Fórum Febrasgo

Aborto Previsto em Lei na Violência Sexual

Aborto nos casos de violência sexual: avanços e desafios

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CNE Febrasgo Violência Sexual e Interrupção gestacional prevista em le

Global Doctors for Choice Brazil

Rede Feminista de Ginecologistas e Obstetras

Número de serviços brasileiros

Com assistência a mulheres em situação de aborto legal

Madeiro & Diniz (2016)

Julho/2013 - Março/2015

- 68 serviços pesquisados
  - 37 realizavam aborto legal
    - 15 realizaram < 10 procedimentos nos últimos 10 anos

Número de serviços brasileiros

Com assistência a mulheres em situação de aborto legal

Madeiro & Diniz (2016)

Principais obstáculos

- Falta de conhecimento sobre a legislação
- Número reduzido de profissionais – “objeção de consciência”

Objeção de consciência

Recusa do médico em cumprir seu **dever legal/profissional** quando esse dever é contrário aos seus valores morais/éticos ou religiosos

Wicclair, 2011

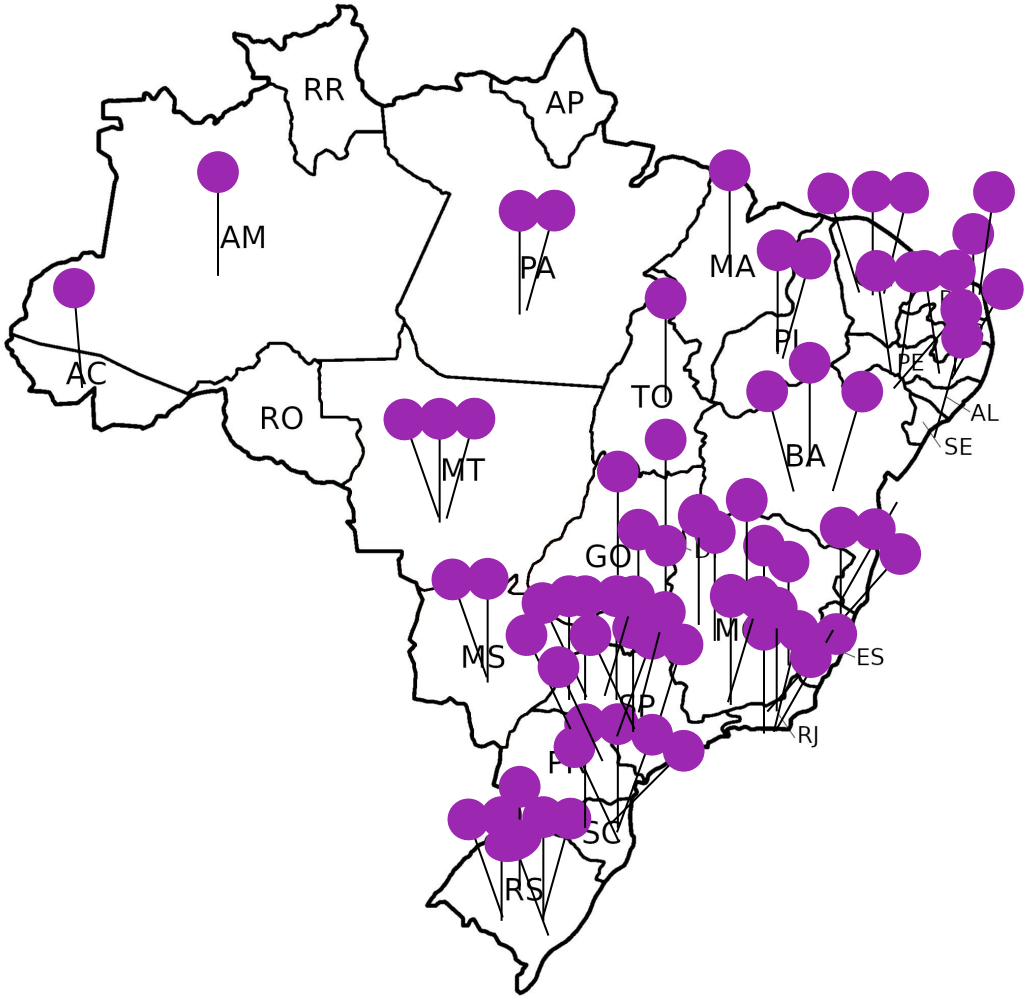
“O dever consciente primário de ginecologistas-obstetras [...] é, em todos os momentos, tratar ou beneficiar e prevenir prejuízos a pacientes pelas quais são responsáveis. Qualquer objeção de consciência ao tratamento da paciente é secundária a esse dever.”

