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GOVERNING ABORTION BY STANDARDS. ABORTION POLICIES IN BRAZIL SINCE THE LATE 1980S

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Abstract: Brazil is one of the few countries with restrictive abortion laws to have implemented specialized hospital services to attend patients eligible for non-criminal abortion. Studying the regulation process which accompanied the implementation of these services from the late 1980s onward, the present article describes the emergence of a “government by standards” applied to legal as well as clandestine situations of abortion.

Key-words: Abortion; Norms; Liberalism; Public policies.

1. INTRODUCTION

Abortion is illegal in Brazil,¹ except in cases of pregnancy resulting from rape, or when it is resorted to in order to save the patient’s life.² Restrictive abortion laws, admitting similar exceptions, can be found in most Latin American countries; but only in Brazil have hospital services been set up to attend patients eligible for non-criminal abortion. The first such services, however, only became operative in the late 1980s, following the country’s return to democratic government. The Women’s movement, unwilling to scramble for an unlikely revision of abortion laws, encouraged instead the regulation and implementation of authorized exceptions already provided for by the penal code

¹ The empirical material used in this article is taken from my Master dissertation. In 2008, I had the opportunity of doing ethnographic work in Rio de Janeiro and São Paulo. In particular, I conducted interviews with health professionals in non-criminal abortion programs and with activists campaigning for the decriminalization of abortion. I also worked in the CEPEDISA (Centros de Estudos e Pesquisa em Direito Sanitário) at the University of São Paulo, where I collected a comprehensive bibliography on the subject (Castelbajac, 2008).

² Código Penal, Decreto-lei 2.848, December 7, 1940, article 128. In both cases the procedure must be performed by a licensed medical doctor. A third exception which was not originally contemplated by the legislator, but which is regularly authorized by judicial decision, is abortion in case of fetal malformation incompatible with extra-uterine life. See, in particular, Diniz, 2003.

(Barsted, 1992). In the last two decades, this middle course has become the principal source of abortion policies in Brazil.

This is an unusual, though perhaps not unique, instance of social change fostered in the gap between lawmaking and implementation. To describe it, I borrow Laurent Thévenot's analysis of a "government by standards". This style of policymaking can be defined as "a form of government which pushes back the question of normative principles in the concretization of objects and in the proceduralization of places of debate and judgment" (Thévenot, 1997: 234).³ It is typically carried out by committees of experts, in "compromising devices" (Thévenot, 2001), i.e., in specialized working groups seeking local arrangements between various normative principles. In such places, however, evaluative judgment usually comes down to measuring standardized properties, fixed in objects and procedures. This "reifying reduction" (Thévenot, 2009) not only limits the expression of broader normative principles, it also curtails ways of engaging with the world other than the normalized use of standardized objects. It is especially unfavorable to a more personal fashion of engaging with a proximal environment (Thévenot, 2006). Government by standards is commonly used on commodities or commercial services. Little by little, though, it has spread to other arenas, in particular to education (Normand, 2008) and medicine (Thévenot, 2009). Evaluative judgment, in these arenas, is limited to assessing the factual qualities of, respectively, some merchandise, classroom material, or pharmaceutical product.

This paper explores another arena, that of civic rights. The question I want to address is the following: How is a form of government usually employed for the technical measurement of things extended to human agents? With respect to the right to choose, government by standards also leads to a reduction to fixed properties. These, however, are not expected from things in this case, but from human agents. And while objects and procedures lend themselves to the requirements of standardization, human agents are not so readily procrusteanized. Government by standards, in this case, is likely to have crushing effects. This, I discuss in the final section of this paper. I begin, however, by painting a broad picture of how non-criminal abortion was regulated and implemented. I then analyze how it was done. In particular, I argue that a federal government handcuffed by decentralization and a context of healthcare reforms played in favor of a dispersed, non-legislative regulation process.

2. GENERAL OVERVIEW OF THE PROCESS

There have been specific abortions laws in Brazil since 1830. These have changed a great deal over time, except for one constant. From the start criminal abortion has been

³ All translations into English are mine, except when otherwise stipulated.

defined in relation with legal exceptions for which abortion is not punished.⁴ Formally, then, there always have been at least two possibilities with regard to abortion, i.e. punishment or tolerance. I will call *legality test* the juridical, technical, and moral criteria used to determine whether a situation should be punished or authorized. Here, a seeming paradox ought to be pointed out. Despite the vehemence displayed by abortion laws, it seems that there always have been very few situations of abortion actually put to the test of legality. Most empirical cases seem to have eluded public judgment. They were neither punished nor tolerated, but lost in the blur of clandestine actions.⁵

