

## Women victims of sexual violence: critical paths in the search for the right to legal abortion

Mulheres vítimas de violência sexual: rotas críticas na busca do direito ao aborto legal

Mujeres víctimas de violencia sexual: rutas críticas en la búsqueda del derecho al aborto legal

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### Abstract

*Legal abortion in cases of pregnancy resulting from rape has been provided for in Brazil since 1940. However, access to this right is still very restricted, and there are numerous barriers that hinder women's access to referral services that perform the procedure. This article discusses the trajectory of women who had an abortion due to rape from 2000 to 2018 at a public referral hospital in the city of Porto Alegre (Rio Grande do Sul State, Brazil). This is a qualitative, documentary, and retrospective study that used the concept of Critical Paths to understand the difficulties encountered by the women, the decisions made in the face of sexual violence and the discovery of pregnancy, as well as, the consequences resulting from this situation. Data were collected from women's medical records, totaling 127 cases. Based on the content analysis, three interrelated categories were identified and subsequently ordered to explain the sequence of facts, actions, and complications in women's lives, according to the dynamics of the critical paths produced: between the secrecy of violence and the silencing of rights; psychological illness and social disorganization; institutional flows: validation of the word and conscientious objection. We noticed that there is a silencing in the face of sexual violence, and the performance of legal abortion proved to be an invisible problem surrounded by stigmas. The psychosocial disorganization resulting from violence was aggravated by misinformation, the precariousness of the service networks, and the professionals' conscientious objection.*

*Legal Abortion; Sexual Violence; Rape*

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## Introduction

It is estimated that one in three women worldwide experienced intimate partner violence or sexual violence at some point in their lives <sup>1</sup>. In Brazil, there is an alarming number of rapes, with a 4.1% increase in reported cases from 2014 to 2018. In 2018, 180 rapes were reported per day <sup>2</sup>. The consequences of this violence affect the physical and mental health of the victims, hampering their social achievements and their socioeconomic maintenance <sup>3</sup>.

According to the Brazilian law, rape is a crime against sexual freedom. Zapater <sup>4</sup> attributes to this crime the nature of human rights violations. When the victim is under 14 years of age, sexual intercourse, or a libidinous practice, regardless of consent, is considered rape of a vulnerable person. This is due to the legal understanding that, until that age, the person does not have full capacity to decide on their actions yet, which also applies to people who, due to a temporary or permanent disability, are unable to consent, because of some deficiency or because they are under the influence of psychoactive substances <sup>5</sup>.

Unintended pregnancy may be one of the consequences of rape, occurring in approximately 7% of cases <sup>3,6</sup>. Discovering a pregnancy after sexual violence is often perceived as a new violence <sup>7</sup> and can trigger complex psychological and social reactions <sup>8,9</sup>. Despite having been provided for in law since 1940, abortion in these cases is not a guaranteed right in Brazil yet, and women have a long way to go in the search for the procedure <sup>7</sup>. The scarcity of services is one of the obstacles, and health care, when provided, is often marked by moral judgments, hostility, and discrimination, consisting in another source of violence <sup>10</sup>.

In this article we discuss the search for legal abortion due to rape, considering the trajectory taken by women from the occurrence of sexual violence to the completion of the procedure. As literature on the topic is scarce in Brazil, and most of the research comes from large centers in the Southeast and Northeast regions of the country <sup>3</sup>, we will contribute to the understanding of the dynamics involved in legal abortion by providing data from the South Region.

## Methodology

This is a qualitative, retrospective, and documentary research conducted at a referral service for legal abortion in a public hospital in the city of Porto Alegre (Rio Grande do Sul State, Brazil), by the analysis of the medical records of women who suffered sexual violence and had a legal abortion from 2000 to 2018. The technical team of this service is composed of professionals from the fields of medicine, nursing, psychology, and social work. The average number of cases attended up to 2013 was two per year, with a gradual increase reaching a total of 29 legal abortions in 2018, with an average of 18 cases per year in the last five years analyzed. Data on history, psychological or clinical symptoms, and other information on the patient and the suffered violence, as well as the discussion on the issues that involved decision-making about abortion, completed protocols, and referrals made, were registered in the clinical records. Until 2016, data were collected in physical medical records; and thereafter, in electronic medical records.

