

EDITORIAL

Abortion in Brazil: when Alice in wonderland doesn't know which way to go

Jefferson Drezett^a, Gabrieli Kotzias^b



^aProfessor do Departamento de Saúde e Sociedade. Faculdade de Saúde Pública da USP. São Paulo (SP), Brasil;

^bMestranda do Programa de Pós-Graduação em Saúde Pública. Faculdade de Saúde Pública da USP. São Paulo (SP), Brasil.

Corresponding author

drezett@usp.br

Orcid authors:

Jefferson Drezett - <https://orcid.org/0000-0003-4072-3636>

Gabrieli Kotzias - <https://orcid.org/0000-0002-0703-5906>

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Abstract

In recent decades, many countries have reformed their laws that criminalized abortion. They abandoned their confrontation from a moral or religious perspective, assuming it as a matter of public health and women's human rights. The decision is based, above all, on the evidence that the prohibition of abortion does not reduce its practice, but determines the search for clandestine and unsafe procedures, responsible for 39,000 preventable deaths of women each year. Brazil has maintained the criminalization of abortion unchanged since 1940 in the Penal Code, with only two legal permissions: when there is a risk of death for the pregnant woman, or when the pregnancy results from a sexual crime. In 2012, the Federal Supreme Court ruled that abortion in cases of anencephaly was not criminal. However, these permissives repeatedly suffer conservative and fundamentalist attacks, which seek greater restrictions or prohibition. The recent resolution CFM 2,378/2024, from the Federal Council of Medicine, prohibited doctors from performing abortions through fetal asystole after the 22nd week in pregnancies resulting from sexual violence. Almost at the same time, Bill 1904/2024 was presented in parliament, with a similar proposal, but significantly increasing the penalties for women who had an abortion after the 22nd week, greater than those foreseen for sexual offenders. This editorial analyzes Brazil's position on the international scene, the arguments behind these restrictive initiatives, and the most vulnerable women who would potentially be affected.

Keywords : legal abortion, induced abortion, violence against women, violation of human rights, sexual crimes.

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Few nonsense works are as popular as “Alice in Wonderland”, published by Charles Lutwidge Dogson, in 1865, under the pseudonym Lewis Carroll. Alice's adventures take place in a fantasy world with fascinating characters such as the Mad Hatter, the Caterpillar, the Mock Turtle and the Queen of Hearts. But the episode with the Cheshire Cat stands out. Confused and hesitant at a crossroads, Alice asks the Cat which way to go, to which the Cat asks: “Where do you want to go, Alice?” And the girl replies: “I don’t know!”. Simply put, the Cat declares: “So, it doesn’t matter which way you go.”

Just like Alice, who faces challenges in “Wonderland”, women in Brazil face the challenge of resisting recurring attempts to violate their few rights when it comes to abortion. Many of these attacks are so absurd and so unimaginable that they could be found in Lewis Carroll's story. However, the role of not knowing which path to take lends itself to the Brazilian State. On the one hand, it does not decide to definitively tackle abortion as a public health and human rights issue. On the other hand, it cannot move away from abortion as a moral and fundamentalist agenda¹.

This is not about rhetoric, but about analyzing Brazil's position on the international scene. The Center for Reproductive Rights classifies countries into five categories, according to the type of legislation that is more or less restrictive in relation to abortion. In Category I countries, abortion is not criminalized. Around 660 million women of reproductive age live in these countries, most of which are developed, or 34% of the world's female population. In Category II countries, there are 460 million women, 23% of the world's women, supported by broad social and economic grounds for allowing abortion, such as the United Kingdom, India, Ethiopia and Zambia². Almost 60% of women in the world have guaranteed autonomy to decide on abortion, without State intervention and without having to resort to clandestine and unsafe procedures.

Category III includes most African countries and others such as Pakistan, Saudi Arabia, Malaysia, Bolivia, Peru and Ecuador. In addition to the allowances for the risk of death to women and pregnancy resulting from sexual violence, abortion is permitted when the woman's health is threatened or in cases of serious fetal anomalies. There are over 230 million women living in these countries, 12% of the world population of women of reproductive age².

Brazil is placed in category IV, with strong legal restrictions on abortion, permitted only in exceptional situations. There is no developed country in this category, so Brazil aligns itself with nations such as Afghanistan, Iran, Somalia, Nigeria, Tanzania, Sudan, Gabon, Venezuela and Paraguay. It is estimated that around 410 million live in these countries, 20% of women in the world².