FIGO, 2012

Serviços brasileiros durante a pandemia da COVID-19

Brasil antes da pandemia

Serviços de aborto legal no Brasil - Mapa do Aborto Legal (Artigo 19)



Brasil durante a pandemia

Serviços de aborto legal no Brasil - Mapa do Aborto Legal (Artigo 19)

(contato telefônico realizado entre 27 de abril e 7 de maio de 2020)

Portaria 2.282/2020

Dispõe sobre o Procedimento de Justificação e Autorização da Interrupção da Gravidez nos casos previstos em lei, no âmbito do Sistema Único de Saúde-SUS.

Artigo 1º

Notificação obrigatória (**denúncia**) à autoridade policial

Sigilo profissional

"O médico guardará sigilo a respeito das informações de que detenha conhecimento no desempenho de suas funções, com exceção dos casos previstos em lei".

CFM, 2019. Código de Ética Médica.
Princípios Fundamenais.

Sigilo profissional

“É vedado ao médico: **Art. 73** - Revelar fato de que tenha conhecimento em virtude do exercício de sua profissão, salvo por motivo justo, dever legal ou consentimento, por escrito, do paciente.
Parágrafo único. Permanece essa proibição: a) mesmo que o fato seja de conhecimento público ou o paciente tenha falecido; b) quando de seu depoimento como testemunha (nessa hipótese, o médico comparecerá perante a autoridade e declarará seu impedimento); c) na investigação de suspeita de crime, o médico estará impedido de revelar segredo que possa expor o paciente a processo penal”.

CFM, 2019. Código de Ética Médica.

Sigilo profissional

Art. 154 – “Revelar alguém, sem justa causa, segredo de que tenha ciência, em razão de função, ministério, ofício ou profissão, e cuja revelação possa produzir dano a outrem. Pena - detenção de 3 meses a 1 ano”.

Código Penal Brasileiro (1940)

Portaria 2.282/2020

Dispõe sobre o Procedimento de Justificação e Autorização da Interrupção da Gravidez nos casos previstos em lei, no âmbito do Sistema Único de Saúde-SUS.

Artigos 3º-6º

- Relato circunstanciado
- Termo de responsabilidade
- TCLE*
- Parecer técnico
- Termo de aprovação

Brazilian doctors condemn new rules on abortion

Experts say that the new rules for health workers will discourage access to health services and increase the risk of unsafe abortion. Lise Alves reports from São Paulo.

An ordinance passed by Brazil's Health Ministry at the end of August, 2020, related to abortion has led to widespread criticism by doctors. Under the new rules, medical staff must report rapes to police and health workers must offer the patient a chance to see the embryo or fetus via ultrasound before abortion.

"[The ordinance] does not look out for the woman's best interest. It is a disservice to women who are already in a condition of extreme vulnerability", César Eduardo Fernandes, scientific director at Febrasgo (the Brazilian Federation of Gynecology and Obstetrics Associations) and president-elect of the Brazilian Medical Association, told *The Lancet*.

Febrasgo released a statement saying that the mandatory notification of sexual assault to the police violates women's rights and goes against doctor–patient confidentiality.