The (re)construction of the historical series of abortion due to rape was carried out in two stages. The first, based on the association of diagnoses related to sexual violence and pregnancy, according to the *International Classification of Diseases*, 10th revision (ICD-10) <sup>11</sup>: Y05 Sexual assault with physical force; Y04 Assault by bodily force; T742 Sexual abuse, confirmed; and Z35.1 Supervision of pregnancy with history of abortive outcome; Z32 Encounter for pregnancy test and childbirth and childcare instruction; Z32.0 Encounter for pregnancy test, result unknown; Z32.1 Encounter for pregnancy test, result positive. The list of abortions for medical and legal reasons (ICD O04) was also analyzed. The total number of identified cases was 223, of which, after reading the medical records, 96 were excluded because the abortion was not related to sexual violence or it was not the outcome. Cases in which the abortion was not performed were excluded due to the lack of records in the medical records referring to these situations. Another two cases were excluded because the physical record was not located, resulting in a total of 127 cases of legal abortion due to rape attended during the period.

The obtained information was submitted to content analysis<sup>12</sup>, as it allowed, in addition to the description of the occurrences, the understanding of subjective aspects such as values, beliefs, attitudes, and opinions reported by women and registered in the medical records. The analysis categories were based on the concept of critical paths by Sagot<sup>13</sup>, who discusses the process of seeking help as a way to trace women's trajectories and decisions to leave the situation of violence. In the medical records, the authors sought to identify the paths taken to access the right to legal abortion. The trajectory begins with the woman's decision to break the silence about rape and continues with the identification of the difficulties faced and the impact of violence and institutional experience on her life. The present analysis identified the trajectory (critical paths) and the encountered difficulties (critical nodes), explaining factors that inhibited or impelled women in the search for legal abortion after sexual violence and the discovery of pregnancy. These factors, in addition to the geographical route, included the biopsychosocial aspects involved in the situation.

After reading the medical records, the results were divided into three analysis categories: (1) between the secrecy of violence and the silencing of right; (2) psychological illness and social disorganization; and (3) institutional flows: validation of the word and conscientious objection. These categories are interrelated and demonstrate the sequence of facts, actions, and complications in women's lives according to the dynamics of the critical paths produced. To guarantee anonymity, the participants' names were encoded with letters and numbers (with 01 being the oldest case and 127, the most recent).

This study was approved by the Ethics Research Committee of the Presidente Vargas Maternal-Child Hospital (CAAE 98117718.5.0000.5329 and opinion n. 2.926.060).

## Results and discussion

In Table 1 we show the general characteristics of the 127 cases of legal abortion due to sexual violence attended during the period.

Of the 127 cases, most participants (60%) were over 18 years old, and 23% of them were under 14 years of age. Ages ranged from 10 to 42 years, with an average age of 22. Most women were white (77%), single (75%), with uncompleted elementary school (34.6%), and lived in Porto Alegre and the Metropolitan Region (73%). Regarding occupation, 33% were formally employed and 55% were students. In 30% of the cases, violence was the first sexual intercourse and in 64% it was the first pregnancy. Violence was a unique episode in 74% of the cases, and 68.5% reported the violence to the police. Regarding the aggressors, 45% were unknown to the victim; the means of coercion used in the violence were use of physical strength (42%), threats (34%), firearm/knife (25%), and use of psychoactive substances (27%). According to Article 217-A of *Law 12,015/2009*<sup>5</sup>, 55% of the cases were deemed rape of vulnerable person: 23% of adolescents under 14 years of age; 5% of women over 18 years of age with intellectual disabilities; and 27% who were under the influence of a psychoactive substance at the time of the sexual assault. The sample profile complements and qualifies the qualitative analysis presented next.

### Between the secrecy of violence and the silencing of right

In this category we highlight the secrecy regarding sexual violence and present factors that inhibited or delayed the search for help. Denial, the desire to forget, guilt, stigma, and misinformation about the right to abortion were the main aspects involved in this dynamic between secrecy and silencing. Our data showed that many women believed that keeping the suffered violence secret would allow them to forget what happened and move on with their lives. The secret is uncovered with the discovery of pregnancy, as we can see in the following descriptions:

*"She says it was the worst thing that had happened in her life and that she just wanted to forget it, not tell anyone and wait for it to pass, but with the pregnancy her plans fell apart"* (B115, 20 years old).