Category V brings together a few countries that still maintain an absolute ban on abortion: Palao, Tonga, Philippines, Laos, Iraq, Malta, Madagascar, Senegal, Congo, Sierra Leone, Mauritania, Egypt, El Salvador, Dominican Republic, Nicaragua, Suriname, Haiti, Jamaica, Honduras and Curaçao. Only 6% of women live under draconian laws in these countries, around 110 million². These are countries that decide that the death of a woman is tolerable so that an abortion cannot be performed.

However, the positioning within these legal categories has shown notable transformations over the last three decades. More than 60 countries have reduced or eliminated legal obstacles. Many developing countries such as South Africa, Mozambique, Albania, Tunisia, Benin, Ethiopia, Turkey, Nepal, Rwanda, Guinea-Bissau and Somalia have ended criminalization. In South America, Uruguay, Colombia and Argentina².

Only four countries showed setbacks in the same period. Poland, expanding restrictions, and El Salvador and Nicaragua, adopting bans². The most controversial change occurred in the USA, with the conservative majority of the Supreme Court overturning the 1973 *Roe v. Wade*³. Since then, American states such as Texas and Alabama have adopted the criminalization of abortion, while others, such as Oregon and California, seek its protection⁴.

Brazil appears indifferent to progressive trends on the international scene. Since 1940, abortion has been criminalized in the Penal Code. The few permissions are provided for in article 128, to prevent the death of the pregnant woman or when the pregnancy results from a sexual crime⁵. The only progress occurred within the scope of the Federal Supreme Court (FSC), which judged the Claim of Non-Compliance with Fundamental Precept 54, on cases of pregnancy with anencephaly. It was decided that criminal abortion does not constitute criminal abortion in these cases⁶. However, the decision does not cover other fetal anomalies that are equally serious and inexorably incompatible with extrauterine life¹.

Whether or not to criminalize abortion matters due to its consequences for public health. In countries with less restrictive laws, 87% of abortions are performed safely. In places with legal restrictions, 75% of abortions are unsafe or very unsafe⁷. The World Health Organization (WHO) estimates that 98% of unsafe abortions occur in developing countries where legal restrictions prevail⁸. Women who decide to terminate their pregnancies end up resorting to clandestine and potentially unsafe abortions, without the possibility of receiving qualified and humanized assistance from the State.

The perverse relationship between clandestinity and unsafe abortion has devastating impacts on women. The WHO estimates that around five million women around the world face health problems each year due to complications from unsafe abortion, mainly for reproductive health. Abortion can represent up to 25% of all maternal mortality, mainly due to infection or hemorrhage. The highest death rates from unsafe abortion are in developing countries, reaching 220/100,000 unsafe procedures⁸, contrasting sharply with the mortality rates from legal and safe abortion, of 0.7/100,000⁹. There are 39,000 female deaths each year, one every 13.4 minutes². Few would have lost their lives if they had access to adequate procedures.

It is also necessary to recognize who are the women most vulnerable to unsafe abortion. Let us analyze what is happening in Brazil based on the National Abortion Survey¹⁰. One in seven women declares that they have resorted to clandestine abortion in their lifetime. The prevalence of clandestine abortion is significantly higher among black and indigenous women, living in poverty and

with low education. Almost half of them are girls under 19. The highest rates of clandestine abortion are found in the North and Northeast regions¹⁰, which have lower Human Development Indexes and fewer opportunities for reproductive care¹¹. Almost 45% of these women end up hospitalized for treatment of complications. They also confront their religious beliefs: 56% are Catholic and 25% Evangelical, religions that are axiomatic in relation to the prohibition of abortion¹⁰.

The prevalence of clandestine abortion is also related to determinants of unwanted pregnancy. Almost 50% of pregnancies in the world are unplanned, with a rate of 64/1,000 pregnancies among women of reproductive age. The highest values are in East and Southern Africa, at 101/1,000 women, and the lowest in developed countries, with 34/1,000 women. On average, 60% of these pregnancies are terminated¹². Furthermore, unplanned pregnancy rates are higher the worse the Gender Inequality Index is, which particularly affects women in developing countries¹².

