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GLOBAL HEALTH JUSTICE PARTNERSHIP GHJP

FIRST, DO NO HARM

How Police Reporting Requirements for Health Professionals Endanger Brazil's Obligations to Support Sexual and Reproductive Health and Rights

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The Center for Reproductive Rights is a global human rights organization of attorneys and advocates working to ensure reproductive rights are protected in law as fundamental human rights for the dignity, equality, health, and well-being of every person. Through our work across five continents, we have played a critical role in securing legal victories before national courts, United Nations Committees, and regional human rights bodies on reproductive rights issues including access to life-saving obstetrics care, contraception, maternal health, and safe abortion services, as well as the prevention of forced sterilization and child marriage.

Nevertheless, significant progress has been made in this field. They are part of the Causa Justa movement, which achieved the decriminalization of abortion in Colombia up to the 24th week. They are also involved in the Niñas No Madres movement, raising awareness about the causes and consequences of forced motherhood in girls in Latin America and the Caribbean.

Through their efforts, the Center has played a crucial role in securing legal victories before national high courts, United Nations committees, and the Inter-American Human Rights System to ensure access to violence-free and nondiscriminatory obstetric care, emergency contraception, quality maternal health services, legal and safe abortion services, and comprehensive sexual education. Additionally, the Center conducts innovative work on various topics, such as the impact of agrotoxic use on reproductive health.

The Global Health Justice Partnership (GHJP) is an initiative of the Yale Law School and Yale School of Public Health established in 2012 to promote interdisciplinary, innovative, and effective responses to key problems in health justice. It is a transformative collaboration integrating different fields in order to make critical policy interventions, develop new kinds of cross-cutting research, and provide educational opportunities straddling a variety of academic disciplines. Leveraging Yale's institutional assets, GHJP trains students to undertake collaborative, real-world research and advocacy to promote health justice in the U.S. and globally. It also organizes conferences and events; builds partnerships with local non-governmental organizations and social movements in New Haven, the U.S., and around the world to move research and critical analyses into action; and nurtures a truly interdisciplinary brain trust dedicated to effecting social change. The cornerstone of GHJP is a practicum/clinic course fusing didactic and experiential learning on critical topics at the intersection of public health, rights, and justice in the 21st century.

CRR and GHJP have a long-standing commitment to the progressive development and application of human rights, especially in the context of sexual and reproductive health, globally but more particularly in Brazil. Over the past decade, each organization has collaborated—jointly and separately—in research and advocacy with on-the-ground partners in Brazil. Publications include *Center for Reproductive Rights, Women and Health Initiative of the Harvard T. H. Chan School of Public Health & Global Health Justice Partnership of Yale Law School and the Yale School of Public Health, Unheard Voices: Women's Experiences with Zika: Brazil (2018); Global Health Justice Partnership of Yale Law School and the Yale School of Public Health, Reservoirs of Injustice: How Incarceration for Drug-Related Offenses Fuels the Spread of Tuberculosis in Brazil (2019); Center for Reproductive Rights, Center for Justice and International Law, Instituto Anis & Global Health Justice Partnership, Hearing Request to the Inter-American Commission on Human Rights (IACHR) on the Human Rights Situation of Women and Girls in Brazil (2021); and Global Health Justice Partnership of Yale Law School and the Yale School of Public Health, Expert Statement Analyzing the Ministry of Health's Zika and Microcephaly Protocol (2016).*

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I. Introduction

This Technical Note sets out the human rights and ethical obligations put at risk by legal provisions in Brazil requiring health professionals to provide information to law enforcement authorities when patients seek legal abortion following rape. The regime of police reporting requirements has developed through over half a decade of interconnected revisions to laws and regulations affecting health professionals and victims of crimes. Even as this Note seeks to make clear the many shifts in regulatory regimes, its focus is the perils of this complex landscape, as a whole, for patients and health professionals alike.

In doing this, it is important to transfer the greatest attention from the pretext of police reporting requirements and narratives of what they might do, to their impact in real-life contexts. For example, police reporting requirements have been claimed, by the authorities creating them and others, to support efforts to respond to sexual violence. In practice, however, they undermine criminal as well as more holistic and structural public responses. Paradoxically, they undercut efforts to bring gender-based violence out of the private sphere, and ultimately facilitate greater scrutiny of patients seeking abortion and thus greater abortion criminalization. Critically, they do so while transforming health professionals into agents of the criminal legal system, in direct opposition to their ethical duties to patients and the provision of appropriate and accessible medical care. Police reporting requirements erode the trust in health providers that is essential to effective sexual and reproductive health care, and create barriers to legal abortion that endanger the health and lives of women and girls across Brazil, many of whom die from unsafe abortion each year. [1]

The many revisions across multiple laws and regulations in this space are scattered and confusing, but even when pieced together add up to incomplete guidance for health professionals. This creates room for inadvertent disclosure and for contestation over the scope and legitimacy of police reporting in specific cases, lessens clarity in accountability efforts for illegitimate reporting, and raises the stakes: in a politicized time of rights regression, the risks are high for misunderstanding and misinformation that undermines health professional ethics and women's equality, autonomy, and health rights. As a result, existing laws and regulations, if interpreted incorrectly, pose the very present risk that the identity of persons seeking care after an assault, and the circumstances of that assault, may be disclosed to police.

Law No. 10778 of November 24, 2003, which we call the "Reporting Law," as amended in 2019, now contains a police reporting requirement: health professionals must report to police, within 24 hours, cases in which there is "evidence or confirmation" of violence against women "for appropriate measures and for statistical purposes."[2] Prior to 2019, this Reporting Law required only de-identified notification within the health system of violence against women discovered during care, for the purpose of epidemiological surveillance and structural policy responses. When the Reporting Law was passed in 2003, access to abortion in cases of rape was governed by a complex and confusing array of state and municipal laws; in 2005, federal Ministry of Health regulations standardized the authorization process.[3] Importantly, the Reporting Law still states that the identification of survivors of violence outside health services should occur only exceptionally.[4]

However, this more general police reporting requirement was reframed and gained new significance for abortion care in 2020 with the passage and attempted justification of a different, highly invasive, abortion-specific police reporting requirement added directly into the Ministry of Health regulations governing the process for authorizing a legal abortion in cases of rape. This police reporting requirement—now revoked—required health professionals, in all cases where a patient sought a legal abortion on the basis of rape, to report "evidence or confirmation" of rape to police and to collect and immediately share any physical evidence with police.[5] Remarkably, following the propagation of this 2020 regulation, the United Nations Special Procedures mandate holders expressed concerns that these measures were retrogressions with regard to women's and girl's

right to legal access to abortion.[6] The Bolsonaro administration responded by denying this; it claimed that the regulations, including the obligation to collect physical evidence, did not create any new rights or obligations and had an almost identical scope to the Reporting Law.[7] We argue, as have others, that such a reading was in bad faith, against conventional legal interpretation, and, critically, contrary to law.[8]

This abortion-specific police reporting requirement was revoked in January 2023, when President Luiz Inácio Lula da Silva took office. In doing so, the new administration removed that police reporting requirement's particularly onerous and specific obligations on health professionals, signaling a commitment to addressing harm to reproductive rights committed under Lula's predecessor. As a result, the process for obtaining an abortion in cases of rape is governed by the now-reinstated Ministry of Health regulations originally issued in 2005.[9] Nevertheless, the Reporting Law (2003), with its police reporting requirement of 2019, is still in force. Observation shows that this Reporting Law serves both as a fallback provision and as a hook for (inaccurate) claims that police reporting of a similar scope is still required.

This Technical Note was developed, in part, out of concern for the real risk that this confusing state of law means that regressive misreading can easily occur at the intersection of regulations governing the authorization process for legal abortion in cases of rape and the police reporting requirement in the Reporting Law—a misreading that will continue to be embraced by some health professionals and actors in the criminal legal system (police, judges, prosecutors). This type of claim is enabled, as explored below, by the recent revocation of regulatory guidance on modalities for reporting, and long-standing practice in Brazil of health professionals and legal actors imposing additional requirements for abortion with no basis in law.[10] This has occurred more recently even in the most clear-cut cases of legally permitted abortion, including to deny abortions to children under 14, which are always authorized because pregnancy in such cases is, by law, considered to be the result of rape.[11]

As explored across this Technical Note, police reporting, particularly where it involves the risk or reality of identifying survivors and circumstances of rape to police, has serious implications for human rights and health professional ethics. The law in Brazil has for over 80 years provided that abortion in cases of rape is legal.[12] However, combining this narrow but legal path to abortion with mandatory police reporting for health professionals in a context of general abortion criminalization produces a result at odds both with the actual language of the law and with the trend in Latin America and globally toward removing conditions on abortion.[13] Moreover, its implications run counter to international human rights standards providing that women undergoing abortion after rape should not be criminalized.[14]

This Note seeks to make clear what the confusing series of interconnected legal and regulatory revisions around police reporting and the process for authorizing legal abortion in cases of rape have served to obfuscate: that the state of Brazil is in danger of letting past state action undermine its duty to create the legal and material conditions in which health, particularly reproductive health, and associated rights can be protected, including the rights to health, non-discrimination, privacy, life, and dignity.

This Note also flags that legacies of meddling in the intertwined regimes of criminal law and health regulations harm the Brazilian structures supporting health ethics. While ethics are separate from rights, they can play a key complementary role in the protections for patients as rights holders. Human rights and ethics, alongside constitutional standards and proper legal interpretation, hold particular importance in this moment in providing guidance in the face of real and manufactured uncertainty around the scope of the Reporting Law and underscoring the consequences of misinterpretation and broad interpretation.

This Technical Note begins in Section II with a summary of overarching human rights and ethics concerns related to mandatory reporting in the context of abortion, and then explores the recent legal developments creating police reporting requirements that impact access to abortion in Brazil. It discusses the proper legal interpretation of the police reporting requirement under the Reporting Law and explores how reporting that identifies survivors seeking abortion following rape to police reorients the process for authorizing legal abortion toward a police surveillance process and undermines structural responses to violence enabled by de-identified mandatory reporting. The Note then elaborates the particular risk of the police reporting requirement being interpreted widely to restrict abortion, pushing against global norms increasing access to abortion.

The Note focuses on three potential implications that police reporting in such cases has for human rights and health professional ethics: Section III analyzes the specific barriers that this requirement imposes on access to legal abortion, and its ramifications for Brazil's obligations concerning the rights to life, health, and non-discrimination. Section IV examines the specific impacts on the relationship between health professionals and their patients, particularly as related to obligations of confidentiality under human rights and principles of professional ethics, and the deleterious impact that this has on patients' dignity. Finally, Section V discusses how such reporting requirements are discriminatory, perpetuating gender stereotypes that Brazil has a duty to address and overcome.

The Technical Note concludes that the risks that police reporting requirements pose to human rights and professional ethics can be resolved only by ensuring that such requirements do not apply to cases of abortion, or only in very exceptional cases, with attention to the important limitations examined in this Note. With the recent revocation of the police reporting requirement that targeted abortion (originally passed in 2020), the correct result can be effected by accurately and narrowly interpreting the Reporting Law so that it does not violate human rights or ethics. Human rights and ethical standards underscore the particular risk of involving the criminal legal system in abortion care, even ostensibly to support survivors.

Ultimately, removing all preconditions, legal or otherwise, including authorization processes, and instead focusing on providing material support and good-quality, unbiased care is essential to ensuring real access to legal abortion.

II. Background: The Legal and Regulatory Environment of Police Reporting in Brazil

Police reporting under the Reporting Law occurs within a complex and confusing landscape that has shifted through a series of changes across distinct and interconnected laws and regulations, with implications for abortion care, mandatory reporting more generally, Brazil's alignment with regional norms increasing access to abortion, international human rights, and health professional ethics. The various pieces of this landscape are explored here in order to clarify the specific changes, their impact on reporting and its proper scope, and the likelihood of misinterpretation. As a whole, they inform the dynamics of abortion care and police reporting in Brazil and the implications of these dynamics for human rights and ethics.

Relevant International and National Human Rights Protections

The Inter-American Court of Human Rights has noted that mandatory reporting requirements in abortion-restrictive contexts are particularly fraught where the scope of reporting obligations is unclear, leading to the arbitrary criminalization of those who seek reproductive health care and to a chilling effect on health care seeking.[15] Where police reporting identifies survivors and circumstances of rape, intentionally or inadvertently, it applies police scrutiny to disclosures of rape, carrying the risk that key actors in the criminal law regime will not believe survivors and/or will reject evidence and disallow the exception, criminalizing the patient for seeking abortion care. This risk is exacerbated by complicated combinations of stigma around abortion, rape, and, in some circumstances, intimate partner or family violence. Notably, there are also recorded cases of health professionals simply reporting patients to police for prosecution for abortion and other crimes.[16]

An important international human rights finding by the Committee on the Elimination of Discrimination against Women more than a decade ago stated that the criminalization of abortion in the case of rape is a violation of women's right to health.[17] Similarly, Brazilian Supreme Court majority opinions have recognized that the criminalization of abortion is linked to preventable maternal mortality and morbidity and has a disproportionate impact on women who face specific barriers in accessing health care and legal assistance, such as poor women, Black and Brown women, and adolescent girls.[18] International human rights standards on sexual and reproductive health are rooted in the protection not only of the right to health but also the rights to life, privacy and confidentiality, dignity, and non-discrimination for all survivors of rape, regardless of their gender identity. Each of these rights is implicated in the ways that police reporting, and even the mere risk of identifying survivors to police, transforms the health care setting, access to care, the safety of survivors, and responses to violence.

This engages Brazil's obligations under international human rights law, and its Constitution.[19] Importantly, Brazil's Supreme Court has recognized that international human rights treaties have "supralegal" status,[20] and its Constitution provides that ratified human rights treaties may be afforded equal status to constitutional amendments.[21] Brazil's Constitution establishes a fundamental right to health, a national Unified Health System (Sistema Único de Saúde), and duties on the state to guarantee universal and equal access to all health services, to provide educational and scientific resources for the exercise of the right to family planning, and to prohibit any coercion by public or private institutions.[22] Majority opinions of the Supreme Court have recognized that women's constitutional right to health extends beyond physical health to mental and social well-being. In enforcing women's rights related to abortion (including the rights to life, to health, and to freedom from torture and inhuman and degrading treatment), Court decisions have underscored why abortion is necessary for the full exercise of citizenship rights across genders as a fundamental principle under Brazil's 'Citizen Constitution."[23]

Professional Ethics and Human Rights: Complementary Regimes

In their interactions with health professionals, patients are protected under both international human rights standards and the ethical obligations of those professionals, as set out in both globally accepted standards and national ethical guidelines across professional bodies.[24] Professional ethics concerns behavior and decision-making, beyond scientific or technical expertise, in providing rational criteria for moral action informed, for example in the case of medical ethics, by the traditions of the medical profession, and the values, rights, and responsibilities engaged in medical practice.[25]

Human rights and professional ethics operate synergistically: the development of human rights has influenced ethical codes on the national and international level, which integrate commitments to core human rights concerns and may even explicitly include obligations not to violate human rights and civil liberties.[26] Likewise, international human rights bodies have recognized and incorporated professional ethics into human rights standards and obligations.[27] Reference to human rights as "an agreed-upon, universally applicable set of moral principles" can aid health professionals in navigating situations of ethical difficulty, including "dual loyalty,"[28] where they have incompatible simultaneous responsibilities to both patients and a third party, such as the government (for example, in the case of police reporting).[29]

In addition to its impact on human rights, police reporting puts health professionals' ethical obligations at risk, forcing them to act in ways that go against their duties to respect the dignity, autonomy, confidentiality, and best interests of their patients, as well as justice and human rights.

Recent Developments in Reporting Obligations and Abortion Regulation

Police reporting requirements for health professionals have emerged through parallel developments in the Reporting Law and its regulations and regulations governing the authorization process for legal abortion in cases of rape, each claiming justification in efforts to respond to sexual violence.

Prior to 2005, in the absence of federal regulations setting out procedures for public hospitals, varied state and municipal laws provided additional legal requirements for abortion in cases of rape, including a report of physical examination, police record,

or court order.[30] Complicated procedural requirements for legal abortion, combined with the limited number of providing facilities and widespread attitudes against abortion among health professionals, led to only a small number of legal abortions being performed officially.[31]

In 2005, federal regulations standardized the authorization process for accessing legal abortion in cases of rape. Ordinance No. 1508 of September 1, 2005,[32] established four stages in this process, each requiring detailed forms signed by the patient, annexed to the medical record and subject to confidentiality duties. Because this process was carried forward into later regulations and has now been reinstated, we refer to this regulation as the "Process Regulation." The four stages are as follows:

- **Written documentation** of the circumstances of the rape by the patient, with two health professionals from the national Unified Health System signing as "witnesses." The form provided requires the patient's name and ID number, and distinguishes between unknown and known aggressors, asking for their name and "degree of kinship or social and affective relationship."

- **Verification**, through medical history, physical and gynecological examination, review of the ultrasound, etc., in order for a doctor to issue a "technical opinion" concerning the compatibility between the gestational age and the date of the alleged sexual violence. A "multi-professional health team," including "at least an obstetrician, anesthesiologist, nurse, social worker and/or psychologist," is called in to give the patient "specialized attention and evaluation." Three team members must sign an approval form for the abortion to proceed, and their assessment must match the doctor's technical opinion. The form provided requires the team to attest to compliance with the legal exception for abortion in cases of rape and to the patient's request for an abortion having been made "without the presence of indicators of false allegation."

- **Assumption of criminal responsibility,** through the patient signing a "statement of responsibility" for the crimes of misrepresentation and abortion if they are later not believed and not formally recognized as a survivor of rape and therefore excluded from this exception for legal abortion.

- **Consent**, through the patient signing an informed consent form noting the patient's free decision to terminate the pregnancy; guarantees of privacy and confidentiality of information provided, except in the case of judicial request; and that the patient has been informed of the "possibility" of maintaining the pregnancy and integrating the child into their family or putting it up for adoption, and that they have received information on the procedures, possible risks, etc.

Importantly, the Process Regulation explicitly references a Ministry of Health Technical Standard and its clear acknowledgment that survivors of sexual violence are not required to submit a police report as part of the authorization process for legal abortion within the national Unified Health System.[33] The Technical Standard specifies that this would be incorrect and illegal, in contravention of constitutional, criminal, and ethical protections.[34]

The Process Regulation was in force in 2019 when the legislature amended the Reporting Law to include a police reporting requirement compelling health professionals to notify the police within 24 hours of "evidence or confirmation" of violence against women "for the appropriate measures and for statistical purposes."[35] This law, as originally enacted, sought to support epidemiological surveillance and public policy responses by establishing de-identified reporting internal to the health system for a range of acts of violence against women discovered when women access public or private health services.[36]

The police reporting requirement was framed as a means to fill data gaps in tracking cases of violence as a result of underreporting and a lack of communication channels between police stations and hospitals, and facilitate "more consistent preventive actions."[37] It was also framed as an initiative to protect women, on the assumption that quicker communication between health professionals and police could prevent further harm to individual women.[38] Importantly, the law places a specific obligation of confidentiality on health professionals: disclosures identifying a survivor of violence outside the scope of health services may occur only exceptionally, in cases where there is risk to the community or survivor, and at the discretion of the health authority, with prior knowledge of the survivor or their guardian.[39]

The amendments passed only after Congress overturned then-President Bolsonaro's veto of the measure on the basis that it went against the public interest. The president argued that identifying survivors outside the health system without consent and where there was no risk of death made them more vulnerable, "especially when both [the victim and aggressor] still live in the same home or have not yet broken the relationship of affection or dependency."[40] This echoed some commentators opposed to the amendments, who also raised how police reporting revictimizes survivors and violates their autonomy, privacy, and confidentiality, in contravention of Brazil's international obligations.[41] Some feminist organizations, health providers, public defenders' offices, and judges noted how police reporting inhibits help seeking; undermines trust between patients and health professionals and the duty of professional secrecy; and takes away women's decision-making power and intrudes in their private life, all without the guarantee that these costs will advance efforts against gender violence.[42]

However, Bolsonaro's opposition, particularly in light of measures implemented the following year, indicates the complicated place of police reporting in debates over responses to violence against women. Some feminist organizations and advocates against gender-based violence have supported police reporting, pointing to health services as a space of intervention and often the first point of detection of crimes against women, even suggesting that health professionals' responsibility for public safety requires them to assist prosecutions.[43] But the president's veto, unaccompanied by any apparent commitment to alternative strategies to end violence against women, seemed to weaponize opposition to police reporting as a means to hinder such initiatives generally. Defense of the amendments was therefore also shaped by broader contestation around the landmark Maria da Penha Law, enacted in 2006 and engaging police and criminal law among more holistic measures regarding violence against women with the goal of implementing international human rights standards.[44] Indeed, the 2019 amendments were initially going to be made to the Maria da Penha Law before they were ultimately added to the Reporting Law.[45]

1940

1990

2003

2019

2020

Mandatory Reporting Laws

Law No 8069 of 13 July 1990
Requires notification by public or private health services in cases of suspected or confirmed violence against children and adolescents to municipal Guardianship Councils (child protection and services).

Law No 10741 of 1 October 2003
Requires notification by public or private health services in cases of suspected or confirmed violence against the elderly to health authorities for epidemiological surveillance, and to any of the following: police; public prosecutors' offices; or municipal, state or national Councils for the Elderly.

Reporting Law
Law No 10778 of 24 November 2003
Established compulsory de-identified reporting within the health system for a broad range of violence against women discovered when they are assisted in public or private health services for the purpose for epidemiological surveillance and public policy responses.

Reporting Law Regulations
Ordinance No 2406 of 5 November 2004
Established the system for compulsory de-identified reporting within the health system for epidemiological surveillance.

Reporting Law Amended
Law No 13931 of 10 December 2019
Amended the Reporting Law to add a police reporting requirement. Health professionals are required to notify police within 24 hours of "evidence or confirmation" of violence against women "for the appropriate measures and for statistical purposes."

Test Regulation (Revoked 2020)
Ordinance No 2282 of 27 August 2020
Revoked and replaced the Process Regulation with the same authorization process but added a police reporting requirement. Required doctors, other health professionals, and even healthcare facility managers to report any "evidence or confirmation" of rape to the police, and to preserve and immediately hand over to police any possible physical evidence of the rape. Added a requirement for the care team to offer to show the fetus or embryo via ultrasound to the patient and added a selective and misleading list of possible risks to the consent form.

Abortion Regulations in Cases of Rape

Criminal Code
Decree-Law No 2848 of 7 December 1940
Provides that abortion performed by a doctor is not punishable if the pregnancy is the result of rape and the procedure is consensual.

Prior to 2005, in the absence of federal regulations setting out procedures for public hospitals, varied state and municipal laws provided additional legal requirements for abortion in cases of rape, including a report of physical examination, police record, or court order.

Process Regulation (Revoked 2020-2023)
Ordinance No 1508, of September 1 2005
Standardized the authorization process to access legal abortion in cases of rape with four stages. Explicitly referenced a Minisry of Health Technical Standard noting that survivors of sexual violence are not required to submit a police report as part of the authorization process.

Mandatory Reporting Laws

Abortion Regulations in Cases of Rape

2020

Revised Regulation (Revoked 2023)
Ordinance No 2561 of 23 September 2020

Revoked and replaced the Test Regulation, maintaining the same authorization process and police reporting. Removed the additional requirement to offer to show the ultrasound to the patient, and reduced misleading information in the consent form.

2021

Reporting Law Regulations Amended
Ordinance No 78 of 18 January 2021

Added provisions governing police reporting. Individual health units where survivors are treated are to report cases. They must also forward the communication form to the local health authority. Where reporting by the individual health unit is not possible, the state health authority communicates cases to the police within 24 hours of weekly consolidation of the state notification database (VIVA SINAN).

Specified that in general, reporting was only through a consolidated form using information from the VIVA SINAN database, with a model form provided. In exceptional cases where a survivor is identified, reporting should include only named information. Explicitly stated that neither the medical record nor the VIVA SINAN notification form could be used for police reporting, and regulations noted that this incurs administrative, civil and criminal liability. Police reporting had to be signed by the state health authority and done securely.