*"She told her grandmother that she had a misunderstanding with her boyfriend and that's why she was crying (...) she only told her boyfriend when she felt strange, queasy, with sore breasts, suspecting that she was pregnant"* (Y91, 19 years old).

**Table 1**

Characterization of cases of legal abortion due to sexual violence attended at a public referral hospital in the municipality of Porto Alegre, Rio Grande do Sul State, Brazil, from 2000 to 2018 (N = 127).

<b>Characteristics</b>	<b>n (%)</b>
Age group (years)	
< 14	29 (22.8)
≥ 14 and < 18	22 (17.3)
≥ 18	76 (59.8)
Ethnicity/Skin color	
White	98 (77.2)
Black	17 (13.3)
Mixed-race	10 (7.8)
Indigenous	2 (1.6)
Level of education	
Illiterate	2 (1.6)
Some elementary school	44 (34.6)
Elementary school	7 (5.5)
Some high school	10 (7.8)
High school	32 (25.2)
Some higher education	17 (13.3)
Complete higher education	14 (11.0)
Marital status	
Single	95 (74.8)
Married/Common-law marriage	16 (12.6)
Separated	15 (11.8)
Widowhood	1 (0.8)
Occupation	
Students	69 (54.3)
Formally employed	42 (33.1)
Unemployed	16 (12.6)
Place of origin	
Porto Alegre	55 (43.3)
Metropolitan area	38 (29.9)
Small city in the municipality	33 (26.0)
Type of violence	
Chronic	33 (26.0)
One-time event	94 (74.0)
Aggressor	
Unknown	57 (44.9)
Identifiable	30 (23.6)
Father/Stepfather	21 (16.5)
Other relative	10 (7.8)
Ex-husband/Boyfriend	4 (3.1)
Boyfriend	3 (2.4)
Location of violence	
Public	45 (35.4)
Private	79 (62.2)

(continues)

**Table 1 (continued)**

Characteristics	n (%)
Has suffered previous violence	31 (24.4)
Sexual violence was the 1st sexual intercourse	38 (29.9)
Women with cognitive impairment	7 (5.5)
1st pregnancy	88 (69.3)
Made a police report	87 (68.5)
Forms of coercion	
Physical strength	53 (41.7)
Threats	43 (33.8)
Firearm/Knife	32 (25.2)
Alcohol/Drugs	36 (28.3)
Others	15 (11.8)
How did you get to the referral service	
Security/Protection Services	50 (39.3)
Healthcare services	41 (32.2)
The Internet *	14 (11.0)
Friends	12 (9.4)

Note: totals may differ by the number of nonresponses.

\* Data recorded from 2015 onwards.

Studies show that only 10% of cases of sexual violence are reported to public security <sup>2,3</sup>, and of these, only half receive emergency prophylactic care at health services <sup>9</sup>, which shows us the social scope of the aforementioned reports, in which secrecy becomes a strategy to avoid trauma, guilt, and social stigma.

Silencing also results from lack of information, and this is one of the reasons for the long journey until arriving at the referral hospital. The hospital was the first service sought in only 19 cases (15%), evidencing women's misinformation regarding the right to interrupt the pregnancy. The healthcare reports show that women only learn about the right to abortion after confirmation of the pregnancy, and this occurs through different means and sectors of society, including: health services (32%); security or protection agencies (39%) – police stations, judiciary, Public Prosecution, Child Protective Council; friends (9%); furthermore, as of 2015, the information was also accessed via the Internet (11%). In these cases, women report having typed the word “abortion” or “how to have an abortion” and found news or reports about sexual violence and legal abortion. Thus, the search for information on the Internet and the creation of a service network with various sectors of society seem to enhance access to abortion rights. Primary health care proved to be an important reference in the search for help by women, as did the security and protection agencies, together representing almost 70% of the sources of information on legal abortion.