Abortion laws (and especially authorized exceptions of non-criminal abortion) were seldom, but not never, put to use. They were occasionally enforced, though not as systematically as their severe, detailed and wide-ranging provisions would suggest.⁶ This is easily explained. What is asked by law to punish or permit an abortion is so difficult to satisfy that it seems to have held most empirical cases below the test of legality. This constricted situation constitutes something like a “juridical boundary effect” (Bourdieu, 1980), i.e., an informal *numerus clausus*. A high, almost unreachable level of legal requirements not only repressed out of the public sphere the great bulk of induced abortions; it also undergirded the social selection of a small sample of the phenomenon. Thus, only the few situations measuring up to the strict requirements of the law are in fact exposed to public judgment.⁷

The politicization of this issue was slow and lingering. For one, the low number of authorized abortions came with an equally low number of abortions punished to the full extent of the law, and this precarious equilibrium probably offered a satisfying compromise to the conservative segments of society. How narrow the test was, furthermore, was something women struggled against in isolated circumstances. To expose this diffuse injustice in the public sphere, women needed to aggregate their individual experiences under a collective banner. In the vocabulary of Laurent Thévenot and Luc Boltanski, they had to perform a “*montée en généralité*”.⁸ The

⁴ I have drawn a genealogy of Brazilian abortion laws in an article submitted to the *Revista de Direito Sanitário* (Castelbajac, 2009).

⁵ The scarcity of punished cases is a well documented fact (Ardaillon, 1998). Likewise, reports of authorized abortions in public hospitals were extremely rare prior to the 1980s (Faúndes *et al.*, 2002: 121; Villela, 2000: 78).

⁶ Therapeutic abortion, for instance, was practiced exceptionally, though certainly more rarely than it could have been, considering the constantly high rate of mortality during pregnancies in Brazil throughout the XXth century (Faúndes & Torres, 2002:147).

⁷ With regard to the legal situation prevailing in France before abortion was decriminalized by the *Loi Weil*, Luc Boltanski questions “whether the role tacitly imparted to the law was really to make abortion disappear, or at least to limit it numerically, or if, instead, it was meant to block out moral experiences linked to abortion from the public sphere” (Boltanski, 2004: 218).

⁸ “*Montée en généralité*” is the process of extracting oneself from a local situation to reach a higher level of generality in debate. It can also be applied to the aggrandizement of particular claims into a common

political exclusion of women until the recent period explains in part why the gap between the official status of the law and the rarity of its real use persisted without sparking controversy throughout most of the 20th century. But with the country's return to democratic government in 1985, political opportunities started opening up for progressive groups and for women's rights activists. As the Women's movement gained greater clout on the political scene, tight access to non-criminal abortion was finally exposed to social criticism. But in the uncertain conjuncture of a new regime, promoting the full enforcement of extant legal rules seemed to offer better prospects than campaigning for the decriminalization of induced abortion (Barsted, 1992).

The regulation of non-criminal abortion thus started with a claim for what was already in the law. The Women's movement deplored an absurd situation. The legislator had only provided that abortion should not be punished in certain cases. He had omitted to say how eligible women should apply for the procedure. As a result, there were no specialized hospital services in Brazil offering non-criminal abortions. Most medical practitioners were either ignorant of the law or unwilling to venture into an area of dubious legality (Faúndes *et al.*, 2002: 122). To set up specialized services, one of two things, then, was necessary. Either an additional civil law should be voted, to clarify the exceptions mentioned in the penal code; or else specific regulations should be laid down, to make these exceptions accessible. The first solution simply failed; bill proposal 020/91 was never passed (Talib & Citeli, 2004: 20). By default the introduction of specialized hospital services had to go through a lengthy regulation process.

The first non-criminal abortion programs were created by municipal ordinances, state decrees and university rules,⁹ in select localities throughout Brazil. This process started in São Paulo and spread thence to other cities. The first truly operative service was established within the Jabaquara Hospital in São Paulo. This pioneer initiative followed a decisive 1989 municipal ordinance compelling city hospitals to attend women eligible for non-criminal abortion.¹⁰

cause. Luc Boltanski and Laurent Thévenot have described how civic movements and public causes build up on denunciations of injustice (Boltanski and Thévenot, 1991).

⁹ University rules are used in the case of university hospitals with autonomous status.

¹⁰ A year before, in 1988, the Women's movement successfully supported a municipal ordinance instituting non-criminal abortion programs in two public hospitals of Rio de Janeiro. However local resistance to the project thwarted its full implementation until a few years later. Prior to 1988, though doctors at the Campinas University's faculty of medicine performed non-criminal abortions on a sporadic basis, the University Hospital's non-criminal abortion program was only formalized in 1994 (Faúndes *et al.*, 2002: 122).