Silvana Quintana is coordinator of SEAVIDAS (Brazil's Domestic Violence and Sexual Assault Service) and associate professor of gynaecology and obstetrics at Ribeirão Preto Medical School in São Paulo. She said: "It damages the doctor–patient relationship when a patient asks you not to report the violence and you say it is legally necessary."

Fernandes also considers it cruel to ask the patient if she wants to see an ultrasound image of the embryo or fetus before the procedure. "It brings even more suffering to these women. It looks like we are trying to dissuade her from her decision", agreed Helena Paro, professor at the Federal University of Uberlândia, and member of Global Doctors for Choice Brazil.

The ministry's ordinance in August comes after Brazil's Congress passed a law in December, 2019, saying that health workers had to notify police if there was evidence of violence against women.

The new ordinance specifies that doctors and other staff, including those working at abortion clinics, must tell police if there is evidence of rape, and that they must keep fragments of embryos or fetuses as evidence. Although the 2019 law did not specify notification in case of legal abortions,

> "'These rules can damage the bond of trust between doctor and patient.'"

doctors contacted by *The Lancet* also criticised the requirement of notifying police authorities in cases of violence against women without the consent of the patient.

"We should not be aiming at only revoking the ordinance but repealing the law", said Quintana. "These rules can damage the bond of trust between doctor and patient."

Paro said that the ordinance will keep women away from health services. "The great majority of women who suffer sexual violence do not want to proceed with a police complaint. If they lose confidence in health professionals who have a duty of professional secrecy, they will end up not seeking these services", she said. "This will lead women to seek unsafe ways to terminate the pregnancy, even though they are legally entitled to access this service."

And that could mean an increase in deaths due to complications. "For [women] with money, it means a good health clinic; for those without money, the possibility of losing one's uterus or one's life", said Quintana.

Brazil has some of the most restrictive abortion rules in the world, being legal under only three circumstances: pregnancy as a result of rape, when the woman's life is at risk, and when the fetus is found to be anencephalic. "There are only between 60 to 70 approved health facilities that provide legal abortions for the entire country. Four states have no such facility whatsoever", said Quintana.

The law and ordinance might also decrease the already scarce number of facilities that provide the procedure legally. "Many of these facilities will feel even more fragile and end up closing", said Paro. She feared that many health professionals will leave services dealing with sexual violence.

"It seems to me that the intention of both the law and the ordinance is to make sexual violence invisible in Brazil. If women don't seek official health services, the number of [officially recorded] abortions will decrease", said Paro.

Not all lawmakers, however, agree. Senator Eduardo Girão told *The Lancet*: "[The ordinance] maintains the right to abortion, but indicates the need for prior forewarning on all the risks inherent in the intervention; therefore, in addition to contributing to the reduction of the monstrous crime of rape, it also advances in preserving the health of women, who have already experienced great trauma with this violence, and may have to go through another trauma, which is abortion."

Congressional Representative Renata Abreu, who introduced the bill voted into law last year, told *The Lancet* that notification of police will speed up investigations and to help deter violence against women. "The aim of my law is to reduce this communication time gap between doctors and police, making mapping the crime scene much faster, without the need to expose the victim."

Lise Alves

Aborto: manejo e tratamento

"Medical abortion care encompasses the management of various clinical conditions including spontaneous and **induced abortion (both viable and non-viable pregnancies)**, incomplete abortion and intrauterine fetal demise, as well as post-abortion contraception."