Reporting Law Regulations Amended
Ordinance No 1077 of 26 May 2021

Revoked provisions specifying the communication forms for police reporting and the extent of information sharing

2023

Process Regulation (Reinstated)
Ordinance No 1508, of September 1 2005

Reinstated by Ordinance No 13 of 13 January 2023, which revoked the Revised Regulation.

In 2020, the Ministry of Health issued new regulations on the authorization process for legal abortion following rape, requiring police reporting by health professionals in all cases. Ordinance No. 2282 of August 27, 2020, replaced the Process Regulation, carrying forward much of the same text and the authorization process it established. However, it added that health professionals, and even health care facility managers, were required to report any "evidence or confirmation" of rape to the police and to preserve and immediately hand over any possible physical evidence of the rape, including embryo or fetus fragments, with the ostensible goal of potentially identifying the aggressor by obtaining and storing the DNA profile in the criminal forensics database.[46] It also added a requirement for the care team to offer to show the fetus or embryo via ultrasound to the patient and expanded the consent form by adding a selective and misleading list of possible risks to health from abortion, heightening the perception of risk.[47]

We refer to this ordinance as the "Test Regulation" because, following public pressure and the likelihood that it would be declared unconstitutional,[48] it was replaced less than a month later by Ordinance No. 2561 of September 23, 2020. We refer to this second ordinance as the "Revised Regulation" because it maintained police reporting in the procedure to access legal abortion but removed the other elements.[49]

A joint communication from United Nations Special Procedures mandate holders signaled that the Test Regulation represented a normative retrogression with regard to women's and girls' legal access to abortion, in violation of international standards.[50] Notably, in responding to this communication, the Brazilian government relied on the 2019 amendments to the Reporting Law to claim that the ordinance "d[id] not contain procedural or criminal innovations," as that law "already determines compulsory notification to the police in cases of violence against women who seek public or private health services."[51] The Test Regulation was said to "contain[] only minor changes" to update the Process Regulation[52] "following 2019 changes in law mandat[ing] the criminal prosecution of sexual crimes," including rape, as crimes of unconditional public criminal action, meaning that criminal proceedings can be initiated by public prosecutors and proceed without representation of the person harmed. Both regulations retain the asserted concern for the legality of abortion procedures in the Process Regulation but additionally claim justification for police reporting in these 2019 amendments. The Revised Regulation prefaced its police reporting requirement, in the same article, with the statement that it was "due to" these changes.[53]

Public defenders' offices underscored the unconstitutionality, illegality, and therefore nullity of the Test Regulation and called for immediate repeal,[54] and both regulations have been the subject of a range of statements highlighting the breach of the professional obligation of confidentiality, including refutations by medical associations, the national Unified Health System, and the National Council for Human Rights.[55] Some viewed police reporting as a distraction aimed at shifting the focus of the authorization process and hindering the performance of health professionals truly invested in addressing violence against women.[56]

The regulations form part of a series of explicit actions against sexual and reproductive health and rights by the Bolsonaro administration in domestic and international spaces, gaining particular momentum in 2020.[57] The Ministry of Health admitted that the Test Regulation was created following increased pressure from anti-abortion organizations related to the highly politicized case of a 10-year-old girl seeking a legal abortion after years of repeated rape by her uncle. The girl was denied care when the hospital where she was admitted claimed that it did not have legal authority to perform the procedure.[58] The Test Regulation entered into force 10 days after she ultimately received an abortion: she obtained the abortion weeks later, after obtaining a judicial authorization on the basis of risk to her life, even though such an authorization was legally unnecessary and ignored that abortion is specifically permitted in cases of rape, and traveling over 1,400 kilometers and hiding from protesters to receive care.[59] The then-Minister of Women, Family, and Human Rights reportedly also made efforts prevent the abortion.[60]

In January 2021, four months after the Revised Regulation was promulgated, the Ministry of Health issued amendments to regulations for the Reporting Law specifying the police reporting process. These provide that individual health units are to report cases of violence against women to the police within 24 hours from the moment the violence is discovered and to also forward the communication form to the local health authority.[61] Critically, these amendments also included additional provisions defining the communication forms to use and the modalities of information-sharing for police reporting,[62] which were revoked just four months later without explanation, removing necessary guidance. Notably, they listed permitted information and the model form for consolidated reporting in general cases, explicitly stating that this could not contain any data identifying the survivor or the notifying health professional.[63] For cases identifying survivors "exceptionally … in case of risk to the community or the victim, at the discretion of the health authority and with prior knowledge of the victim or their guardian," reporting was to include listed information only, could not be done using the medical record or the notification form for epidemiological surveillance, and had to be done securely, preferably through a secure electronic system, with physical documents transferred in a way that would guarantee security and secrecy.

In early January 2023, the Ministry of Health, under the newly elected Lula administration, revoked the Revised Regulation and its police reporting requirement[64] and reinstated the Process Regulation to govern the authorization process for legal abortion in cases of rape.[65] However, the police reporting requirement under the Reporting Law, and its limited regulations, remain in force.

If the Reporting Law is interpreted with the scope alleged by the previous administration—in other words, to entail all the same "rights or obligations"[66] as the abortion-specific police reporting requirement in the regulations issued in 2020—this would mean that there has been little change to the legal landscape. According to this understanding, the police reporting requirement for health professionals under the Reporting Law would be triggered in all cases by the necessary disclosure of rape, as a form of violence against women, to meet the exception and access legal abortion, and in all cases information identifying survivors would be shared with police. As explored below, that interpretation is incorrect.

The Scope of Police Reporting under the Reporting Law, as Applied in Cases of Abortion Following Rape

The proper narrow interpretation of the police reporting requirement of the Reporting Law, in line with the text of the law, relevant regulations, and other legal obligations, is critical to giving full effect to the goals and protections of the Reporting Law as they apply to incidences of rape as a form of violence against women that is necessarily disclosed in the authorization process for legal abortion on that basis.

The police reporting requirement in the Reporting Law must be read narrowly to maintain the reasonable meaning of the law's text, which clearly does not have the same scope as the now-revoked Revised Regulation. There is now no basis in law for sharing physical evidence with police, unless "communication" of "evidence or confirmation of violence against women" is stretched beyond ordinary meaning. Critically, the Reporting Law qualifies reporting with explicit obligations of confidentiality: a survivor of violence can be identified outside the health system only "exceptionally, in case of risk to the community or the victim, at the discretion of the health authority and with prior knowledge of the victim or their guardian."[67]

This threshold test for reporting that identifies survivors is rarely met during the authorization process for legal abortion following rape. Reporting that identifies survivors can occur only in cases of risk to the survivor or community exceptionally. This means that any claim of generalized risk on the basis that an abuser is at large is not sufficient, as that occurs in every case of violence where the aggressor is not immediately apprehended. Moreover, arguments about risk must also consider how risks may be created or exacerbated by reporting itself, including through exposing a survivor to retaliation, or harms of delayed or unsafe abortion where individuals avoid or delay care from health care providers due to fear of police reporting. The serious consequences of police reporting are explored throughout this Technical Note. Further, health authority discretionary decision-making must involve concerns for individual and population health, including harms to care outcomes and population health data where reporting reduces access to care. Likewise, the requirement for prior knowledge of the survivor or their guardian, more than a notice requirement to patients, indicates, in line with professional ethics, some form of consultation in which the health professional will learn of potential harms to the patient and their preferences for care.

The text of the Reporting Law, without the additional guidance of now-revoked regulatory provisions defining permissible information to share and model reporting forms, does provide a slightly widened scope of possible action. However, these provisions largely restated already binding obligations on health professionals.[68] Indeed, a state health department protocol provides that communication under the Reporting Law requires the free, informed, and written consent of the woman and must be read in concert with the Constitution, Maria da Penha Law, codes of professional ethics, and other laws and regulations.[69] The police reporting requirement must be read narrowly to ensure its conformity with these obligations.

However, in removing clear, consolidated regulatory guidance for health professionals to follow, there is now more room for misinformation, contestation, and non-compliance. Particularly, the revocation of the model forms and explicit direction not to use the patient's medical record or the epidemiological notification form, leaves no standardized options and creates a risk that these forms will be used. In cases of de-identified reporting, disclosing too much personal information will identify survivors, a risk already identified even for epidemiological surveillance forms by respondents to a survey of health professionals.[70] In cases of police reporting identifying survivors, forms used may disclose an unnecessarily wide range of information, such as referrals made or other care accessed.

Over-disclosure risk is acute in cases of abortion following rape due to the breadth of information collected during the authorization process. The Process Regulation explicitly notes that the confidentiality of completed forms must be ensured, in line with more general legal obligations. However, the consent form also notes that the information may be subject to judicial request, highlighting a dynamic ripe for broader disclosure: where police reporting and investigation takes place, it increases the chance of such a judicial request and therefore of the disclosure of this information to criminal legal actors.

Reading the police reporting requirement narrowly—meaning that de-identified reporting occurs in the majority of these cases—is not to suggest impunity or lack of responses to violence against women, but rather that access to health care should not be conditional on police reporting against survivors' wishes. Moreover, the purpose of police reporting in the Reporting Law "for the appropriate measures and for statistical purposes" is much wider than the goal of potential prosecution of individual cases in the now-revoked Test and Revised Regulations. "Appropriate measures" may extend to, for example, measures seeking to enhance access to health care, measures coordinating the geographical spread and training of officers and precincts, and preventive programs and services. Further, as explored below, police reporting that identifies survivors undermines the goals it has been claimed to advance and may frustrate "appropriate measures" when it occurs in during abortion care. In these and all cases, there is a need for more creativity, drawing on more holistic cultural transformation mechanisms, as exemplified in the Maria da Penha Law, beyond singular reliance on criminal complaints and public security measures.[71]

Police Reporting Transforms the Process for Legal Abortion and Mandatory Reporting Generally

The proper narrow interpretation of the police reporting requirement of the Reporting Law is also critical because police reporting identifying survivors in cases of abortion following rape frustrates rather than furthers "appropriate measures" in those cases by shifting the focus and function of the Process Regulation, the Reporting Law, and other mandatory reporting requirements.

Police Reporting Shifts the Process Regulation's Concern for Legality from Compliance to Criminalization

The Process Regulation, as well as its now-revoked successors, asserts considerations of legality: that abortion in cases of rape is excepted from the general prohibition of abortion in criminal law, that the Ministry of Health must regulate measures to

"ensure the legality" of abortion procedures within the national Unified Health System, and that there is a "need to guarantee ... effective legal certainty" to health professionals carrying out legal abortions.[72] Importantly, the Process Regulation pairs these with explicit statements that survivors of rape are not required to submit a police report as part of the authorization process and that this process does not apply to abortions under the other exception in the Penal Code: risk to life.[73] These assurances make at least plausible both the asserted concern with legality and the idea that the multi-professional team—even given the verification aspects of its role—could be equipped by involving psychologists and social workers to guarantee more holistic care and support.[74]

However, the potential and practice of police reporting that identifies survivors shifts the concern with legality from affirming conformity with the law at the level of service provision prior to care to police oversight and scrutiny of abortions, widening the net of police engagement and enforcement for abortion as a criminalized activity generally. In addition to flagging individual cases and the possibility for judicial request for records, even if ostensibly focused on criminal action against perpetrators of rape, reporting may facilitate detailed information-sharing with the police about whether a patient met the rape exception. This creates more opportunities for police interpretation of this information, potentially shaped by abortion stigma and stereotypes, to deny the exception and criminalize survivors.[75]

This brings new urgency to the patient's signed "statement of responsibility," which makes their exposure to criminalization more probable and runs contrary to clear protections in the text of a specific law criminalizing the failure to report a crime, which indicates that sanctions do not apply to health professionals where reporting exposes patients to criminal proceedings.[76] Further, police reporting marginalizes care by the multi-professional team by creating individual reporting obligations that encourages sharing information with police at the expense of inter-professional trust and decision-making in the best interests of the patient.

Police Reporting Undermines the Operation of the Reporting Law and Other Types of Mandatory Reporting

In the current legal landscape in Brazil, mandatory reporting falls into three categories: epidemiological surveillance reporting internal to the health system; external reporting to bodies tasked with supporting and protecting special interest groups, which may entail, among other measures, indirect engagement of the criminal legal system; and direct police reporting. The first two categories align with longer-standing mandatory reporting laws in Brazil and worldwide[77] and allow for more holistic and structural responses, with criminal law, if used, as one part among many in efforts to prevent and protect from abuse. Direct police reporting that identifies survivors is categorically different and undermines these efforts.

Prior to the addition of the police reporting requirement in 2019, the Reporting Law functioned similarly to other mandatory reporting laws in Brazil,[78] which also center the protection of individuals and their rights,[79] confidentiality, and proportional intervention[80] in requiring notification by health services in cases of violence. For children and adolescents, reporting is to bodies charged with child services.[81] For the elderly, reporting is through the same epidemiological surveillance system as the Reporting Law in support of targeted public policy,[82] as well as to at least one of five bodies on a discretionary basis, including police.[83] Reporting to bodies external to the health system can have legal consequences, but these are not limited to police investigation and prosecution.[84]

While police notification has been possible in cases involving the elderly since 2003 (making it an outlier for many years), reporting of violence against all women under the Reporting Law marked a turning point in the mandatory reporting landscape generally, in narrowing health professionals' discretion to whether or not to identify a survivor, instead of allowing (as previously) autonomy to not report to police at all and to mitigate risks attendant on reporting while pursuing more proportional or holistic interventions, providing space for more patient-centered care. This narrowing laid the groundwork for the monumental shift in 2020 in the now-revoked requirement for individualized police reporting and evidence transfer in every relevant case, which were unique worldwide in their scope, justification, and positioning as conditions for care.[85] To the extent that reporting identifies survivors to police, it conveys an image of gender-based violence and response that is "individual, punctual and fragmented," as opposed to a structural problem that requires broader responses beyond an individual aggressor and survivor.[86]

Moreover, on a structural level, police reporting likely undermines both the Reporting Law's original goal of epidemiological surveillance and any claimed facilitation of investigation and prosecution. Police reporting may contribute to underreporting by health professionals by increasing workload, a dynamic already evidenced in research on reasons for not completing compulsory epidemiological surveillance reporting, and because it is unequivocally denunciatory.[87] This reduces available data and impacts measures based on those data. Underreporting already occurs, in part, due to professionals' lack of knowledge about epidemiological reporting forms and the perception that they are a tool of formal complaint or functionally have that result because their detail enables the identification of survivors.[88] A key factor identified in hesitation to complete epidemiological reporting is fear of retaliation from the aggressor, both toward the survivor and the health professional, compounded in cases of intimate partner or family violence where the health professional has direct contact with the whole family.[89]

Reporting that identifies survivors to police, and even the possibility of reporting, also inhibits contact with health professionals in the first place by creating barriers to care, including fear of police scrutiny and other consequences of breached confidentiality, such as retaliation by abusers. Where survivors avoid care to avoid reporting, this also reduces and skews data and relevant responses according to populations most affected by barriers to care, including children, women of color, and poor women, in addition to inhibiting investigation and prosecution. There is "a sensitive and importance difference" between a health professional encouraging someone to report sexual violence and the person knowing that if they relate an incident of violence to a health professional it may be reported to police against their wishes.[90]
Mandatory reporting worldwide applies primarily to children, with some jurisdictions extending it to intimate partner violence.[91] In cases of child sexual abuse, it is a means of detecting abuse and providing care where children may not be

comfortable or able to express and advocate for their needs and interests.[92] This justification is less persuasive into adolescence with the increasing autonomy of the person, and in adulthood smacks of paternalism. The autonomy and rights of people who have faced sexual violence must be respected, which may include—if, and only if, the person wishes to do so—support to make a police report and understand rights during that process.[93] As noted by groups opposed to the police reporting requirement in the Reporting Law,[94] mandatory police reporting removes patients' (and specifically women's) autonomy to decide whether and when to involve police and how to navigate any harms brought about by engaging the criminal legal system, including against themselves.

Given that the impacts of identifying patients to police are far-reaching in the context of abortion care following rape and frustrate the operation of the Reporting Law and structural responses, a consistently narrow reading of the law that patients should not be identified in such cases is essential. This should be supported by official, clear, public guidance not to identify survivors in these cases—with safeguards for sharing only necessary information as part of de-identified reporting so as not to inadvertently identify survivors.

The Particular Risk of Improper Wide Interpretation in the Context of Abortion

There is particular risk that reporting identifying survivors will occur widely in cases of rape disclosed during the authorization process for legal abortion, despite the particular importance of the narrow interpretation of the Reporting Law in these cases. This is due to a long history in Brazil of unnecessary prerequisites to legal abortion being imposed, combined with more recent uncertainty and obfuscation regarding the law, and cases of health professionals reporting patients to police for the crime of abortion, against obligations of confidentiality and the exceptions for legal abortion.[95] The only requirement under the Criminal Code for legal abortion in cases of rape is the patient's consent to the procedure.[96]

For decades, lack of knowledge among gynecologists and obstetricians of what is and is not required by law to perform legal abortions in cases of sexual violence has been a key obstacle to the provision of these services.[97] The idea that a court order is necessary has been one of the most enduring misconceptions.[98] This is, in part, due to practices established in the absence of regulation, most notably prior to a landmark municipal ordinance in 1989,[99] and the federal Process Regulation, originally entering into force in 2005, with no requirement for a court order and explicitly stating that a police report is not required.

This explicit statement sought to address cases of police reporting imposed even prior to the 2019 amendments to the Reporting Law and the now-revoked regulations passed in 2020. A recent judgment of the Superior Court of Justice suspended criminal proceedings against a woman investigated by police in 2011 after seeking care for complications from inserting abortion pills into her vagina and being reported by the attending physician. The judge noted that the unlawfulness of the evidence in the case, including the physician's examination of the fetus and sharing the woman's medical record with police without her consent, was reinforced by the fact that she "consented to the filing of the police report [only] because it was a condition imposed by the doctor to provide her with medical care."[100]

Notably, a gestational age limit of 12 weeks was often also imposed. Technical standards have since provided that this should be expanded to 20–22 weeks, provided that the fetus weighs less than 500 grams, despite the fact that neither of these requirements is established by law and they restrict the sexual health and reproductive rights of the most vulnerable girls and women.[101] A recent study found that 82% of legal abortion providers adopted a 20- to 22-week limit, with only three providers not including a gestational age limit in their protocols.[102] Commentators have emphasized that these requirements are incompatible with fundamental rights, not based in law, and outside of the Ministry of Health's regulatory power. Abortion providers are supported by the broad exception under the Criminal Code allowing abortion in cases of rape to disregard this non-binding guidance.[103]

Yet, superfluous prerequisites to abortion have been sanctioned or even ordered by judges. In 2022, a second high-profile case of a 10-year-old being denied an abortion following rape centered on health professionals' refusal to provide abortion care at just over 22 weeks, claiming that the pregnancy did not pose a risk to her life (ignoring both real risks and the distinct legal ground authorizing abortion in cases of rape) and that the hospital needed judicial authorization, citing hospital regulations permitting abortion only up to 20 weeks.[104]

The girl was then subject to an injunction for protective measures in the Childhood Courts, granted ostensibly to protect her from further sexual violence but explicitly "not only to protect her, but to protect the unborn baby, if there is viability of extrauterine life."[105] During the hearing, the judge echoed the claims of the hospital, ignored evidence of risk to life, including the testimony of other doctors at the hospital where care was initially refused, cited a Technical Standard to claim that abortion, definitionally, involved the interruption of pregnancy only up to 20–22 weeks, and subjected the girl to invasive questioning, such as asking if the father would agree to adoption and if she could "bear [the pregnancy] a little longer" to increase the chance that the fetus would survive outside the womb.[106] The injunction separated the girl from her family and placed her in a shelter without the possibility of abortion care until the day after she was released, six weeks later. This followed a flurry of legal action across criminal and civil courts and jurisdictions, including a judicial authorization for abortion on the basis of risk to life, withdrawn due to jurisdiction issues; a request for her release to have an abortion, denied on the basis of no risk to life; another court authorizing early cesarean section; and a further appeal and request for release across courts.[107]

This and the 2020 case that precipitated the Test Regulation underscore how additional requirements for care without basis in law can be imposed in bad faith as an excuse not to provide care. They also may be required in good faith by professionals uncertain of the law, or because any sense of conflicting obligation, including around obligations to report to the police and their scope, engages institutional bureaucratic reflexes to avoid liability by deferring or modifying care, regardless of whether measures are targeted to have that impact. As testimony in the

2022 case from doctors from the same hospital that denied care makes clear, the availability of care can also be dependent on the specific individuals providing care at different times within these institutions. This is significant, as they may variably have knowledge of abortion law and procedures, be opposed to abortion,[108] or minimize violence against women.[109]

In a context of general abortion criminalization, barriers imposed by the actions of health professionals and judges[110] are enabled and exacerbated by the wide discretion these actors possess, the various interpretations of the law that can be applied (even those stretching beyond reasonable legal boundaries), and the limited avenues available for individuals to challenge or hold them accountable for their decisions, often lacking timely or any form of review. The 2022 case only underscores that these obstacles require a tremendous amount of legal advocacy to overcome and how this legal advocacy, while required in efforts to protect these rights and ensure access to care, may generate further barriers, such as psychological hardship during hearings and incorrect statements of law that exacerbate confusion about the requirements for legal abortion. Further, the focus by health professionals and judges on risk to life indicates how the rape exception is ignored, yet how both action to restrict abortion and strategic action to enable it by drawing on the urgency of the further exception of risk to life and the force of a court order can entrench the marginalization of the rape exception, as well as the idea that judicial authorization is required.

Within this landscape, the likelihood of an improper wide reading of the police reporting requirement in the Reporting Law being imposed has been enhanced by the Test and Revised Regulations introducing a new model for police reporting, of broad scope and integrated into the authorization process for legal abortion, spuriously claimed as identical to obligations under the Reporting Law. This offers a possible, plausible, or recognizable additional requirement that might be raised by health professionals or judges, notwithstanding its now-revoked regulatory basis and the reinstatement of the statement that police reports are not required under the Process Regulation. This is exacerbated by the everyday relationships and practices of information-sharing that the regulations facilitated between health professionals and criminal legal actors and that push the specifics of law (and its reform) out of focus.

Improper wide reading is also enabled by the revocation of regulatory provisions setting out reporting modalities for the Reporting Law, which creates uncertainty and space for obfuscation around the law and its distinctions, particularly as it informs which forms, types, and scope of information to share. This occurs in an environment where health professionals already may disagree, even in good faith, on the level of risk to the survivor or community required to meet the threshold test for identification in the Reporting Law,[111] in addition to potentially disagreeing on medical determinations in these cases.[112] Clear statements, such as those found in the revoked provisions, are important, but even they are no guarantee of consistent interpretation and the absence of strategic misinterpretation.

Police Reporting's Restrictive Impact Runs Contrary to Global Norms of Increased Access to Abortion

Police reporting is contrary to global shifts steadily lessening abortion restrictions and expanding women's access to health systems.[113] Global organizations that set standards related to health and human rights in the context of gender, sexuality, and reproduction counsel against encumbering abortion access with legal and administrative requirements. In general, international human rights law is tending toward supporting access to abortion as an essential service to promote the health, life, and equal rights of girls and women.[114] Indeed, faced with the COVID-19 pandemic, Argentina, Bolivia, Brazil, Colombia, Ecuador, Peru, and Uruguay all recognized reproductive health services as essential, and Argentina, Colombia, and Uruguay deemed abortion an essential service.[115]

The World Health Organization, in tracking trends in unsafe abortion worldwide, has noted that placing conditions on abortion laws can act against any stated purpose of legal abortion, "with the effect that scarcely any official abortions can take place." For example, it notes that in Zambia the "abortion procedure requires the endorsement of several doctors, including a specialist, in a country where doctors and specialists are scarce." This holds particular salience for Brazil's requirement, since 2005, that a multi-professional team and witnesses be included in multiple stages of the authorization process, particularly if police reporting pulls the medical setting into criminal legal bureaucracy. Indeed, "where the laws are restrictive most abortions are unsafe," and this occurs in a sliding trend proportionate to restriction: "where abortion laws are the least restrictive there is no or very little evidence of unsafe abortion, while legal restrictions increase the percentage of unlawful and unsafe procedures."[116]

International human rights bodies have been particularly skeptical of legal restrictions imposed on sexual assault survivors seeking to access abortion, noting that they can infringe a range of health-related rights and the right to privacy, and constitute discrimination.[117] Such restrictions, notably, run contrary to increasing recognition in international human rights law of the importance of protecting the life, health, dignity, privacy, and equality of women through safe, legal, and effective access to abortion, as a key component of sexual and reproductive health and rights. In cases where carrying a pregnancy to term would cause substantial pain or suffering, such as pregnancy resulting from rape, states have a specific obligation to provide access.[118] Importantly, access to abortion in cases of rape should not require additional procedural hurdles, such as medical certification, judicial authorization, or a police report.[119] Indeed, judicial authorization, in some cases, may be an "insurmountable obstacle" to abortion access.[120]

Particularly burdensome restrictions against abortion have also been criticized on a national level. While the U.S. has recently regressed in abortion rights protections, for nearly 50 years U.S. constitutional law protected abortion access in the first trimester and prohibited state governments from placing substantial obstacles (unnecessary health regulations) in the way of abortion such that they were undue burdens.[121] This recent setback is unique to U.S. constitutional jurisprudence, has met strong criticism from international human rights actors, and has little bearing on international human rights trends in abortion. Indeed, in the last 25 years, "[m]ore than 50 countries with previously restrictive laws have liberalized their abortion legislation."[122] There is a progressive trend in Latin America

removing conditions on abortion,[123] in conformity with international standards providing that women undergoing abortion after rape should not be criminalized.[124] Brazil, Argentina,[125] Bolivia,[126] Chile,[127] Colombia,[128] Cuba,[129] Guyana,[130] Mexico,[131] Panama,[132] and Uruguay[133] have all decriminalized abortion in the case of rape.