For my immediate purposes, I only need to point out a few key events.¹¹ First, a woman running as candidate for the Workers party was elected as mayor of São Paulo.¹² The new city government immediately created a Secretariat of Women's Health. Second, a special committee was convened by the Secretariat to reflect on the opportunity of regulating non-criminal abortion. Representative organs of juridical professions and medical federations were then assembled in "hybrid forums",¹³ where experts, political actors and civil society representatives made recommendations for the regulation of non-criminal abortion. After this period of consultation, an enquiry was conducted to determine the ideal location for a pioneer experiment. The Jabaquara hospital, a medical complex specialized in traumatology, was selected. Although situated in the periphery of the city, the hospital, with its large emergency department, had a thorough experience with clandestine abortion. Preliminary investigations also identified several individuals within the hospital staff, who seemed sensitive to the issue and ready to cooperate. Finally, a multi-professional team including psychologists, surgeons and social workers was formed within the hospital.

The Jabaquara experience is now twenty years old. It has paved the way for kindred initiatives in other hospitals of São Paulo and of several other cities in Brazil, many of which have adopted its organizational chart, operating rules and regulations.¹⁴ But these innovations have also been imitated in other services within the same hospitals. In particular, the concept of a multi-professional team has been generalized to rehabilitation programs for drug addiction and to family planning services. As a result, an initially marginal program, with rather experimental methods, and whose staffs were perceived in the beginning as renegades by their colleagues,¹⁵ has become a standard reference for the modernization of public hospitals in Brazil.

3. ANALYSIS

3.1. CRIPPLING DIFFICULTIES FACED BY FEDERAL INSTITUTIONS

Regulation of non-criminal abortion is by and large the result of dispersed initiatives. The place of origin of these initiatives (city councils, state parliaments, hospitals, and

¹¹ The following is based on our interviews (Castelbajac, 2008). First-hand accounts of this process have also been provided by actors who took part in it (see, in particular: Talib, Citeli, 2005; Araújo, Maria José de Oliveira, 1993; Villela, Araújo, 2000: 78-79; Faúndes *et al.*, 2002: 121-124; Pereira, 2008).

¹² Luiza Erundina was the first left-wing politician to be elected mayor of São Paulo (1989-1992).

¹³ The concept of "hybrid forums" was introduced by the sociology of "technical democracy" (Callon *et al.*, 2001). See below, note 17.

¹⁴ The *Inter-professional Forums* organized by the CEMICAMP of Campinas have served as an important catalyst for the diffusion of common standards between fledgling specialized services (Faúndes *et al.*, 2002: 123).

¹⁵ Interviews with three of the first medical doctors who took part in these teams reveal that they were not only scorned by colleagues but also cast out of the community of recommendable professionals. All recall that they had to work hard to vindicate their professionalism and gain respect for their work (Castelbajac, 2008).

university boards) is revelatory of the kind of policies that they have ushered in. Without anticipating on further developments, suffice it to say that these policies energize two concomitant dynamics, one marked by innovating experimentations in the area of local democracy, the other by an influx of experts and specialized technicians in public administrations (see below).¹⁶ Regulation of non-criminal abortion has mostly been carried out in this form, initially without much apparent involvement of the federal government. The latter only stepped in 1998, when the Ministry of Health issued a technical Norm that recapitulated and confirmed the common standards contrived by the first non-criminal abortion services (Ministério da Saúde, 1999). To understand this belated intervention, it is useful to recall that healthcare administration in Brazil is amply decentralized. The Unified Health System (*Sistema Único de Saúde*) was municipalized in the 1980s, roughly at the same time as non-criminal abortion was regulated in São Paulo. Since then the federal government has hardly been able to muster this complex system composed of more than seven thousand medical facilities. And in the absence of federal laws requiring public hospitals to keep up functional non-criminal abortion services, the Ministry of Health only has authority to set general guidelines and address recommendations to the services already in place.

Decentralization is not the only constraint limiting the federal government's competence. Technical difficulties also slacken the evaluative control which the Ministry of Health is supposed to maintain on existing services. Admittedly the most serious limitation to federal oversight is the Ministry's ignorance of the exact number of hospitals with non-criminal abortion services. The last precise census was realized by a team of the NGO *Católicas Pelo Direito de Decidir* (Talib & Citeli, 2005). The census reported a total of 56 services concentrated in a little less than forty Brazilian cities, with an uneven geographic distribution; several states of the Union (Brazil is a federative Republic) have no access whatsoever to non-criminal abortion.