Even so, abortion bans persist in many countries, justified as necessary to control abortion rates. This claim is absolutely false. Abortion rates in developed countries, without criminalization, have been significantly reduced. Between 1994 and 2014, they ranged from 46/1,000 to 27/1,000 women of reproductive age. In the same period, they varied from 39/1,000 to 36/1,000 in developing countries that criminalize it, with an increasing trend¹³.

Abortion bans are known to be ineffective in reducing abortion rates, but they are effective in causing women's death. Among the available examples, take the case of Romania. The ban on abortion in the mid-1970s increased mortality from abortion from around 20/100,000 to almost 150/100,000, without reducing rates¹⁴. The failure of the ban is admitted by the WHO, which recommends that laws and policies on abortion should protect women's health and human rights, and not criminalize them⁸. The International Human Rights System positions itself in the same way. The United Nations recommends that States consider abortion as a public health issue¹⁵. For its Human Rights Committee, denying access to non-criminal abortion constitutes a violation of women's most basic human rights.

The evidence should be sufficient to alert Brazilian society about the urgent need to reform the archaic legislation on abortion. But that's not what happens. The Brazilian parliament accumulates more bills that seek to further restrict abortion than initiatives to the contrary. It is worth reflecting on recent events. In March 2024, the Federal Council of Medicine (FCM) published resolution CFM 2,378/2024¹⁶ prohibiting abortion due to fetal asystole in cases of pregnancy resulting from a sexual crime lasting more than 22 weeks, which would make care unfeasible. The explanatory memorandum used arguments such as the "inviolability of life from conception", the "rights of the unborn child", and that "the concept of human life is objectively established through embryology". He classified fetal asystole as a "profoundly unethical" and "irresponsible" act, with "higher rates of serious maternal complications".

The FCM's arguments based on the interpretation

of laws are fragile and unsustainable. In the bioethical and technical field, they were contested and dismantled by the International Federation of Gynecology and Obstetrics (FIGO)¹⁷, among other institutions. But it is important for the FCM to resort to the Pact of São José da Costa Rica¹⁸. Indeed, Article 4 states that everyone has the right to life and that "this right must be protected by law and, in general, from the moment of conception". As Brazil is a signatory to the document, the FCM understands the article as an absolute right of the fetus. But it's not true. The Inter-American Court of Human Rights itself clarifies that article 4 aims to protect pregnant women, and not to impede abortion¹⁹. In the same sense, the European Court of Human Rights declares that the fetus does not enjoy an absolute right to life: "the necessary balancing of goods, involving the collision between the rights of the woman and the rights of a potential life (rights of the fetus), must be guided by the principle of proportionality, in its triple dimension – adequacy, necessity and strict proportionality".

In any case, restricting access to legal abortion due to gestational age has no basis in the Brazilian legal system. The legal-criminal concept of abortion is clear and considers any intentional act that intentionally seeks fetal loss, regardless of gestational age²⁰. But that's not all. The WHO advises against laws and regulations that limit abortion based on gestational age, recommending protocols for cases over 22 weeks that include fetal asystole²¹. The same conduct is recommended by FIGO²².

On the other hand, there is the clinical concept of abortion that is guided by the expectation or not of fetal viability depending on its development, somewhere around 22 weeks. This parameter is intended to differentiate abortion from other obstetric events and guide care procedures for each gestational age^{8,21}. Legal and clinical concepts are not exclusive and have different purposes. However, they are often confused and influence the positions of health professionals and their class representations.

The FCM resolution ended with its effects suspended by the FSC due to a precautionary measure requested in the Claim of Non-Compliance with Fundamental Precept 1141²³ and, until July 2024, it was awaiting judgment. The response from the conservative and religious bench of the Brazilian parliament was immediate. Federal Deputy Sóstenes Cavalcante presented Bill 1904/2024, signed by 32 parliamentarians²⁴. The urgent request was accepted by the Board of the Chamber of Deputies and approved, symbolically, for Bill 1904 to be voted on in plenary.

Bill 1904 intends to amend the Penal Code by equating the penalties for the crime of abortion, provided for in articles 124 to 126, with the penalties for simple homicide when carried out after 22 weeks of gestation. It would also amend article 128, ending the legal permit for abortion in cases of sexual violence after the 22nd week of pregnancy²⁴. The woman's prison sentence would go from one to three years to six to twenty years. In cases of abortion due to sexual violence, women and girls would end up being penalized more harshly than the sexual aggressor himself, who faces a sentence of between six and ten years in prison⁵. In part, the justifications for Bill

1904 take up some arguments from resolution CFM 2,378, but they are so much more dubious and inconsistent that they do not even deserve analysis.

