CSP CADERNOS DE SAÚDE PÚBLICA
REPORTS IN PUBLIC HEALTH

ARTIGO
ARTICLE

Objection of conscience or ideological instrumentalization? An analysis of discourses of managers and other professionals regarding legal abortion

Objeção de consciência ou instrumentalização ideológica? Uma análise dos discursos de gestores e demais profissionais acerca do abortamento legal

¿Objeción de conciencia o instrumentalización ideológica? Un análisis de los discursos de gestores y demás profesionales sobre el aborto legal

July Grassiely de Oliveira Branco [1]
Aline Veras Morais Brilhante [1]
Luiza Jane Eyre de Souza Vieira [1]
Almudena Garcia Manso [2]

doi: 10.1590/0102-311X00038219

Abstract

This article sought to understand objection of conscience based on an analysis of the ideological formations that permeate access to legal abortion in cases of sexual violence in the perspective of workers and managers who work at reference centers. It is a qualitative research with semi-structured interviews of 20 workers (six of whom were also managers) of these services. The study used discourse analysis. Results show that objection of conscience emerged as a central discursive element. The contextualized analysis of the discourses showed an instrumentalization of the prerogative according to ideological reasons, flowing toward the organization of the following categories: the instrumentalization of objection of conscience and the disarticulation of the network; and instrumentalization of the objection of conscience in order to surveil and punish. We conclude that objection of conscience as discursive formation was re-signified so as to compose a complex and refined system of internal sabotage – both conscious and unconscious – of the health care services for women victims of sexual violence, despite the existing legal framework and advancements.

Legal Abortion; Sex Offenses; Health Care (Public Health)

Correspondence
J. G. O. Branco
Universidade de Fortaleza.
Av. Washington Soares 1321, Fortaleza, CE 60811-905, Brasil.
julybranco.upa@gmail.com

[1] *Universidade de Fortaleza, Fortaleza, Brasil.*
[2] *Universidad Rey Juan Carlos, Madrid, España.*

This article is published in Open Access under the Creative Commons Attribution license, which allows use, distribution, and reproduction in any medium, without restrictions, as long as the original work is correctly cited.

Introduction

Objection of conscience is a legitimate prerrogative [1]. However, health professionals' right to autonomy cannot compromise access to sexual and reproductive rights, in accordance with the legal restrictions of each country [2,3,4,5]. The principle's application, however, has been distorted, culminating in the denial of safe abortion to women who meet the legal criteria for the procedure [2]. Thus, analyzing the discourses of professionals and managers regarding the practice of legal abortion is crucial for identifying and confronting the ideological barriers to the structuring of specific services.

The *Constitutional Amendment Proposal* (PEC, in Portuguese) *181/2015* (Câmara dos Deputados. https://www.camara.leg.br/proposicoesWeb/fichadetramitacao?idProposicao=2075449), currently under consideration in Brazil, interferes with the interpretation of all infra-constitutional laws and ordinances that address legal abortion. In addition to the stated proposal of increasing maternity leave in case of premature delivery, *PEC 181/2015* seeks to ensure the "dignity of the human person" (article 1st) and the "inviolability of the right to life" (article 5th) "since conception". The proposal criminalizes all terminations in the cases currently permitted by the Brazilian legislation, namely, fetal anencephaly, risk of maternal death and pregnancy resulting from rape [6]. The proposal's conservative nature, singularities aside, points to different movements around the world, such as a law approved on May 2nd, 2018, in the state of Iowa, in the United States, which limits the procedure to the period preceding the detection of a fetal heartbeat, a period in which it is highly likely that individuals will not yet have detected the pregnancy [7].

Both the US law and *PEC 181/2015* use discursive artifices in order to – in practice and backed by law – ban abortion. Despite evidence that supports the promotion of safe abortion care [8], the perennial appearance of barriers – both cultural and institutional – to the legal termination of pregnancy is not new [1,9,10]. In Brazil, despite the legal prerogative of abortion in cases of pregnancy resulting from sexual violence [11], manuscripts have shown difficulties in obtaining abortions due to late access to health services [12,13] and to professionals' objection of conscience [1,9,10]. Thus, discourses regarding the legal termination of pregnancy are ideologically marked by two main points: the notion of Christian morality of what is socially acceptable and the social position of the subject who implements them [14,15]. The stigma associated with abortion and sexual violence, as well as the silencing of existing policies, are upheld by discursive formations that compromise the effectiveness of legal instruments [16].