However, these services and resources also presented access barriers, such as moral judgments, poor infrastructure, bureaucracy, lack of professionals, and misinformation about laws and flows, as shown in the following reports:

*“She sought care at hospital F last Friday, but there was no doctor to attend this type of situation on that day. She was instructed to seek another hospital (...) she felt judged by the emergency care, cause when she arrived, the doctor told her that it wasn't that simple to go there and have an abortion” (S130, 30 years old).*

*“She went to hospital Z, where she discovered the pregnancy by abdominal ultrasound due to pain in the lower abdomen, but she didn't tell about the rape. Then, she went to hospital F to request an abortion. She was instructed to return the following week. A friend took her to the Referral Center M and there a social worker accompanied her to hospital G, but they said it was overcrowded due to childbirths. Then, she arrived here at 17 weeks pregnant already” (P99, 24 years old).*

*“She felt even worse at the Women's Police Station (...) she was exposed, humiliated 'cause everyone who was there heard her story. She stayed there for 3 hours and her testimony was interrupted several times by other cases,*

either in person or by telephone. The attendant at the Women's Police Station said that 'it was a shame to have twins aborted' – this made her feel even more guilty. She says that this sentence still echoes in her head after the abortion" (S37, 36 years old).

"At the Women's Police Station, she was referred to the public defender's office and a hearing was scheduled with a judge to authorize the abortion" (J133, 21 years old in 2018).

We observe that the misinformation affecting women also affects the service network, both health care and public security, resulting in unnecessary referrals or erroneous guidance. The reports illustrate a trajectory that intensifies the trauma of the suffered violence to the extent that it victimizes women.

The fear of social judgment also encourages the maintenance of the secrecy of violence. There are recurrent verbalizations regarding "why did they go to the party, have drunk, or even about the clothes they were wearing, of guilt for not remembering precisely what happened, or how they ended up in that place after accepting a drink at the party". Women themselves question their behavior, blaming themselves for what happened:

"She feels guilty. She says she believes that if she wasn't wearing a skirt this might not have happened" (L105, 25 years old).

"She says she woke up dirty with sperm in one of the rooms in a house. She felt so ashamed and guilty. That's why she didn't tell anyone (...) she figured that someone might have had sexual intercourse with her, but she immediately decided to pretend nothing had happened" (D85, 20 years old).

Giugliani et al.<sup>9</sup> address the victims' blaming through their attitudes and behaviors and the social tolerance in relation to sexual violence, which naturalizes abusive dynamics rooted in gender inequalities and reproduces the culture of rape. Women report feeling judged by professionals, both in healthcare services and police stations, and fear that this will happen with their families, which is why many decide not to disclose the situation of violence. In a nationwide opinion survey, 42% of men and 37% of women<sup>14</sup> agreed with the sentence "Women who respect themselves are not raped", which shows the strength with which moral assessment affects women. It is a judgment that triggers feelings of guilt and makes women themselves responsible for the suffered violence<sup>7</sup>.

This dynamic, which ranges from secrecy to silencing, maintains the lack of information that led some women to try abortive alternatives, such as teas or pills, before seeking hospital care, attempting to solve the pregnancy issue on their own:

"She took four cytotec pills the previous week, but was unable to abort" (L83, 15 years old).

"She used herbal infusions and medications she can't even name – trying to abort" (L62, 34 years old).

In other cases, concerning children and adolescents, the arrival at the hospital occurred due to various clinical complaints such as gastric disorders or abdominal pain. Cognitive and psychosocial immaturity may hinder the perception of physical changes associated with pregnancy and even the understanding of the violence to which they were subjected. Hospitalization and clinical investigation demonstrated the diagnosis of pregnancy, uncovering the secret of sexual violence:

"She was hospitalized for nausea, abdominal pain, and gastric problems, with no improvement. Only then was the pregnancy diagnosis made and she told us she was sexually abused by the stepfather" (E81, 10 years old).

Several authors report that fathers and stepfathers are the main sexual aggressors of children and adolescents, and also point to early age as hindering the understanding of the abusive relationship<sup>15,16</sup>. We add that the reduced number of referral services and the need for a large geographical displacement in the search for the procedure is an additional obstacle to be overcome and that denotes the insufficiency of this public policy. In the study population, less than 50% of women lived in the capital, and some traveled more than 400km to access the service. In most Brazilian municipalities, there are no accredited facilities for carrying out legal abortion<sup>10,17</sup>. In the country, of the 68 referral hospitals registered, only 37 had performed at least one legal abortion from 2013 to 2015<sup>10</sup>, which evidences inequality in access as an important critical issue in the exercise of the right to abortion<sup>18</sup>.