WHO (2018)

Primeiro trimestre gestacional

WHO (2014)

≤12–14 WEEKS

Medical abortion	Vacuum aspiration
■ Avoids surgery ■ Mimics the process of miscarriage ■ Controlled by the woman and may take place at home (< 9 weeks) ■ Takes time (hours to days) to complete abortion, and the timing may not be predictable ■ Women experience bleeding and cramping, and potentially some other side-effects (nausea, vomiting) ■ May require more clinic visits than VA	■ Quick procedure ■ Complete abortion easily verified by evaluation of aspirated POC ■ Takes place in a health-care facility ■ Sterilization or placement of an intrauterine device (IUD) may be performed at the same time as the procedure ■ Requires instrumentation of the uterus ■ Small risk of uterine or cervical injury ■ Timing of abortion controlled by the facility and provider
May be preferred in the following situations: ■ For severely obese women ■ Presence of uterine malformations or fibroids, or previous cervical surgery ■ If the woman wants to avoid surgical intervention ■ If a pelvic exam is not feasible or unwanted	**May be preferred in the following situations:** ■ If there are contraindications to medical abortion ■ If there are constraints for the timing of the abortion

Primeiro trimestre gestacional

WHO (2018)

RECOMMENDATION 3A

Medical management of induced abortion at < 12 weeks of gestation[9]

RECOMMENDATIONS	COMBINATION REGIMEN (RECOMMENDED[a])		MISOPROSTOL-ONLY (ALTERNATE)
	MIFEPRISTONE » 1–2 DAYS »	MISOPROSTOL	MISOPROSTOL
INDUCED ABORTION < 12 WEEKS	200 mg PO once	800 µg B, PV or SL[b,c]	800 µg B, PV or SL[b,c]

B: buccal; PO: oral; PV: vaginal; SL: sublingual

We recommend the use of 200 mg mifepristone administered orally, followed 1–2 days later by 800 µg misoprostol administered vaginally, sublingually or buccally.[b,c] The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.

For the misoprostol-only regimen, we recommend the use of 800 µg misoprostol administered vaginally, sublingually or buccally.[b,c]

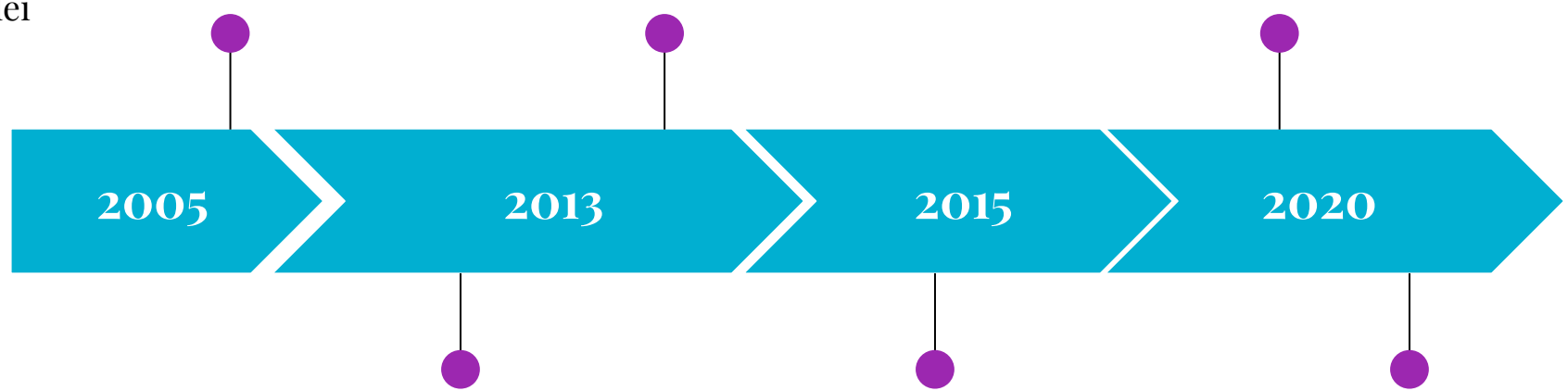
Primeiro trimestre gestacional: aborto por telessaúde

ANIS - Instituto de Bioética; NUAVIDAS HCU/UFU (2020)

Portaria 1508/2005
(Portaria consolidação 5/2017)
Procedimento de Justificação e Autorização da Interrupção da Gravidez nos casos previstos em lei

Lei 12.845/2013
Dispõe sobre o atendimento obrigatório e integral de pessoas em situação de violência sexual

