dispensed with by decree of the Ministry of Health.<sup>30</sup> In legal abortion services, between 1989 and 2004, there were conducted 1,266 procedures to interrupt pregnancy: 845 between 1989 and 2002; 161 in 2003 and 171 in 2004. Close to 75% of the cases were in the Southeast region of the country, the most developed in the country.<sup>31</sup>

33. The creation of anti-discrimination laws related to gender, sexual orientation, race and ethnicity in the state and national level, has started to construct a new approach for social movements, in partnership with legislatures. Cities like Campinas (São Paulo) and Porto Alegre (Rio Grande do Sul), administratively punish commercial establishments, public servants (states and municipalities), and individuals who practice discrimination against gays, lesbians, bi-sexuals, transvestites and transsexuals. The legislation opens the opportunity for complaints and reparations, and also makes possible the combating of invisibility of the phenomenon, but it is not a guarantee of the reduction of discrimination or of impunity. Of 77 complaints filed with the Homosexual Defense Hotline of Campinas Municipality, 20 were filed by lesbian women, trans-sexuals and bi-sexuals, against whom the incidence of discrimination tends to be more accentuated in the family sphere, commercial establishments and in schools.

34. The multiple social exclusion that characterizes sectors like the women prison population, is reflected in invisibility, omission and forgetfulness by the diverse spheres of Brazilian society in relation to this group of women, as well as by the female penitentiary institutions that are under the authority of the Brazilian Penitentiary System. Among the marginalized population that overcrowds Brazilian prisons, the women are practically forgotten by the State, which worries little about collecting data about them, leaving the task to academic studies and civil society organizations.<sup>32</sup> It should be noted that in 2006, incarcerated women represented 4.5% of the prison population (14,058 to 308,786 persons) and that, between 2000 and 2006, the rate of increase in this percentage was 135.37%, much higher than that of men, which was 53.36%. (Table 2).

**Table 2 – Prison population in Brazil: 2000 – 2006**

	Population in the Prison System		Total Population		Number of prisoners (per 100.000 people)		Increase (%)
	2000	2006	2000	2006	2000	2006	
<b>Women</b>	5601	14,058	86,223,155	91,946,392	6.50	15.29	<b>135.37</b>
<b>Men</b>	169,379	294,728	83,576,015	94,824,221	202.66	310.82	<b>53.36</b>
<b>Total</b>	174,980	308,786	169,799,170	186,770,613	103.05	165.33	<b>60.43</b>

Source: National Penitentiary Department (DEPEN) at [www.mj.gov.br/depem/](http://www.mj.gov.br/depem/)

<sup>30</sup> See dispositions in this regard in the Technical Norms of Prevention and Treatment of Harms resulting from Sexual Violence against Women and Adolescents, and the Technical Norms of Humanized Attention on Abortion, both of the Ministry of Health, among other documents that deal with the legal aspects involved in the assistance for sexual violence.

<sup>31</sup> Study on legal abortion in Brazilian public hospitals (1989-2004) by Rosângela Aparecida Talib and Maria Teresa Citeli, in Catholics for the Right to Choose Notebooks, number 13, 2005.