### **Psychological illness and social disorganization**

In this category, we highlight the different psychological reactions resulting from violence, such as fear, shame, anger, disgust, worthlessness, anhedonia, sleep disorders, and suicidal ideation, and discuss their impact on various spheres of life. We identified that emotional reactions made it difficult to

seek help, impaired the victims' psychosocial resources to respond to the trauma, and were characterized as one of the obstacles to accessing legal abortion:

*"She says she is deeply afraid, she feels that the aggressors are going to invade her house. She can't stand the presence of her partner. She feels angry and disgusted by the fetus"* (K25, 28 years old).

*"She is frightened, angry, tearful, and has negative feelings about the pregnancy and the fetus. She says her life is over. She can't sleep, eat, or work. She has resigned from her job"* (C20, 27 years old).

*"She has trouble sleeping, eating, caring for her 4-year-old daughter"* (L105, 25 years old).

The reports we analyzed corroborate studies that demonstrate the intensity of the clinical conditions and psychological reactions triggered by situations of sexual violence, from the most immediate, such as shame, fear, anger, and disgust<sup>14,19</sup>, to chronic conditions of alcohol and/or other drugs abuse, or the triggering or aggravation of other mental illnesses<sup>1</sup>. In addition, we identified that pregnancy resulting from sexual violence can be experienced as a new traumatic situation, intensifying the symptomatic condition already established as a consequence of violence<sup>8</sup>. Thoughts of death, with or without previous suicide attempts, were identified in some cases:

*"She cries a lot, has insomnia, thoughts of death (...). She can't access the memory of the situation and that makes her very anxious"* (E87, 31 years old – raped when she was unconscious).

*"She's ashamed and guilty. She shows great psychological fragility. She still has thoughts of death and ruin. She's very close, her affective and social bonds are scarce and fragile. She has intense recurring nightmares. She's afraid of being alone and going out on the street. There were two suicide attempts after the sexual violence: one taking two and a half tablets of medicine – she told her family that she attempted suicide because she was feeling very much alone in city X and was depressed [because she didn't tell anything about the sexual assault]. When her period was late and she noticed she was pregnant, she attempted suicide again, this time at her mother's house, by hanging herself"* (N97, 19 years old).

A study conducted with 37 women victims of sexual violence found changes in sleep quality, an increase in the sense of fear of having contracted a sexually transmitted infection, fear of others' reaction and judgment, difficulty in interpersonal relationships, negative impact on the quality of sexual life, in addition to a negative perception about themselves and their own body. The presence of post-traumatic stress disorder (PTSD), depression, and decreased self-esteem were also identified, with a significant correlation between depression and PTSD<sup>20</sup>. In the aforementioned reports, we can see that the idea of suicide, in the face of psychological disorganization and lack of information, was an attempt to solve the problem of pregnancy. Self-harm, including suicide attempts, is not always analyzed when discussing this type of violence<sup>21</sup>.

Abandonment from work, withdrawal from studies, difficulties with children, avoidance of partner, family members, and friends are part of the disorganization that characterizes this situation and, in our data, these elements are directly related to sexual violence and unintended pregnancy:

*"She didn't go to school for several days. She tried to resume it, but she saw the aggressors and had the feeling they were laughing at her, so she dropped out of college for good"* (N97, 19 years old).

*"She realizes she's not ok. She was unable to keep her job (...) now she has had constant nightmares of persecution. She's afraid to meet the men who raped her. (...) The family kept away because they are against abortion"* (J132, 39 years old).

*"She no longer had sexual intercourse with her husband after that (...) she's been absent from work"* (S130, 30 years old).

*"She doesn't leave the house anymore and she won't let her kids out. She gave up starting her job"* (T90, 25 years old).

We notice that disorganization in daily life increases the suffering and the risks of mental illness, entails new obstacles, and prevents the resumption of the way of life prior to violence. The impacts of rape and subsequent pregnancy affect the world of work and relationships altogether, causing social, occupational, and financial losses<sup>3</sup>. These are problems that also affect families and close people and that break up social ties, hinder care relationships, and access to resources<sup>3</sup>.