Lei 13.989/2020
Telemedicina



Decreto 7958/2013
Diretrizes para o atendimento às vítimas de violência sexual pelos profissionais de segurança pública e da rede de atendimento do SUS

Portaria Interministerial 288/2015

Portaria 1662/2015
Critérios para habilitação para realização de Coleta de Vestígios de Violência Sexual no SUS

RDC 357/2020 ANVISA

Segundo trimestre gestacional

WHO (2014)

>12–14 WEEKS

Medical abortion	Dilatation and evacuation (D&E)
■ Avoids surgery ■ Mimics the process of miscarriage ■ Takes place in a health-care facility ■ Takes time (hours to days) to complete abortion, and the timing may not be predictable ■ Women experience bleeding and cramping, and potentially some other side-effects (nausea, vomiting) ■ Women remain in the facility until expulsion of the pregnancy is complete ■ Women with a uterine scar have a very low risk (0.28%) of uterine rupture during medical abortion between 12 and 24 weeks	■ Quick procedure ■ Complete abortion easily verified by evaluation of aspirated POC ■ Takes place in a health-care facility ■ Sterilization or placement of an IUD may be performed at the same time as the procedure ■ Requires cervical preparation in advance of procedure ■ Requires instrumentation of the uterus ■ Small risk of uterine or cervical injury ■ Timing of abortion controlled by the facility and provider
May be preferred in the following situations: ■ For severely obese women ■ The presence of uterine malformations or fibroids, or previous cervical surgery ■ If the woman wants to avoid surgical intervention ■ If skilled, experienced providers are not available to provide D&E	**May be preferred in the following situations:** ■ If there are contraindications to medical abortion ■ If there are time constraints for the abortion

Segundo trimestre gestacional

WHO (2018)

RECOMMENDATION 3B Medical management of induced abortion at ≥ 12 weeks of gestation

RECOMMENDATIONS	COMBINATION REGIMEN (RECOMMENDED[a])		MISOPROSTOL-ONLY (ALTERNATE)
	MIFEPRISTONE » 1–2 DAYS »	MISOPROSTOL	MISOPROSTOL
INDUCED ABORTION ≥ 12 WEEKS	200 mg PO once	400 µg B, PV or SL every 3 hours[b,c]	400 µg B, PV or SL every 3 hours[b,c]