Finally, as mentioned before, governmental impotence is due to the absence of positive federal legislation on non-criminal abortion. To account for this situation, a few words should be said about the reluctance of national legislators to address the issue of abortion. The last bill proposal for the decriminalization of elective abortion was rejected about a year ago (*Folha de São Paulo*, 07/05/2008). In view of the fact that abortion laws have never been reformed since their enactment in 1940, despite a staggering accumulation of more than 80 bill proposals to that effect in the last 40 years (Rocha, 2006), it is tempting to conclude that the legislative road is a blind alley.

¹⁶ This double dynamic is characteristic of technical democracy (i.e. the public debate on and participation of interest groups in technical controversies), as analyzed by Michel Callon (Callon *et al.*, 2001) and Bruno Latour (2004). The articulation of a government by standards with technical democracy is realized in "compromising devices" (Thévenot, 1995), where the activity of standard-setting is typically carried out.

There is no need to suspect the occult influence of catholic lobbies in this matter. At this level, the dilatory tactics and the persuasive force of the Church are probably less formidable than what is frequently suggested.¹⁷ Partisan dispersion, the insufficient representation of women in the two national legislative bodies, the content agreement of morally conservative majorities with the compromise sanctioned by current abortion laws, and the other well-known causes of parliamentary inertia in Brazil, suffice to explain why the legal rules relative to abortion have never been changed since 1940. The principal obstacle to the decriminalization of abortion is, really, the crass slovenliness of legislative institutions. By default, abortion policies have principally been discussed in decentralized circuits, at the level of some city councils and public hospitals, while the federal government has done little more than reiterate in the form of technical Norms standards that were devised in the first specialized services.

3.2. THE MEDICALIZATION OF ABORTION

Despite the federal government's slack grip on the issue, regulation of non-criminal abortion has indirectly affected the governability of abortion. Without any modification in the letter of the law, its spirit has been bent by regulation, so to speak, to serve new purposes. The priority of the state is no longer to quell abortion, but to organize it. An indication of this transformation is that the standards of medical assistance, care, and safety conquered by the regulation of non-criminal abortion have been extended to the medical treatment of complications related to clandestine abortion. The last technical Norm issued by the Ministry of Health has confirmed this extension (MS, 2005).¹⁸

Apart from occasional witch hunts, police control and criminal court actions against illegal abortion remain low, whereas the realization of non-criminal abortion in public hospitals (340 in 2005) and the number of hospitalizations for complications related to

¹⁷ The conspiracyist pattern is commonplace in the literature on abortion politics. To give an example, taken from a nonetheless remarkable article: "(...) although the Church is separated from the state since the proclamation of the Republic (1889), it has the power of influencing and very often of defining state positions, in particular on issues relating to morals and sexuality (...). In the National Congress the conservative fringes of the Church maneuver to thwart liberal projects, in the corridors of politics, through virulent press campaigns and powerful lobbies." (Hardy e Rebello, 1996: 264). Based on this representation, one wonders why the Church has not succeeded yet in completely outlawing abortion. This is, I think, a typical case of confusion between cause and effect. If the Church nowadays concentrates on "morals and sexuality", it is really because these are the last two issues on which it still retains some authority. The shrinkage of the *Magisterium* to sexual mores corresponds to a change in contemporary attitudes towards sexuality — whose genealogy was sketched out, in particular, by Michel Foucault (Foucault, 1976). More often than not, in Brazil as in other secularized state the "influence" of the Church really boils down to verbal diffusion without concrete political translation. The symbolic violence displayed by the martyrology of sanguinolent fetuses is as high as the Church's political clout is low.

¹⁸ The 2005 Technical Norm of Humanized Care for Abortion thus adds to the standards set by the first specialized services the obligation of treating with dignity and solicitude patients who require emergency treatment after a botched clandestine abortion. Post-abortive situations have thus been officially removed from the competence of the police; the Ministry of Health has extended in this sense the rule of physician-patient privilege (in other words, doctors can be reprimanded for denouncing a woman treated for induced abortion). The Norm not only reasserts the right to non-criminal abortion; it also creates an informal right to curettage, to put it bluntly.

clandestine abortion are increasing (Talib & Citelli, 2005: 53 ss). For all intents and purposes, the right to non-criminal abortion is becoming the norm and criminal abortion the exception. While police control and criminal court actions were never able to seize more than a small and superficial part of it, the medicalization of non-criminal abortion (and of complications related to clandestine abortion) has resulted in a real extension of governmental control over the massive reality of induced abortion. Abortion situations are increasingly invested as contact points with women's health and sexual life. Abortion policies are no longer essentially repressive; they now delineate a constructive zone of governmental control.