### **Institutional flows: word validation and conscientious objection**

This category analyzes the obstacles that arise in the search for abortion, even after discovering the right to have it and arriving at the referral service. These flows are related to the scrutiny of violence and the denial of assistance due to conscientious objection. Hospital records are marked by the team's concern to seek the veracity of the facts, and in order to perform a legal abortion, a woman must be qualified as a victim of rape. This is what guarantees her access to the law. As we can see in the records, this legality must be reconstructed in each case:

*"There are no indications of a false allegation of violence"* (M107, 32 years old).

*"According to the psychological assessment, confusion in the patient's memory is common in this type of traumatic situation (...) the new date of the rape reported by the patient was reconstituted by seeking help from her friend and is now in line with the gestational age, as well as the consistency of the patient's report"* (E87, 31 years old).

We notice that the arrival of a woman victim of rape at the service raises a certain suspicion about what happened and requires teams to validate the report so that the right to legal abortion can be exercised<sup>22</sup>. It is an investigative process to prove the suffered violence and serves to attest the "victim status", insofar as a truth about the rape is established. Fassin & Rechtman<sup>23</sup> address the moral economy of the transformation of a person into a victim as a process that considers the symbolic effects of trauma, while demanding the adaptation of the narrative to moral values, removing the autonomy of the victimized subjects and objectifying them.

The reception and evaluation carried out by the multidisciplinary team of the referral service comply with internal flows and technical criteria established by the regulations of the Brazilian Ministry of Health<sup>24</sup>, so as to demonstrate the legitimacy of the indication of legal abortion. Nevertheless, even after this evaluation and the signing of all the terms required by the protocol, during hospitalization, new questioning about the woman's decision can retrace the decision-making process regarding abortion, as a way of (re)validating the decision to abort. There are several signs in the medical records that indicate the constant search for (re)confirmation of the violence and the decision made:

*"On hospital discharge, the doctor on duty questions again the certainty of the decision to have an abortion"* (E87, 31 years old).

*"Upon admission, a new ultrasound was performed to confirm the gestational age"* (T90, 25 years old).

These questions can be understood as seeking the protection on the part of medical professionals against possible risks of criminalization, which are part of the social imaginary about abortion, but which represent another critical node in the trajectory taken, as they generate exhaustion, doubts, and suffering. We can observe that the suspicion about the truth of the rape and the decision for legal abortion trigger other types of violence, creating new scenes and sensations that are added to the previous trauma:

*"She says that the hospitalization was a very difficult experience, that she was frightened, she felt a lot of pain (...) the worst part was seeing the fetus! She didn't want to see it, but the doctor insisted [on it] three times and she ended up agreeing [to see it] (...) she says that image accompanies her and that this was the most difficult part, and it ends up being a recurrent memory"* (V89, 36 years old).

Thus, even when a woman has access to legal abortion, she does not escape punishment for this act in various situations, either by being questioned several times about her choice or being exposed to situations, such as the aforementioned one, confronting her decision. The inclusion of a humanized model of care for women having abortion seeks to guarantee a safe and effective practice, emphasizing welcoming, non-judgment, guidance, and care<sup>25</sup>. However, we observe that the clinical routine still presents gaps and misconceptions in this regard. In the medical records, legal abortion practices are mixed with those related to prenatal care and desired pregnancy, which can be perceived by the use of several clinical descriptors in hospitalizations for legal abortion:

*"Request for prenatal and sexual abuse exams. (...) Labor induction"* (K25, 28 years old).

*"The patient is well, good fetal movement"* (B72, 12 years old).

According to Madeiro & Diniz<sup>10</sup>, religious beliefs and the fear of stigma permeate abortion practices in the health area and end up alienating professionals from the teams, as many doctors fear being seen as "abortionists" by their peers. The use of terms related to prenatal care in the records we

analyzed in this study may be linked to these beliefs and fears, in an attempt to transpose the pregnant woman's health care to the practices involved in the abortion process.