Although Bill 1904 and the FCM resolution matter for all women, there is a need for careful discussion about who is most harmed. Brazil has alarming and growing indicators of sexual violence against women²⁵. According to the Public Security Yearbook²⁶, in 2022 the country recorded 74,930 cases of rape and rape of vulnerable people, 61.4% against girls under 14 years of age, 56.8% of them black. Known aggressors account for 82.7% of cases, with 63.3% occurring at home. However, this information only relates to reported incidents, and it is estimated that 90% of cases do not come to the attention of public security agencies²⁷.

These indicators deserve further study. According to a study by Blake *et al.*²⁸, in our country, 6% of women resort to legal abortion after 22 weeks when the situation involves sexual violence. They are significantly younger women, raped by related aggressors. Another Brazilian study, by Bessa *et al.*²⁹, has strong evidence that late arrival is associated with the crime of incest committed in the domestic space. In these cases, 21.8% of girls resort to legal abortion after 22 weeks of pregnancy, representing 93.7% of refusals of the procedure. In Santana's thesis³⁰, 13.6% of women with intellectual disabilities who were pregnant due to rape seek a legal abortion after 22 weeks. Almost 45% are black, 75% have little or no education, and 45% are repeatedly raped by relatives.

In all these cases, arriving late to health services is not a choice. Girls may take longer to notice pregnancy than adult women. In people with intellectual disabilities, the diagnosis may depend on the caregiver identifying a missed menstrual period or other sign of an unexpected pregnancy. Girls have fewer internal resources and less support to disclose sexual violence, as well as less autonomy to use health services. Above all, they end up trapped by their proximity to the perpetrator, delaying the disclosure of sexual violence and the taking of appropriate measures^{28,29}. There is no doubt. Extremely vulnerable girls would be the main victims of the Bill 1904 atrocities.

The demonstrations of repudiation gained strength nationwide. The Brazilian Bar Association treated the initiative as unconstitutional, unconventional and illegal. The Brazilian Federation of Gynecology and Obstetrics Associations requested its removal from the legislative agenda. Thousands of women took to the streets of

large cities called upon and supported by organized civil entities. A Chamber of Deputies poll open to the population recorded 90% total disapproval of Bill 1904. From the alleged intention of being an Anti-Abortion Bill, Bill 1904 ended up known as the misogynistic Rape Bill.

The effects appeared. The president of the Conselho Federal de Medicina do Brasil, José Hiran Gallo, who defended "limits to women's autonomy" when it comes to abortion, went on to declare that the entity is an "ally" of the female population and that it has no relationship with Bill 1904. There was no parliamentarian who did not withdraw his signature from the Bill, claiming that he was unaware of all its contents. Pressured by public opinion and their voters, they retreated with Bill 1904. But the wound of abortion as a dispute and political bargaining chip was exposed. If, on the one hand, progressive Brazilian society showed maturity and won a battle, on the other hand, it must be clear that we have not progressed at all. A setback was only prevented. New attacks on women's human rights will certainly come. It will be up to the State to decide whether it will continue to behave as if it were the confused and hesitant Alice.

Finally, giving visibility to public health processes is an integral part of the Journal of Human Growth and Development (JHGD). In the articles listed in this issue (35.1)³¹⁻⁴⁵, the full scope of the journal and its interface with public health are evident, serving as a vehicle for disseminating knowledge from the multidisciplinary and broad field, with various areas of action aimed at improving the health and well-being of the population collectively.

In addition to topics such as legal abortion^{35,36} and nutritional aspects^{35,37,38,39,45}, there are contributions in the area of health surveillance^{40,41,42} within its broad spectrum^{40,41}, women's health^{31,32}, child and adolescent health^{37,43}, mental health, occupational health, health policy and management, health education, health promotion, and the control of non-communicable chronic diseases (NCDs)^{39,42,43,44}.

These are just a few examples of the many areas of public health action. In each of them³¹⁻⁴⁵, public health professionals work with public policies, prevention programs, health promotion, and surveillance to improve the quality of life and address health-related social inequalities. JHGD serves as a platform for disseminating knowledge produced in various locations in Brazil and around the world.