The global and comparative context for police reporting that identifies survivors becomes even more fraught from a human rights perspective when analyzed in light of Brazil's own Constitution and human rights protections. The Brazilian Constitution explicitly links the foundational place of human dignity in the Brazilian legal system to women's health, well-being, and reproductive rights. Human dignity is, along with responsible parenthood, the basis of "special protection" ensuring that "couples are free to decide on family planning ... prohibiting any coercion on the part of official or private institutions."[134] Legislation under this provision specifies that "[f]amily planning is the right of every citizen," understood as part of constitutional equal rights guarantees and as constituting "actions to care for women, men or couples."[135]

III. Police Reporting Requirements That Identify Survivors Are Unnecessary and Create Barriers to Accessing Legal Abortion, with Risks to Life, Health, and Related Rights

Police reporting under the Reporting Law facilitates delay, stigma, and mistrust as barriers to legal abortion. This is so especially where it identifies survivors to police when they seek to access abortion care following rape, either directly or through ostensibly de-identified reporting that nonetheless shares extensive personal information, but also within the dynamic of surveillance created by the mere possibility of identification. This poses significant risks to pregnant people's lives and health contrary to Brazil's duties to respect, protect, and fulfill the human rights to life, health, and non-discrimination.

The Right to Life

Police reporting that identifies survivors obstructs access to abortion in ways that impact the right to life. It enhances the delay, and even denial, of access to safe, legal abortion, as well as access barriers grounded in stigma and criminal reporting. This puts the lives of pregnant people at risk, narrowing the scope of the rape exception, blurring its distinction from the risk-to-life exception, and removing an option for women to access care before the risks escalate to imperil their lives. Moreover, such reporting runs contrary to the explicit statement in the Process Regulation that the authorization process does not apply to risk-to-life cases.[136]

Under international human rights law, states must address general societal conditions that could "prevent individuals from enjoying their right to life with dignity," including through measures "designed to ensure access without delay" to essential services, including health care.[137] State regulation of abortion should not put the lives of pregnant people at risk, cause physical or mental pain or suffering, discriminate, interfere with privacy, or lead to unsafe abortion.[138] Notably, where states fail to respect an individual's privacy in relation to their reproductive functions—such as by imposing a legal duty on health professionals to report survivors to police, who may then be engaged during the abortion process—the right to life, among others, may be implicated.[139] International human rights bodies have long recognized that restrictive abortion regulations contribute to maternal deaths from unsafe abortion and risk the right to life. For instance, the Human Rights Committee has instructed states, when reporting on the right to life, to include information on measures that ensure that people do not resort to life-threatening, unsafe abortions.[140] Similarly, the Committee on the Elimination of Discrimination against Women considers restrictive abortion laws that result in unsafe, clandestine abortion as potential violations of the right to life, often tying these to high rates of maternal mortality.[141] States should remove existing barriers and not introduce new hindrances to safe and legal abortion access.[142] Moreover, states have an obligation to ensure access to abortion care where the continuation of pregnancy would cause the pregnant person significant suffering, "most notably where the pregnancy is the result of rape."[143]

Regional human rights experts have also raised concerns about laws restricting abortion. The Rapporteur on the Rights of Women and Chair of the Inter-American Commission on Human Rights has underscored that women in the region face "significant obstacles in exercising their sexual and reproductive rights" and are "forced to continue pregnancies that put their lives at risk or that are the result of rape."[144]

Mechanical Reduction in the Window for Legal Abortion

Police reporting requirements, if engaged during the multistage authorization process for abortion, further reduce the window for access to abortion by requiring health professionals to prioritize reporting. This compounds the increased workload already observed in a study on compulsory notification for epidemiological surveillance.[145] Further, additional requirements for the authorization of abortion regarding consent and counseling "may complicate and prolong the application procedure, sometimes meaning that a pregnancy progresses past the legally permitted time period for induced abortion."[146] While no such legal limit exists in Brazil, the majority of abortion providers have adopted a 20- to 22-week limit.[147] Restrictive laws making health workers "gatekeepers" who determine whether a person qualifies for a legal abortion introduce delay generally but also create variation in the process based on the approach of the individual provider. Moreover, such laws have a "chilling effect," as workers unsure of law and policy, including provisions exempting them from liability for involvement in the crime of abortion based on their justified belief that rape occurred, seek to avoid penalties or reprisals.[148]

Barriers to Rape Reporting as Barriers to Care

Mandatory reporting that identifies survivors creates specific barriers also by fusing the act of seeking abortion, as care related to rape, with the (proxy) reporting of that rape to police. As a result, those seeking care must simultaneously anticipate and navigate the numerous barriers and harms of engaging with the criminal system.[149] In addition to the potential for stigma and re-traumatization through any criminal process, police reporting also requires health providers to act as criminal investigators, creating additional risk of trauma for rape survivors.[150] This may lead persons seeking abortion to hesitate, take more time to weigh their options, or decide not to access care at all, in addition to causing time delays from the additional steps in the authorization process. It may also impact health providers, leading them to hesitate in their decision-making, thus delaying care, or even to redefine their scope of practice.

Barriers are compounded in the case of a known perpetrator, as envisaged in the authorization process forms, because reporting a person in one's social circle to the police holds specific risks and harms. Indeed, many people do not report intimate partner violence generally. Given that the criminal process is geared toward punishment, and not the safety and well-being of survivors, it is not an option for those who want violence to end but not to break up their family. Reporting also raises the specter of placing one's partner in the harmful prison environment, which can cause the survivor to face serious economic hardship through both the loss of the partner's income and having to provide for them while they are in prison.[151]

Increased Stigma in the Authorization Process

Police reporting encumbers access by increasing the stigmatizing nature of the process to seek or obtain an abortion. Abortion stigma is a social phenomenon of sanction, communicating and reinforcing negative attitudes and assumptions about abortion by marking those who seek or obtain abortions with a perceived deficiency vis-à-vis societal norms and gendered expectations. This includes attitudes classifying abortion as a repudiation of motherhood and womanhood or as resulting from the mismanagement of sexual activity, with the assumption that pregnancy is always avoidable and that the material conditions and information for the full exercise of sexual and reproductive rights are always present.[152] In cases of legal abortion following rape, this stigma may compound with rape stigma and, depending on the circumstances, the stigma associated with intimate partner or family violence.[153]

Stigma, along with related gender stereotypes, is a demonstrated obstacle to safe abortion, even where the procedure is provided by law and where there are policies and protocols for care.[154] Stigma operates on internalized, interpersonal, and structural levels and is present in feelings of shame in seeking abortion, in non-disclosure and isolation for those who have had an abortion, and, upon disclosure, in judgment, dissuasion, rumors, and discrimination in the family, community, and health centers. Stigma alters decision-making around abortion and creates barriers to services. It can mean avoiding health care providers who object to abortion, as well as avoiding health services usually accessed for other needs, and even seeking out clandestine abortion.[155] Further, given that "[w]omen are often reluctant to report having had an induced abortion, especially when its availability is restricted by law,"[156] this can lead to lower disclosure and visibility of the procedure, which in turn can have compounding systemic effects on the accessibility of abortion by creating a false perception that there is reduced demand for abortion in specific localities and impacting institutional decisions regarding the organization and distribution of material and human resources.[157] Racial discrimination intersects with abortion stigma to compound barriers to abortion-related care for Black and Brown women in Brazil.[158]

Police reporting requirements mobilize and reinforce abortion stigma by strengthening the association of those seeking abortion with criminality, against the backdrop of the general criminal prohibition expressing official state condemnation of abortion as inherently wrong, emphasized by the rape exemption (as an "exemption"). Additionally, by conditioning abortion care on lack of consent, it also messages, in line with regressive ideas around women's sexuality, that women who are sexually active and seek abortion following consensual sex do not deserve care.[159] Where reporting identifies survivors seeking abortion following rape and automatically engages the criminal legal system, it shares the fact of their exemption with police, opening the exemption up to further scrutiny and opening the door for survivors to be criminalized if they are not believed and the exception is considered not to apply.

By expanding information-sharing between the medical and criminal legal systems, police reporting also enhances stigma as an abortion access barrier by raising the risk of unauthorized disclosure of a survivor's attempt to seek or obtain an abortion. Notably, given its already stigmatized nature, this information remains concealed yet becomes sensationalized, spreading rapidly and extensively upon discovery through breaches of medical privacy or by other community members (a risk increased in smaller communities).[160] Police reporting significantly expands the number of actors privy to the information to include not only medical and non-medical staff in the national Unified Health System (meaning that a case may be reported to the police by someone in a health professional's office, regardless of whether that person was treating the patient) but also those in the police hierarchy and the court system. Furthermore, while the informed consent form has—since 2005—allowed for the possibility of sharing information collected during the authorization process upon judicial request, police notification increases the probability that such a request will occur by flagging cases of rape, and the existence of possible evidence, even where the authorization process for abortion is abandoned. The stigmatizing nature of this process means that more women may choose not to disclose cases of rape to doctors, in turn removing the possibility of legal abortion care, leading to forced pregnancy or unsafe abortion.

This adds to stigma during the authorization process under the Process Regulation, which, as explored above, shifts the focus from access to legal abortion to scrutiny around the applicability of the rape exception. In streamlining the process, it adds administrative requirements for abortion in cases of rape. These requirements categorically separate out women seeking abortion on that basis as deviant and subject them to scrutiny through health professionals' evaluation of compliance with the exemption, which "disproportionately degrades women as liable not to be telling the truth about suffering a severe violation, or not being worthy of respect for the decisions they make in good faith about their health and well-being."[161] The authorization process specifically requires the patient to complete multiple stages with multiple providers and to provide a detailed account of the rape to two health professionals, and it engages the scrutiny of the multi-professional team tasked in part with discovering false allegations. This brings social judgment and discomfort with abortion into the examination room through specific requirements in the process that reflect and formalize them, creating a dynamic of answerability and forcing the patient to speak despite the stigma labeling abortion as something not to be done or even talked about. This also plays into harmful narratives of rape and abortion—and the extended process to obtain an abortion—as the consequences of the mismanagement of sexuality.

The reinstatement of the Process Regulation also reinstates its version of the consent form, which includes the patient affirming that they have been informed of the possibility of maintaining the pregnancy with guaranteed prenatal care and of either keeping the child or putting it up for adoption. In addition to acting as a tool of dissuasion, this feeds anti-abortion stigma through ideas of moral failure in not parenting one's biological offspring and of abortion as unnatural, compounded by the spurious implication that prenatal care, and therefore adequate support, is available and refused.[162]

Finally, police reporting adds to the stigma for health professionals involved,[163] which may dissuade them from providing abortion, leading to fewer available service providers. Where reporting is triggered by, and integrated into, the authorization process under the Process Regulation, it curates a particularly

uncomfortable professional environment, inviting the scrutiny of other professionals and police at different stages, with the likelihood that one or more these professionals hold anti-abortion biases increased by the sheer number of people who must be involved. Police reporting that identifies survivors not only discloses the rape but may also disclose the name of the health professional who provides abortion care. This is significant also because that professional may be called to testify in abortion-related cases and have a compounded risk with each abortion they provide.

The Right to Health

Similar to its infringement of the right to life, police reporting identifying survivors, in creating access barriers to abortion, infringes on Brazilians' right to the highest attainable standard of mental and physical health, which includes safe and lawful abortion as provided for by Brazilian law. Importantly for the right to health, these barriers also have serious impacts on physical and mental health and facilitate violence toward survivors of rape. Further, where it increases restrictions on abortion, police reporting is a retrogressive measure, undermining Brazil's obligations to guarantee equitable access to the right to health, including sexual and reproductive health; to take concrete steps toward the full realization of the right to health; and to reform or repeal measures that unjustifiably interfere with the right to health.

The Committee on Economic, Social and Cultural Rights has underscored that "[t]he right to sexual and reproductive health is an integral part of the right to health" and the freedoms and entitlements that it contains. Sexual and reproductive freedom is one such freedom, as an aspect of the right to control one's health and body, which also includes the right to be free from interference, such as from non-consensual medical treatment. Entitlements include "the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health."[164]

Brazil has "a core obligation to ensure, at the very least, minimum essential levels of satisfaction of the right to sexual and reproductive health," which includes the obligations "[t]o guarantee universal and equitable access to affordable, acceptable and quality sexual and reproductive health services …"; "[t]o repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine access" to such services; and "[t]o take measures to prevent unsafe abortions …." As discussed in the previous section, police reporting that identifies survivors increases the risk of unsafe abortion by enhancing the delay, and even denial, of access to safe, legal abortion; but Brazil also has the specific "obligation to respect, protect and fulfil the right of everyone to sexual and reproductive health." This includes the immediate obligation to eliminate discrimination and guarantee the "equal right to sexual and reproductive health" by repealing or reforming all law and policies that "nullify or impair the ability of certain individuals and groups to realize their right to sexual and reproductive health." The "criminalization of abortion or restrictive abortion laws" are among "laws, policies and practices that undermine autonomy and right to equality and non-discrimination in the full enjoyment of the right to sexual and reproductive health."[165]

Brazil must also, within its maximum available resources, take steps to "adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures" to ensure the full realization of the right to sexual and reproductive health. This includes "aim[ing] to ensure universal access without discrimination for all individuals, including those from disadvantaged and marginalized groups, to a full range of quality sexual and reproductive health care, including … safe abortion care." This also includes the requirement "to liberalize restrictive abortion laws [and] to guarantee women and girls access to safe abortion services." Access to safe abortion services is also part of the obligation to "guarantee physical and mental health care for survivors of sexual and domestic violence in all situations …."[166]

Procedural Delays

If applied to the process for authorizing abortion care, police reporting requirements undermine access to lawful abortion by expanding an already extensive and involved process. Police reporting adds further steps—namely, the recording of relevant information, (potentially) evidence collection, and the relaying of relevant details to the police—which provides more opportunity for delays to arise and compound in the authorization process. It increases the administrative burden experienced by the multi-professional team members. Further, reporting requirements are taxing on patients, requiring their exposure to further discussions and processes unrelated to care and linking them to the criminal legal system. As noted in the previous section, these impacts can make a patient ineligible for abortion if compliance efforts outlast the 20- to 22-week limit that has been adopted, without legal basis, by the vast majority of abortion providers.[167] It is not possible to obtain guarantees against such delays, nor is there an enforceable commitment to the timely completion of these procedures in any of Brazil's 26 administrative states. Police reporting that identifies survivors directly undercuts timely abortion.

Chilling Effect on Patients across Gender, Race, and Place

Reporting requirements that identify survivors seeking abortion care following rape have a chilling effect, undermining the accessibility of abortion by creating dynamics expected to cause eligible patients to forgo legal abortion, either by causing them to hesitate in their decision-making or by creating a wholly inaccessible service environment because of its psychological or mental health impact. Such reporting requirements insert the fear of being scrutinized, disbelieved, and stigmatized by police into the authorization process. The Human Rights Committee, in reviewing the (now excepted) blanket criminalization of abortion in Chile, warned that "the legal duty imposed upon health personnel to report on cases of women who have undergone abortions may inhibit women from seeking medical treatment, thereby endangering their lives."[168] Abortion in cases of rape is legal in Brazil, but where reporting requirements force health professionals to share a patient's abortion with the police, they force engagement with the criminal system in a context of close scrutiny in which the patient signs a statement of criminal responsibility should they be deemed not to meet the exception. Further, even without criminal consequences for the patient, a patient may decide not to seek a legal abortion out of fear that reporting will occur and will initiate legal proceedings against the perpetrator, if that is not an outcome that they wish to see.

Police reporting may also enhance dynamics of scrutiny and

abortion-related stigma in patients' interactions with health professionals. The international community has agreed that "in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible."[169] States are required to "take measures to eradicate practical barriers to the full realization of the right to sexual and reproductive health" and engage with how services are performed, as represented in the obligation to "ensure that health-care providers are adequately trained on the provision of quality and respectful sexual and reproductive health services ...."[170] As noted in the previous section, police reporting can shift the nature of abortion health care and the focus of the authorization process. Where health professionals involved in that process feel obligated or enabled to report patients to police, it can facilitate an environment where those with anti-abortion views are given opportunities to stigmatize and, given that the Process Regulation requires a multi-professional team and health professionals to act as witnesses for the description of the rape, to subject the views, actions, and care of pro-abortion health care professionals to scrutiny and negation.

These types of dynamics are important because states must address the conditions and attitudes that "perpetuate inequality and discrimination ... to enable all individuals and groups to enjoy sexual and reproductive health ...."[171] Such conditions and attitudes include "entrenched social norms and power structures ..., such as gender roles, which have an impact on the social determinants of health," and "discriminatory stereotypes, assumptions and norms concerning sexuality and reproduction that underlie restrictive laws and undermine the realization of sexual and reproductive health."[172]

Cost

Police reporting requirements may increase the associated costs of abortion, which also limits access and availability. Where police reporting aggravates dynamics of stigma and breaches of confidentiality, it increases the cost for patients through its chilling effect on willing abortion providers and by providing opportunities for anti-abortion health professionals to block care.

The reduced access and availability of providers increases delays in access to care, particularly in increasing the distance that patients must travel, as well as the associated logistics and funding they must obtain.[173] In other countries, unnecessary regulations targeting abortion providers have had a geographic effect on accessibility, with abortion services becoming concentrated in urban areas.[174] Critically, the COVID-19 pandemic led to a drastic reduction in the number of hospitals providing legal abortion in Brazil, from 175 to 42 hospitals, with 13 of the country's 26 states lacking a provider.[175] The now-revoked police reporting requirement in the Test Regulation came into force shortly after a 10-year-old girl from Espírito Santo who became pregnant as a result of rape had to travel by plane to Recife to access her right to abortion, despite her unquestionable eligibility (and court authorization), given that there were no willing abortion providers in her area.[176]

Costs to travel long distances due to an insufficient number of services in rural areas combine with costs entailed by the delay in receiving abortion care, such as the compounding risk per week of gestational age of technical difficulties in surgical interventions and the need for transfusions and hospitalization.[177] These dynamics also increase the administrative and cost burden of abortion for providers. As has been noted for the U.S., "[t]he costs and risks associated with being forced to travel farther and farther distances to access abortion are multi-faceted, and include financial, emotional, and physical burdens, as well as immigration risks [and] disproportionately impact pregnant people who are already facing systemic discrimination, including immigrants, people of color, low-income people, young people, and people with disabilities."[178] The Committee on the Elimination of Racial Discrimination has underscored that "some forms of racial discrimination have a unique and specific impact on women."[179]

Conflicting Duties for Health Professionals

According to the United Nations Working Group on Discrimination against Women and Girls, "Autonomy means that a woman seeking services in relation to her health, fertility or sexuality is entitled to be treated as an individual in her own right, the sole beneficiary of the service provided by the health-care practitioner, and fully competent to make decisions concerning her own health."[180] But the dynamic of stigma discussed above highlights how—to the extent that the police reporting requirement under the Reporting Law is interpreted to bind health professionals during abortion care—this legal obligation conflicts with health professionals' duties to patients, particularly with regard to duties of confidentiality. This has an impact on the right to health. This dynamic of dual loyalty, which inevitably leads to practitioners' inability to provide the highest standard of care, is discussed in detail in Section IV.

Third-Party Violence

As noted above, Brazil has an obligation to protect the right to sexual and reproductive health, which requires it to "to take measures to prevent third parties from directly or indirectly interfering with the enjoyment of the right ...."[181] Brazil is required "to put in place and implement laws and policies prohibiting conduct by third parties that causes harm to physical and mental integrity or undermines the full enjoyment of the right ...," including "prohibition of violence and discriminatory practices, such as the exclusion of particular individuals or groups from the provision of sexual and reproductive health services."[182] During oral arguments before the Inter-American Commission on Human Rights, attorneys from the Center for Reproductive Rights emphasized that requirements to report abortions undermine the accessibility of health care that is free from violence, as part of the right to health.[183] Pregnant women seeking abortion are in a state of heightened vulnerability, and reporting that identifies survivors who seek care can increase the number of people who are aware of their intention to have an abortion, thereby increasing the risk that they will be personally threatened or attacked.

Police reporting requirements may also lead to (fear of) retaliation against health professionals involved in providing care to survivors by the person responsible for the reportable violence—in this case, rape.[184] Indeed, a state health department protocol notes that the task of dealing with and reporting cases of violence in general should be shared among members of a

team in order to provide greater protection to individual notifiers.[185] Fear of retaliation may also lead to other practices by health professionals aimed at minimizing this risk. Such practices restrict access to abortion and undermine the stated objectives of police reporting requirements and even epidemiological surveillance reporting. This may risk sanctions that could impede health professionals' ability to provide care in the long term or lead them to avoid cases involving reportable violence altogether.

Prohibitions against Retrogressive Measures

States will also violate the right to health if they adopt "any retrogressive measures incompatible with the core obligations under the right to health,"[186] including "the adoption of legislation or policies which are manifestly incompatible with pre-existing domestic or international legal obligations in relation to the right to health." While Brazil's obligations with regard to the right to sexual and reproductive health extend beyond this limited ground for violation, as a baseline, police reporting requirements applied during abortion care appear to be a clear case of a retrogressive measure, in implementing new restrictions for those seeking to make a lawful claim to abortion services under a long-standing provision in the Brazilian Penal Code permitting abortion in cases of rape.

Following the promulgation of the now-revoked Test Regulation, a joint communication from United Nations Special Procedures mandate holders highlighted the regulation's police reporting requirement, as integrated into the authorization process for legal abortion following rape, and expressed concern about the regulation as a normative retrogression.[187] The claims by the Brazilian government in response—that the regulation entailed only "minor changes" from the existing (and now-reinstated) landscape of the coexisting police reporting requirement of the Reporting Law and the Process Regulation—are incorrect on two fronts: first, as explored above, the Test Regulation had a wider scope, and second (and more foundationally), the government's claim ignores the fact that the police reporting requirement in the Reporting Law is also a new development, from 2019.[188] To the extent that the current landscape is claimed to have the same scope as the Test Regulation and implemented accordingly, it is a normative retrogression. Indeed, this is true to the extent that, contrary to Brazil's core obligations under the right to sexual and reproductive health, it in any way creates barriers to legal abortion or modifies the dynamics of the authorization process, undermining access to affordable, acceptable, and quality abortion services, as well as sexual and reproductive health services more generally, and enhancing factors that lead to unsafe abortions.

Beyond Brazil's core obligations, the Committee on Economic, Social and Cultural Rights has emphasized that retrogressive measures regarding sexual and reproductive health in particular should be avoided.[189] These include, for example, the imposition of barriers to sexual and reproductive health services.[190] When retrogressive measures do occur, the state has the burden of proving their necessity.[191] It is highly unlikely that the police reporting requirement in the Reporting Law, especially to the extent that it is used to condition access to abortion on the identification of survivors, could meet this burden.