The fear of being framed can also trigger questions about the veracity of the sexual violence suffered by women. In our analysis, we identified allegations of conscientious objection as another critical node. In these cases, doctors and other health professionals refused to adopt the necessary procedures to perform the abortion, declaring an impediment due to moral, religious, or ethical principles.

*"I admit the patient and await the professional to agree to the procedure (...) I talk to the patient about the team's decision not to initiate the procedure due to ethical conflict"* (medical note – F42, 17 years old).

*"The anesthesiologist registers in the medical record that he is against abortion, exempting himself from providing care due to conscientious objection"* (A5, 12 years old).

*"As it is not an emergency, we will resume the procedure the next day [medical note]. The patient heard the doctor of the department saying she is against abortion and that she should keep the pregnancy and give the child up for adoption"* (L17, 37 years old).

In these excerpts, we can see explicit conscientious objection, in which a professional publicly denies performing the procedure, but we also see implicit behavior, such as "resume the procedure the next day." These situations demonstrate that institutional flows are an important critical node in the path towards access to legal abortion and hinder its implementation in a humanized manner. Both in the bureaucratic procedures for validating the word, and in the nuances of "medical conscience" that lead to treating a legal abortion as prenatal care or the allegation of conscientious objection, we observe a moral economy that must be denounced and confronted.

It is worth emphasizing that the prerogative of conscientious objection provided for in the Code of Medical Ethics is not an absolute right and cannot be used in the absence of another physician, in urgent cases, or if the refusal causes irreversible harm to the patient<sup>24</sup>. When health care is denied due to conscientious objection, the person to whom care was denied is the most seriously affected party. Neglect in providing care in abortion cases with conscientious objection is a phenomenon that violates the ethical principle of nonmaleficence and has serious consequences for women, especially those who are more vulnerable and marginalized. A woman who has been denied an abortion may be forced to continue with the unintended pregnancy, or may resort to a clandestine and unsafe abortion<sup>26</sup>.

According to research conducted in Brazil, medical decisions regarding the performance of legal abortion differ when the victims are adult women, to whom healthcare teams tend to present greater conscientious objection, considering that children and adolescents are more easily perceived as innocent victims<sup>22</sup>. We perceive a social assessment of sexual crimes, which may consider them both heinous, especially when they involve children, and may involve a certain trivialization of the situation, based on the image made of the victim, their behavior, and morality<sup>27</sup>, which reproduces the moral economy and social construction of the victim<sup>23</sup>. Nonetheless, in the analyzed population, we could not verify differences between the levels of conscientious objection in relation to the victims' age, and the allegation was present in both adolescents and adult women cases.

## Final considerations

The trajectory taken by women to have an abortion due to rape is unique and permeated by obstacles. The emotional impact and the attempt to keep the suffered violence secret are added to the psychological reactions that result from trauma, behavioral changes, and social disorganization with emotional and financial losses.

Misinformation, present both in society and in the healthcare and protection network, was one of the main barriers identified, creating unnecessary referrals, lengthening the trajectories, and delaying the abortion. This study reinforces the findings of Machado et al.<sup>28</sup>, indicating that, in addition to the formulation of public policies that address these situations, there must be adequate dissemination of this right and of the services that can be accessed by women after suffering sexual violence. Furthermore, in the circumstances in which abortion is allowed, healthcare teams and managers must ensure safe access to the procedure, adopting an institutional approach with the necessary measures to guarantee this right.

We emphasize the importance of raising awareness and continuing education for professionals who provide care for women who have suffered sexual violence and who seek abortion, focusing on humanized care and non-judgment<sup>25</sup>. It is worth highlighting that this educational work must extend to the actors and services that compose the broad service network such as those in public security, social service, sectors of the judiciary and the Public Prosecution, and the healthcare network altogether. As we demonstrated, these services produce situations that aggravate the critical trajectories.

When pointing out the critical nodes involved in performing legal abortion, even after arriving at the referral service, we listed aspects that are still barely visible on this trajectory. We infer that the context of illegality contributes to the maintenance of the stigma related to abortion. Allegations of conscientious objection, for example, burden the cost of the procedure, as they extend the length of hospital stay and cause more suffering. We noticed how the work related to performing legal abortion is on the margin of other healthcare services, as it involves social pressures and constant tensions that hinder its implementation in accordance with technical guidelines and standards.