This extension seems to have fostered the kind of shift "from the criminal register to that of public hygiene" which has been observed in other countries where the issue of abortion has gained greater visibility (Isambert, 1982: 366). The framing of abortion as a matter of Public Health, with epidemic dimensions, is often described by activists of the Women's movement and the Hygienist movement (*Movimento sanitário*) as a political "strategy" (Cunha, 2006).¹⁹ Now, this notion can be misleading. Granted, there seems to have been early on an intuition that this move would allow a less emotional, and hence more fruitful, debate on abortion; but it would be very strange if committed activists admitted so openly to picking their justifications, based only on a concern for scoring points. From the fact that this reorientation yielded the benefits of a more rational discussion, it does not follow that this was indeed what determined it. In fact, the strategy alluded to by activists has little to do with this kind of flimsy discursive strategy, and really refers to a broader practical redeployment. New arguments, redefining abortion in the language of epidemiology, were simply called for by the opening of a favorable "political opportunity structure" within the Brazilian Public Health system. Response to this opportunity is, most likely, what activists call "strategy".²⁰

This opportunity had two facets. First, public hospitals were already coping with the problem of clandestine abortion. Every year, more than 230 000 women are hospitalized after a botched abortion; complications related to clandestine abortion represent the sixth cause of hospitalization in Brazil (Emmerick *et al.*, 2007: 17 ss). Over the years public hospitals have had to deal with the most visibly unacceptable results provoked by the criminalization of abortion (septic abortions, life-long sequels,

¹⁹ Anna Lúcia Santos da Cunha gave an account of how this strategy was used in the special committee who drafted the last bill proposal for the decriminalization of abortion (Cunha, 2006).

²⁰ I am not quite satisfied with the idea of "political opportunity structure", but it is useful to explain how changes in the structure of the state create opportunities for social mobilization (Tarrow, 1996). My discontent is with the notion of opportunity, which seems to call for a *strategic* response, i.e. a capacity to react based on rational calculation. This is not what political activists usually describe when they talk about their "political strategy". More often than not, they simply mean a long-range course of action, guided by a concern for some ideal or some principle of justice). With this caveat, I adopt the concept of opportunity structure in the limited sense of a pragmatic constraint affecting what social actors do.

violent deaths, and the innumerable list of potential complications described by Faúndes and Barzelatto, 2004). Short of decriminalizing abortion, the easiest measure to take was to officialize this makeshift arrangement. Directing political attention to the domain of Public Health was only a matter of normalizing a de facto situation: virtually, abortion had already become a Public Health problem.

Second, the opportunity for this normalization was brought about by the reform of Healthcare administration in the 1980s. Reform began in the final years of the military regime. New healthcare programs, directed at specific segments of the population (and in particular at women) were launched in the early 1980s, in a final effort of the dictatorship to appease social movements.²¹ These programs, — along with the policy of *abertura* undertaken in the final years of the military regime;²² the liberalization of political institutions, following the regime's demise; and then, the implementation of an unprecedented overhaul of the Brazilian healthcare system throughout the 1990s (Bresser-Pereira, 1998: 253 ss) — brought within state institutions an influx of administrators from the Women's movement, the Hygienist movement, and other social movements.

As I have pointed out before, implementation of non-criminal abortion programs has coincided with the creation of the Unified Health System. This reform ushered in a form of public management inspired by neo-managerial techniques and neoliberal programs,²³ and this ideological orientation has had some lasting incidences on the definition of the special healthcare programs directed at women that were implemented in the late 1980s and on non-criminal abortion programs in particular. These special programs share one feature. Breaking with the highly hierarchical organization which had prevailed until then in physician-patient relations, they all pursue an ideal of

²¹ In particular the Integral Care for Women's Health Program (Programa de Assistência Integral à saúde da Mulher, PAISM) represents the first medical approach to the issue of abortion, though it was only a minor dimension of the program, linked to the larger issue unwanted pregnancy (on PAISM, see, in particular, Osís, 1998). The two technical norms issued by the Ministry of Health (Ministério da Saúde, 1999, 2005) on non-criminal abortion both make reference to the objectives set by the PAISM.

²² The period of *abertura* (1974-1985) corresponds to the liberalization of the military regime. The dictatorship itself began in 1964 and ended in 1985.