Given this, the following questions emerged: what are the meanings attributed by workers and managers of services that provide integral care to women who have experienced sexual violence to the legal termination of pregnancy resulting from sexual violence? What are the ideological formations that pervade these workers and managers' discourses regarding the legal termination of pregnancy? Beyond what is said, what are the silenced obstacles to the sustainable implementation of services that guarantee access to the right to abortion established by law? What are the uses and meanings of the objection of conscience in the context of the provision of care? To answer these questions, a wide-reaching study was carried out in order to analyze the ideological formations that permeate the care provided to women who experience sexual violence, based on the discourses of workers and managers of sexual violence reference centers in a municipality in the Northeast of Brazil. Given the central place of the objection of conscience in the discourse, this article is based on the theoretical framework of gender studies and of the integral lines of care, seeking to analyze the intentionalities hidden in the allegations of objection of conscience which permeate access to the termination of pregnancies resulting from sexual violence.

Methods

Context description

The municipality where this research took place is the fifth largest in the country in terms of population, with 2,452,185 inhabitants, 53.19% of whom are women [17]. In 2010, the Municipal Human Development Index (MHDI) was of 0.754, putting it in the 17th place in the ranking of the country's state capitals [18]. Using the number of homicides as a parameter, the municipality is the seventh most violent in the world [19]. As for violence against women, in 2017, 3,433 cases were reported [20].

Participant selection

We used the snowball sampling technique – a non-probabilistic sampling that uses reference chains [21]. Based on access to a key informant (the technical assistant in the women's health area), we requested a nomination of another professional who provided care to women who experience sexual violence, and repeated the process successively.

The inclusion criteria were: working in the provision of care to women who experience sexual violence in any of the institutional devices recommended for this care, whether in the health field (medicine, nursing and psychology) or in other areas that intersect with it (social service and law), provided that the work was directly related to the access to legal abortion, in addition to having at least six months of experience at the service and having, during that period, provided care to women who had the right to the legal termination of pregnancy. Because they are directly involved in providing care to these women, these professionals experience the difficulties and obstacles of the network on a daily basis and are broadly aware of the justifications and discursive formations that normatize these barriers. The definition of a minimum period is justified by the need for immersion in the service, experiencing its obstacles, and for an approximation with coworkers, which enabled them to come into contact with different forms of thinking and acting made evident in informal and polarized dialogues. Since professional disagreements regarding the legal termination of pregnancy are not rare, the service managers were included. It is worth noting that, in the absence of a professional capable of performing a legal abortion, it would be up to the management to perform it or provide a referral, guaranteeing access and respecting professionals' objection of conscience. As a manager, therefore, this professional is close to the constant allegations of objection of conscience. We excluded from the study professionals who were away from the service due to vacations or for health-related reasons. The number of participants was determined by the saturation of the sample framework.

The study included the following participants: the former coordinator of the women's policies area (at the time of the study, the coordination was vacant), four workers from the women's reference center and 15 health professionals (six of whom also worked in management) who worked in seven institutions accredited to provide care to women who experience sexual violence – six municipal units and one federal unit. Of these, only two provide legal terminations of pregnancy.

Data collection

We carried out in-depth interviews with open-ended questions, allowing the participants to freely talk about their perceptions regarding legal abortion and, subsequently, about access to this right in their service. If their service did not perform abortions, the questions focused on the causes for the lack of offer and the recommended conduct for ensuring access to the procedure. The objection of conscience emerged in the interviews as a central element in the deprivation of the right to access. Because of this, it was explored in the in-depth interviews. Each interview was previously scheduled and took place at a reserved location chosen by each participant.

Interviews were carried out individually by a researcher with a nursing degree and lasted around 25 minutes. Interviews were recorded and transcribed by the researcher after obtaining a signed written authorization from participants. We also took field notes [22]. The notes were based on impressions regarding the physical structure of the services, the dynamics of the provision of care and the professionals' reactions when discussing the subject.

Analysis procedure

The analysis was guided by principles of Discourse Analysis (DA) [23]. After transcribing the interviews, the material was read exhaustively and in-depth. Based on the discursive information, we sought to "*understand the process of meaning production and its relationship with ideology*" [24] (p. 43). In this process, the discursive formations were contextualized and related to prevailing social discourses. This process led to the emergence of the discourses' contradictions and the ideological formations that situate them. By ideological formation, we mean "*a complex set of attitudes and representations that are 'neither individual' 'nor universal', but are more or less directly related to class positions in conflicts with one another*" [25] (p. 166). The discursive formations were associated with the ideological formations and the semantic phenomena in light of the socio-historical context, leading the unsaid to emerge [24]. Thus, "*words do not have meaning in themselves, they derive their meanings from the ethical formations in which they are inscribed. Discursive formations, in turn, represent ideological formations in the discourse. Thus, meanings are always ideologically determined*" [24] (p. 43).

Ethical procedures

We followed the ethical principles established in the National Health Council's *Resolution n. 466/2012*. In order to keep participants' identities confidential, they are identified by the letter T ("trabalhador", worker in Portuguese) followed by a number (1,2,3…), as follows: T1, T2, and so on. This research was approved by the Ethics Research Committee of the Fortaleza of University under n. 2.327.063/2017.