This study has limitations regarding the fact that the data source is restricted to information and documents contained in medical records, which were completed in a non-standard manner and by different professionals. In addition, the study was restricted to a single service and excluded from the analysis of women who sought the service and did not have an abortion. We believe that the issues raised in this article can be expanded in future research, which includes a wider range of services as well as situations in which the procedure was not performed. Nevertheless, the analysis highlighted problematic aspects that are likely to be repeated in the scarce referral services throughout the country.

All in all, we emphasize that questioning the right to legal abortion is to reaffirm the inferiority, objectification, and blaming of women, and that projects aimed at the extinction of this already-restricted right represent a social throwback and a threat to the construction of gender equity and democracy.

## Contributors

A. E. Ruschel contributed to the elaboration of the research proposal, collection, analysis production, writing and review of the text. F. V. Machado, C. Giugliani and D. R. Knauth contributed to the elaboration of the research proposal, production of analysis and review. All authors approved the final version for publication.

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## Resumo

*O aborto legal nos casos de gravidez resultante de estupro é previsto no Brasil desde 1940. No entanto, o acesso a esse direito ainda é muito restrito, havendo inúmeras barreiras que dificultam o acesso das mulheres aos serviços de referência que realizam o procedimento. Este artigo discute a trajetória das mulheres que realizaram aborto por estupro entre 2000 e 2018 em um hospital público de referência na cidade de Porto Alegre (Rio Grande do Sul, Brasil). Trata-se de um estudo qualitativo, documental e retrospectivo, que utilizou o conceito das Rotas Críticas para compreender as dificuldades enfrentadas, as decisões tomadas diante da violência sexual e da descoberta da gravidez e as consequências oriundas dessa situação. Os dados foram coletados dos prontuários clínicos das mulheres, totalizando 127 casos. A partir da análise de conteúdo, foram traçadas três categorias que se inter-relacionam, sendo ordenadas de modo a explicitar a sequência de fatos, ações e intercorrências na vida das mulheres, de acordo com a dinâmica das rotas críticas produzidas: entre o segredo da violência e o silenciamento do direito; o adoecimento psíquico e a desorganização social; fluxos institucionais: validação da palavra e objeção de consciência. Percebeu-se que existe um silenciamento diante da violência sexual, sendo que a realização do aborto legal se mostrou um problema invisibilizado e cercado de estigmas. A desorganização psicossocial decorrente da violência foi agravada pela desinformação, pela precariedade das redes de atendimento e pela objeção de consciência dos profissionais.*

*Aborto Legal; Violência Sexual; Estupro*

## Resumen

*Se admite el aborto legal en casos de embarazo resultante de violación en Brasil desde 1940. Sin embargo, el acceso a este derecho sigue siendo muy restringido, con muchas barreras que dificultan el acceso de las mujeres a los servicios de referencia que realizan el procedimiento. Este artículo discute la trayectoria de las mujeres que tuvieron abortos por violación entre 2000 y 2018 en un hospital público de referencia en la ciudad de Porto Alegre (Rio Grande do Sul, Brasil). Se trata de un estudio cualitativo, documental y retrospectivo, que utilizó el concepto de Rutas Críticas para comprender las dificultades enfrentadas, las decisiones que se adoptaron ante la violencia sexual, el descubrimiento del embarazo y las consecuencias derivadas de esta situación. Se recogieron datos de los historiales clínicos de las mujeres, con un total de 127 casos. A partir del análisis de contenido, se delinearon tres categorías que se interrelacionan, ordenándose para explicar la secuencia de hechos, acciones y complicaciones en la vida de las mujeres, de acuerdo con la dinámica de las rutas críticas: Entre el secretismo de la violencia y el silenciamiento de la ley; la enfermedad psíquica y la desorganización social; y los flujos institucionales: validación de la palabra y objeción de conciencia. Se notó que hay un silenciamiento frente a la violencia sexual, y la realización del aborto legal demostró ser un problema invisibilizado y rodeado de estigmas. La desorganización psicossocial derivada de la violencia se agravó por la desinformación, las redes de atención precarias y la objeción de conciencia de los profesionales.*

*Aborto Legal; Violencia Sexual; Violación*

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