²³ There is a vast literature on the impact of new public management on the managerial reform of the Brazilian healthcare system (see, for instance, Bresser-Pereira, 2008). To the extent that the importation of neo-managerial techniques and neoliberal programs serves republican principles, Carlos Bresser-Pereira has proposed to label this kind of reform of the state a "social-liberal" program (Bresser-Pereira, 1998). This question is beyond the purpose of this paper, but it is important to make a distinction between two different things: a social-liberal compromise between two types of justification; and a typically liberal course of action justified by social considerations. In the case of the reform of the Brazilian healthcare system, it is clearly the latter that applies.

individual autonomy and the project of empowering patients.²⁴ Their mission is to help women become “active agents of their own health” (Aguar, 1998: 24). This is clearly a liberal definition of healthcare: causes of hospitalization are equated with partial or complete loss of autonomy, and appropriate care and cure with the patient’s rehabilitation as a responsible and self-reliant individual.²⁵ Ideally, in this construction, patients become managers of their own health.²⁶ This liberal definition of healthcare is highly compatible with neo-managerial policies of minimal state intervention. In the case of non-criminal abortion, governmental self-limitation takes the form of a government by standards, whereby executive activity is limited to setting guidelines, conventional procedures and standards for the qualitative measurement of medical care. In short, the global evolution of the abortion issue from the criminal register to that of Public Health has meant one thing; this transition was born by women, now treated as autonomous agents responsible for their own health, within specialized hospital services keeping to a neoliberal arrangement between a philosophy of individual autonomy and a government by standards.

4. DISCUSSION

In this section I would like to tackle some questions raised by the regulation of non-criminal abortion in Brazil. I will suggest a critical perspective that attempts to go deeper than the indiscriminate condemnation of the process on the habitual ground that it creates power relations between women and doctors. More specifically, I want to argue that the *modality* chosen to open up access to non-criminal abortion, rather than the process itself, has inherent oppressive tendencies. This argument echoes Laurent Thévenot’s suggestion that “the process of standard-setting faces dramatic challenges when it comes to coping with things that are closely related to persons, their bodies, and personal usages” (Thévenot, 2009). Government by standards puts actors in neatly arranged environments, furnished with standardized objects and routinized procedures. This kind of normalized setting leaves little room for the more personal

²⁴ In part, this is due to the fact that the Women’s movement attempted to write objectives of emancipation in these women-oriented health programs, which they helped elaborate (see, for instance: Alvarez, 1990, in particular chapters 8-10; Aguilar, 1998; and Osis, 1998). However, the collective approach to emancipation and empowerment traditionally favored by the Movement was changed, in this process, into a more individualistic approach, despite initial efforts to set up support group for women and other collective experiences.

²⁵ A lengthy version of this definition can be found in Fleury-Teixeira *et al.* (2008), who also show how the concepts of autonomy and empowerment, introduced in international Health institutions, were then transposed in the normative principles of the Brazilian Unified Health System.

²⁶ For a broader perspective on this definition of health, see Resende (2005). A similar valuation of individual autonomy is found in other forms of professional care, in particular in social work (Pattaroni, 2006; Breviglieri, 2008).

attachments and emotions stirred by the prospect of abortion.²⁷ Even though health professionals are often extremely sensitive to their patient's history (and to her way of telling her story), the requirements of the procedure tend to subordinate the concern for more personal attachments.²⁸ Failure to adopt the impersonal attitude required by the procedure is treated as a form of deviance, sometimes resulting in the inadmissibility and rejection of the patient's demand, though more often than not it simply leads health professionals to re-qualify it. The patient is asked to rephrase her determination, her fears, and the ambiguity of her motivations, in a pre-established, highly standardized format. This format is quite objectively imposed by the clinical forms and juridical documents she is asked to fill; the ritualized succession of preliminary interviews with the very same people who are habilitated to grant or reject her demand; and the fact that her choice cannot be justified by her own motivations, but only by the general circumstances — rape or risk of death — stipulated in the law. Presumably, women who apply for elective abortion after they were raped or because they might die cannot comply with all these requirements as if they were mere formalities. Here, formalities are formidable constraints.²⁹

The 2005 *Technical Norm of Humanized Care for Abortion* is a good example of such constraints. The Norm includes among other things a script for preliminary interviews with the patient. It recommends that doctors should “not be judgmental”; instead they should adopt a “therapeutic attitude”, i.e. “the capacity to listen without prejudice or imposition of values”. Their motto should be “hospitality” (*acolhimento*), i.e. an attitude of “listening, recognition and acceptance of differences”, as well as an attitude of “respect for the right to choose” (MS, 2005: 17-18). Moreover, the Norm reaffirms the importance of alleviating the patient's suffering. It renders mandatory the administration of anesthetics and analgesic drug. It should be noted that it is still common practice in many Brazilian hospitals to tyrannize women who turn up after a botched abortion by treating them only after they have lost a lot of blood or by operating on them without anesthetics (Soares, 2003: 401); this is to say that the Norm formalizes a therapeutic attitude that does not go without saying.