The Human Rights Committee has expressed concern "about the introduction of excessive requirements such as the obligation to submit proof that legal proceedings have been opened in cases of rape or incest," calling for their elimination to "ensure that women have effective access to legal abortions ...."[192] Indeed, if police reporting under the Reporting Law is applied in abortion care, patients seeking abortion following rape can access care only if they accept that the information they provide may be used as evidence for future criminal proceedings, not only against the aggressor but also (through the statement of responsibility and the laws it cites) potentially against themselves.

The Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment has noted that "[l]imited and conditional access to abortion-related care, especially where this care is withheld for the impermissible purpose of punishing or eliciting a confession, remains of concern."[193] If a patient does not want to be identified through the rape being reported, they can ensure that outcome only by deciding not to access care. The Human Rights Committee has also expressed concern about a dynamic similar to one advanced in the Process Regulation, and for which the application of police reporting, as explored above, shifts the focus to criminalization: a "requirement that three physicians must consent to an abortion may constitute a significant obstacle for women wishing to undergo legal and therefore safe abortion."[194]

The Inter-American Commission has considered it necessary, in evaluating whether a retrogressive measure is compatible with the American Convention on Human Rights, "to determine whether it is justified by reasons of sufficient importance."[195] Guatemala was found to have violated the principle of non-retrogressivity for creating legal barriers to access to health care, much as police reporting prevents the rapid, effective, and full realization of the right to health.[196] The Constitutional Court of Colombia has also—in a balancing test similar to those adopted by the Constitutional Courts in Ecuador, Peru, and Guatemala—"indicated that a measure is understood to be retrogressive when: (i) the substantive sphere of protection of the right in question is reduced or limited; (ii) it substantially increases the requirements to access the respective right; and (iii) it significantly reduces or diverts the public resources allocated to satisfying it."[197] Police reporting that identifies survivors significantly limits the sphere of protection of the right to the extent that it nullifies the rape exception by preventing access to abortion in cases of rape. If it is applied to the authorization in this way, it also adds to and therefore increases access requirements. And police reporting requires and therefore diverts public resources from the actual medical procedure to administrative work that is not necessary to perform the procedure and, moreover, does not advance—and indeed detracts from—police reporting's stated goals, rendering it entirely unnecessary.

The Right to Non-Discrimination

The right to health is closely related to and dependent on the realization of other human rights, including the rights to life and non-discrimination, which address integral components of it.[198] Police reporting that identifies survivors under the Reporting Law engages the right to non-discrimination as it

informs the right to health because it singles out specific survivors of a specific form of violence against cis-women (i.e., women who might become pregnant as a result of penile-vaginal sexual assault) who seek treatment in public and private health facilities for additional regulation for purposes unrelated to health needs.

Where applied in the context of abortion, it frustrates a subgroup of survivors' access to legal abortion by making their status as a survivor of rape (which enables legal abortion under the rape exception) a unique ground for police reporting, as subsumed under the general category of violence against women, and triggering such reporting's associated barriers to care. Indeed, the risk of police reporting undercuts legal abortion sought also under the other permitted grounds of anencephaly and risk to life,[199] whenever accessed by a survivor who discloses violence or whenever evidence of violence is discovered during medical consultation. This creates significant incentives not to disclose, or to hide evidence of, sexual violence and abuse, and not receive necessary care for that abuse, as a cost for accessing abortion care on these other grounds. Police reporting does not restrict access to health care, however, for women who are not survivors of violence; for women who carry their pregnancies to term and are therefore not exposed to the scrutiny of the authorization for legal abortion following rape, although violence may still be discovered during routine care; or for cisgender male patients seeking reproductive or other health care.

This creation of barriers for an arbitrarily created subgroup of rape survivors violates the right to non-discrimination and equal treatment, which "requires that the distinct sexual and reproductive health needs of particular groups, as well as any barriers that particular groups may face, be addressed."[200] In addressing the instrumentalization of women's bodies within the health sector, the United Nations Working Group on Discrimination against Women and Girls has recommended that states "eliminate discriminatory barriers to access to legal termination of pregnancy not based on medical needs ...."[201] States "cannot invoke women's biological difference to men and their reproductive capacity as a basis for permissibly restricting their rights"[202] and must ensure that health services accommodate such biological differences, including in reproduction.[203]

This attention to difference and needs demonstrates how non-discrimination and equality require substantive equality in addition to legal and formal equality.[204] Substantive equality is part of measures that states must adopt to achieve the "effective and equal empowerment of women:"[205] "[d]ue to women's reproductive capacities, the realization of the right of women to sexual and reproductive health is essential to the realization of the full range of their human rights."[206] To treat genders equally, and to treat differently situated persons within and across genders equally, involves addressing health-related risks that are unjustly distributed. In a communication regarding Brazil issued in 2011, the Committee on the Elimination of Discrimination against Women concluded that a failure to provide timely and quality care through maternal health procedures also used in abortion constituted discrimination on the basis of sex, socio-economic background, and status as a woman of African descent.[207] It has also noted "the existence of de facto discrimination against women" in Brazil, "especially women from the most vulnerable sectors of society such as women of African descent," and how it is "exacerbated by regional, economic and social disparities."[208] Further, the Committee has recognized that "discrimination against women based on sex and gender is inextricably linked to other factors that affect women, such as race, ethnicity, religion or belief, health, status, age, class, caste, and sexual orientation and gender identity."[209] Inhibiting access to health services and abortion for women who are survivors of violence amounts to gender discrimination, in addition to and as it intersects with these factors.

IV. Police Reporting Requirements That Identify Survivors Turn Health Professionals into Agents of the Criminal Law Apparatus, Contrary to Human Rights and Professional Ethics

Reporting requirements to identify survivors to police pull physicians and other health professionals providing abortion-related care into the criminal investigation process. This alters their relationship with patients by creating a dynamic of dual loyalty in which they have simultaneous obligations to both patients and the government. This imperils their obligations under both international human rights law and professional ethics, particularly by compelling breaches of medical confidentiality, with deleterious impacts on the rights to privacy and health and on the dignity of patients.

Dual Loyalty

Dual loyalty is a phrase capturing a dynamic of incompatible responsibilities to both patients and a third party: in this case, the government. This poses a risk to ethics and human rights. Under principles of medical ethics, physicians may place third-party interests above those of their patients only in exceptional situations, such as the mandatory reporting of diseases where the important interests of the broader population prevail. In situations such as a police or military order to participate in fundamental human rights violations such as torture, the conflict is clearly resolved in favor of patients.[210] The gray area between clear cases "requires considerable discernment"[211] and has been used by states to expand exceptions to confidentiality in ways that risk, or seriously violate, human rights.[212]

Health professionals worldwide have been both coerced and enabled agents of criminal law, including in reproductive health contexts. They have been prosecuted and placed in danger for resisting reporting laws requiring access to the medical records of torture victims, involved in reporting women seeking care after unsafe abortion in service of their prosecution, and engaged in joint efforts with law enforcement to seek incriminating evidence of drug use against women seeking prenatal or obstetric care.[213] As the International Dual Loyalty Working Group notes, "It is not part of the health professional's function to participate in law enforcement activities ...."[214] Where a state requires health professionals to inform on their patients, particularly in cases of abortion, they "change the basis of the relationship between doctor and patient" and "violate the protection of health and life for which doctors are responsible."[215] As noted by NUDEM, the imposition of reporting obligations on health professionals in Brazil misplaces an obligation that is squarely in the responsibility of the criminal legal system and prosecutors. It is not the role of health professionals to investigate crimes of sexual violence, and any information gathered should be forwarded to police only in an anonymized manner.[216]

Where health professionals are required to balance their obligation to provide quality, ethical care to patients against contrary legal obligations, including public health[217] and criminal sanctions, medical questions of risk becoming legal ones, determined by lawyers instead of through clinical judgment. Indeed, where there is scope for interpretation, such as questions of what constitutes a sufficient risk to a survivor or community to justify identifying a patient to police, or of which forms to use to report in identified and de-identified cases and the nature and amount of information to share, contestations by health professionals over what they should do in the moment to comply with legal questions add to and compound difficult questions also of medical necessity and ethics.

These choices can be stark: refusing to report may reduce barriers for patients, but legal penalties are daunting, and fear of exposure to them can dissuade professionals from working in this area, while actually incurring them can halt practice. Meanwhile, engaging in police reporting creates barriers to care and may lead to poor health outcomes, and waiting until these degrade to the point that a further ground for legal abortion that does not by definition raise the question of reporting (risk to life) can be used, very directly and explicitly risks death and serious morbidities.[218]

The Right to Confidentiality

The dual loyalty dynamics of identified police reporting force the violation of obligations of confidentiality under the human rights to health and privacy. Police reporting under the Reporting Law, if applied to the authorization process for abortion, may require the disclosure of confidential information to police and facilitate wider sharing of the medical file and authorization forms in criminal legal proceedings, while creating risk for unauthorized disclosures across both systems.

The right to confidential medical care is an element of the right to health because ensuring the non-disclosure of private information is critical for ensuring access to acceptable health services.[219] Patients' trust and expectation that health professionals will not reveal their personal information is essential for ensuring that patients feel secure in sharing, and not withholding, important and necessary information, so as not to hinder physicians in providing effective and proper medical care.[220] Further, breaches of medical confidentiality may, "when accompanied by stigmatization, lead to unlawful dismissal from employment, expulsion from families and communities, physical assault and other abuse."[221] To guarantee the right to health, states have a general obligation to "[e]nsure the removal of all barriers to women's access to health services, ... including in the area of sexual and reproductive health,"[222] as well as the specific obligation to take effective measures to ensure medical confidentiality and privacy,[223] including regulating medical services to ensure that they are respected.[224] Separately, under the Universal Declaration on the Human Genome and Human Rights, stored genetic data that identify a person must also be held confidential in conditions (and with any limitations) set by law. [225]

The right to privacy also provides individuals with the

right to confidential medical care and the protection of health data, and doctors with the right and duty to maintain confidentiality. This is because the information and physical evidence that physicians come to know through patient disclosure and observation—particularly information of a sexual nature—"describe[s] the most sensitive or delicate aspects of an individual."[226] The Inter-American Court of Human Rights recently held in Manuela v. El Salvador that all states under its jurisdiction, including Brazil, must "ensure that doctor-patient confidentiality is specially protected in cases in which reproductive rights are a matter of concern ...."[227] The right to privacy also engages the confidentiality of medical records, requiring states to take effective measures to ensure that information is not handled by persons not authorized by law, and never used for purposes incompatible with human rights protections.[228]

The Human Rights Committee has noted that "[s]tates impos[ing] a legal duty upon doctors and other health personnel to report cases of women who have undergone abortion" is illustrative of a failure to respect privacy.[229] Police reporting that identifies survivors seeking abortion also reports the fact that they sought an abortion, albeit in a narrowly legalized context, as well as the identity of the health professional involved. It also facilitates judicial requests for the disclosure of more extensive patient information. The right to privacy is not absolute, but abortion restrictions must not arbitrarily interfere with privacy—in other words, they must meet the human rights requirements of legality, necessity, and proportionality.[230] Police reporting that identifies patients seeking abortion likely does not meet these requirements.

Under the requirement of legality, any disclosure of sexual and reproductive health information related to abortion will violate the right to privacy unless it follows a precise law that "include[s] clear and detailed rules" which are "unambiguous, so that they do not raise doubt in those responsible for applying the restriction, and do not enable them to act in an arbitrary or discretionary manner ...."[231] A lack of clarity in the laws and regulations governing disclosure, notably, leads health professionals to err on the side of disclosing private information out of fear of otherwise being sanctioned.[232] Provisions under the Reporting Law providing for reporting that identifies survivors likely cannot meet the requirement of legality because they further muddle a contradictory landscape of legal obligations providing insufficient guidance for health professionals to regulate their conduct.

Similar to the ambiguous state of Salvadoran law examined in Manuela,[233] Brazil's criminal law restricts the disclosure of private information discovered in the performance of professional functions,[234] including when testifying,[235] while also making it a criminal misdemeanor for health professionals not to communicate a crime of public action such as rape (although this does not apply when it exposes a patient to criminalization)[236] and, through the Reporting Law, creating a further obligation to identify specific survivors and cases to police in exceptional cases, and de-identified information in all cases, always with the risk of incidental identification. Protections are also included in the Code of Criminal Procedure and protections of intimacy and privacy in the Brazilian Constitution.[237] This also conflicts with rights recognized at the state level. For example the State Health Code of São Paulo, as part of recognizing and safeguarding individual rights in health care, the need to ensure that "the confidentiality of personal information disclosed is guaranteed and respected," with no exceptions. .[238]

These provisions cannot be reconciled. The magnitude of the information collected and annexed to the patient's medical record, and that could be disclosed along with that record, including potentially the genetic data of the pregnant person if the same scope as the Revised Regulation is claimed, extends far beyond any pertinent information covered by "just cause" or "release."[239] Further, those concepts are not widened through any particular patient consent because of the heavily constrained nature of the consent process under the Process Regulation. Even if consent under this process could be claimed to be meaningful in general terms, it is squarely oriented toward the abortion procedure, and the consent form only incidentally mentions disclosure under judicial request. The patient must either accept this process as a whole or forfeit the possibility of legal abortion.

In addition to the uncertainty of contradictory legal obligations, the possibility for disagreement over the scope of police reporting under the Reporting Law—over whether the threshold for risk to survivor or community has been reached, or the type and amount of information to include in reporting forms for identified and de-identified reporting—means that health professionals may err on the side of reporting that identifies survivors or sharing an amount of information that incidentally identifies them, even in cases where they have decided to proceed only with de-identified reporting.

In examining requirements of necessity and proportionality, it is important to consider why the government has created a legal requirement for health professionals to report confidential health information, because the "cause invoked" to justify restrictions on the right to privacy must be one permitted by human rights.[240] The ostensible purpose of the police reporting requirement in the Reporting Law has been framed as a strategy to fill data gaps due to underreporting and the lack of communication between health professionals and the police, and therefore to better inform related public policymaking and to protect women by signaling the risk of harm.

But to the extent that this police reporting requirement is claimed to have the same scope as the Revised Regulation, and to apply to cases of legal abortion following rape, these claimed justifications illegitimately tip the balancing required by necessity or proportionality tests if they are afforded any weight, because they must be pretextual. This is because when applied in the context of the abortion authorization process following rape, in which police reporting is triggered and identification may occur, the outcomes for access to care are so extreme that it becomes clear that these claimed goals are not only not advanced but frustrated. Therefore, whether through intentional strategy or refusal to address this dynamic, the underlying goal must be abortion restriction.

Identifying a chilling effect on access to legal abortion as the actual purpose of any application of the police reporting requirement of the Reporting Law to abortion underscores that, especially in that context, police reporting is not necessary. Further, even if the claimed purpose of facilitating reporting and prosecution is taken at face value, the necessity test is not

met, as there are existing and possible alternative measures to the aim that do not disclose confidential health information at all or that disclose it in a manner that is less harmful,[241] including ordinary channels for crime reporting.

Critically, police reporting requirements are even more exposed to critiques of rape reporting in that they completely remove the agency of survivors to report but have the same, and likely more, attendant harms. Indeed, they compel incursions into confidentiality on the homogenizing assumption that police reporting is both always the desired goal of survivors and always occurs in circumstances entailing a loss of confidentiality, making it a self-fulfilling prophecy. But loss of confidentiality in reported cases is a real loss, and not a binary: it is not simply kept or lost, but can have scale. The extent of disclosure through compelled reporting, especially in cases that identify survivors, is significant, with the scope of information and actors privy to that information routinely extending even beyond those implicated in risks to confidentiality encountered in ordinary in-person reporting in precincts without privacy.[242] Non-compelled criminal reporting by the survivor provides the tools to comply with calls under international human rights law to investigate and prosecute sexual violence in a manner that does not also compromise the medical profession, patient care, and human rights.

Identifying abortion restriction as the actual purpose of applying police reporting to that context is also important in highlighting that the harmful impacts of any requirement to disclose confidential health information are disproportionate to any ostensible advantages. Even where a measure is necessary to achieve its aim, the costs it demands must not be "exaggerated or disproportionate" compared to any advantages to the interest justifying it and any legitimate aim it facilitates; it must interfere only to the lowest extent possible with the right to privacy, or it will breach that right.[243]

In finding a violation of right to privacy in Manuela, the Inter-American Court of Human Rights found, in the case of obstetric emergencies, that where there is conflict between the duty to maintain professional confidentiality and a duty to report, the duty to professional confidentiality must prevail. This was due to a number of serious harms consequent on the duty to denounce those who had undergone abortions. As the Court recognized, "disrespect for medical confidentiality can inhibit people from seeking medical attention when they need it," specifically restricting access to care for women.[244]

The Committee on the Elimination of Discrimination against Women has underscored that a "lack of respect for the confidentiality of patients" has a disparate impact on women, deterring them from seeking medical advice and treatment for sexual and reproductive health issues.[245] Moreover, the Human Rights Committee has noted for over two decades that a "legal duty imposed upon health personnel to report on cases of women who have undergone abortions may inhibit women from seeking medical treatment, thereby endangering their lives."[246] As noted above, police reporting identifying survivors imposes significant barriers to accessing abortion and creates serious harms against survivors' rights to physical and mental health, life, privacy, dignity, and non-discrimination.

The extent of the disclosure of confidential information, potentially including physical evidence of rape, gathered during medical examination underscores the excessive interference of police reporting with the right to confidentiality.[247] Medical information about the patient's body gathered during an examination is protected as sensitive personal data under Brazil's Health Code,[248] Criminal Code,[249] and Code of Criminal Procedure,[250] as well as the right to privacy.[251] It is also protected under a constitutional amendment[252] and dedicated legislation.[253] Comparable foreign legislation, such as the Health Insurance Portability and Accountability Act of 1996 in the U.S., underscores that to be effective, obligations of data privacy and patient confidentiality must extend across all actors privy to medical information, including administrators and those in third-party systems.[254] Mandated disclosure extends across multiple health professionals and criminal legal actors in every case, and the Reporting Law provides no framework for targeted sharing. Particularly, as in Manuela, and following the revocation of dedicated regulations, there are no "clear criteria on the circumstances in which the medical authorities could share someone's medical record."[255] Further, as noted above, there are significant concerns regarding the voluntariness and real scope of consent under the authorization process and regarding the legitimacy of disclosure requirements through police reporting under the Reporting Law.

Confidentiality and Other Professional Ethics[256]

Health professionals[257] cannot identify survivors seeking legal abortion following rape under police reporting requirements without violating fundamental ethical duties and obligations to patients accepted by their professional communities in Brazil and worldwide. Physicians and other health care providers have a joint responsibility to uphold patients' rights and to "pursue appropriate means to assure or to restore them"[258] when legislation or government action denies them, and they may be ethically bound not to comply with laws or institutional or collaborative practices that demand unethical behavior.[259] Health professionals may also have rights and duties to bring unethical conduct to the attention of competent bodies,[260] policymakers, politicians, and the public[261] and to participate in the development of institutional protocols, as well as social policy,[262] health education, and legislation.[263]

The Declaration of Cordoba reaffirms opposition to government interference and urges governments, health authorities, medical associations, physicians, and patients to defend, protect, and strengthen the patient-physician relationship, and physicians to preserve ethical values.[264] Relevant ethical principles explored below are confidentiality; respect for autonomy; the practice of beneficence and non-maleficence; commitments to justice and non-discrimination; and the defense of human rights.

Confidentiality: Physicians, nurses, social workers, and psychologists must respect patients' rights to privacy and confidentiality.[265] Ethical codes for these professions provide varied guidance on when it may be ethical to disclose confidential information, such as only with explicit patient consent; to the extent strictly necessary with colleagues in joint patient care or to remove the threat of harm; for just cause; in the professional's own defense; or if provided by law, including mandatory reporting or judicial determination.[266] Obligations of confiden-

tiality persist when testifying,[267] and physicians must not reveal confidential information exposing a patient to criminal liability in the investigation of a crime.[268] Further, reporting by nurses to criminal legal actors in cases of domestic and family violence is appropriate only where there is risk to the community or survivor, and with prior notification to the survivor.[269] Physicians must keep all personal information protected and appropriately stored,[270] and physicians and nurses have separate obligations to maintain the confidentiality of medical records.[271] Nurses also have an obligation to maintain patients' right to give and withdraw consent to access genetic information.[272]

Police reporting required based on information discovered in a confidential medical setting may encompass, if "evidence" is interpreted broadly akin to the Revised Regulation, the collection of embryo or fetus fragments during consultations for DNA testing. This involves highly sensitive patient data that are then not used according to the patient's direction but as relevant to criminal proceedings. This runs counter to patients' legitimate expectation, in line with physicians' duty to act in their best interests, that the information will be held in confidence and used for their benefit, not for some other purpose.[273]

Both the reporting and involvement of numerous professionals in the authorization process expand the chain of information-sharing and increase risk of unauthorized disclosures. As noted earlier, any possibility of patient consent to these disclosures is fraught given that the informed consent form is squarely oriented toward abortion care and only incidentally mentions disclosure under judicial request. The patient must accept this process as a whole or lose the possibility of obtaining a legal abortion. Further, reporting in these cases does not count under exceptions for disclosures "by law"[274] due to a lack of clarity on disclosure in the broader legal landscape[275] —and unjust laws, as argued here, cannot be the basis of "legal duty." While some professionals may claim that ethics requires disclosure based on the risk of harm to a patient, it is important, particularly in the context of abortion, that the scope of cases that meet this exceptional threshold be interpreted narrowly, both to appreciate actual risk of harm (as well as the particular harms that reporting can create in these cases) and to not functionally erase confidentiality obligations completely.

Autonomy: Physicians must have the freedom to exercise professional judgment in the care and treatment of their patients without undue or inappropriate influence by parties outside the patient-physician relationship,[276] particularly for political purposes.[277] Nurses and social workers, likewise, have the right to exercise their profession with autonomy,[278] and psychologists must not establish third-party relationships that interfere with their services.[279] Where police reporting is applied to abortion following rape, it repurposes the authorization process and reshapes health professionals' roles by defining a set of interventions with patients, including police reporting and potentially evidence transfer, not according to independent clinical assessment or medical necessity but rather coopting medical expertise in service of criminal surveillance and prosecution. These health professionals must also respect patient autonomy and consent.[280] However, reporting forces these interventions, with new purpose, on patients in cases of abortion following rape, and they must accept them or lose the possibility of securing a legal abortion. Necessarily individualized consent to sharing confidential information and data is also lost in this process.

Beneficence and non-maleficence: Patient health and well-being is the physician's first consideration.[281] Physicians must act in patients' best interests, alleviate suffering, and not cause harm by act or omission or allow attacks on dignity and integrity.[282] Nurses must work to promote and restore health, prevent illness, and alleviate suffering, while psychologists and social workers must maximize benefits and minimize potential harms to individuals, and psychologists must work to promote health and quality of life.[283] Police reporting subverts the best interests and well-being of patients in service of criminal evidence collection, prosecution, and the deterrence of legal abortion and may require unnecessary and non-therapeutic interventions, such as the collection of physical evidence. Even if these interventions could be beneficial to a specific patient, the blanket process of the police reporting requirement and the criteria for identification based on risk rather than therapeutic outcomes within care are problematic, since beneficence and non-maleficence require individualized care, recognizing that what may be a benefit for one patient may be harmful to another.[284]

Justice and non-discrimination: Physicians must guarantee justice[285] and have a duty not to discriminate across age, disease, disability, race, ethnic origin, nationality, gender, sexual orientation, or social standing,[286] while patients have a right, without discrimination, to appropriate medical care.[287] Nurses must uphold principles of justice[288] and, along with social workers and psychologists, must also provide care without discrimination.[289] These professionals also have obligations to act with and advocate for equity and social justice[290] and the elimination of discrimination.[291] As explored in Sections III and V, police reporting means that women who are survivors of violence seeking legal abortion are singled out for identification and exceptional regulation in health care in a discriminatory manner, drawing on and perpetuating stereotypes of womanhood, pregnancy, and abortion, for purposes unrelated to health needs, with harmful impacts on their rights to life, health, privacy, and related rights.