Results

The analytical process revealed three discursive formations: Barriers to access to legal abortion services; Right to choose versus compulsory motherhood; and Social normatization of violence. Objection of conscience emerged as a central discursive element in all three. The contextualized analysis of discourses, however, showed an instrumentalization of the prerogative according to ideological reasons, flowing toward the organization of the results in the following categories: the instrumentalization of the objection of conscience and the disarticulation of the network; and the instrumentalization of the objection of conscience in order to surveil and punish.

Participant characterization

Participants in this study were aged between 25 and 61 years. One participant was a man and the remaining 19 were women. Nine were married, five were single, two were widows, three were in a stable union and one was divorced. Thirteen participants stated they had been Catholic since birth. Of these, half stated they go to church once a week. The others stated they do not regularly go to church or that they pray at home. There were also three Spiritists, two evangelical Christians, one atheist and one participant who follows multiple religions. Participants' professions were medicine, nursing, psychology, social service, law and management. They had graduated between 7 months and 30 years prior to the interviews and had been working in the service between 7 months and 23 years. Ten participants stated that they participated in courses on the sexual violence. Among these, eight took courses offered by the state two or more years prior. Among the participants, two professionals stated that they effectively participated in performing legal abortions at the institutions where they work.

The instrumentalization of the objection of conscience and the disarticulation of the network

Results show that, although the interviewed professionals consider legal abortion to be a woman's right, there are service barriers that hinder access. In this sense, T20 tells us that "*there is a great difficulty for* [women] *to access this right, either because of a lack of information or because of a lack of a functioning network*". The network's structure, however, is at the mercy of its recognition by successive

administrations, since it is not treated as a State policy. T12 exemplifies this issue when discussing the lack of articulation regarding actions planned by the previous administration after the new one took over, stating that *"in 2012, we tried to form a team during the former mayor's administration, but since she left office, the administration did not continue, it didn't move forward"*.

Given the lack of permanent State action, the responsibility for these services' operation falls to a few professionals. The discourses re-affirm the willingness of the professionals involved in the services to ensure sexual and reproductive rights, even in the face of personal reservations, as T18 exemplifies by stating that: *"although it is often difficult to work with this, I try my best to continue to give the support I've been giving. Working my personal detachment and my non-judgment of accounts, given the outcomes"* (T18).

In this context, objection of conscience emerges as a frequent discursive element in the barriers encountered in the day-to-day activities of the services that perform the legal termination of pregnancy. One of the cases recounted by T1 illustrates a patient with the legal right to the service, but who *"encountered a professional who didn't want to do it and they had difficulty finding another professional in the area to do it, and with that time went on"*, which culminated in not performing the procedure, despite the fact that the woman sought out the service in time. The prerogative, however, not only hinders access to legal termination of pregnancies in the services that provide it, but is also used as a justification for not offering it in other services directed toward women who have experienced sexual violence. The service where T8 works, for example, provides care to women who have experienced sexual violence, but does not provide abortions, and the justification is simply that "(...) *there are no professionals who want to do it*". The fact is corroborated by T9, who faces a similar reality in their service. T9 further adds that there is a refusal not only with regard to abortions, but to the provision of care to women who have experienced sexual violence itself, even if they are not pregnant. According to T9, the justification is the fear of giving visibility to the service. In their words, *"Here in our hospital, unfortunately, we don't have professionals, if they already create difficulties even to provide care and give visibility to what happened, can you imagine them performing abortions"*. The allegation for refusing to provide care to non-pregnant women who have experienced sexual violence is based on the fear that, given a public awareness of the service, a demand for abortion would arise, which, in theory, is to be desired. Paradoxically, this silencing drives the number of abortions, whether legal or illegal, to the extent that access to emergency contraception is flawed, as T18 notes by stating that: *"If we had a stronger network of post-exposure prophylaxis, we wouldn't have so many legal abortions, and this is one of our main goals, to close that flow so we're able to work on that prophylaxis, in preventing unwanted pregnancy, whether or not it is a result of rape"* (T18).

It is worth highlighting that four of the six accredited sexual violence services do not provide abortions. In those services, none of the professionals, including the ones interviewed for this study, who participate directly in providing care to women who have experienced sexual violence, perform this procedure, as T14 clarifies by stating "We don't do it here, when someone shows up, I refer them [to another service]". The possibility of referral, however, is forgotten in some discourses, as that of T17, who states that *"In the times I've had to face these situations, I give guidance, but I make it clear: I don't have the courage to do it due to a series of personal issues"*. In these cases, the proper procedure would be to refer the patient to a professional who does not share the same restrictions and who is willing to provide an abortion. The web of barriers, however, is so structural to the system that informal practices such as clandestine abortions are naturalized. In that context, T17 continues, narrating a fictitious episode, regarding what they would do if a patient sought them out for a legal abortion, and states that they would be willing to care for the patient after the procedure, but neglects, at that moment, to mention a referral. T17 narrates, beginning with the imagined patient's account: *"'And if I need to have [an abortion], will you take care of me afterwards?' 'I'll take care of you, just don't ask me to do it, to place the pill* (...). *If you bleed, come see me. I'll do the curettage, no problem, because I'm taking care of you, I take on my role as a caretaker, I just can't generate a termination"* (T17). This account demonstrates that the professional understands their role as a health provider. However, forgetting the network and the possibility of referrals – whether intentionally or not – contributes to the fragility of the provision of care.