REFERENCES

1. Drezett J. Editorial. Reproducao & Climaterio [Internet]. 2014 [cited 2024 Aug 25];3(29):85–7. Available from: <https://www.infona.pl/resource/bwmeta1.element.elsevier-1bd90f48-fdd1-3015-9ec2-54a804a27df0>
2. The World's Abortion Laws [Internet]. Center for Reproductive Rights. 2022 [cited 2024 Aug 28]. Available from: <https://reproductiverights.org/maps/worlds-abortion-laws/>
3. Owens DC, de Londras F, Gutierrez-Romine A, Schoen J, Tillet S, Wulf K. Roe V. Wade: Fifty Years After [Internet]. University of Georgia Press; 2024. 241 p. Available from: <https://play.google.com/store/books/details?id=YAgVEQAAQBAJ>
4. Ziegler M. The end of Roe v. Wade. Am J Bioeth [Internet]. 2022 Aug;22(8):16–21. Available from: https://www.tandfonline.com/doi/abs/10.1080/15265161.2022.2075962?casa_token=XmPxve5ShrwAAAAA:DW1LbFmW_S6yhL6HkU5JLP9vmFkc_Ymivwrj3Uzo9SutvK2-whxui4JR6WqgcRByZNW67XHCr0Ts7-J

5. Masson C. Código Penal Comentado [Internet]. 7th ed. Método; 19 fevereiro 2019 [cited 2024 Aug 25].
6. BRASIL. Supremo Tribunal Federal. Arguição de Descumprimento de Preceito Fundamental (ADPF) 54. Brasília; 12 de abril de 2012. Available from: <https://portal.stf.jus.br/noticias/verNoticiaDetalhe.asp?idConteudo=204878#:~:text=STF%20conclui%20o%20julgamento%20da,direito%20de%20interromper%20a%20gravidez>
7. Unintended Pregnancy and Abortion Worldwide [Internet]. Guttmacher Institute. 2020 [cited 2024 Aug 28]. Available from: <https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide>
8. World Health Organization. Safe abortion: technical and policy guidance for health systems. 2th ed. Geneva: World Health Organization; 2012. Available from: https://iris.who.int/bitstream/handle/10665/173586/WHO_RHR_15.04_eng.pdf?sequence=1
9. Bartlett LA, Berg CJ, Shulman HB, Zane SB, Green CA, Whitehead S, et al. Risk factors for legal induced abortion-related mortality in the United States. *Obstet Gynecol* [Internet]. 2004 Apr;103(4):729–37. Available from: https://journals.lww.com/greenjournal/FullText/2004/04000/Risk_Factors_for_Legal_Induced_Abortion_Related.20.aspx
10. Diniz D, Medeiros M, Madeiro A. National Abortion Survey - Brazil, 2021. *Cien Saude Colet* [Internet]. 2023 Jun;28(6):1601–6. Available from: <https://www.scielo.br/j/csc/a/mDCFKkqkyPbXtHXY9qcpMqD/>.
11. Programa das Nações Unidas para o Desenvolvimento. Relatório especial 2023. 25 anos desenvolvimento humano no Brasil: construir caminhos, pactuando novos horizontes. Brasília, DF. UNPD. [cited 2024 Aug 28]. Available from: <https://www.undp.org/pt/brazil/publications/relatorio-especial-2023-25-anos-desenvolvimento-humano-no-brasil-anexo-estatistico>
12. Fundo de População das Nações Unidas. Relatório situação da população mundial 2022. Vendo o invisível: em defesa da ação na negligenciada crise da gravidez não intencional. [Internet]. UNFPA Brasil. [cited 2024 Aug 28]. Available from: <https://brazil.unfpa.org/pt-br/publications/situacao-da-populacao-mundial-2022>
13. Levy G. Abortion Rates: Where and Why They're Falling [Internet]. U.S. News & World Report. 2018 [cited 2024 Aug 28]. Available from: <https://www.usnews.com/news/data-mine/articles/2018-03-21/abortion-rates-where-and-why-theyre-falling>.
14. Stephenson P, Wagner M, Badea M, Serbanescu F. Commentary: the public health consequences of restricted induced abortion--lessons from Romania. *Am J Public Health* [Internet]. 1992 Oct;82(10):1328–31. Available from: <http://dx.doi.org/10.2105/ajph.82.10.1328>.
15. Convention on the Elimination of All Forms of Discrimination Against Women. CEDAW general recommendation no. 24: Article 12 of the convention (women and health) [Internet]. Refworld. Refworld - UNHCR's Global Law and Policy Database; 2023 [cited 2024 Aug 28]. Available from: <https://www.refworld.org/legal/general/cedaw/1999/en/11953>
16. Conselho Federal de Medicina. Resolução CFM Nº 2.378/2024. Regulamenta o ato médico de assistolia fetal, para interrupção da gravidez, nos casos de aborto previsto em lei oriundos de estupro. *Diário Oficial da União*; 64(1):92. Available from: [Resolucao-cfm-2378-2024-03-21.pdf](https://www.planalto.gov.br/ccivil_03/_ato2024/2024-03/2024-03-21/Resolucao-cfm-2378-2024-03-21.pdf) (abmes.org.br)
17. FIGO position statement on the recent prohibition of induction of fetal asystole for legal abortions in Brazil [Internet]. Figo. [cited 2024 Aug 28]. Available from: <https://www.figo.org/figo-position-statement-recent-prohibition-induction-fetal-asystole-legal-abortions-brazil>
18. Brasil. Decreto Nº 678, de 6 de novembro de 1992. Promulga a Convenção Americana sobre Direitos Humanos (Pacto de São José da Costa Rica), de 22 de novembro de 1969. Brasília (DF): Diário Oficial da União; 1992. Available from: [D678](https://www.planalto.gov.br/ccivil_03/_ato2024/2024-03/2024-03-21/Resolucao-cfm-2378-2024-03-21.pdf) (planalto.gov.br)
19. Brena Sesma I. Interpretación del artículo 4.1 de la Convención Americana sobre la Protección de los Derechos Humanos, sentencia de la Corte Interamericana de Derechos Humanos, caso Artavia Murillo y otros (fecundación in vitro) vs. Costa Rica. *Cuest Const Rev Mex Derecho Const* [Internet]. 2014 Jan 1; Available from: https://www.scielo.org.mx/scielo.php?script=sci_arttext&pid=S1405-91932014000200001&lng=es&nrm=iso
20. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Pragmáticas Estratégicas. Aspectos jurídicos do atendimento às vítimas de violência sexual: Perguntas e respostas para profissionais de saúde. 2a. ed. Brasília: Editora do Ministério da Saúde; 2011. Available from: https://www.tjac.jus.br/wp-content/uploads/2015/05/Cartilha_Perguntas_e_Respostas_para_Profissionais_da_Saude_do_Ministerio_da_Saude.pdf