Defense of human rights: Physicians must not use medical knowledge to violate human rights and civil liberties, even under threat,[292] while nurses, social workers, and psychologists have ethical obligations to respect and promote human rights generally.[293] These health professionals also have specific obligations to respect, for example, patients' rights to dignity, health, privacy, confidentiality, and non-discrimination.[294] Human rights and professional ethics operate synergistically: specific violations of human rights—including those explored in this Technical Note—are also breaches of professional ethics.

Precluding a Dignity-Informed Therapeutic Relationship

Police reporting, especially when it identifies survivors but also more generally in setting up a dynamic in which such identification is a possibility, reconfigures the relationship between health professionals and patients within the process for legal abortion, with a particular impact on patient dignity. Respect for human dignity is protected as a foundational and substantive principle across human rights[295] and medical ethics. Dignity, further, has a particular character in Brazil as "a fundamental pillar of the country's post-1988 constitutional order"[296] and is explicitly linked to protections for family planning.

Dignity is a standard for the human right to health generally: "Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity."[297] And it is a standard for health care service provision specifically: service provision that respects women's dignity is part of making services acceptable and therefore accessible to women, and states should not permit coercive practices that violate women's dignity.[298] The Brazilian Constitution, likewise, explicitly links dignity—and its foundational place in the Brazilian legal system—to women's health, well-being, and reproductive rights: human dignity is, along with responsible parenthood, the basis of "special protection" ensuring that "couples are free to decide on family planning ... [and] prohibiting any coercion on the part of official or private institutions."[299] Legislation under this provision specifies that "[f]amily planning is the right of every citizen," understood as part of constitutional equal rights guarantees and as constituting "actions to care for women, men or couples."[300]

Professional ethics complement human rights and the Brazilian Constitution in promoting dignity in the provider-patient relationship. For example, the commitment in medical ethics to respect personhood overlaps with the respect for dignity and equality at the core of human rights: health professionals who follow ethical principles in respecting women's autonomy are also combating gender discrimination, and, in eliminating racial and gender bias in interactions with patients in line with the ethical principle of justice, they are upholding human dignity.[301]

Professional ethical codes also address dignity specifically. Respect for human dignity is both an ethical duty of physicians[302] and one of the "principal rights of the patient that the medical profession endorses and promotes."[303] It is a right of patients inherent in nursing and a primary obligation for nurses,[304] social workers, and psychologists.[305] Human dignity is "one of the core values of medicine and is an essential element of a good therapeutic relationship," particularly in undergirding compassion, which facilitates trust and healing.[306] In practice, ethical codes specify that respect for dignity includes entitlement to relief from suffering;[307] respect for diversity, cultural difference, free and informed consent, privacy, confidentiality, and fairness and justice in treatment;[308] treating people as they want to be treated; forming empathetic relationships; challenging stigmatizing beliefs and actions; critically reflexive practice; acknowledging vulnerability;[309] not allowing or covering up acts against dignity;[310] and not using the power of one's position to impose political ideologies or prejudice violating human dignity.[311]

Police reporting requirements force patients and health professionals to engage in additional steps in a predefined multistage process to authorize legal abortion. On a foundational level, in establishing barriers to abortion,[312] police reporting, especially where it identifies patients, impinges on dignity as autonomy in life and family planning, as protected by the Brazilian Constitution. Further, it undermines the autonomy of provider-patient relationships and the scope for compassionate, empathetic, and individualized care defined alongside patients according to their needs and well-being. Police reporting requirements in these cases, in addition to undermining trust in provider-patient relationships by threatening confidentiality and reinforcing stigma, also undermine patient-directed care by removing the patient's ability to decide whether to report a rape—and thus expose themselves to the criminal system and its harms—instead making it a condition for the ability to obtain an abortion. One of the few decisions within the discretion of a health professional is whether to identify the patient or to not report at all and thus contravene the law; but even so, other professionals involved in the case may decide to report in that person's place.

While it might be argued—in alignment with the prosecution of crimes of public action—that reporting sexual violence discovered during abortion consultations could promote the dignity and integrity of patients in service of redress, the removal of a survivor's ability to decide whether to report is particularly fraught in these cases given the subversion of autonomy in sexual violence. This is as compounded by pregnancy as an outcome and how the dynamic of the authorization process, reshaped by the possibility of police reporting, restricts decision-making also about abortion. Further, even if police reporting were a desired goal of a specific patient, the barriers and stigma created by reporting means that it in fact reduces the likelihood of a patient's engagement with the legal abortion process, reporting, and the initiation of criminal proceedings. In removing patient autonomy, including the developing autonomy of minors, the reporting dynamic worsens "asymmetry in the exercise of power" in the physician-patient dynamic, as noted by the Inter-American Court on Human Rights in a case affirming the importance of autonomy in the sphere of health to protect against paternalism and the instrumentalization of patients.[313]

The psychological impacts of this process are contrary to healing and the therapeutic relationship. In every case, the possibility of police reporting that identifies the patient exposes that patient to the multi-professional team's scrutiny and medical examination in service of a specter of false allegation, with significant penalties if the patient is not believed, as well as to the potential harms of criminal reporting. This polices limitations on abortion and forces those with pregnancies that do not fall under this or other exceptions, or who cannot provide evidence that will be acceptable under such exceptions or are fearful that such required evidence will not be found, to continue their pregnancy.

Drawing on an equivalent status given to dignity as a foundational constitutional value in the Colombian Constitution,[314] the Constitutional Court of Colombia has noted how dignity as a constitutional value infuses the right to health, requiring consideration of the "integral and complete whole" of the individual, and that the right to health includes both physical and mental health, including as related to reproductive health.[315] This aligns with majority opinions of Brazil's Supreme Court in ADPF 54 recognizing women's constitutionally protected right to health as including mental and social well-being, as well as Brazil's international obligations under the rights to life and health, which include both physical and mental well-being.[316] Particularly where pregnancy is the result of rape, the "rights to dignity, privacy, autonomy and freedom of conscience are abnormally and extraordinarily violated," and legally forcing continued pregnancy is an "enormous burden" that shows "indifference to her value as a subject of rights" in making a woman an "instrument of procreation."[317] Interna-

tional human rights bodies have noted that the forced continuation of pregnancy has short- and long-term psychological consequences and is a form of gender-based violence that may amount to torture or cruel, inhuman, or degrading treatment.[318] Brazil has an "affirmative obligation to reform restrictive abortion legislation that perpetuates torture and ill-treatment by denying women safe access and care," such as administrative and bureaucratic hurdles.[319]

Where applied to abortion care within the authorization process under the Process Regulation, police reporting reconfigures that process from one that standardizes authorization and access to care, albeit with a number of requirements as barriers, to one that retains those barriers and decenters health professionals' care and concern for their patients, shifting the aim of consultation toward the collection of evidence for prosecution. Health professionals must consider and prioritize interests that may be contrary to those of their patients. This is different from the process that would occur were it determined based on professional judgment in accordance with ethics, standards, and practices.

Indeed, police reporting with the possibility of identifying patients may fundamentally shift the nature of the medical consultation from an abortion consultation to something more akin to a forensic evaluation for state purposes. This type of evaluation, performed in contexts from the assessment of social security benefits eligibility to competency to stand trial, is a "perversion of the fundamental medical role" that raises concerns for medical ethics and human rights even if conducted for legitimate purposes, because it breaches the duties of health professionals to be loyal to patients and act only for their benefit: "The lack of therapeutic purpose is an affront to the person's dignity as well as bodily integrity."[320] They may cause a health professional to disclose confidential information about a person irrelevant to the purpose of the evaluation or "infringe the right to dignity and to the highest attainable standard of health. Rape investigations, for example, are notorious for degrading the victim."[321]

The impacts of police reporting on dignity hold particular importance, given the foundational place of dignity in the Brazilian Constitution. With regard to the equivalent status of dignity in the Colombian Constitution, the Constitutional Court of Colombia has noted that as an "essential feature of the legal system," it must be reflected in legal regulations, government activity, and judicial decisions and serve as a limit on government power, meaning that the legislature, in enacting criminal laws, "cannot ignore that a woman is a human being entitled to dignity" and "must not impose the role of procreator on a woman against her will."[322] In this ruling, the Court found that human dignity, along with the right to health, is the basis for the establishment of a fundamental right to reproductive rights and abortion and thus decriminalized abortion in limited cases, including rape and non-consensual pregnancy.[323] Subsequently, in 2022, it decriminalized all abortion prior to 24 weeks.[324]

V. Police Reporting Requirements That Identify Survivors Further Gender Stereotyping by Singling Out Survivors of Violence Seeking Abortion for Exceptional Regulation, Constituting Discrimination

If applied during abortion care and particularly where it identifies survivors, police reporting under the Reporting Law singles particularly where it identifies survivors, singles out women survivors of violence seeking legal abortion for exceptional regulation in health care, restricting access to legal abortion in a discriminatory manner that draws on and furthers stereotypes about womanhood, pregnancy, and abortion. In doing so, it violates Brazilians' right to non-discrimination and equal treatment, as well as their rights to self-determination and personal autonomy,[325] contravening the state's duty of non-discrimination in the provision of health care and preventing women from enjoying substantively equal health care.

Brazil has international and domestic obligations to shift gender dynamics to end discrimination. Brazil must "modify the social and cultural patterns of conduct of men and women" to eliminate prejudice and practices based on ideas of superiority, inferiority, or stereotyped roles.[326] The Brazilian Supreme Court, in finding that transgender people can change their name and gender administratively without verification of body modification, has expressly recognized that gender stereotyping cannot create barriers to a person's access to fundamental rights.[327] Justice Marco Aurelio has acknowledged the state's duty to prevent "the imposition of the will of the majority based on exclusively moral choices, especially when it comes to a person's inalienable somatic constitution."[328]

The scope and logic of police reporting's restrictions on legal abortion are shaped by and reinforce stereotypes, but on a foundational level, they further gender stereotypes simply by imposing restrictions and barriers because making it difficult for survivors of rape to exercise their right to abortion indirectly makes childbearing the default expectation. Restrictions on abortion can reflect "a gender stereotype that understands the exercise of a woman's reproductive capacity as a duty rather than a right."[329]

For example, the Human Rights Committee has found that withholding abortion services in cases of unviable pregnancies subjects a woman to wrongful gender-based stereotyping as "a reproductive instrument."[330] This engages the "gender-based stereotype that women should continue their pregnancies regardless of circumstances, because their primary role is to be mothers and caregivers, thus infringing on her right to gender equality."[331] Abortion prohibition, "[t]hrough its binding, indirectly punitive and stigmatizing effects," "targets women, by virtue of being women, and places them in a specific situation of vulnerability that is discriminatory in comparison with men"[332] —who are not expected to disregard their health needs in service of their reproductive functions[333] —and with regard to similarly situated women who decide to carry such pregnancies to term.[334]

Likewise, majority opinions of the Brazilian Supreme Court have held that forcing women to be mothers is opposed to their status as rights-bearing citizens who can decide to undertake motherhood by choice.[335] Further, these opinions, in recognizing the right to health as including mental and social well-being in addition to physical health, move away from "an interest in brute physical survival—reasoning about women as if they had no social, intellectual, or emotional identity that transcended their physiological capacity to bear children."[336]

Gender stereotyping in the abortion restrictions created by police reporting is underscored by the fact that reporting's scope of application, if applied during abortion care, completely envelops the rape exception to the general criminalization of abortion. The authorization process for legal abortion in these cases calls for disclosure and examination related to rape, as a category of violence against women under the Reporting Law, that triggers police reporting to entail an evaluation of risk to the survivor or community that could lead to their identification to the police.

This specific level of scrutiny is not present for those who have experienced violence but do not seek abortion, such as women who continue their pregnancies to term, women who cannot conceive due to their age (notably excluding a subset of older women and younger women also who fall under provisions criminalizing rape of the vulnerable—i.e., crimes of public action), and people who cannot conceive for other reasons, such as transgender women.

It is also, more generally, not present in health care for people whose circumstances do not trigger reporting or the rape exception, such as women not who are not survivors of violence and cisgender male patients seeking reproductive health care. Not only does this reinforce the harmful narrative that pregnancy and motherhood are paramount for women—and that they must be maintained even where pregnancy is the result of sexual violence—but it also applies only to people who are physically able to conceive, punishing them for the mere fact that they can become pregnant and casting reproductive capacity as a core characteristic of "women" in a measure purportedly designed as a response to violence against women. In further invisibilizing male survivors of violence, it also props up stereotypes that assign women the status of archetypal victim of sexual violence.

Both the rape exception in the Penal Code and the authorization process in the Process Regulation apply specifically to a "pregnant woman," while the police reporting requirement in the Reporting Law applies to "violence again women." As a result, police reporting may not apply to a transgender man who has elected to be registered as a man and who does become pregnant as a result of rape, or he may be misgendered through stereotypes related to gender and reproductive capacity and drawn into its restrictions. As noted in the Technical Standard cited in the Process Regulation, vulnerabilities and exposure to sexual violence can vary across gender, place, race, age, disability, and economic circumstance; and lesbian, gay, bisexual, transgender women, and cisgender and transgender men can suffer sexual violence, and need equal access as well as specialized care.[337] Police reporting, as funneled through the Process Regulation, therefore functions selectively in how it leverages heightened scrutiny.

The ever-present possibility of police involvement throughout the authorization process for legal abortion following rape, as noted above, shifts that process from one that could be claimed as good-faith compliance with legality to one that surveils the rape exception and general criminalization of abortion, enhancing its paternalism and interference with reproductive rights. Elements of that process recording the relevant facts (proof) of the rape—including the responsible physician and multi-professional team checking gestational age, the multi-professional team attesting no false allegation of rape, and the patient signing a statement of responsibility—are even more clearly focused on evidence collection for the reporting requirement and its claim of serving prosecution or otherwise enhancing measures to address violence against women. That the collection of this information also acts functionally as screening for police reporting also gives greater urgency to the fact that the process is linked explicitly to, and now more likely to result in, police investigation and judicial request for this information.

This dynamic of police reporting in these cases functions, at a structural level, to treat people who can get pregnant as incompetent. It does so both simply in adding the requirement to report, but also specifically in creating a situation where police (and associations of police with serious cases of criminality, investigation, and justice) are called in to manage these cases, and in which medical professionals (and associations of these professionals with serious harm and care for the vulnerable) are called on to speak and act in place of patients. This portrayal suggests they are too vulnerable to report assault on their own terms, or untrustworthy decision-makers whose decision-making process must be rigidly defined and verified by numerous professionals. Moreover, the specter of false allegation draws on and furthers the stereotype that women lie about rape for malicious reasons and furthers ideas about false rape reporting generally, since criminal reporting is now fused to the medical process.

More generally, police reporting offers a veneer of professional seriousness, making the rape exception to the criminalization of abortion even more exceptional by conditioning access to abortion on scrutiny across two institutions: police and medicine. The administrative steps of the Process Regulation concentrate decision-making power in the hands of health professionals and preclude pregnant patients from questioning or countering the beliefs and decisions of their doctor, at a time when "modern trends in medicine have shifted away from 'doctor knows best' paternalism and patients are routinely trusted, and indeed expected, to make their own informed medical decisions."[338] This is exactly the kind of imposition of will of the majority over a moral decision concerning the body of a person that the Brazilian Supreme Court rejected in ADI 4275.[339]

In this combined surveillance dynamic, police reporting and the stages outlined in the Process Regulation work together to entrench stereotypes that conflate womanhood, reproductive capacity, and motherhood, fostering the idea that the police and a multi-disciplinary team are needed to secure the interests of motherhood when, in fact, it is the woman whose health and victimhood is at issue. Given that police reporting is made more likely by the scrutiny of the abortion authorization process, it is the pregnancy itself that causes women survivors of rape to be subject to police involvement.

Within the landscape of reporting, pregnancy is placed on a pedestal requiring comprehensive state knowledge and intervention. In addition, the claim that reporting helps strengthen accountability and other responses to violence clouds the fact that it subverts patients' right to make autonomous and lawful decisions concerning their reproductive health. It treats patients differently on the basis of their biological characteristics, further limiting already restricted access to abortion in cases of rape. As noted by Lucía Berro Pizzarossa in an analysis of rape exceptions in Uruguay's abortion law, abortion as a remedial measure for sexual violence is justified through a narrative of women as tragic victims that presents women's agency over reproductive health "not as a woman's desired choice but as a painful decision available in the absence of choice," enabling equivalence between consensual intercourse and desired conception.[340] Perversely, it seems that police reporting for the purpose of prosecution and other responses to violence might be seen to provide "justice" for and therefore cure the wrong and harm committed in the rape, therefore shifting the needle toward desired conception and removing the need for abortion.

Restrictions basing access to abortion on the decisions and discretion of health care providers, such as those at the heart of police reporting within the context of the authorization process for legal abortion following rape, have been the basis for finding violations of obligations under the Convention on the Elimination of All Forms of Discrimination against Women to eliminate sex role stereotyping and prejudice,[341] with the Committee on the Elimination of Discrimination against Women underscoring that this implicates the obligation not only to make abortion legal for women who have been raped but to ensure the availability of abortion services.[342] The Human Rights Committee also found, in a case where a woman was denied lawful access to an abortion at the discretion of her health care providers and maintained that her "special needs were ignored because of her sex,"[343] that having to carry to term a pregnancy of a fetus with fatal abnormalities was a violation of protections against torture and cruel, inhuman, or degrading treatment or punishment, as well as her right to privacy.[344] Further, the Committee found violations of the right to non-discrimination and equal treatment in a case where a legal therapeutic abortion was denied by hospital staff to a mentally disabled women in their care who became pregnant as a result of rape.[345] These cases highlight Brazil's responsibility for the tangible consequences of stereotyping stemming from the police reporting requirement in the Reporting Law and its impacts across the legal landscape related to abortion provision. Despite placing discretion on local authorities to make abortion available, Brazil knowingly neglects to ensure non-discrimination and equality in the provision of reproductive health care.

VI. Conclusion

The police reporting requirement added in 2019 to the Reporting Law should be interpreted narrowly, and only in the most extreme cases be applied to survivors of violence seeking abortion following rape, in order to give full effect to its confidentiality protections and goal of facilitating effective public policy responses to violence against women. However, there is particular risk that the requirement will be read more widely. This risk is heightened by the assertions by the previous administration claiming that its scope matches that of the police reporting requirement under now-revoked regulations passed in 2020. Additionally, the long-standing practice in Brazil of health professionals and judges imposing additional requirements for abortion with no basis in law, either though good-faith misapprehension of the law or strategic efforts to limit abortion, further intensifies this risk. Furthermore, current instances of health professionals reporting on patients for prosecution, including under the crime of abortion, contrary to their legal obligations and legal exceptions, contribute to the heightened risk. This risk may be exacerbated by superficial readings of the Reporting Law's confidentiality protections that ignore the broader landscape of legal protections and the consequences of reporting, and the revocation of regulations explicitly laying out the means of reporting for both identified and de-identified reporting. Such a wide reading would make Brazil an outlier even among abortion-restrictive countries.

A narrow reading of this provision is important because it is the correct interpretation of the text of the law—and aligns with Brazil's 80-plus-year-old law establishing that access to abortion in cases of rape is lawful, with the sole requirement being the patient's consent to the procedure—But it is also important because reporting, particularly where it identifies survivors of rape to the police, fundamentally shifts the nature of the authorization process for abortion in cases of rape, compounding stigmatization, harm, and barriers to legal abortion. As explored in this Technical Note, these barriers and their impacts on survivors are contrary to Brazil's obligations under the rights to life, health, privacy, and non-discrimination.

Where it is applied to patients seeking abortion, police reporting imperils the rights to life and health by promoting a chilling effect, the delay or denial of abortion, the integration of criminal reporting barriers into the medical process, third-party violence, and conflicting duties for health professionals. It also violates the right to non-discrimination by imposing intense scrutiny on the rape exception for legal abortion and patients undergoing the authorization process for abortion on that ground. Police reporting in these cases singles out survivors of rape seeking abortion for exceptional regulation; furthers stereotypes conflating womanhood, reproductive capacity, and motherhood; and forces survivors into a criminal complaint rather than empowering them to make decisions about their lives and to access necessary health care. In doing so, it reshapes the provider-patient relationship in ways contrary to patient dignity and pressures health professionals to violate fundamental principles of medical ethics.

Human rights and medical ethics, as explored throughout this Technical Note, provide important guidance to help chart uncertainty in the implementation of the police reporting requirement to minimize these harms. This may also help prevent police reporting that undermines, and may even render ineffectual, broader goals across mandatory reporting provisions that seek to address violence against women. Ultimately, the untenable conflict between human rights and professional ethics, on the one hand, and police reporting requirements in the context of abortion, on the other—given the broader context of abortion criminalization, stigma, short time frames for care, and the routine imposition of extra-legal requirements—can be resolved only by ensuring that they do not apply to cases of abortion, or only in very exceptional circumstances.

This can be effected by accurately and narrowly interpreting the Reporting Law so that it does not violate human rights and ethics or unduly hobble abortion access in light of Brazil's legal and constitutional guarantees. The repeal of the Revised Regulation in early 2023 was an important departure from the continued retrogressive shift of the last few years in the context of abortion. Clear guidance that the Reporting Law does not apply to abortion, or applies only in the most extreme cases, will further support access to care.

More foundationally, the impact of police reporting on access to legal abortion highlights the dangers of drawing the criminal legal sphere into health care practice. Removing all preconditions, legal or otherwise, including authorization processes, and instead focusing on providing material support and quality, unbiased care, is essential to ensuring real access to legal abortion.

1 Monica Malta et al., Abortion in Brazil: the case for women's rights, lives, and choices, 4 THE LANCET e552, e552 (2019). Maternal deaths from abortion are likely underreported: see generally Rosa Maria Soares Madeira Domingues et al., Unsafe abortion in Brazil: a systematic review of the scientific production, 2008-2018, 36 (Suppl 1) CAD. SAÚDE PÚBLICA e00190418 (2020).

2 Lei No. 10.778, de 24 de novembro de 2003, Diário Oficial da União [D.O.U.] de 25.11.2003, art. 1 § 4; 2 (Braz.), as amended by Lei No. 13.931, de 10 de dezembro de 2019, Diário Oficial da União [D.O.U.] de 11.12.2019 (Braz.). See discussion of compulsory reporting for epidemiological surveillance infra Section II, Police Reporting Shifts the Operation of the Reporting Law and Other Types of Mandatory Reporting.

3 See infra Section II, Recent Developments in Reporting Obligations and Abortion Regulation.

4 Lei No. 13.931, de 10 de dezembro de 2019, Diário Oficial da União [D.O.U.] de 11.12.2019, arts. 1–3 (Braz.).

5 Portaria No. 2.282, de 27 de agosto de 2020, Diário Oficial da União [D.O.U.] de 28.08.2020, art. 1 (Braz.). Portaria No. 2.561, de 23 de setembro de 2020, Diário Oficial da União [D.O.U.] de 24.09.2020, art. 7 (Braz.). Revoked by Portaria No. 13, de 13 de janeiro de 2023, Diário Oficial da União [D.O.U.] de 20.01.2023, art. 1, III (Braz.).

6 Elizabeth Broderick, Tlaleng Mofokeng & Dubravka Šimonovic, Letter OL BRA 09/2020 dated Sept. 16, 2020, from the mandates of the Working Group on discrimination against women and girls; the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; and the Special Rapporteur on violence against women, its causes and consequences addressed to the Government of Brazil (Sept. 16, 2020), https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=25560 [hereinafter Retrogression Letter].

7 Permanent Mission of Brazil to the United Nations, Letter dated Sept. 18, 2020, from the Permanent Mission of Brazil to the United Nation addressed to the Office of the United Nations High Commissioner for Human Rights Special Procedures Divisions (Sept. 18, 2020), https://spcommreports.ohchr.org/TMResultsBase/DownLoadFile?gId=35578 [hereinafter Response to Retrogression Letter]. This claim refers to the version of the reporting requirement in Portaria No. 2.282/2020, but the content of the obligations is the same. Compare Portaria No. 2.561/2020 and Portaria No. 2.282/2020.

8 See, e.g., ADRIANA RAMOS DE MELLO & LIVIA DE MEIRA LIMA PAIVA, LEI MARIA DA PENHA NA PRÁTICA, Ch. 5.3.2.2 (2022). See infra Section II, The Scope of Police Reporting under the Reporting Law, as Applied in Cases of Abortion Following Rape.