Additionally, even when referrals are mentioned, it is worth remembering that all patients in the network are directed to the two only services in the municipality where abortions are performed.

However, even after arriving at these services, access is not guaranteed, as T1's remarks at the beginning of this topic illustrate.

The discourses demonstrate, therefore, the instrumentalization of the prerogative of objection of conscience in order to prevent the effective structuring of a network of care for women who have experienced sexual violence, encouraging silencing, obstacles to the offer of the legal interruption of pregnancy and barriers to its provision in the few services that offer it.

The instrumentalization of the objection of conscience in order to surveil and punish

Beyond the barriers to accessing the legal termination of pregnancy, the accounts unveil mechanisms for punishing women who have legal abortions despite these obstacles. The punishment mechanisms are present at different moments and in different spheres of care. When implemented before the procedure, they seek to emotionally destabilize women, as T18 observed on many occasions: "*They put the patient in the ultrasound to know if the fetus is alive or not (...). This de-structures the woman who has to once again hear the heartbeat of that fetus, of that conceptus that she doesn't even recognize as a child*".

The uses of the objection of conscience as a discursive formation, however, are not restricted to attempts to prevent the procedure from happening. The prerogative is invoked to prevent the provision of care even after the termination, as T18 also exemplifies by stating that "*It's happened that a patient had already eliminated the conceptus at the moment of curettage and a nursing technician would say that she wouldn't participate or wouldn't hand over a cannula for an aspiration or a curette to the professional performing the curettage because she doesn't agree, when in fact that conceptus had already been eliminated*".

Women are not the only targets of punitive actions, but so are the professionals who care for them and perform the procedure. The discourses of professionals who perform legal abortions show that they are patrolled. In addition to this surveillance, there is isolation and social punishment, such as the aggressions that T18 has suffered, as expression in their statement: "*There's a pediatrician who turns his face every time he sees me since the service was implemented.* (...) *On more than one occasion, I've heard someone say, at the nursing station, 'that one already has a section reserved for her in hell'*".

The punitive attitudes are not isolated but are part of a complex structure for controlling female bodies which, having an ideological basis, even pervade the discourses of professionals who claim to be aligned with sexual and reproductive rights. The right to legal termination of pregnancies resulting from rape was unanimously considered legitimate by the study's participants. Some discourses, however, unveil a continuous surveillance and conditioning of the access to legal abortion to a subjective validation from a professional. T20, for example, received countless "*accounts of women who seek out health services and the professionals, instead of taking them in, takes on a police-like attitude, reporting that woman seeking an abortion to the police*".

Even in the absence of such drastic attitudes, in which professionals tasked with providing care to women who have experienced sexual violence can take on an investigative attitude. T16, for example, conditions access to a verifiable proof of violence when stating that "*It if it's sexual violence, if it is proven to be sexual violence, it's highly distressing, it's too much suffering for the user to have an unwanted child which was a violence*". If the professional does not acknowledge the veracity of the accounts, care may be denied, as T18 exemplifies by stating that "*Many termination requests are denied because, when you investigate, you see that there is an enormous incompatibility between what she is telling you and that pregnancy she is asking you to terminate*".

Going against the norms regarding the provision of this care, the discourses reveal a rhetoric that mistakenly appropriates legal aspects. The onus of proof falls to the woman, at a delicate time in which she needs care, when the legislation itself requires no proof. According to a mistaken interpretation of the legislation, T11 fears committing a crime in the absence of a factual proof of violence and states that "*Nowadays, there's no need for a court order for the procedure, the woman only has to say that that pregnancy was the result of a violent act. So if she makes that statement, she can begin the process of terminating a pregnancy, and then some wonder 'what If she's lying?', 'what if it's not true', I'm committing a crime*". It is worth noting the absence, in the participants' accounts, of the reverse: what if the woman is a victim of sexual violence and I am obstructing her access to a sexual and reproductive right? This silencing itself is a contingent element of hegemonic ideological formations in care.