21. World Health Organization. WHO. Abortion care guideline. Geneva: World Health Organization; 2022. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/35344310>
22. International Federation of Gynecology and Obstetrics. FIGO Misoprostol only dosing chart (for use only when mifepristone is not available). Recommended regimens 2023. Available from: <https://www.figo.org/sites/default/files/2023-11/FIGO-Miso-Chart-11-2023%20FINAL.pdf>
23. BRASIL. Supremo Tribunal Federal. Arguição de Descumprimento de Preceito Fundamental (ADPF) 1141. Autorização para Interrupção de Gravidez (Aborto), Controle de Constitucionalidade. Available from: <https://www.jusbrasil.com.br/jurisprudencia/stf/2494929019/inteiro-teor-2494929022>
24. Câmara dos Deputados. Projeto de Lei N° 1904/2024. Altera o Decreto-Lei nº 2.848, de 7 de dezembro de 1940. Available from: <https://www.camara.leg.br/proposicoesWeb/fichadetramitacao?idProposicao=2434493&fichaAmigavel=nao>
25. MFG Monteiro, JAF Romio, J Drezett. Is there race/color differential on femicide in Brazil?: The inequality of mortality rates for violent causes among white and black women. J Hum Growth Dev [Internet]. 2021 Aug 3;31(2):358–66. Available from: http://pepsic.bvsalud.org/scielo.php?pid=S0104-12822021000200018&script=sci_arttext
26. Fórum Brasileiro de Segurança Pública. 17o Anuário Brasileiro de Segurança Pública: 2023. 2023 [cited 2024 Aug 28]; Available from: <https://publicacoes.forumseguranca.org.br/items/6b3e3a1b-3bd2-40f7-b280-7419c8eb3b39>
27. Instituto de Pesquisa Econômica Aplicada. Nota técnica. Estupro no Brasil: uma radiografia segundo os dados da Saúde. Brasília: IPEA; 2014. Available from: <https://www.ipea.gov.br/atlasviolencia/artigo/75/estupro-no-brasil-uma-radiografia-segundo-os-dados-dasaude>
28. Blake M, Drezett J, Machi GS, Pereira VX, Raimundo R, Oliveira FR, et al. Factors associated with the delay in seeking legal abortion for pregnancy resulting from rape. Int Arch Med [Internet]. 2015 Mar 1;8. Available from: <http://dx.doi.org/>
29. Bessa MMM, Drezett J, Adami F, Araújo SDT de, Bezerra IMP, Abreu LC de. Characterization of adolescent pregnancy and legal abortion in situations involving incest or sexual violence by an unknown aggressor. Medicina (Kaunas) [Internet]. 2019 Aug 13;55(8):474. Available from: <https://pubmed.ncbi.nlm.nih.gov/31412605/>
30. Santana WA. Aspectos associados a gestações decorrentes de violência sexual entre mulheres e adolescentes vulneráveis pela deficiência intelectual [tese]. Santo André: Centro Universitário Saúde ABC; 2019. Available from: https://sucupira.capes.gov.br/sucupira/public/consultas/coleta/trabalhoConclusao/viewTrabalhoConclusao.jsf?popup=true&id_trabalho=7935730
31. Pimentel RMM, Júnior HM, Souza e Silva R, Andreoni S, Drezett J. The influence of religion on the refusal of legal abortion among brazilian women with pregnancy resulting from sexual violence. J Hum Growth Dev. 2025; 35(1):13-24. DOI: <http://doi.org/10.36311/jhgd.v35.17293>
32. Santana WA, Feitosa WMN, Pimentel RMM, Farah BQ, Hodroj FCSA, Barbosa CP, Drezett J. Legal abortion in situations of pregnancy resulting from sexual violence in women and adolescents with intellectual disabilities. J Hum Growth Dev. 2025; 35(1):25-35. DOI: <http://doi.org/10.36311/jhgd.v35.16783>
33. Maselli-Schoueri JH, Carvalho LEW, Roediger MA, Fonseca FLA, Sousa LVA, Paiva LS. Income gaps, doctors, and ncd burden: correlating mortality, hospitalizations, and costs in brazil. J Hum Growth Dev. 2025; 35(1):36-45. DOI: <http://doi.org/10.36311/jhgd.v35.17288>
34. Santos EVL, Barreto YE, Campos MF, Bortolin da Silva VE, Souza OF, Abreu LC. Temporal trend of the mortality coefficient and proportional mortality due to stroke in the populations of the states of rio grande do norte and paraíba, in northeastern brazil. J Hum Growth Dev. 2025; 35(1):46-55. DOI: <http://doi.org/10.36311/jhgd.v35.17294>
35. Pestana ABC, Vieira TS, Tosta BFCB, Roni GM, Santos GL, Moratti EN, Sartorio CL, Neto LCBS, Ferro PL, Raimundo RD, Moreno IAA, Olinda AS, Silva AMA, Abreu LC. Relationship between chronic stress, nutritional status, neutrophil-lymphocyte ratio, and heart rate variability among active military police officers in a metropolitan region. J Hum Growth Dev. 2025; 35(1):56-67. DOI: <http://doi.org/10.36311/jhgd.v35.16614>
36. Quintino FF, Reis CLB, Ferreira FF, Matsumoto MAN, Stuari MBS, Romano FL, Pinheiro LHM, Fonseca BA, Antunes LS, Antunes LAA, Küchler EC, Oliveira DSB. Dental age assessment in children and teenagers with different craniofacial skeletal patterns. J Hum Growth Dev. 2025; 35(1):68-75. DOI: <http://doi.org/10.36311/jhgd.v35.15505>