9 Portaria No. 1.508, de 1 de setembro de 2005, codified as Portaria de Consolidação No. 5, de 28 de setembro de 2017, Diário Oficial da União [D.O.U.] de 03.10.2017, arts. 694–700 (Braz.). Portaria No. 13/2023, art. 2, II. See also Decreto-Lei No. 4.657, de 4 de setembro de 1942, Diário Oficial da União [D.O.U.] de 09.09.1942, art. 2 (Braz.).

10 See infra Section II, The Particular Risk of Improper Wide Interpretation in the Context of Abortion.

11 CÓDIGO PENAL [C.P.] [Criminal Code], arts. 217-A § 5; 128, II (Braz.); see, e.g., Delphine Starr, A 10-Year-Old Girl's Ordeal to Have a Legal Abortion in Brazil, HUMAN RIGHTS WATCH (Aug. 20, 2020), https://www.hrw.org/news/2020/08/20/10-year-old-girls-ordeal-have-legal-abortion-brazil; Andrea Carvalho, Judge Tries to Block Abortion for 11-Year-Old-Rape Survivor in Brazil, HUMAN RIGHTS WATCH (June 25, 2022), https://www.hrw.org/news/2022/06/25/judge-tries-block-abortion-11-year-old-rape-survivor-brazil. Every year in Brazil, more than 19,000 live births occur to mothers between the ages of 10 and 14, who are disproportionately Black and Indigenous, following pregnancies that are largely unintentional and the result of abuse and sexual violence: Apesar da redução dos índices de gravidez na adolescência, Brasil tem cerca de 19 mil nascimentos, ao ano, de mães entre 10 a 14 anos, UNFPA (Sept. 23, 2021), https://brazil.unfpa.org/pt-br/news/apesar-da-redu%C3%A7%C3%A3o-dos-%C3%ADndices-de-gravidez-na-adolesc%C3%AAncia-brasil-tem-cerca-de-19-mil.

12 Terminating a pregnancy resulting from rape has been lawful under a justification defense to the crime of voluntary abortion in the Penal Code since its passage: CÓDIGO PENAL [C.P.] [Criminal Code], art. 128, II (Braz.). The defense requires only that the abortion be performed with "the consent of the pregnant woman or, where incapable, of her legal representative." See also art. 23, I.

13 Carin Zissis, Chase Harrison, Jon Orbach & Jennifer Vilcarino, Explainer: Abortion Rights in Latin America, AS/COA (June 28, 2022), https://www.as-coa.org/articles/explainer-abortion-rights-latin-america; The World's Abortion Laws, CENTER FOR REPRODUCTIVE RIGHTS (n.d.), https://reproductiverights.org/maps/worlds-abortion-laws/ (last visited Mar. 27, 2024). See infra Section II, Police Reporting's Restrictive Impact Runs Contrary to Global Norms of Increased Access to Abortion.

14 Hum. Rts. Comm., General Comment No. 36, ¶ 8, U.N. Doc. CCPR/C/GC/36 (Sept. 3, 2018).

15 Manuela v. El Salvador, Preliminary Objections, Merits, Reparations and Costs, Inter-Am. Ct. H.R. (Ser. C) No. 441, ¶ 215, 227–28 (Nov. 2, 2021) (citations omitted).

16 See, e.g., Wanderley Preite Sobrinho, Algemada no hospital: médicos ignoram lei e denunciam mulheres que abortam, UOL (July 7, 2023), https://noticias.uol.com.br/saude/ultimas-noticias/redacao/2023/07/07/aborto-mulher-algemada-medicos-quebram-sigilo-medico.htm. Notably, this article cites a study by the Federal University of Paraná analyzing cases against 43 women in that state between 2017 and 2019 and finding that 44% were reported to the police by health professionals and that 65% had their medical records shared with the police without their consent. It also cites a study by the Rio de Janeiro Public Defender's Office finding that, of 42 women prosecuted by the state in 2017, 30.9% were denounced by a hospital or health center: See Katie Silene Cáceres Arguello & Vanessa Fogaça Prateano, Cuidar Ou Delatar? A Violação do Sigilo do Prontuário Médico na Criminalização de Mulheres por Aborto Autoprovocado no Estado do Paraná (2017 a 2019), 18(100) RDP BRASÍLIA 550 (2021), and DEFENSORIA PÚBLICA GERAL DO ESTADO DO RIO DE JANEIRO, ENTRE A MORTE E A PRISÃO: QUEM SÃO AS MULHERES CRIMINALIZADAS PELA PRÁTICA DO ABORTO NO RIO DE JANEIRO (2018).

17 Comm. on the Elimination of Discrimination against Women, L.C. v. Peru, ¶¶ 8.18–9, U.N. Doc. CEDAW/C/50/D/22/2009 (Nov. 25, 2011).

18 Assis Machado & Cook, supra note 23, at 221 (citing ADPF 54). See also Beatriz Galli, Negative Impacts of Abortion Criminalization in Brazil: Systematic Denial of Women's Reproductive Autonomy and Human Rights, 65 U. MIAMI L. REV. 970 (2011).

19 CONSTITUIÇÃO FEDERAL [C.F.] [CONSTITUTION] Preamble, arts. 1 ¶ III, 5 & 6 (Braz.).

20 For a discussion of the meaning of supra-legality and relevant cases, see Antonio Moreira Maués, Supralegalidade dos Tratados Internacionais de Direitos Humanos e Interpretação

Constitucional, 10(18) SUR - INT'L J. HUM. RTS. 215 (2013); Luiz Flávio Gomes, Direito dos direitos humanos e a regra interpretativa "pro homine," REVISTA JUS NAVIGANDI (July 26, 2007), https://jus.com.br/artigos/10200.

21 Constitution, art. 5, LXXVIII,§§ 2–5, as amended by Emenda Constitucional No. 45, de 30 de dezembro de 2004, Diário Oficial da União [D.O.U.] de 31.12.2004.

22 CONSTITUIÇÃO FEDERAL [C.F.] [CONSTITUTION] arts. 6, 196, 197, 198 & 226 § 7 (Braz.).

23 Marta Rodriguez de Assis Machado & Rebecca J. Cook, Constitutionalizing abortion in Brazil, 5(3) REVISTA DE INVESTIGAÇÕES CONSTITUCIONAIS 185, 208–09, 217–18 (2018) (citing Superior Tribunal de Justiça [S.T.F.], ADPF No. 54 MC/DF, 04.12.2012, Diário da Justiça Eletrônico [D.J.E.] 04.30.2013 (Braz.)).

24 See CENTER FOR REPRODUCTIVE RIGHTS (CRR) & GLOBAL HEALTH JUSTICE PARTNERSHIP OF YALE LAW SCHOOL AND THE YALE SCHOOL OF PUBLIC HEALTH (GHJP FIRST, DO NO HARM HOW POLICE REPORTING REQUIREMENTS FOR HEALTH PROFESSIONALS ENDANGER BRAZIL'S OBLIGATIONS TO SUPPORT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (2024).

25 WORLD MED. ASS'N, MEDICAL ETHICS MANUAL 8-10 (2015) [hereinafter MEDICAL ETHICS MANUAL].

26 See infra Section III, Confidentiality and Other Professional Ethics. See also CRR & GHJP, supra note 24, Defense of Human Rights.

27 See, e.g., Caso Cuscul Pivaral v. Guatemala, Preliminary Objections, Merits, Reparations and Costs, Inter-Am. Ct. H.R. (Ser. C) No. 359, ¶ 106 (Aug. 23, 2018).

28 INT'L DUAL LOYALTY WORKING GROUP, DUAL LOYALTY AND HUMAN RIGHTS IN HEALTH PROFESSIONAL PRACTICE: PROPOSED GUIDELINES & INSTITUTIONAL MECHANISMS 15 (2003), https://phr.org/our-work/resources/dual-loyalty-and-human-rights-in-health-professional-practice/.

29 MEDICAL ETHICS MANUAL, supra note 25, at 68.

30 Alessandra Casanova Guedes, Abortion in Brazil: Legislation, reality and options, 8(16) REPROD. HEALTH MATTERS 66, 66–67, 69 (2000). For an overview of the history of legal abortion and associated regulatory developments in Brazil, see CRISTIÃO FERNANDO ROSAS & HELENA BORGES MARTINS DA SILVA PARO, SERVIÇOS DE ATENÇÃO AO ABORTO PREVISTO EM LEI: DESAFIOS E AGENDA NO BRASIL (2021).

31 Id. at 67, 69.

32 Portaria No. 1.508, de 1 de setembro de 2005, codified as Portaria de Consolidação No. 5, de 28 de setembro de 2017, Diário Oficial da União [D.O.U.] de 3.10.2017, arts. 694–700 (Braz.). This regulation revoked and replaced a similar but less detailed regulation promulgated less than two months earlier: Portaria No. 1.145, de 7 de junho de 2005, Diário Oficial da União [D.O.U.] de 8.6.2005 (Braz.).

33 The Technical Standard also underscores that health services, given their objective to guarantee the right to health, should not have their processes confused with those of policing or the legal system: MINISTÉRIO DA SAÚDE, NORMA TÉCNICA: PREVENÇÃO E TRATAMENTO DOS AGRAVOS RESULTANTES DA VIOLÊNCIA SEXUAL CONTRA MULHERES E ADOLESCENTES 69 (3rd ed., 2012). The Technical Standard "Humanized Attention to People in Situations of Sexual Violence with Registration of Information and Collection of Evidence" is more emphatic, providing that "[h]ealth services DO NOT replace the functions and attributions of public security, such as forensic medicine ..." and that the decision not to file a police report must be respected, without prejudice to full health care and rights: "The woman's decision must always be respected!": MINISTÉRIO DA SAÚDE, MINISTÉRIO DA JUSTIÇA & SECRETARIA DE POLÍTICAS PARA AS MULHERES, NORMA TÉCNICA: ATENÇÃO HUMANIZADA ÀS PESSOAS EM SITUAÇÃO DE VIOLÊNCIA SEXUAL COM REGISTRO DE INFORMAÇÕES E COLETA DE VESTÍGIOS 20–21 (2015). Evidence collection in cases of sexual violence is formally assigned to experts at the Forensic Institute or other professionals legally appointed for that purpose, with health professionals playing a limited role only in some circumstances, such as for emergency care or where reporting occurred at a later date and examination is no longer possible: id. at 26, 69, 86. The 2015 Standard was superseded by a 2022 Technical Standard "Technical Attention for Prevention, Evaluation and Conduct in Cases of Abortion," which deals with abortion only in the context of violence against women, in line with contemporaneous legal developments: MINISTÉRIO DA SAÚDE, ATENÇÃO TÉCNICA PARA PREVENÇÃO, AVALIAÇÃO E CONDUTA NOS CASOS DE ABORTAMENTO (2022).

34 The Technical Standard also highlights that health professionals should presume the veracity of women's statements that they have experienced sexual violence, particularly since Brazilian law exempts health professionals from liability for the crime of abortion if they have a justified belief that sexual violence occurred. It also notes that continued lack of access to safe services leads to unsafe abortion even when allowed by law and that access to abortion in cases of rape is a right guaranteed under the Constitution and international human rights law: MINISTÉRIO DA SAÚDE, PREVENÇÃO E TRATAMENTO, supra note 33, at 10, 26–27, 67 et seq.

35 Lei No. 10.778, de 24 de novembro de 2003, Diário Oficial da União [D.O.U.] de 25.11.2003, art. 1 § 4; 2 (Braz.), as amended by Lei No. 13.931, de 10 de dezembro de 2019, Diário Oficial da União [D.O.U.] de 11.12.2019 (Braz.).

36 These regulations provide for compulsory notification through a model form, provided as an annex, to be filed at the health unit where the survivor was treated. This form contains specific information, including whether the survivor was pregnant; their age range (child, adolescent, adult, elderly); their name and complete address; the type of violence that occurred during the incident, including sexual violence; the relationship of aggressor to survivor; and any outcomes of the violence, including genital trauma, other physical trauma, sexually transmitted infections, and abortion or fetal death. It also contains information on referrals, including for legal guidance or emergency contraception. The form is sent to the relevant municipal health department's epidemiological surveillance service for data entry, with consolidated information forwarded to the State Department of Health and then Department of Health Surveillance: Portaria de Consolidação No. 4, de 28 de setembro de 2017, Diário Oficial da União [D.O.U.] de 28.09.2017, arts. 12–13, 14, 15–16 (Braz.), as originally issued through Portaria No. 2.406, de 5 de novembro de 2004, Diário Oficial da União [D.O.U.] de 05.11.2004 (Braz.). See also Decreto No. 5.009, de 3 de junho de 2004, Diário Oficial da União [D.O.U.] de 4.6.2004 (Braz.). See generally MELLO & PAIVA, supra note 8, Ch. 5.3.2.2; Alessandra Lucena Wolff et al., Defensoria Pública da União, Nota Técnica No 5 - DPGU/SGAI DPGU/GTMLR DPGU, DEFENSORIA PÚBLICA DA UNIÃO, (2020), https://promocaodedireitoshumanos.dpu.def.br/wp-content/uploads/2021/06/Nota-Tecnica-no-SEI-4011697-GTM.pdf. Since 2011, violence against women has also been on the National List of Compulsorily Notifiable Diseases and Injuries: Portaria No. 104, de 25 de janeiro de 2011, Diário Oficial da União [D.O.U.] de

26.1.2011, Annex I (Braz.). Currently regulated under Portaria de Consolidação No. 4/2017, Ch. IV, Annex 1 of Annex V.
37. MELLO & PAIVA, supra note 8, Ch. 5.3.2.2 (citing Câmara dos Deputados. Justificativa do Projeto de Lei No 2538 de 2019).
38 Lola Nicolas, Promulgada a 'Lei Renata Abreu' que dá mais segurança às mulheres vítimas de violência, RENATA ABREU OFICIAL (Dec. 11, 2019), https://www.renataabreuoficial.com.br/2019/12/11/promulgada-a-lei-renata-abreu-que-da-mais-seguranca-as-mulheres-vitimas-de-violencia%ef%bb%bf/.
39. Lei No. 13.931, de 10 de dezembro de 2019, Diário Oficial da União [D.O.U.] de 11.12.2019, art. 1–3 (Braz.).
40 Id. (citing Presidência da República. Mensagem nº 495, de 9 de outubro de 2019, Diário Oficial da União [D.O.U.] de 10.10.2019 (Braz.)). See also Lei obriga serviços de saúde a notificar casos de violência contra a mulher em 24h, Migalhas (Dec. 12, 2019), https://www.migalhas.com.br/quentes/316949/lei-obriga-servicos-de-saude-a-notificar-casos-de-violencia-contra-a-mulher-em-24h.
41. MELLO & PAIVA, supra note 8, Ch. 5.3.2.2 (citing Comm. on the Elimination of Discrimination against Women, General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19, ¶ 28, U.N. Doc. CEDAW/C/GC/35 (July 26, 2017); United Nations, Report of the International Conference on Population and Development: Cairo, 5–13 September, 1994. 1995, ¶ 4.1, U.N. Doc. A/CONF.171/13/Rev.1 (1995); Beijing Declaration and Platform for Action, Fourth World Conference on Women, September 15, 1995, ¶¶ 103, 106(f), U.N. Doc. A/CONF.177/20 (1995)).
42. IBDFAM Communications Office, Publicadas leis de assistência à mulher vítima de violência, anteriormente vetadas pela Presidência da República, Instituto Brasileiro de Direito de Família (Dec. 11, 2019), https://ibdfam.org.br/noticias/7129/-Publicadas+leis+de+assistência+à+mulher+vítima+de+violência,+anteriormente+vetadas+pela+Presidência+da+República. See generally MELLO & PAIVA, supra note 8, Ch. 5.3.2.2.
43. IBDFAM Communications Office, supra note 42. For the amendments to art. 225 of the Criminal Code making these crimes of unconditional public criminal action, see Lei No. 13.718, de setembro 24, 2018, Diário Oficial da União [D.O.U.] de 25.09.2018, art. 2 (Braz.). See also STEFANO RUGGERI, AUDI ALTERAM PARTEM IN CRIMINAL PROCEEDINGS: TOWARDS A PARTICIPATORY UNDERSTANDING OF CRIMINAL JUSTICE IN EUROPE AND LATIN AMERICA 135 (2017).
44. Paula Spieler, The Maria da Penha Case and the Inter-American Commission on Human Rights: Contributions to the Debate on Domestic Violence Against Women in Brazil, 18(1) INDIANA J. GLOB. LEGAL STUD. 121, 137–139 (2011).
45. Lei No. 11.340, de 7 de agosto de 2006, Diário Oficial da União [D.O.U.] de 8.8.2006 (Braz.). See Lei obriga serviços de saúde a notificar casos de violência contra a mulher em 24h, supra note 41.
46. Portaria No. 2.282, de 27 de agosto de 2020, Diário Oficial da União [D.O.U.] de 28.08.2020, art. 1 ¶ 2 (Braz.), cross-referencing to processes under Lei No. 12.654, de 28 de maio de 2012, Diário Oficial da União [D.O.U.] de 29.05.2012 (Braz.). Art. 10 of this regulation revoked, at this time, the sections of the consolidated regulation that incorporates the text of the Process Regulation: Portaria No. 1.508, de 1 de setembro de 2005, codified as Portaria de Consolidação No. 5, de 28 de setembro de 2017, Diário Oficial da União [D.O.U.] de 03.10.2017, arts. 694–700 (Braz.).
47. Portaria No. 2.282/2020, art. 8, Annex V (Braz.). This list was copied from the National Health Service website but did not contain any of its contextualization, excluding, for example, the explicit statement that "[a]bortions are generally very safe and most women will not experience any problems," as well as information on the specific frequency of stated risks.
48. ROSAS & PARO, supra note 30, at 18.
49. The Revised Regulation added reporting to "official experts" along with police: Portaria No. 2.561, de 23 de setembro de 2020, Diário Oficial da União [D.O.U.] de 24.09.2020, art. 7, II (Braz.), cf. Portaria No. 2.282/2020, art. 1, ¶ 2. The Public Defender's Office noted that shifting the reporting and evidence transfer requirement from the first article in the Test Regulation to the last article in the Revised Regulation was a positive shift against interpretation that the reporting requirements were the first or main measures to be carried out by health professionals. It also noted that the change in wording from "mandatory" notification (Test Regulation) to measures that the physician "must" observe (2.561) still expressed an obligation on health professionals to report: Wolff et al., supra note 36. The Revised Regulation removed the selective and misleading list of risks in the consent form but maintained a paragraph indicating to the reader that information on risks could be found in the same (English-language) sources.
50. Retrogression Letter, supra note 6.
51. Response to Retrogression Letter, supra note 7.
52. Portaria No. 2.561/2020, Preamble, cross-referencing to CÓDIGO PENAL [C.P.] [Criminal Code], art. 128, II (Braz.), which provides that "[a]bortion performed by a doctor is not punished ... if the pregnancy results from rape and the abortion is preceded by the consent of the pregnant woman or, when unable, of her legal representative." Notably, the exception to Brazil's general criminalization of abortion was the first consideration in the Process Regulation but shifted to second position, after the stated need for regulation to ensure legality, in the Test Regulation and Revised Regulation. Compare Portaria No. 2.561/2020, Preamble, Portaria No. 2.282/2020, Preamble, and Portaria No. 1.508, de 1 de setembro de 2005, Diário Oficial da União [D.O.U.] de 2.9.2005, Preamble (Braz.). See infra Police Reporting Shifts the Process Regulation's Concern for Legality from Compliance to Criminalization.
53. Compare Portaria No. 2.561, de 23 de setembro de 2020, Diário Oficial da União [D.O.U.] de 24.09.2020, art. 7 (Braz.) and Portaria No. 2.282, de 27 de agosto de 2020, Diário Oficial da União [D.O.U.] de 28.08.2020, Preamble (Braz.). See supra note 49.
54. Rosana Leite Antunes de Barros, Maurício Garcia Saporito & Hiram Nascimento Cabrita de Santana, Nota Técnica – CPDDM/CONDEGE – Urgente, Assunto: Portaria No 2.282, de 27 de agosto de 2020, DEFENSORIA PÚBLICA DO ESTADO DE RORAIMA (2020), http://www.defensoria.rr.def.br/comunica%C3%A7%C3%A3o/noticias/2910-nota-t%C3%A9cnica-%E2%80%93-cpddm-condege-urgente; Wolff et al., supra note 36.
55. For a list of public statements by organizations opposed to the police reporting requirement in one or both regulations, see NUDEM, RELATÓRIO DO NÚCLEO ESPECIALIZADO DE PROMOÇÃO E DEFESA DOS DIREITOS DAS MULHERES (NUDEM) SOBRE O ACESSO AO ABORTO PREVISTO EM LEI NO ESTADO DE SÃO PAULO 38–40 (2021). See also Marcos Felipe Silva de Sá, Maria de Fátima Freire de Sá & Lucas Costa de Oliveira, Interrupção legal da gravidez em crianças no Brasil: o princípio do melhor interesse nas veredas do direito, da medicina e da ética, 12(1) CAD. IBERO-AMER. DIR. SANIT. 24, 34 (2023).
56. See Silva de Sá et al., supra note 55, at 24, 34.