Discussion

Objection of conscience is a right guaranteed to professionals [1], based on the freedoms of religion, conscience and thought, recognized in several international human rights treaties, as well as in national constitutions [2]. However, this prerogative is not absolute, requiring balance between patient and professional rights and reasonable values for a just society [26,27]. This study's results, however, show a lack of balance, with the scales weighing against sexual and reproductive rights. These findings are not exclusive to Brazil. The literature shows that objection of conscience is an important obstacle in providing care to women who have experienced sexual violence [28,29]. Despite being more frequent in Latin America, due to cultural and religious issues [5], the use of this prerogative by reproductive health providers has also been cause for concern in Europe. According to the Italian Ministry of Health, in 2008, nearly 70% of gynecologists refused to provide abortions due to moral reasons [3].

To date, there are no official and institutional data regarding the occurrence of objection of conscience in Brazil, and this silence is, itself, symptomatic, since that which is not recorded is more easily neglected. To this are added the contradictions of the discursive omissions we found, and we arrive at the enunciative contingent and its hidden intentionalities [24]. An effective network of care for women who have experienced sexual violence, in addition to specific care, provides emergency contraception [2,4], reducing the number of pregnancies resulting from rapes and, consequently, the need for abortions [30]. A specific technical norm standardized emergency care, in the first 72 hours after the violence occurs, regarding welcoming patients, provision of emergency contraception and prophylaxis of STIs, viral and bacterial diseases [31]. Termination of pregnancy would therefore be restricted to failures [32]. In this context, professionals' refusal to provide care to women who have experienced sexual violence even when they are not pregnant not only contradicts the moral and ethical principles that guide the health field [33], but also contribute to an increase in the number of abortions [32]. Their actions therefore promote that to which their conscience objects.

The objection of conscience stand out from other regulatory barriers to the legal termination of pregnancy [32,34] because it based on moral, religious and/or philosophical principles [12]. Thus, as a discursive formation, the prerogative carried the whole weight of hegemonic moral rules and ideologically aligns itself with them. Considering that the social order determines the modes of symbolizing different forms of violence, it is not for nothing that discursive formations regarding objection of conscience move toward the morality artifice that determined who will receive the social sanction of sexual violence victim and who will be subjected to punishment [35]. This normatization strengthens the structures that created the stereotype of women as deceptive beings who will tend to lie in their accounts of rape [36,37,38]. In that process, women are burdened with the onus of proof, ignoring the prerogative of presumption of truthfulness established in the *Penal Code* [7]. One cannot – nor do we intend to – deny the occurrence of untrue accounts, something that applies to all criminal complaints. The exception, however, should not serve as justification given the risk of revictimization. It is a paradox. On the one hand, individuals claim to doubt women so the law will be followed, on the other, they act to limit an established right. These actions result in a gap between the law and its enforcement [26].

These contradictions show that, beyond legal norms and the objection of conscience, there is a complex ideological mechanism for controlling these women's bodies [39], anchored in moral principles [40,41,42]. As individuals whose subjectivities were constructed amid these discursive processes [43], many professionals naturalize them in their care practices. This happens because *"Identity, in this sociological conception, bridges the gap between the 'inside' and the 'outside' – between the personal and the public worlds"* [44] (p. 11). The primacy of doubt over care is, therefore, a reflex of the social structure that tends toward the preliminary blaming of the victim of sexual violence [41,42,43,44,45,46]. Beyond the refusal to provide care, to give a referral to an accredited service or professionals and the revictimization, the intentional de-structuring of the network culminates in an increased mortality among these women to the extent that it increases the demand for clandestine abortions [28]. Additionally, it reinforces a social structure in which female subjectivity succumbs to the reproductive capacity [45,47,48], in addition to predisposing women to psychic suffering. Women who carry pregnancies resulting from sexual violence to term are more likely to develop mental health-related problems [39]. The surveillance and consequent punishment, however, are not restricted to women. Professionals who effectively participate in providing care to women who have experienced sexual violence are also stigmatized

and suffer different forms of punishment [29,30], which reinforces silencing [49,50]. Thus, a tacit, silent, unwritten rule is constructed which remains in effect because it is consistent with ideological formations found in society. The fear of being stigmatized by peers [1,29] is added to the cultural framework that legitimizes sexual violence and blames victims and serves as a structure and support for the ideological formations shown in this study.

Laws and policies are crucial to maintaining sexual and reproductive rights [51,52] and this must be emphasized in a political moment when the loss of rights is discussed. However, laws and policies are carried out by people whose subjectivities were molded in an ideological context [43]. These individuals reproduce this context in care, so that the network remains unstructured due to internal sabotage, whether conscious or not. It is worth noting that we should not blame the professional who invokes the prerogative, among other reasons, because the existence of a well-regulated network, with the implementation of a mechanism for timely and systematic referrals, would ensure that the objection of conscience would be an individual decision with no risks to sexual and reproductive rights [2]. The lack of an effective network, however, shares the same ideological origin as the discursive formations regarding the objection of conscience, and we must unveil them in order to find an effective solution.