There is more remarkable still for this discussion. The Norm recommends that patients should be referred to a family planning program after their operation to learn about contraception, sexual protection and reproductive autonomy. This is supposed to

²⁷ Borrowing extensively from the phenomenological tradition, Luc Boltanski has proposed a descriptive model of the intimate experiences linked to abortion (Boltanski, 2004: 261 ss).

²⁸ Again, to quote Laurent Thévenot: “Although attention paid to the ‘patient pathway’ might open medical care to (...) the patient's familiar attachments in her personal life, standardizing this pathway's organization threatens to reduce familiar concern” (Thévenot, 2009).

²⁹ I have provided empirical illustrations of these constraints in other works (Castelbajac, 2008, 2009b).

be the procedure's apex.³⁰ It concerns patients who successfully claimed their right to non-criminal abortion as well as patients who were hospitalized after a botched abortion. In both case, the requested procedure (whether abortion or curettage) will only be performed on the condition that it shall be subordinated to a project of sexual autonomy and self-care. This project imparts on women alone the responsibilities generated by the fundamental indeterminacy of sexual relations, a carefree attitude and blissful ignorance being on the other hand expected from or allowed to men. Abortion, in this construction, is conceived as a failure to assume these responsibilities, and abortion care, as a chance for a new beginning, rather than the termination of her pregnancy.

Beside this uneven distribution of responsibilities between the sexes, the Norm also contains an internal tension, with potentially oppressive effects. As an administrative instrument, its vocation is, from a juridical point of view, purely technical. But in fact it purports to do much more than that: it establishes a new moral and political relation between patients and health professionals; it exhorts the latter to show greater solicitude toward the former. Finally, it redefines the choice for abortion as a choice for something else. According to the Norm, the benefit of abortion is not abortion itself, but the return to sexual autonomy.

This benefit, however, is conditional: the Norm subordinates the choice of eligible patients to the *nihil obstat* of a college of health professionals. Patients are asked to meet a series of standards to qualify for the procedure. Among other things, they must turn up in the period of time delimited by the Norm; in cases of pregnancies resulting from rape, they must give the college of health professionals no reason to suspect that they are lying, or that the aggression they report is not, strictly speaking, a case of rape. Finally, they must endure a series of interviews with a social worker, a psychologist, and a physician, before the latter three decide if they will grant her demand.³¹

These are clear examples of how the regulation and implementation of a law can modify its content (not for the best, in this case). The penal code says nothing about time or the preapproval of the patient's demand. It only asks that the operation should be performed by a medical doctor. This situation seems in clear violation of the principle that the state is obligated to grant healthcare access to all, without other restrictions than those stipulated by law.³²

³⁰ "(...) the hospitalization of a woman following abortion complications is only complete when accompanied with orientation on contraception and on existing methods immediately after post-abortion procedures." (MS, 2005: 30).

³¹ I have detailed the requirements made by these colleges elsewhere (Castelbajac, 2008; 2009b).

³² For a discussion of this principle, see: Faúndes, Torres, 2002: 153 ss.

But that is not all. Standard procedure creates a double bind. On the one hand, women are asked to behave as autonomous agents of their own health. On the other hand, enormous limitations are imposed on their right to choose (which must be pre-approved, as just said, by a college of health professionals); moreover, their choice is limited to circumstances (rape or risk of death) in which they are supposed to have lost the kind of autonomy that is required by the liberal model of rational individual choice.³³ Evaluation of the patient's need for assistance by an authorized college of health professionals also implies a measurement of women's suffering (conspicuous distress serving as proof of the patient's eligibility). This standardization of suffering is conducive to the fabrication of a pathological stereotype of women victims, to whom abortion is not given as a choice, but as an unfortunate necessity.

Preliminary interviews are similarly ambiguous. Although health professionals often show empathy, solicitude, and sensitivity, strict adherence to protocol tends to dilute such marvelous qualities. I do not want to suggest that this process is nothing but a trying ordeal. However, the positive effect that might be expected from a first contact with caring health professionals is tampered with by the routine investigation, the strict requirements and the intrusive questions that health professionals are supposed to make, in accordance with hospital rules and federal Norms.