B: buccal; PO: oral; PV: vaginal; SL: sublingual

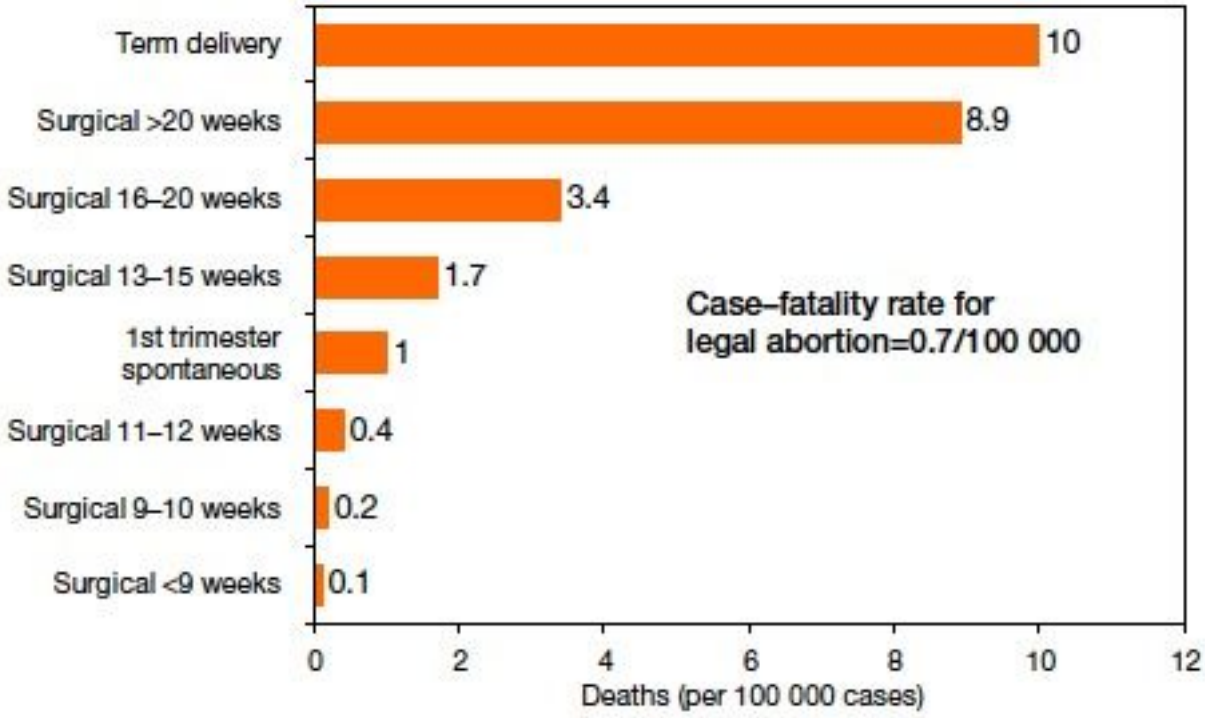
We suggest the use of 200 mg mifepristone administered orally, followed 1–2 days later by repeat doses of 400 µg misoprostol administered vaginally, sublingually or buccally every 3 hours.[b,c] The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.

For the misoprostol-only regimen, we suggest the use of repeat doses of 400 µg misoprostol administered vaginally, sublingually or buccally every 3 hours.[b,c]

Segurança do aborto previsto em lei

Figure 1.2 Case–fatality rates of legal induced abortions, spontaneous abortions or term deliveries, per 100 000 procedures, USA

Reproduced, with permission, from reference 32.



Bartlett et al. (2004)

Aborto previsto em lei acima de 22 semanas

Epidemiologia

WHO (2018)

NICE (2019)

EUA

- 1,4% após 20 semanas

Inglaterra

- 0,1% após 23 semanas

Meninas e mulheres mais vulneráveis

FIGO
INTERNATIONAL FEDERATION OF GYNECOLOGY & OBSTETRICS
www.figo.org

MISOPROSTOL-ONLY RECOMMENDED REGIMENS 2017

<13 weeks' gestation	13–26 weeks' gestation	>26 weeks' gestation[8]	Postpartum use
Pregnancy termination[a,b,1] 800µg sl every 3 hours *or* pv*/bucc every 3–12 hours (2–3 doses)	**Pregnancy termination**[1,5,6] 13–24 weeks: 400µg pv*/sl/bucc every 3 hours[a,e] 25–26 weeks: 200µg pv*/sl/bucc every 4 hours[f]	**Pregnancy termination**[1,5,9] 27–28 weeks: 200µg pv*/sl/bucc every 4 hours[f,g] >28 weeks: 100µg pv*/sl/bucc every 6 hours	**Postpartum hemorrhage (PPH) prophylaxis**[i,2,10] 600µg po (x1) ***or*** **PPH secondary prevention**[i,11] (approx. ≥350ml blood loss) 800µg sl (x1)

Morris et al. (2017)

Indução de óbito fetal

Injeção intracardíaca de KCl

Lee et al. (2005)

SFP (2010)

ACOG (2013)

- Não reduz tempo de indução
- Não há percepção fetal de dor antes 29ª sem
- 0,1% após 23 semanas
- Fatores emocionais relacionados aos sinais transitórios de vida após expulsão fetal

Ausência de profissional da Medicina Fetal não deve limitar o acesso

“Women belong in all places where decisions are being made. It shouldn't be that women are the exception.”

Ruth Bader Ginsburg

(15/03/33 - 18/09/2020)

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