37. Soares LVO, Salaroli LB, Rosario TC, Pierote MR, Fukuda RP, Silva GG, Prado CB, Podestá OG, Viana KCG, Rocha RM, Lenzi J, Podestá JRV, Souza ED, Haraguchi FK, Petarli GB, Soares FLP. Nutritional risk and associated factors in patients with head and neck cancer in a referral hospital in Brazil. *J Hum Growth Dev.* 2025; 35(1):76-85. DOI: <http://doi.org/10.36311/jhgd.v35.17247>
38. Matalani CFA, Uyeda GL, Melo DMD, Silva IMI, Tannuri ACA. Sigmoid volvulus as a complication of imperforate anus: a case report. *J Hum Growth Dev.* 2025; 35(1):86-90. DOI: <http://doi.org/10.36311/jhgd.v35.17290>
39. Lisboa NAS, Pezzin IM, Soares LBP, Mawandji NBS, Haraguchi FK, Romero WG, Fiorin BH, Bolsoni-Lopes A. Assessing Short-Term Quality of Life Changes After Bariatric Surgery: A Longitudinal Study. *J Hum Growth Dev.* 2025; 35(1):91-100. DOI: <http://doi.org/10.36311/jhgd.v35.17287>
40. Ferreira BM, Souza MAB, Avellar MCF, Rodrigues e Mello MA, Rocha FLRMM, Dias LN, Ponte PFA, Tannuri ACA. Pancreatic Diversions in Pediatric Patients: a case series. *J Hum Growth Dev.* 2025; 35(1):101-110. DOI: <http://doi.org/10.36311/jhgd.v35.17289>
41. Pessanha RM, Grippa WR, Neto LCBS, Dell'Antonio LS, Dell'Antonio CSS, Lopes-Júnior LC. Trends of incompleteness of epidemiological variables in hospital cancer registries of women with malignant breast neoplasia in espírito santo, brazil. *J Hum Growth Dev.* 2025; 35(1):111-123. DOI: <http://doi.org/10.36311/jhgd.v35.15861>
42. Oliveira FS, Morais MJD, Souza CS, Pérez-Riera AR, Abreu LC. Biomarkers hematological in detection of inflammation with illness renal chronicle in hemodialysis: one analysis evaluation. *J Hum Growth Dev.* 2025; 35(1):124-134. DOI: <http://doi.org/10.36311/jhgd.v35.16080>
43. Sousa DF, Sepúlveda JJR, Klippel LPS, Salaroli LB. Cognitive, metabolic and cardiovascular effects of probiotics use among older adults: an umbrella review with meta-analysis and evidence mapping. *J Hum Growth Dev.* 2025; 35(1):135-157. DOI: <http://doi.org/10.36311/jhgd.v35.17286>
44. Pérez Riera AR, Barros RB, Souza DHK, Raimundo RD, Sclarovsky S, Nikus K. Accelerated idioventricular rhythm in the adult: an update. *J Hum Growth Dev.* 2025; 35(1):158-165. DOI: <http://doi.org/10.36311/jhgd.v35.17291>
45. Monfort- Pañego M, Miñana-Signes V, Noll M. Back Health in Health Education: reflections on Musculoskeletal Fitness. *J Hum Growth Dev.* 2025; 35(1):166-172. DOI: <http://doi.org/10.36311/jhgd.v35.17301>