57. For a summary of these actions, see ROSAS & PARO, supra note 30, at 4–5, 12–13.
58. Leandro Prazeres, Ministério da Saúde admite que publicou portaria por pressão de entidades antiaborto, O GLOBO (Oct. 3, 2020), https://oglobo.globo.com/brasil/ministerio-da-saude-admite-que-publicou-portaria-por-pressao-de-entidades-antiaborto-24675541.
59. Starr, supra note 11.
60. Carolina Vila-Nova, Minister Damares Alves Tried Prevent Abortion of A 10-year-old Child, FOLHA DE SÃO PAULO (Sept. 21, 2020), https://www1.folha.uol.com.br/internacional/en/brazil/2020/09/minister-damares-alves-tried-prevent-abortion-of-a-10-year-old-child.shtml.
61. Lei No. 10.778, de 24 de novembro de 2003, Diário Oficial da União [D.O.U.] de 25.11.2003, art. 1 § 4; 2 (Braz.), as cross-referenced by Portaria de Consolidação No. 4, de 28 de setembro de 2017, Diário Oficial da União [D.O.U.] de 28.09.2017, Annex V, art. 14A (Braz.). Art. 14A ¶ 1 notes that the communication of cases of violence against children, adolescents, and elderly women follows the procedures outlined in the related specific statutes. Where reporting by health units is not possible, the state health authority is to communicate cases to police within 24 hours of the weekly consolidation of the Information System for Notifiable Diseases of the Ministry of Health (VIVA SINAN). The state health authority defines, with the state public security agency, which police authority will be responsible for receiving communications: Portaria de Consolidação No. 4/2017, Annex V, arts. 14A–14C, as added by Portaria No. 78, de 18 de janeiro de 2021, Diário Oficial da União [D.O.U.] de 19.01.2021 (Braz.).
62. Id. arts. 14D–14F (Braz.), as added by Portaria No. 78, de 18 de janeiro de 2021, Diário Oficial da União [D.O.U.] de 19.01.2021 (Braz.) and revoked by Portaria No. 1.077, de 26 de maio de 2021, Diário Oficial da União [D.O.U.] de 27.05.2021 (Braz.). See also MELLO & PAIVA, supra note 8, Ch. 5.3.2.2.
63. This included the absolute number of cases of violence notified by health services in the reference period, stratified by the consolidation reference period, the municipality of notification, the age of the survivor, the race/color of the survivor, the neighborhood of the survivor, the place where the violence occurred, the type of violence, the means of aggression, whether it was recurrent violence, the gender of the "probable perpetrator of the violence," and any relationship of the survivor to the aggressor: id., art. 14-D, II § 1, I–XI; Annex 4 of Annex V.
64. Portaria No. 13, de 13 de janeiro de 2023, Diário Oficial da União [D.O.U.] de 20.01.2023, art. 1, III (Braz.).
65. Id. art. 2, II (Braz.). See also Decreto-Lei No. 4.657, de 4 de setembro de 1942, Diário Oficial da União [D.O.U.] de 09.09.1942, art. 2 (Braz.).
66. Response to Retrogression Letter, supra note 7.
67. Lei No. 10.778, de 24 de novembro de 2003, Diário Oficial da União [D.O.U.] de 25.11.2003, art. 3 (Braz.). Indeed, contrary to the scope claimed by the previous government, advocates have argued that these obligations in the Reporting Law applied to police reporting even under the now-revoked regulations, according to a "systematic interpretation of the legal system," given that they provided for "external communication in cases of violence against women": NUDEM, supra note 55, at 36–37. For the claimed scope for the Test Regulation, see Response to Retrogression Letter, supra note 7. See also MELLO & PAIVA, supra note 8, Ch. 5.3.2.2.
68. See discussion infra Section III, The Right to Confidentiality.
69. SECRETARIA DE ESTADO DA SAÚDE DO PARANÁ (SESA), PROTOCOLO DE ATENÇÃO INTEGRAL À SAÚDE DAS PESSOAS EM SITUAÇÃO DE VIOLÊNCIA SEXUAL: ABORDAGEM MULTIDISCIPLINAR 41 (2021).
70. Luciana Kind et al., Subnotificação e (in)visibilidade da violência contra mulheres na atenção primária à saúde, 29(9) CAD. SAÚDE PÚBLICA 1805, 1810–12 (2013); Cássia Virgínia Pereira Soares, Qualidade dos dados das notificações de violência contra mulheres no Estado de Minas Gerais 106 (Aug. 9, 2021) (Master's Dissertation, Instituto René Rachou), https://www.arca.fiocruz.br/handle/icict/50185.
71. Myllena Calasans de Matos, Priscilla Brito & Wânia Pasinato, A nova Lei Maria da Penha: análise das alterações recentes da lei de enfrentamento à violência doméstica, in TECENDO FIOS DAS CRÍTICAS FEMINISTAS AO DIREITO NO BRASIL II: DIREITOS HUMANOS DAS MULHERES E VIOLÊNCIAS: VOLUME 2, NOVOS OLHARES, OUTRAS QUESTÕES 22, 64 (Fabiana Cristina Severi, Ela Wiecko Volkmer de Castilho & Myllena Calasans de Matos, eds.).
72. Portaria No. 1.508, de 1 de setembro de 2005, Diário Oficial da União [D.O.U.] de 2.9.2005, Preamble (Braz.), cross-referencing to CÓDIGO PENAL [C.P.] [Criminal Code], art. 128, II (Braz.). Compare Portaria No. 2.561, de 23 de setembro de 2020, Diário Oficial da União [D.O.U.] de 24.09.2020 (Braz.), and Portaria No. 2.282, de 27 de agosto de 2020, Diário Oficial da União [D.O.U.] de 28.08.2020 (Braz.).
73. Portaria de Consolidação No. 5, de 28 de setembro de 2017, Diário Oficial da União [D.O.U.] de 3.10.2017, arts. 694 (Braz.). Criminal Code, art. 128, I ("necessary abortion") provides that "[a]bortion performed by a doctor is not punished ... if there is no other way to save the life of the pregnant woman."
74. See MINISTÉRIO DA SAÚDE, PREVENÇÃO E TRATAMENTO, supra note 33, at 19.
75. INTERNATIONAL COMMISSION OF JURISTS, THE 8 MARCH PRINCIPLES FOR A HUMAN RIGHTS-BASED APPROACH TO CRIMINAL LAW PROSCRIBING CONDUCT ASSOCIATED WITH SEX, REPRODUCTION, DRUG USE, HIV, HOMELESSNESS AND POVERTY (2023).
76. Decreto-Lei No. 3.688, de 3 de outubro de 1941, Diário Oficial da União [D.O.U.] de 13.10.1941, art. 66 (Braz.). See also Wolff et al., supra note 36.
77. It must be noted that mandatory reporting, generally, is not without criticism or harm. See, e.g., Beverly Chia Chi Liu & Michael S Vaughn, Legal and policy issues from the United States and internationally about mandatory reporting of child abuse, 64(2) INT'L J. L. PSYCHIATRY 219 (2019), and Jill R. McTavish et al., Mandated reporters' experiences with reporting child maltreatment: a meta-synthesis of qualitative studies, 7(10) BMJ OPEN e013942 (2017).
78. For the 2019 amendments, see Lei No. 13.931, de 10 de dezembro de 2019, Diário Oficial da União [D.O.U.] de 11.12.2019 (Braz.).
79. Compare Lei No. 10.778, de 24 de novembro de 2003, Diário Oficial da União [D.O.U.] de 25.11.2003, art. 1 § 3 (Braz.); Lei No. 8.069, de 13 de julho de 1990, Diário Oficial da União [D.O.U.] de 16.07.1990, art. 3 (Braz.); Lei No. 10.741, de 1 de outubro de 2003, Diário Oficial da União [D.O.U.] de 3.10.2003, arts. 1, 2, 3 & 43 (Braz.).
80. Compare Lei No. 10.778/2003, art. 3; Lei No. 10.741/2003, art. 19 § 2, cross-referencing Lei No. 6,259, art. 10. See also Wolff et al., supra note 36. Art. 13 of Lei No. 8.069 provides that reporting must be done without prejudice to other legal provisions, while art. 100 stipulates that implementation of specific protective measures is governed, inter alia, by respect for privacy and minimal intervention involving only essential authorities and institutions. The National List of Compulsorily Notifiable Diseases and Injuries similarly provides that health authorities shall guarantee the confidentiality of personal information included in compulsory notification: Portaria de

Consolidação No. 4, de 28 de setembro de 2017, Diário Oficial da União [D.O.U.] de 28.09.2017, Ch. IV, Annex 1 of Annex V, art. 7 (Braz.).
81. Lei No. 8.069/1990, art. 13. See also Hemerson Luiz Pase et al., The Guardianship Council and public policy for children and adolescents, 18(4) CAD. EBAPE.BR 1000-1010 (2020).
82. Lei No. 10.741, de 24 de outubro de 2003, Diário Oficial da União [D.O.U.] de 3.10.2003, art. 19 § 2 (Braz.). See also Lei No. 6.259, de 30 de outubro de 1975, Diário Oficial da União [D.O.U.] de 31.10.1990 (Braz.), cross-referenced by Lei No. 10.778, art. 6.
83. Lei No. 10.741/2003, art. 19. Compare Lei No. 10.778/2003, arts. 1 § 4 & 2. See also MINISTÉRIO DA SAÚDE, PREVENÇÃO E TRATAMENTO, supra note 33, at 24–25. Art. 19 of Lei 10.741/2003 provides: "Cases of suspected or confirmed violence committed against the elderly will be subject to compulsory notification by public and private health services to the health authority, as well as being compulsorily communicated by them to any of the following bodies: I – Police Authority; II – Public Prosecutor's Office; III – Municipal Council for the Elderly; IV – State Council for the Elderly; V – National Council for the Elderly."
84. See Informações Básicas para Notificação de Violência, CENTRO ESTADUAL DE VIGILÂNCIA EM SAÚDE (n.d.), https://www.cevs.rs.gov.br/informacoes-basicas (last visited Mar. 27, 2024).
85. Some states in the U.S. require police reporting by a survivor as a precursor to abortion care as part of rape exceptions for legal abortion: see, e.g., MISS. CODE ANN. §§ 41-41-45(3) (2017). However, none of these laws include mandatory reporting or evidence transfer by health professionals, as included in the Test and Revised Regulations.
86. Soares, supra note 70, at 106.
87. Janaina Marques de Aguiar et al., Atenção primária à saúde e os serviços especializados de atendimento a mulheres em situação de violência: expectativas e desencontros na voz dos profissionais, 32(1) SAÚDE SOC. e220266pt, 10 (2023) (citing Kind et al., supra note 70, and Ana Flávia Pires Lucas d'Oliveira et al., Obstáculos e facilitadores para o cuidado de mulheres em situação de violência doméstica na atenção primária em saúde: uma revisão sistemática, 24 INTERFACE e190164 (2020)).
88. Kind et al., supra note 70, at 1810–12; Soares, supra note 70, at 106.
89. Kind et al., supra note 70, at 1810–11.
90. Aguiar et al., supra note 87, at 10.
91. WORLD HEALTH ORGANIZATION, RESPONDING TO INTIMATE PARTNER VIOLENCE AND SEXUAL VIOLENCE AGAINST WOMEN: WHO CLINICAL AND POLICY GUIDELINES vii (2013).
92. But see sources cited supra note 77.
93. MINISTÉRIO DA SAÚDE, PREVENÇÃO E TRATAMENTO, supra note 33, at 31–32, 34. See also WORLD HEALTH ORGANIZATION, RESPONDING TO INTIMATE PARTNER VIOLENCE, supra note 91 at 41.
94. IBDFAM Communications Office, supra note 42. See generally MELLO & PAIVA, supra note 8, Ch. 5.3.2.2.
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96. CÓDIGO PENAL [C.P.] [Criminal Code], art. 128, II (Braz.). See also ROSAS & PARO, supra note 30, at 6.
97. ROSAS & PARO, supra note 30, at 7–8.
98. Id. at 8.
99. Portaria No. 692, de 26 de abril de 1989, Diário Oficial do Município de São Paulo de 26.4.1989 (Braz.).
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101. ROSAS & PARO, supra note 30, at 8. See MINISTÉRIO DA SAÚDE, ATENÇÃO TÉCNICA, supra note 33, at 37.
102. ROSAS & PARO, supra note 30, at 16.
103. Silva de Sá et al., supra note 55, at 24, 34.
104. See Paula Guimarães, Bruna de Lara & Tatiana Dias, 'Suportaria ficar mais um pouquinho?' Video: em audiencia, juíza de SC induz menina de 11 anos gravida após estupro a desistir de aborto legal, THE INTERCEPT BRASIL (June 20, 2022), https://theintercept.com/2022/06/20/video-juiza-sc-menina-11-anos-estupro-aborto/; MINISTÉRIO DA SAÚDE, NORMA TÉCNICA: ATENÇÃO HUMANIZADA AO ABORTAMENTO (2005).
105. Guimarães, de Lara & Dias, supra note 104.
106. Andrea Carvalho, supra note 11; Guimarães, de Lara & Dias, supra note 104.
107. Andrea Carvalho, supra note 11; Guimarães, de Lara & Dias, supra note 104.
108. See generally Lisa A. Goldman, Sandra G. García, Juan Díaz & Eileen A. Yam, Brazilian obstetrician-gynecologists and abortion: a survey of knowledge, opinions and practices, 2(10) REPROD. HEALTH 1 (2005). See also ROSAS & PARO, supra note 30, at 15.
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112. Compare PHYSICIANS FOR HUMAN RIGHTS, THE OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE & CENTER FOR REPRODUCTIVE RIGHTS, NO ONE COULD SAY: ACCESSING EMERGENCY OBSTETRICS INFORMATION AS A PROSPECTIVE PRENATAL PATIENT IN POST-ROE OKLAHOMa 14 (2023).
113. MELLO & PAIVA, supra note 8, Ch. 5.3.2.2.
114. Working Group on discrimination against women and girls, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Special Rapporteur on violence against women, its causes and consequences, Working Group on arbitrary detention, Abortion is essential healthcare and women's health must be prioritized over politics, OHCHR (Sept. 28, 2021), https://www.ohchr.org/en/statements/2021/09/abortion-essential-healthcare-and-womens-health-must-be-prioritized-over.
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117. See, e.g., Comm. on the Elimination of Discrimination against Women, L.C. v. Peru, ¶ 8.15, U.N. Doc. CEDAW/C/50/D/22/2009 (Nov. 25, 2011); Hum. Rts. Comm., L.M.R. v. Argentina, ¶ 9.3, U.N. Doc.

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124. Hum. Rts. Comm., supra note 14, at ¶ 8.
125. Argentina has allowed abortion in cases of rape under an exception in the Penal Code since 1921, and decriminalized abortion in all cases before 14 weeks in December 2020: CÓDIGO PENAL [COD. PEN.] [Criminal Code] art. 86, I (Arg.); Lei No. 27.610, enero 24, 2020, B.O. 34.562 (Arg.).
126. Bolivia has allowed abortion in cases of rape, among other exceptions, since the enactment of the 1973 Criminal Code and eliminated the requirement for a court order in such cases, as well as the requirement that a woman report a rape to the police in order to obtain an abortion in the case of rape or incest, in 2014: CÓDIGO PENAL [COD. PEN.] [Criminal Code] art. 266 (Bol.); Tribunal Constitucional Plurinacional [T.C.P.] [Plurinational Constitutional Court], febrero 5, 2014, Sentencia 0206/2014 (Bol.), https://jurisprudencia.tcpbolivia.bo/Fichas/ObtieneResolucion?idFicha=13712.
127. In Chile, the Congress voted to allow abortion in cases of rape, among other grounds, in 2017: Lei No. 21.030, septiembre 23, 2017, DIARIO OFICIAL [D.O.] (Chile); Tribunal Constitucional (T.C.) [Constitutional Court), agosto 28, 2017, Sentencia No. Rol 3729-17 (Chile), https://www.tribunalconstitucional.cl/descargar_sentencia2.php?id=3515.
128. In Colombia, the Constitutional Court decriminalized abortion in cases of rape in 2006, among other grounds, and decriminalized abortion in all cases before 24 weeks in February 2022: Corte Constitucional [C.C.] [Constitutional Court], mayo 10, 2006, Sentencia C-355/06, Gaceta de la Corte Constitucional [G.C.C.] (Colom.), https://www.corteconstitucional.gov.co/relatoria/2006/c-355-06.htm; Corte Constitucional [C.C.] [Constitutional Court], febrero 21, 2022, Sentencia C-055/22, Gaceta de la Corte Constitucional [G.C.C.] (Colom.), https://www.corteconstitucional.gov.co/Relatoria/2022/C-055-22.htm.
129. Cuba has allowed abortion in cases of rape, among other grounds, since 1936. Abortion in cases of rape was first allowed, prior to the Cuban Revolution, under the 1936 Social Defense Code and maintained, among other grounds, even after the gestational limit imposed for abortion generally since it was made available in 1965: CÓDIGO PENAL [C.P.] [Criminal Code] art. 355 (Cuba); MINISTERIO DE SALUD PÚBLICA, RESOLUCIÓN MINISTERIAL NO. 24 (2013); Paula E. Hollerbach, Recent Trends in Fertility, Abortion and Contraception in Cuba, 6(3) INT'L FAM. PLAN. PERSP. 97, 100–101 (1980); Danièle Bélanger & Andrea Flynn, The Persistence of Induced Abortion in Cuba: Exploring the Notion of an "Abortion Culture," 40(1) STUD. FAM. PLAN. 13, 16 (2009).
130. Guyana has allowed abortion generally up to 8 weeks, generally, and up to 12 weeks in cases of rape since 1995: Medical Termination of Pregnancy Act 1995 (Guy.).
131. Mexico has waived all penalties for abortion in cases of rape under its Federal Penal Code since it was enacted in 1931, and all states have historically also waived penalties for abortion, among other grounds. In 2021, Mexico's Supreme Court found a constitutional right to abortion, invalidating a new state law limiting abortion in cases of rape to the first three months of pregnancy. In 2023, the Court found the criminalization of abortion in the Federal Penal Code unconstitutional, requiring the federal public health service and all federal health institutions across the country to provide abortion services to anyone who requests them: Código Penal Federal [C.P.F.] [Federal Criminal Code] art. 333 (Mex.); Suprema Corte de Justicia de la Nación [S.C.J.N.] [Supreme Court of Justice of the Nation], Acción de Inconstitucionalidad 148/2017, DIARIO OFICIAL DE LA FEDERACIÓN (D.O.F], https://www.dof.gob.mx/nota_detalle.php?codigo=5640922&fecha=19/01/2022; Corte Despenaliza el Aborto a Nivel Federal, GIRE (Sept. 6, 2023), https://gire.org.mx/blog/corte-despenaliza-el-aborto-a-nivel-federal/.
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196. Id. at 146–48.
197. Cuscul Pivaral v. Guatemala, Preliminary Objections, Merits, Reparations and Costs, Inter-Am. Ct. H.R. (Ser. C) No. 359, Separate Opinion of Judge Eduardo Ferrer Mac-Gregor Poisot, ¶ 16 (Aug. 23, 2018) (citing Corte Constitucional [C.C.] [Constitutional Court], mayo 8, 2017, Sentencia T-302/2017, Gaceta de la Corte Constitucional [G.C.C.], https://www.corteconstitucional.gov.co/relatoria/2017/t-302-17.htm, ¶ 8.1.5 (Colom.)).
198. Comm. on Econ., Soc. Cultural Rts., supra note 164, at ¶ 3.
199. See CÓDIGO PENAL [C.P.] [Criminal Code], art. 128, I (Braz.); Superior Tribunal de Justiça [S.T.F.], ADPF No. 54 MC/DF, Relator: Min. Marco Aurélio de Mello, 04.12.2012, Diário da Justiça Eletrônico [D.J.E.] 04.30.2013 (Braz.).
200. Comm. on Econ., Soc. Cultural Rts., supra note 165, at ¶ 24.
201. Hum. Rts. Council, Report of the Working Group on the issue of discrimination against women in law and in practice, ¶ 107(c), U.N. Doc. A/HRC/32/44 (Apr. 8, 2016).
202. Hum. Rights. Comm., Views adopted by the Committee under article 5 (4) of the Optional Protocol, concerning communication no. 2324/2013, Mellet v. Ireland, ¶ 5.13, U.N. Doc. CCPR/C/116/D/2324/2013 (Nov. 17, 2016).
203. Hum. Rts. Comm., General comment No. 18: Non discrimination (1989), ¶ 8, Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 146 (2003); Hum. Rts. Comm., supra note 139, at ¶ 15.
204. Comm. on Econ., Soc. Cultural Rts., supra note 165, at ¶ 24.
205. Hum. Rts. Comm., supra note 139, at ¶ 8.
206. Comm. on Econ., Soc. Cultural Rts., supra note 165, at ¶ 25.
207. Comm. on the Elimination of Discrimination against Women, Views: Communication No. 17/2008, Alyne da Silva Pimentel Teixeira v. Brazil, ¶ 7.7, U.N. Doc. CEDAW/C/49/D/17/2008 (July 25, 2011).
208. Id.; Comm. on the Elimination of Discrimination against Women, Concluding comments on the sixth periodic report of Brazil, ¶ 11, U.N. Doc. CEDAW/C/BRA/CO/6 (Aug. 10, 2007).
209. Comm. on the Elimination of Discrimination against Women, General recommendation No. 28 on the core obligations of States parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women, ¶ 18, U.N. Doc. CEDAW/C/GC/28 (Dec. 16, 2010); Comm. on the Elimination of Discrimination against Women, Views: Communication No. 17/2008, Alyne da Silva Pimentel Teixeira v. Brazil, ¶ 7.7, U.N. Doc. CEDAW/C/49/D/17/2008 (July 25, 2011).
210. MEDICAL ETHICS MANUAL, supra note 25, 68–69.
211. Id. at 68.
212. INT'L DUAL LOYALTY WORKING GROUP, supra note 28, at 47.
213. Id. at 46.
214. Id. at 66.
215. Access to Information on Reproductive Health from a Human Rights Perspective, Inter-Am. Comm'n H.R. OAS/Ser.L/V/II., doc. 61., ¶ 79 (Nov. 22, 2011) (citations omitted).
216. NUDEM, supra note 55, at 37.
217. See Lei No. 10.778, de 24 de novembro de 2003, Diário Oficial da União [D.O.U.] de 25.11.2003, art. 5 (Braz.).
218. PHYSICIANS FOR HUMAN RIGHTS, supra note 112, at 1, 4, 21 (2023).
219. MEDICAL ETHICS MANUAL, supra note 25, at 52; Manuela v. El Salvador, Preliminary Objections, Merits, Reparations and Costs, Inter-Am. Ct. H.R. (Ser. C) No. 441, ¶ 203 (Nov. 2, 2021) (citations omitted).
220. Id.; Inter-Am. Comm'n, supra note 215, at ¶ 81; Comm. on Hum. Rts., The right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Report of the Special Rapporteur, Paul Hunt, ¶ 40, U.N. Doc. E/CN.4/2004/49 (Feb. 16, 2004).
221. Id.
222. Comm. on the Elimination of Discrimination against Women, General Recommendation No. 24, Article 12 of the Convention (women and health), in Rep. of the Comm. on the Elimination of Discrimination against Women, U.N. Doc. A/54/38/Rev.1, at Ch. 1 ¶¶ 31(a)–(b) (1999).
223. Comm. on Hum. Rts., supra note 220.
224. Comm. on Econ., Soc. Cultural Rts., supra note 164, at ¶ 12. See also Poblete Vilches v. Chile, Merits, Reparations and Costs,