Final thoughts

The analysis of ideological formations related to the objection of conscience in cases of legal abortions following sexual violence shows intentionalities anchored in curtailing of rights, punitivism and social stigma. The objection of conscience as discursive formation was resignified so as to compose a complex and refined system of internal sabotage – both conscious and unconscious – of the services that provide care to women who have experienced sexual violence, despite the existing legal framework and advancements. The prerogative, despite being a right of professionals, must not justify the violation of women's rights or their revictimization by punitive attitudes. Likewise, the objection cannot push these women to death in clandestine abortions without adequate care.

As a ramification of this study, we suggest developing new studies focusing on access to legal interruption of pregnancy, as well as establishing and analyzing institutional records regarding the structural and subjective barriers to the services' effective establishment.

Contributors

J. G. O. Branco, A. V. M. Brilhante and L. J. E. S. Vieira participated in the research conception and planning, analysis of results and manuscript drafting. A. G. Manso contributed to the research conception and approval of the final text.

Additional informations

ORCID: July Grassiely de Oliveira Branco (0000-0001-6188-9745); Aline Veras Morais Brilhante (0000-0002-3925-4898); Luiza Jane Eyre de Souza Vieira (0000-0002-5220-027X); Almudena Garcia Manso (0000-0002-8781-5020).

References

1. Faúndes A, Duarte AG, Osis MJD. Conscientious objection or fear of social stigma and unawareness of ethical obligations. Int J Gynaecol Obstet 2013; 123 Suppl 3:S57-9.
2. Zampas C. Legal and ethical standards for protecting women's human rights and the practice of conscientious objection in reproductive healthcare settings. Int J Gynaecol Obstet 2013; Suppl 3:S63-5.
3. Zampas C, Andion-Ibaniez X. Conscientious objection to sexual and reproductive health services: international human rights standards and European law and practice. Eur J Health Law 2012; 19:231-56.