<sup>32</sup> For example, see Report on Incarcerated Women, March 2007, by the Center for Justice and International Law (CEJIL). CEJIL is one of the organizations that form the Study and Working Group on Incarcerated Women. The other organizations in the Study and Working Group are: Association of Judges for Democracy (Associação Juizes para a Democracia - AJD); Land, Work and Citizenship Institute (Instituto Terra, Trabalho e Cidadania - ITCC); National Prison Pastoral Service (Pastoral Carcerária Nacional); Institute of the Defense of the Right to Representation (Instituto de Defesa do Direito de Defesa - DDD); Dandara Center of Female Popular Public Prosecutors (Centro Dandara de Promotoras Legais Populares); Brazilian Association for the Defense of Women, Infancy and Youth (Associação Brasileira de Defesa da Mulher, da Infância e da Juventude - ASBRAD); the Teotônio Vilela Commission (Teotônio Vilela Commission - CTV); and the Brazilian Institute for Criminal Science (Instituto Brasileiro de Ciências Criminais - IBCCRIM). The Group also benefitted from the assistance of CLADEM-Brazil and the Latin America Program of the International Women's Health Coalition (IWHC). Report available on the AJD website, [http://www.ajd.org.br/ler\\_noticia.php?idNoticia=129](http://www.ajd.org.br/ler_noticia.php?idNoticia=129). See also the study by the non-governmental organization Feminine Plural Collective (Coletivo Feminino Plural) of Porto Alegre, which was sponsored by UNESCO and by the Inter-Disciplinary Center on Studies on Women of UFRGS (Núcleo Interdisciplinar de Estudos sobre a Mulher da UFRGS), published under the title "Health, Life and Sexuality of Women in Semi-Open Detention" ("Saúde, Vida e Sexualidade das Mulheres no Regime Semi Aberto", by Aparecida Fernandes and Telia Negrão (coordinators), Porto Alegre, 2005.

Further, the following is documented with regard to the female prison population<sup>33</sup>: a) the masculinization of female prisons; b) the absence of programs for social inclusion for prisoners; c) a scarcity of legislation specific to women prisoners and lack of compliance with the existing laws; d) precariousness of physical space dedicated to incarcerated women; e) lack of national studies in the academic realm and the lack of emphasis on this topic in political struggles conducted by feminist groups.<sup>34</sup>

35. In the legal sphere, in spite of extensive legislation that deals with criminal sentences, the inclusion of specifics for the female prison population is rare. An exception is the “Minimum Rules for the Treatment of Prisoners in Brazil”, which addresses care for pregnant prisoners, prisoners in labor, and convalescent prisoners. Among the provisions of these Rules are the guarantee of the right of the women to stay with their infants during the breastfeeding period; however, therein lies one of the greatest violations of their rights, as the women must give up their right to reduction of sentence in order to be able to be with their children, as this recourse is not available in the “semi-open” detention in which women breastfeed. This is in addition to the lack of pre-natal care and of exams to prevent cervical and breast cancer, among other procedures.

#### **Facts:**

According to the newspaper *Folha de São Paulo*, female prisoners were prohibited from breastfeeding after birth, and were induced to receive injections to interrupt lactation. Such acts violate the right to maternity of incarcerated women, demonstrating the vulnerability of this sector, and further, violates another Brazilian legal norm, the Statute of the Child and Adolescent (Estatuto da Criança e do Adolescente – ECA) (“São Paulo leaves child of prisoners without mother’s milk”, *Folha de São Paulo*, October 13, 2006, p.C1)

36. The discrimination against women directed at other characteristics like age, rural origin or ethnic origin, constitute other violations of rights. Women 60 years old or older are the majority of the population (55%), this age group being the most populated because of greater female life expectancy. However, this does not translate into access to social security. Government statistics on 2004 indicate that in this period, only 20.5% were receiving pensions (The Brazilian Institute for Geography and Statistics - IBGE). The high percentage of unprotected women demonstrates a grave problem for the near future, which elderly women who were excluded from the workplace are going through now: the lack of access or difficulty of access, to income in old age.

**Porto Alegre (Brazil), 19 de novembro de 2007.**

#### **The Brazilian Feminist Network of Health, Sexual Rights and Reproductive Rights – RFS**

**Avenida Salgado Filho, 28 – cj 601 – Porto Alegre – Rio Grande do SUL**

**CEP 90010220 – Brazil**

**Phone: 55 51 32124998 – E-mail: [redefeminista@uol.com.br](mailto:redefeminista@uol.com.br)**

**[www.redesaude.org.br](http://www.redesaude.org.br)**

---

<sup>33</sup> Rita Laura Segato, Women and the application of sentences of incarceration (As mulheres e a aplicação de penas de privação de liberdade) (research project), CNPQ, 2005.

<sup>34</sup> In Rio Grande do Sul, for example, only one feminist NGO (Feminine Plural Collective) conducts work in the area of health, sexuality and prevention of STDs.