Resumo

Nas últimas décadas, muitos países reformaram suas leis que criminalizavam o aborto. Abandonaram seu enfrentamento pela perspectiva moral ou religiosa, assumindo-o como questão de saúde pública e de direitos humanos das mulheres. A decisão se fundamenta, sobretudo, nas evidências de que a proibição do aborto não reduz sua prática, mas determina a busca por procedimentos clandestinos e inseguros, responsáveis por 39.000 mortes evitáveis de mulheres a cada ano. O Brasil mantém inalterada a criminalização do aborto desde 1940 no Código Penal, com apenas dois permissos legais: quando há risco de morte para a gestante, ou quando a gestação decorre de crime sexual. Em 2012, o Supremo Tribunal Federal decidiu como não criminoso o aborto em casos de anencefalia. Contudo, esses permissivos reiteradamente sofrem investidas conservadoras e fundamentalistas, que pretendem maior restrição ou sua proibição. A recente resolução CFM 2.378/2024, do Conselho Federal de Medicina, proibiu que médicos realizassem o aborto por meio da assistolia fetal após a 22ª semana em gestações decorrentes de violência sexual. Quase ao mesmo tempo, o Projeto de Lei 1904/2024 foi apresentado no parlamento, com proposta semelhante, mas aumentando significativamente as penalidades para as mulheres que realizassem o aborto após a 22ª semana, maiores do que as previstas para o agressor sexual. Neste editorial se analisa a posição do Brasil no cenário internacional, os argumentos dessas iniciativas restritivas, e as mulheres mais vulneráveis que potencialmente seriam atingidas.

Palavras-chave: aborto legal, aborto induzido, violência contra a mulher, violação de direitos humanos, delitos sexuais.

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