4. Lema VM. Conscientious objection and reproductive health service delivery in sub-Saharan Africa. Afr J Reprod Health 2012; 16:15-21.
5. Casas L. Invoking conscientious objection in reproductive health care: evolving issues in Latin America. Toronto: University of Toronto; 2005.
6. Brasil. Decreto-lei nº 2.848, de 7 de dezembro de 1940. Código Penal. Diário Oficial da União 1940; 31 dez.
7. Estado de Iowa aprova lei mais restritiva ao aborto nos Estados Unidos. Folha de S.Paulo 2018; 2 mai. https://www1.folha.uol.com.br/mundo/2018/05/estado-de-iowa-aprova-lei-mais-restritiva-ao-aborto-nos-estados-unidos.shtml.
8. Sedgh G, Singh S, Shah IH, Åhman E, Henshaw SH, Bankole A. Induced abortion: incidence and trends worldwide from 1995 to 2008. Lancet 2012; 379:625-32.
9. Quinter-Roa EM, Ochoa-Vera ME. Actitudes de los gineco-obstetras ante la interrupción legal voluntaria del embarazo. Rev Salud Pública 2015; 17:776-88.
10. Brooke RJ, Kismodi E, Dragoman MV, Temmernan M. Conscientious objection to provision of legal abortion care. Int J Gynaecol Obstet 2013; 123 Suppl 3:S60-2.
11. Brasil. Lei nº 12.845, de 1º de agosto de 2013. Dispõe sobre o atendimento obrigatório e integral de pessoas em situação de violência sexual. Diário Oficial da União 2013; 2 ago.
12. Santos J, Drezett J, Alves AL. Características sociodemográficas de migrantes bolivianas com gestação decorrente de violência sexual atendidas em serviço público de referência para abortamento legal, São Paulo, Brasil, 2002-2014. Reprod Clim 2015; 30:25-32.
13. Dan EMC. O discurso sobre a anormalidade nas práticas judiciais. Rio de Janeiro: Editora Lumen Juris; 2014.
14. Dornelles JR. O que é crime. São Paulo: Editora Brasiliense; 1988.
15. Pêcheux M. Semântica e discurso: uma crítica à afirmação do óbvio. 5ª Ed. São Paulo: Editora Unicamp; 2016.
16. Costa M. Ditos e interditos: violência sexual, aborto e estigma em uma instituição de saúde pública. Revista Espaço Acadêmico 2018; 200:1-12.
17. Instituto Brasileiro de Geografia e Estatística. Brasil em síntese, 2010 https://cidades.ibge.gov.br/brasil/ce/fortaleza/panorama (accessed on 10/Jun/2018).
18. Instituto de Pesquisa e Estratégia Econômica do Ceará. Perfil básico municipal Fortaleza; 2016. http://www.ipece.ce.gov.br/perfil_basico_municipal/2016/Fortaleza.pdf (accessed on 28/Feb/2017).
19. Seguridad, Justicia y Paz. Consejo Cuidadano para la Seguridad Pública y Justicia Penal AC. Metodología del ranking (2017) de las 50 ciudades más violentas del mundo. http://www.seguridadjusticiaypaz.org.mx/biblioteca/prensa/send/6-prensa/242-las-50 ciudades-mas-violentas-del-mundo-2017-metodologia (accessed on 10/Jun/2018).
20. Observem. Filtro de pesquisa estatística da violência contra a mulher em Fortaleza em 2017. http://observem.com.br/page/estatisticas (accessed on 10/Jun/2018).
21. Vinuto J. A amostragem em bola de neve na pesquisa qualitativa: um debate em aberto. Temáticas 2014; 22:203-20.
22. Creswell JW, Clark VLP. Pesquisa de métodos mistos. 2ª Ed. Porto Alegre: Penso Editora; 2013.
23. Orlandi EP. Discurso e texto: formulação e circulação dos sentidos. Campinas: Editora Pontes; 2001.
24. Orlandi EP. Análise de discurso: princípios e procedimentos. 8ª Ed. Campinas: Editora Pontes; 2009.
25. Pêcheux M, Fuchs C. A propósito da análise automática do discurso: atualização e perspectivas. In: Gadet F, Hak T, organizadores. Por uma análise automática do discurso: uma introdução à obra de Michel Pêcheux. 3ª Ed. Campinas: Editora da Unicamp; 1997. p. 163-252.
26. Prata MCS, Campos RSP, Souza LBLN, Fernandes GL, Hime LDFCC. Abortamento entre mulheres vítimas de violência sexual: conflitos e desafios. Revista de Atenção à Saúde 2015; 13:106-12.
27. Diniz D. Objeção de consciência e aborto: direitos e deveres dos médicos na saúde pública. Rev Saúde Pública 2011; 45:981-5.
28. Madeiro AP, Diniz D. Serviços de aborto legal no Brasil – um estudo nacional. Ciênc Saúde Colet 2016; 21:563-72.
29. Diniz D, Madeiro A, Rosas C. Conscientious objection, barriers and abortion in the case of rape: a study among physicians in Brazil. Reprod Health Matters 2014; 22:141-8.
30. Choi DS, Kim M, Hwang KJ, Lee KM, Kong TW. Effectiveness of emergency contraception in women after sexual assault. Clin Exp Reprod Med 2013; 40:126-30.
31. Departamento de Ações Programáticas Estratégicas, Secretaria de Atenção à Saúde, Ministério da Saúde. Prevenção e tratamento dos agravos resultantes da violência sexual contra mulheres e adolescentes. Norma Técnica. 3ª Ed. Brasília: Ministério da Saúde; 2012. (Série A. Normas e Manuais Técnicos) (Série Direitos Sexuais e Direitos Reprodutivos – Caderno 6).
32. Machado CL, Fernandes AMS, Osis MJD, Makuch MY. Gravidez após violência sexual: vivências de mulheres em busca da interrupção legal. Cad Saúde Pública 2015; 31:345-53.
33. Conselho Federal de Medicina. Revisão do Código de Ética Médica. http://www.rcem.cfm.org.br/index.php/cem-atual#cap2 (accessed on 10/Jun/2018).
34. Blake MT, Drezette J, Machi GC, Pereira VX, Raimundo RD, Oliveira RF, et al. Factors associated to late-term abortion after rape: literature review. Reprod Clim 2014; 29:60-5.
35. Diniz D, Dios VC, Mastrella M, Madeiro AP. A verdade do estupro nos serviços de aborto legal no Brasil. Revista de Bioética 2014; 22:291-8.