Inter-Am. Ct. H.R. (Ser. C) No. 349, ¶ 121 (Mar. 8, 2018) and Cuscul Pivaral v. Guatemala, Preliminary Objections, Merits, Reparations and Costs, Inter-Am. Ct. H.R. (Ser. C) No. 359, ¶ 106 (Aug. 23, 2018) (both citing Comm. on Econ., Soc. Cultural Rts. supra note 164).
225. Universal Declaration on the Human Genome and Human Rights, arts. 7 & 9, adopted by UNESCO General Conference (Nov. 11, 1997) and endorsed by United Nations General Assembly, Resolution AIRES/53/152 (Dec. 9, 1998).
226. See Manuela v. El Salvador, Preliminary Objections, Merits, Reparations and Costs, Inter-Am. Ct. H.R. (Ser. C) No. 441, ¶ 205–06 (Nov. 2, 2021) (citations omitted).
227. Inter-American Court of Human Rights Ruling Will Help Protect Women Seeking Reproductive Health Care, Including Abortion, Center for Reprod. Rts. (Dec. 2, 2021), https://reproductiverights.org/inter-american-court-human-rights-el-salvador-manuela-ruling/; Id. at 326 point 12.
228. Hum. Rts. Comm., General Comment No. 16, Article 17 (The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation), ¶ 10, U.N. Doc. CCPR/C/GC/16 (Apr. 8, 1988) (emphasis added), in INT'L DUAL LOYALTY WORKING GROUP, supra note 28, at 44.
229. Hum. Rts. Comm., supra note 139, at ¶ 20.
230. Manuela v. El Salvador, ¶ 207.
231. Id. at ¶ 212.
232. Id. at ¶ 211–12, 215 (citations omitted). The Court noted that ambiguity in Salvadoran legislation meant that "80% of the obstetric gynecologists interviewed believed that it was compulsory to report all cases of obstetric emergencies," when breaching confidentiality to report should have occurred only in "very limited cases," and that the ambiguity led to frequent reporting of suspected abortion by the administrative or medical staff of health institutions: Id. at ¶ 214.
233. Cf. id. at ¶ 213.
234. Information may not be disclosed "without just cause" where the "disclosure may cause harm to others": CÓDIGO PENAL [C.P.] [Criminal Code], art. 154 (Braz.). This provision requires non-disclosure, or postponed disclosure only after the risk of harm is reduced: see also Wolff et al., supra note 36.
235. Unless "released by the interested party": CÓDIGO DE PROCESSO PENAL [C.P.P.] [Code of Criminal Procedure] art. 207 (Braz.).
236. Except where criminal action depends on representation or the communication exposes the client to criminal proceedings: Decreto-Lei No. 3.688, de 3 de outubro de 1941, Diário Oficial da União [D.O.U.] de 13.10.1941, art. 66 (Braz.).
237. Código de Saúde do Estado de São Paulo [C.S.E] [State Health Code of São Paulo] art. 3 ¶ IV(e) (Braz.).
238. CÓDIGO DE PROCESSO PENAL [C.P.P.] [Code of Criminal Procedure] arts. 388, II; 448, II (Braz.); CONSTITUIÇÃO FEDERAL [C.F.] [CONSTITUTION] arts. art. 5, I, X, XIV (Braz.). See generally SECRETARIA DE ESTADO DA SAÚDE DO PARANÁ (SESA), supra note 185, at 41; NUDEM, supra note 55, at 34.
239. The collection of the genetic data of the alleged perpetrator is also complicated from an ethics and human rights perspective: see DNA Databases and Human Rights, FORENSIC GENETICS POL'Y INITIATIVE, http://dnapolicyinitiative.org/resources/dna-databases-and-human-rights/ (last visited Mar. 27, 2024).
240. Manuela v. El Salvador, Preliminary Objections, Merits, Reparations and Costs, Inter-Am. Ct. H.R. (Ser. C) No. 441, ¶ 217 (Nov. 2, 2021).
241. Id. at ¶ 219 (citation omitted).
242. With regard to disclosure due to lack of privacy during reporting to police, see Maria Laura Canineu, For Brazil's Women, Violence Begins at Home, HUMAN RIGHTS WATCH (Jan. 31, 2018), https://www.hrw.org/news/2018/01/31/brazils-women-violence-begins-home.
243. Manuela v. El Salvador, ¶ 220.
244. Id. at ¶ 220–24 (citations omitted).
245. Comm. on the Elimination of Discrimination against Women, supra note 222, at ¶ 22; Id. at ¶ 224 (citing same).
246. Hum. Rts. Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, ¶ 30, U.N. Doc. A/66/254 (Aug. 3, 2011); see also Hum. Rts. Comm., Concluding observations on the third periodic report of Venezuela, ¶ 19, U.N. Doc. CCPR/CO/71/VEN (Apr. 26, 2001) and Hum. Rts. Comm., Concluding observations on the seventh periodic report of El Salvador, ¶ 16, U.N. Doc. CCPR/C/SLV/CO/7 (May 9, 2018); Id. at ¶ 224 (citing same). See also discussion, infra Section III.
247. Manuela v. El Salvador, ¶¶ 222, 228.
248. Código de Saúde no Estado [C.S.E] [State Health Code] art. 3 ¶ IV(e) (Braz.).
249. CÓDIGO PENAL [C.P.] [Criminal Code], art. 154 (Braz.).
250. CÓDIGO DE PROCESSO PENAL [C.P.P.] [Code of Criminal Procedure] art. 207 (Braz.).
251. Manuela v. El Salvador, at ¶ 225.
252. Emenda Constitucional No. 115, de 10 de fevereiro de 2022, Diário Oficial da União [D.O.U.] de 11.02.2022 (Braz.).
253. Lei No. 13.709, de 14 de agosto de 2018, Diário Oficial da União [D.O.U.] de 15.08.2018, art. 5 ¶ II (Braz.).
254. See, e.g., Anita L. Allen, HIPAA at 25 — A Work in Progress, 384(23) NEW ENGL. J. MED. 2169, 2169 (2021).
255. Manuela v. El Salvador, at ¶ 228.
256. For a more detailed examination of health professionals' ethical obligations and the impact of police reporting requirements, see CRR & GHJP, supra note 24.
257. The different "health professionals" are referred to generally under that terminology in Portaria de Consolidação No. 5, de 28 de setembro de 2017, Diário Oficial da União [D.O.U.] de 3.10.2017, arts. 694–700 (Braz.), except for article 697 § 3, which sets out the professionals who must be part of the multidisciplinary health team: "at a minimum, an obstetrician, anesthesiologist, nurse, social worker and/or psychologist."
258. World Med. Ass'n, Declaration of Lisbon on the Rights of the Patient (1981), Preamble, https://www.wma.net/policies-post/wma-declaration-of-lisbon-on-the-rights-of-the-patient/ [hereinafter Declaration of Lisbon].
259. MEDICAL ETHICS MANUAL, supra note 25, at 12; World Med. Ass'n, Declaration of Geneva (1948), https://www.wma.net/policies-post/wma-declaration-of-geneva/ [hereinafter Declaration of Geneva]; WORLD MED. ASS'N, INTERNATIONAL CODE OF MEDICAL ETHICS (1949) [hereinafter INTERNATIONAL CODE OF MEDICAL ETHICS]; Conselho Federal de Medicina, Código de Ética Médica, Fundamental Principles ¶ IV (2018), Rzesolução CFM No. 2.217, de 27 de setembro de 2018, modificada pelas Resoluções CFM No. 2.222/2018 e 2.226/2019 [hereinafter Brazil Code of Medical Ethics]; INT'L COUNCIL OF NURSES, THE ICN CODE OF ETHICS FOR NURSES ¶ 2.1 (2021) [hereinafter ICN CODE OF ETHICS]; Conselho Federal de Enfermagem, Código de Deontologia de Enfermagem, art. 51 (2017) Anexo da Resolução COFEN No. 564/2017 [hereinafter Brazil Nursing Code of Ethics]; Conselho Federal de Serviço Social - CFESS, Código de Ética do/a Assistente Social, arts. 3; 4, b & c; 10 & 11, c (1993), aprovado em 13 de Março de 1993 com as alterações Introduzidas pelas Resoluções CFESS No. 290/94, 293/94, 333/96 e

594/11 [hereinafter Brazil Social Work Code of Ethics]; International Union of Psychological Science, Universal Declaration of Ethical Principles for Psychologists, Principle IV, 1, 3 (2008), https://www.iupsys.net/about/declarations/universal-declaration-of-ethical-principles-for-psychologists/ [hereinafter Universal Declaration of Ethical Principles for Psychologists]; Conselho Federal de Psicologia, Código de Ética Profissional do Psicólogo, arts. 2, e & 3 (2005) aprovado pela Resolução CFP No. 010/05 [hereinafter Brazil Psychologists' Code of Ethics].
260. Brazil Social Work Code of Ethics, supra note 259, arts. 8, b & 21; Brazil Psychologists' Code of Ethics, supra note 259, art. 1, l.
261. International Federation of Social Workers, Global Social Work Statement of Ethical Principles (2018), Principles 3.4, 9.7 [hereinafter Global Social Work Statement of Ethical Principles].
262. Brazil Nursing Code of Ethics, supra note 259, art. 10; Brazil Social Work Code of Ethics, supra note 259, arts. 2, c; 7, d & 8, c.
263. Brazil Code of Medical Ethics, supra note 259, Fundamental Principles, ¶ XIV.
264. World Med. Ass'n, Declaration of Cordoba on Patient-Physician Relationship ¶¶ 2, 3, 4 (2020), https://www.wma.net/policies-post/wma-declaration-of-cordoba-on-patient-physician-relationship/ [hereinafter Declaration of Cordoba].
265. Declaration of Geneva, supra note 259; Declaration of Lisbon, supra note 258, at ¶¶ 8 & 10; Brazil Code of Medical Ethics, supra note 259, Fundamental Principles, ¶ XI; ICN CODE OF ETHICS, supra note 259, at ¶ 1.4, 1.5; Brazil Nursing Code of Ethics, supra note 259, arts. 12, 43, 52 & 86; Global Social Work Statement of Ethical Principles, supra note 261, Principle 6.1; Brazil Social Work Code of Ethics, supra note 259, arts. 15, 16 & 17; Universal Declaration of Ethical Principles for Psychologists, supra note 259, Principle I, 5, 6; Brazil Psychologists' Code of Ethics, supra note 259, art. 9.
266. INTERNATIONAL CODE OF MEDICAL ETHICS, supra note 259 (consent, joint care); Declaration of Lisbon, supra note 258, at ¶ 8, b (consent, joint care, provided by law); Brazil Code of Medical Ethics, supra note 259, Fundamental Principles ¶ XI (provided by law), arts. 73 (consent, just cause, legal duty) & 89 (court order, own defense); ICN CODE OF ETHICS, supra note 259, at 24 (mandatory reporting, provided by law, regulation); Brazil Nursing Code of Ethics, supra note 259, arts. 52 (consent, harm, joint care, mandatory reporting, provided by law, judicial determination, own defense) & 89; Global Social Work Statement of Ethical Principles, supra note 261, Principle 6.1 (harm, provided by law); Brazil Social Work Code of Ethics, supra note 259, arts. 16 & 17 (joint care), 18 (harm); Brazil Psychologists' Code of Ethics, supra note 259, arts. 1, g); 6, b, & 12 (joint care), 10 (harm, provided by law).
267. Brazil Code of Medical Ethics, supra note 259, art. 73, b; Brazil Nursing Code of Ethics, supra note 259, art. 52 § 3; Brazil Social Work Code of Ethics, supra note 259, arts. 19 & 20; Brazil Psychologists' Code of Ethics, supra note 259, art. 11.
268. Brazil Code of Medical Ethics, supra note 259, art. 73, b.
269. Brazil Nursing Code of Ethics, supra note 259, art. 52 § 5.
270. Declaration of Lisbon, supra note 258, at ¶ 8, c.
271. Brazil Code of Medical Ethics, supra note 259, art. 85. Except to comply with a court order or in their own defense: art. 89; Brazil Nursing Code of Ethics, supra note 259, art. 89 (unless with patient consent or judicial determination). Social workers also have a right to the inviolability of the workplace and its files and documentation, to ensure professional secrecy: Brazil Social Work Code of Ethics, supra note 259, art. 2, d.
272. ICN CODE OF ETHICS, supra note 259, at ¶ 2.9.
273. INT'L DUAL LOYALTY WORKING GROUP, supra note 28, at 73.
274. Brazil's Code of Medical Ethics also specifically provides that physicians must comply with abortion laws, which would notably also include the justification defense for abortion in case of rape: Brazil Code of Medical Ethics, supra note 259, art. 15.
275. See supra Section III, The Right to Confidentiality.
276. World Med. Ass'n, Declaration of Seoul on Professional Autonomy and Clinical Independence, ¶ 2 (2008), https://www.wma.net/policies-post/wma-declaration-of-seoul-on-professional-autonomy-and-clinical-independence/ [hereinafter Declaration of Seoul]; INTERNATIONAL CODE OF MEDICAL ETHICS, supra note 259; Declaration of Cordoba, supra note 264, at ¶¶ 1, 2, 4 & 5; Brazil Code of Medical Ethics, supra note 259, Fundamental Principles ¶ VIII.
277. Brazil Code of Medical Ethics, supra note 259, Fundamental Principles ¶¶ IX, X.
278. Brazil Nursing Code of Ethics, supra note 259, art. 1; Brazil Social Work Code of Ethics, supra note 259, art. 2, b & h.
279. Brazil Psychologists' Code of Ethics, supra note 259, art., 2, j.
280. Declaration of Geneva, supra note 259; INTERNATIONAL CODE OF MEDICAL ETHICS, supra note 259; Declaration of Lisbon, supra note 258, at Preamble, ¶ 3; Declaration of Seoul, supra note 276, at ¶ 3; Brazil Code of Medical Ethics, supra note 259, Fundamental Principles ¶ XXI, arts. 22 & 24; ICN CODE OF ETHICS, supra note 259, Preamble; Brazil Nursing Code of Ethics, supra note 259, arts. 42, 50 & 77; Global Social Work Statement of Ethical Principles, supra note 261, Principles 4 & 5; Brazil Social Work Code of Ethics, supra note 259, I & arts. 5, b; 6, a & c; Universal Declaration of Ethical Principles for Psychologists, supra note 259, Principles 1, 4 & 2, 7; Brazil Psychologists' Code of Ethics, supra note 259, Fundamental Principles, I.
281. Declaration of Geneva, supra note 259; Declaration of Cordoba supra note 264, Preamble; Brazil Code of Medical Ethics, supra note 259, Fundamental Principles ¶¶ I & II.
282. Declaration of Geneva, supra note 259 (best interests); Declaration of Lisbon, supra note 258, at ¶ 1, c (best interests); Declaration of Cordoba, supra note 264, Preamble (alleviate suffering); Brazil Code of Medical Ethics, supra note 259, Fundamental Principles ¶ VI (dignity and integrity), art. 1 (harm).
283. ICN CODE OF ETHICS, supra note 259, Preamble; Brazil Nursing Code of Ethics, supra note 259, Preamble; Universal Declaration of Ethical Principles for Psychologists, supra note 259, Principle II, 2, 3; Global Social Work Statement of Ethical Principles, supra note 261, Principle 9.7; Brazil Psychologists' Code of Ethics, supra note 259, Fundamental Principles, II.
284. Raanan Gillon, Medical ethics: four principles plus attention to scope, 309 BMJ 184, 185 (1994).
285. Declaration of Lisbon, supra note 258, Preamble.
286. Declaration of Geneva, supra note 259; Brazil Code of Medical Ethics, supra note 259, art. 23.
287. Declaration of Lisbon, supra note 258, at ¶ 1, a; Brazil Code of Medical Ethics, supra note 259, Chapter I, ¶ I; art. 23.
288. ICN CODE OF ETHICS, supra note 259, at ¶¶ 1.8 & 4.7; Brazil Nursing Code of Ethics, supra note 259, art. 24.
289. ICN CODE OF ETHICS, supra note 259, Preamble; Brazil Nursing Code of Ethics, supra note 259, Preamble, art. 41; Brazil Social Work Code of Ethics, supra note 259, Fundamental Principles, XI; Universal Declaration of Ethical Principles for Psychologists, supra note 259, Principle I, 3, 7; Brazil Psychologists' Code of Ethics, supra note 259, art. 2, a & b.
290. ICN CODE OF ETHICS, supra note 259, at ¶¶ 1.7, 2.7; Global Social Work Statement of Ethical Principles, supra note 261, Principle 3; Brazil Social Work Code of Ethics, supra note

259, Fundamental Principles V, VI; Brazil Psychologists' Code of Ethics, supra note 259, Fundamental Principles, III, VII.
291. Global Social Work Statement of Ethical Principles, supra note 261, Principle 3; Brazil Social Work Code of Ethics, supra note 259, Fundamental Principles, VIII & XI; Brazil Psychologists' Code of Ethics, supra note 259, Fundamental Principles, II.
292. Declaration of Geneva, supra note 259.
293. ICN CODE OF ETHICS, supra note 259, at ¶¶ 1.2, 4.7; Brazil Nursing Code of Ethics, supra note 259, art. 1. The preamble to the Resolution adopting Brazil's Nursing Code of Ethics notes the Universal Declaration of Human Rights and that its postulates are included in the ICN Code of Ethics, and notes the Universal Declaration on Bioethics and Human Rights. Global Social Work Statement of Ethical Principles, supra note 261, Principles 2 & 9.2; Brazil Social Work Code of Ethics, supra note 259, Fundamental Principles, II.
294. Declaration of Geneva, supra note 259 (dignity, health, non-discrimination); INTERNATIONAL CODE OF MEDICAL ETHICS, supra note 259 (dignity, health, non-discrimination); Declaration of Lisbon, supra note 258, at ¶¶ 1, a (non-discrimination), 8 (confidentiality), 10 (dignity); Declaration of Cordoba, supra note 264, at ¶¶ 1 (health), 5 (dignity); Declaration of Seoul, supra note 276, at ¶ 1 (health); Brazil Code of Medical Ethics, supra note 259, arts. 23 (dignity, non-discrimination), 25 (non-participation in torture), 27, 28 (physical and mental integrity); ICN CODE OF ETHICS, supra note 259, Preamble (dignity, non-discrimination, respect), ¶ 4.1 (health care); Brazil Nursing Code of Ethics, supra note 259, Preamble (dignity, equality, freedom, health, non-discrimination, personal security), arts. 12 (confidentiality), 24 (dignity), 41 (non-discrimination), 43 (privacy); Global Social Work Statement of Ethical Principles, supra note 261, Principles I, 2 & 9.2 (dignity, non-participation in torture); Universal Declaration of Ethical Principles for Psychologists, supra note 259, Principles I, 1, 3 (dignity), 5 (privacy), 6 (confidentiality), 2, 7 (non-discrimination); Brazil Psychologists' Code of Ethics, supra note 259, Fundamental Principles, I (dignity, equality, integrity, freedom).
295. See U.N. Charter, Preamble; G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948), Preamble, art. 1; International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171, Preamble, art. 1; International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3, Preamble; International Convention on the Elimination of All Forms of Racial Discrimination, Mar. 7, 1966, 660 U.N.T.S 195, Preamble; Convention on the Elimination of All Forms of Discrimination against Women, Dec. 18, 1979, 1249 U.N.T.S 1, Preamble; Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S 3, Preamble; Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.N.T.S 3, Preamble, arts. 1 & 3; Organization of American States, American Convention on Human Rights, Nov. 22, 1969, O.A.S.T.S. No. 36, 1144 U.N.T.S. 123, art. 11 ¶ 1.
296. Paulo André Stein Messetti1 & Dalmo de Abreu Dallari, Human dignity in the light of the Constitution, human rights and bioethics, 28(3) J. HUM. GROWTH AND DEV. 283, 284 (2018); CONSTITUTION, supra note 19, art. 1.
297. Comm. on Econ., Soc. Cultural Rts., supra note 164, at ¶ 1.
298. Comm. on the Elimination of Discrimination against Women, supra note 222, at ¶ 22 (non-consensual sterilization, mandatory testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment are provided as forms of coercion that violate women's rights to informed consent and dignity).
299. CONSTITUIÇÃO FEDERAL [C.F.] [CONSTITUTION] art. 226 (Braz.).
300. Lei No. 9.263, de 12 de janeiro de 1996, Diário Oficial da União [D.O.U.] de 15.01.1996, arts. 1–3 (Braz.).
301. INT'L DUAL LOYALTY WORKING GROUP, supra note 28, at 16.
302. Declaration of Geneva, supra note 259; INTERNATIONAL CODE OF MEDICAL ETHICS, supra note 259; Declaration of Cordoba, supra note 264, at ¶ 5; Brazil Code of Medical Ethics, supra note 259, Fundamental Principles ¶ VI, art. 23. See also World Med. Ass'n, Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment, Preamble (2003), https://www.wma.net/policies-post/wma-resolution-on-the-responsibility-of-physicians-in-the-documentation-and-denunciation-of-acts-of-torture-or-cruel-or-inhuman-or-degrading-treatment/.
303. Declaration of Lisbon, supra note 258, at ¶ 10.
304. ICN CODE OF ETHICS, supra note 259, at 1.
305. ICN CODE OF ETHICS, supra note 259, at ¶ 1.8; Brazil Nursing Code of Ethics, supra note 259, art. 69; Global Social Work Statement of Ethical Principles, supra note 261, Principle 1; Universal Declaration of Ethical Principles for Psychologists, supra note 259, Principle I; Brazil Psychologists' Code of Ethics, supra note 259, Fundamental Principles, I.
306. MEDICAL ETHICS MANUAL, supra note 25, at 39.
307 Declaration of Lisbon, supra note 258, at ¶ 10.
308. Universal Declaration of Ethical Principles for Psychologists, supra note 259, Principle I.
309. Global Social Work Statement of Ethical Principles, supra note 261, Principle 1.
310. Brazil Code of Medical Ethics, supra note 259, Fundamental Principles ¶ VI.
311. Brazil Nursing Code of Ethics, supra note 259, art. 69.
312. See supra, Section III, The Right to Life and The Right to Health.
313. I.V. v. Bolivia, Preliminary Objections, Merits, Reparations and Costs, Inter-Am. Ct. H.R. (Ser. C) No. 329, ¶ 160–64 (Nov. 30, 2016).
314. Constitución Política de Colombia [C.P.] [Constitution] art. 1 (Colom.).
315. Corte Constitucional [C.C.] [Constitutional Court], mayo 10, 2006, Sentencia C-355/06, ¶ 8.3, Gaceta de la Corte Constitucional [G.C.C.] (Colom.), https://www.corteconstitucional.gov.co/relatoria/2006/c-355-06.htm (citations omitted).
316. Superior Tribunal de Justiça [S.T.F.], ADPF No. 54 MC/DF, Relator: Min. Marco Aurélio de Mello, 04.12.2012, Diário da Justiça Eletrônico [D.J.E.] 04.30.2013 (Braz.), in Assis Machado & Cook, supra note 12, at 218. See also Comm. on the Elimination of Discrimination against Women, Views: Communication No. 17/2008, Alyne da Silva Pimentel Teixeira v. Brazil, ¶ 4.1, U.N. Doc. CEDAW/C/49/D/17/2008 (July 25, 2011).
317. Sentencia C-355/06, ¶ 10.1 (citing Aclaración de voto a la sentencia C-647 de 2001 suscrita por los magistrados Jaime Araujo Rentería, Alfredo Beltrán Sierra, Manuel José Cepeda y Clara Inés Vargas Hernández).
318. Comm. on the Elimination of Discrimination against Women, supra note 41, at ¶ 18; Hum. Rts. Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, ¶ 43, U.N. Doc. A/HRC/31/57 (Jan. 5, 2016).
319. Hum. Rts. Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, ¶ 44, U.N. Doc. A/HRC/31/57 (Jan. 5, 2016).
320. INT'L DUAL LOYALTY WORKING GROUP, supra note 28, at 33, 47.
321. Id. at 33, 47.

322. Sentencia C-355/06, ¶ 8.1 (citations omitted).
323. Id. at ¶ 10.1.
324. Corte Constitucional [C.C.] [Constitutional Court], febrero 21, 2022, Sentencia C-055/22,, Gaceta de la Corte Constitucional [G.C.C.] (Colom.), https://www.corteconstitucional.gov.co/Relatoria/2022/C-055-22.htm.
325. Hum. Rights. Comm., Views adopted by the Committee under article 5 (4) of the Optional Protocol, concerning communication no. 2425/2014, Whelan v. Ireland, Separate opinion of Committee member Yadh Ben Achour, ¶ 6, U.N. Doc. CCPR/C/119/D/2425/2014 (July 11, 2017). Cf. CONSTITUTION, supra note 19, arts. 3, IV; 5, I.
326. Convention on the Elimination of All Forms of Discrimination against Women, Dec. 18, 1979, 1249 U.N.T.S 1, arts. 2(f) & 5.
327. Superior Tribunal de Justiça [S.T.F.], ADI No. 4275 / DF, 01.03.2018, Diário da Justiça Eletrônico [D.J.E.] 07.03.2019 (Braz.).
328. Id. at 13 (Justice Marco Aurelio).
329. Comm. on the Elimination of Discrimination against Women, L.C. v. Peru, ¶ 7.7, U.N. Doc. CEDAW/C/50/D/22/2009 (Nov. 25, 2011).
330. Hum. Rights. Comm., Views adopted by the Committee under article 5 (4) of the Optional Protocol, concerning communication no. 2324/2013, Mellet v. Ireland, ¶¶ 5.13, 7.11, U.N. Doc. CCPR/C/116/D/2324/2013 (Nov. 17, 2016); see also Hum. Rights. Comm., Views adopted by the Committee under article 5 (4) of the Optional Protocol, concerning communication no. 2425/2014, Whelan v. Ireland, ¶ 7.12, U.N. Doc. CCPR/C/119/D/2425/2014 (July 11, 2017).
331. Mellet v. Ireland, Individual opinion of Committee member Sarah Cleveland (concurring), ¶ 4. See also Whelan v. Ireland, Separate opinion of Committee member Yadh Ben Achour, ¶ 6.
332. Whelan v. Ireland, Separate opinion of Committee member Yadh Ben Achour, ¶ 6.
333. Whelan v. Ireland, ¶ 7.12.
334 Mellet v. Ireland, ¶ 7.11; Individual opinion of Committee member Sarah Cleveland (concurring), ¶ 4; Whelan v. Ireland, ¶ 7.12.
335 Assis Machado & Cook, supra note 12, at 217.
336. Reva Siegel, Reasoning from the body: A historical perspective on abortion regulation and questions of equal protection, 44(2) STAN. L. REV. 261, 362–63 (1992), in id.
337. MINISTÉRIO DA SAÚDE, PREVENÇÃO E TRATAMENTO, supra note 33, at 11–12, 31.
338. Lucía Berro Pizzarossa, "Women are not in the Best Position to Make These Decisions by Themselves": Gender Stereotypes in the Uruguayan Abortion Law, 1 UNIV. OXFORD HUM. RTS. HUB J. 25, 51 (2019).
339. Superior Tribunal de Justiça [S.T.F.], ADI No. 4275 / DF, 01.03.2018, 13, Diário da Justiça Eletrônico [D.J.E.] 07.03.2019 (Braz.).
340. Pizzarossa, supra note 338, at 46.
341. Comm. on the Elimination of Discrimination against Women, L.C. v. Peru, ¶ 7.7, U.N. Doc. CEDAW/C/50/D/22/2009 (Nov. 25, 2011).
342. Id. at ¶ 8.10.
343. Hum. Rts. Comm., Views: Communication No. 1153/2003, K.L. v. Peru, ¶ 3.2(a), U.N. Doc. CCPR/C/85/D/1153/2003 (Nov. 22, 2005).
344. Id. at ¶¶ 6.3–7.
345. Hum. Rts. Comm., Views: Communication No. 1608/2007, L.M.R. v. Argentina, ¶ 3.4, U.N. Doc. CCPR/C/101/D/1608/2007 (Apr. 28, 2011).

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