To give an example, I will briefly describe the opening scene of the powerful documentary realized by Carla Gallo, *O aborto dos outros* ("Someone else's abortion"). The film starts with the psychological interview of a very young teenager applying for non-criminal abortion after she was raped. The patient is visibly traumatized. The psychologist interviewing her is extremely humane. Nonetheless the spectator cannot withhold a feeling of uneasiness. The patient's deaf voice is immediately translated in the psychologist's manuscript notes. Her writing accumulates rapidly on a bundle of information sheets that will subsequently be filed in the patient's medical record. The fortitude displayed by the young girl is impressive and yet disturbing. She endures her interrogation and retells her aggression impassively.

One of the psychologists that I have interviewed says the following about preliminary evaluations:

The first contact is difficult... all this process they have to go through: coming here, telling their story, reliving all their pain, every time they tell their story... so

³³ Pattaroni (2006) argues in the same sense that "the institutionalization of care wears away its cutting-edge critique of the model of the autonomous individual (...). More mischievously still, it can contribute to the sometimes undue extension of the grammar of the autonomous and responsible individual. This extension is made by a rearrangement – a requalification – of familiar attachments in order to make them congruent with the expectations of this grammar (contractualization of family relations, the probation of the poor, and so on)".

that, when she is sent back to us for a follow-up, she [the patient]... in a way, it seems to me that... well, it's empirical, you see, but it seems to me that it's a kind of protection for her when she refuses the follow-up, so that she doesn't have to go through all this again, as if she could erase this part of her history, except this situation can't be erased (Castelbajac, 2008).

I bring up this testimony to clarify my own criticism. I do not pretend to have unveiled a hidden oppression that could only be detected from the prominent position of the external investigator. The critical perspective sketched here merely highlights the kind of internal criticism expressed by health professional themselves. What I have proposed is simply a broader picture.

5. CONCLUSION

From a political point of view, the regulation of non-criminal abortion has prompted a decisive change. Though abortion is still a crime in Brazil, a limited freedom to choose, in cases of pregnancies resulting from rape or in last resort to save a patient's life, has been added to the inalienable rights of Brazilian women in the last two decades. This change extends far beyond women's lives and the general area of reproductive life. In fact it sweeps through all the "architectures of life together in the world" (Thévenot, 2006), from women's intimate experiences, up to the most abstract legal rules, through the neatly organized settings of specialized hospital services. Precisely because the latter mediate the aggrandizement of women's personal experience into public claims, they deserve special critical attention. This was the driving intuition of this article, and I believe it can also constitute a sound basis for political reflection.

Granted, the regulation of non-criminal abortion is a political achievement of great value. The critical perspective sketched here is not directed against this achievement, but raises questions about *how* it was brought about. These questions, in last analysis, have serious implications for the long-term strategy for the legalization of elective abortion, especially for plans to implement it on the model of non-criminal abortion services. Regulation of non-criminal abortion was never conceived as an end in itself by the Women's movement, but as a first step on the road toward the decriminalization of induced abortion (Barsted, 1992). For this reason, careful attention must be paid to what has been done, lest reform projects should replicate some of the stressful and often oppressive tendencies contained in the way non-criminal abortion was implemented. Standard procedure, as defined by ministerial Norms, defeats the purpose which it professes to serve, by inhibiting the often extraordinary humanity of

those health professionals who devote themselves to the care of women. But most importantly, exacting requirements and trying preliminary interviews make non-criminal abortion services an inhospitable environment for the more familiar attachments and intimate experiences brought in by a choice as personal as that of abortion.

Two things, at least, are needed to remedy this situation. One, how a patient frames her choice should not be subordinated to justifications imposed by others or to the only ideal of individual autonomy. By definition, the right to choose is spurious if the patient can only express her choice based on somebody else's justifications.

Second, unnecessary restrictions and extravagant requirements should be dropped altogether. Instead, more emphasis ought to be put on care giving. Familiar attachments should be accommodated, and benevolence for the patient's intimate experiences and emotions rewarded. Of course, a balance would have to be found between the benefits of a close patient-physician relationship and the professional distance necessary to medical practice. But health professionals are already versed in this art of composition. Improving the current situation is only a matter of making it less difficult for them to show their qualities, by removing some of the procedural constraints smothering them.

These two fairly simple steps would make good starting points for further progress on the road toward securing women's right to choose, in Brazil. Making sure that this right is implemented in a safe and welcoming environment should not be left out as a technicality. Campaigning for reproductive rights is crucial, but it is no less urgent to reflect on the conditions of their actual exercise.³⁴

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³⁴ This is, of course, something that many, especially in the Women's movement, have already undertaken (see, for instance, the contributions contained in *Católicas Pelo Direito de Decidir* (org.), 2002).

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