36. Minayo MCS. Violência um problema de saúde dos brasileiros. In: Secretaria de Vigilância em Saúde, Ministério da Saúde, organizador. Impacto da violência na saúde dos brasileiros. Brasília: Ministério da Saúde; 2005. p. 9-41. (Série B. Textos Básicos de Saúde)
37. Farias RS, Cavalcanti LF. Atuação diante das situações de aborto legal na perspectiva dos profissionais de saúde do Hospital Municipal Fernando Magalhães. Ciênc Saúde Coletiva 2012; 17:1755-63.
38. Basow SA, Minieri A. You owe me. Effects of date cost, who pays, participant gender, and rape myth beliefs on perceptions of rape. J Interpers Violence 2011; 26:479-97.
39. Scott J, Rouhani S, Greiner A, Albutt K, Kuwert P, Hacker MR, et al. Respondent-driven sampling to assess mental health outcomes, stigma and acceptance among women raising children born from sexual violence-related pregnancies in eastern Democratic Republic of Congo. BMJ Open 2015; 5:e007057.
40. Foucault M. Vigiar e punir: nascimento da prisão. 4ª Ed. Petrópolis: Editora Vozes; 1986.
41. Lacerda LA. Barreiras enfrentadas pelas mulheres na interrupção legal da gravidez em casos de violência sexual. In: Seminário Internacional Fazendo Gênero 11 & 13th Women's Worlds Congress http://www.en.wwc2017.eventos.dype.com.br/resources/anais/1499469192_ARQUIVO_Barreirasenfrentadaspelasmulheresnainterrupcaolegaldagravidezemcasosdeviolenciasexual.Lacerda,Lais.pdf (accessed on 10/Jun/2018).
42. Foucault M. História da sexualidade: a vontade de saber. Rio de Janeiro: Edições Graal; 1988.
43. Scott J. Gênero: uma categoria útil de análise histórica. Educação e Realidade 1995; 20:71-99.
44. Hall S. A identidade cultural na pós-modernidade. 12ª Ed. Rio de Janeiro: Lamparina; 2015.
45. Despentes V. Teoria King Kong. São Paulo: n-1E edições; 2016.
46. Saffioti HIB. Gênero patriarcado violência. 4ª Ed. São Paulo: Expressão Popular; Fundação Perseu Abramo; 2015.
47. Davis A. Mulheres, raça e classe. 1ª Ed. São Paulo: Boitempo; 2016.
48. Beauvoir S. O segundo sexo: fatos e mitos. 3ª Ed. Rio de Janeiro: Nova Fronteira; 2016.
49. Montesinos-Segura R, Alvarado-Zeballos S, Acevedo-Villar T, Dávila-Adrianzén A, Taype-Rondan A. Opinión de estudiantes de medicina sobre la legalización del aborto en casos de violación, y sus factores asociados, Perú, 2015. Acta Méd Peru 2016; 33:267-74.
50. Diniz D. Três gerações de mulheres. In: Pinsky CB, Pedro JM, organizadores. História das mulheres no Brasil. São Paulo: Contexto; 2016. p. 313-32.
51. Biroli F. O debate sobre aborto. In: Miguel LF, Biroli F, organizadores. Feminismo e política. São Paulo: Boitempo; 2014. p. 123-30.
52. Biroli F. Gênero e desigualdades: limites da democracia no Brasil. São Paulo: Boitempo; 2018.

Resumo

Este artigo objetivou compreender a objeção de consciência com base na análise das formações ideológicas que permeiam o acesso ao abortamento legal decorrente de violência sexual na concepção de trabalhadores e gestores que atuam em serviços de referência. Trata-se de uma pesquisa qualitativa mediante a participação de 20 trabalhadores (seis exerciam, também, a gestão) desses serviços a um roteiro de entrevista semiestruturado. O método de análise usado foi a análise do discurso. Os resultados evidenciam que a objeção de consciência emergiu como elemento discursivo central às mesmas. A análise contextualizada dos discursos evidenciou uma instrumentalização da prerrogativa por razões ideológicas, confluindo para a organização dos resultados nas seguintes categorias: a instrumentalização da objeção de consciência e a desarticulação da rede; e a instrumentalização da objeção de consciência a fim de vigiar e punir. Conclui-se que a objeção de consciência como formação discursiva foi ressignificada, a fim de compor um complexo e refinado sistema de sabotagem interna – consciente e inconsciente – dos serviços de atendimento à mulher em situação de violência sexual, apesar dos marcos e avanços legais.

Aborto Legal; Delitos Sexuais; Atenção à Saúde

Resumen

El objetivo de este artículo fue comprender la objeción de conciencia, a partir del análisis de las formaciones ideológicas que permean el acceso al aborto legal ocasionado por violencia sexual, en la concepción de trabajadores y gestores que actúan en servicios de referencia. Se trata de una investigación cualitativa mediante la participación de 20 trabajadores (seis ejercían, también, la gestión) de estos servicios en un guión de entrevista semiestructurado. El método de análisis utilizado fue el análisis del discurso. Los resultados evidencian que la objeción de conciencia emergió como elemento discursivo central a las mismas. El análisis contextualizado de los discursos evidenció una instrumentalización de la prerrogativa por razones ideológicas, confluyendo a la organización de los resultados en las siguientes categorías: la instrumentalización de la objeción de conciencia y la desarticulación de la red, así como la instrumentalización de la objeción de conciencia, a fin de vigilar y castigar. Se concluye que la objeción de conciencia como formación discursiva fue resignificada, con el fin de componer un complejo y refinado sistema de sabotaje interno – consciente e inconsciente – de los servicios de atención a la mujer en situación de violencia sexual, a pesar de los marcos y avances legales.

Aborto Legal; Delitos Sexuales; Atención a la Salud

Submitted on 26/Feb/2019
Final version resubmitted on 08/May/2019
Approved on 03/Jun/2019