ABORTAR
en el laberinto

la violencia de impedir y obstruir

MxM
fundación

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Abortion in the labyrinth:

The violence of

to impede and obstruct.

la violencia de impedir y obstruir

Index

Who are we?

The MxM Foundation is a feminist, interdisciplinary and intergenerational organization from the province of Tucumán, in northern Argentina.

For the past 12 years, it has promoted access to sexual, reproductive and non-reproductive rights in general, and to abortion permitted by Law 27.610 in particular.
It has an interdisciplinary team made up of professionals and students of law, medicine, psychology, social work and literature, who work in a Community Clinic, a Mental Health Clinic and a Sexual Health Clinic.

Our goal as a Foundation is to strengthen the sexual sovereignty of women and diverse groups so that they can exercise full citizenship in a State that guarantees, beyond all religious fundamentalism, the ac-
I am moving towards a life free from violence.

We actively work for a society where all bodies—uncomfortable, irreverent, defiant, rebellious, and unkempt—fit in.

that historically

Patriarchy has excluded.

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Abortion in Argentina: the girls' odyssey

One early morning in December 2020, we wrested Law 27.610 from the patriarchal system, which enabled us to interrupt-
voluntary termination of pregnancy (VTP).

However, a path already existed for people with the capacity to gestate to access their right. Since 1921, abortion has been legal in certain cases in Argentina, and it remains in effect to this day (ILE)1 .

Article 86 of the penal code established three grounds in which abortion was not punishable: a) when it was intended to avoid a danger to the life of the woman, b) to the health of the woman, c) when the pregnancy was a consequence of sexual abuse.

Abortion has always been considered an autonomous crime, distinct from homicide, of an intentional and result-based nature, since the attempt was never punishable.

It established penalties of up to 4 years for voluntary abortion, both for women and for the people who perform it.
ticasen with their consent.

1 - "ARTICLE 86. - Abortion performed with the consent of the pregnant person up to and including the fourteenth (14) week of the gestational process is not a crime. Outside the time limit established in the previous paragraph, abortion performed with the consent of the pregnant person will not be punishable:
1. If the pregnancy is the result of rape. In this case, the procedure must be guaranteed with the requirement and sworn statement of the pregnant person before the intervening health professional or staff.
In the case of girls under thirteen (13) years of age, the sworn statement will not be required.
2. If the life or overall health of the pregnant person were at risk."

Even after the legal reform, abortion performed outside the provisions of article 86 (outside the 14-week period and not included in the three grounds) is classified by criminal law as a crime.

Article 86 of the Penal Code, from its origins, was the subject of intense doctrinal disputes, restrictive interpretations, and political controversies that, in practice, limited the effective access to these legally permitted abortions.

March 24, 1976, marked the beginning of one of the darkest periods in Argentine history. The dictatorship that seized power did so through state terrorism, imposing fear, persecution, and control over society. In this context, feminist demands were silenced, and the call for abortion rights was completely excluded from any possible debate.

With the backing of the Catholic Church, the regime moved quickly to tighten abortion laws. Just three months after the coup, Decree Law No. 21338 was issued, which increased the restrictions on the grounds for abortion that had been in place during the Onganía dictatorship in 1968.
Thus, control over reproduction and the bodies of women and anyone with the capacity to gestate became an explicit state policy.

With the advent of democracy, inaccessibility to legal abortions continued to be the rule.

This situation will only change thanks to the activism and perseverance of feminist groups that managed to ensure that access to sexual, reproductive and non-reproductive health (Law 25673 of 2002 and Law 26130 of 2006) and comprehensive sex education (Law 26.150 of 2006) were established as public policies at the national level, and that at the same time began to give visibility and judicial follow-up, even before international human rights protection organizations, for dramatic cases of inaccessibility to abortions permitted by law such as that of LMR (2006) in the province of Buenos Aires or that of Ana María Acevedo in Santa Fe (2007).

In 2012, the Supreme Court issued a ruling in case FAL (2012)2 , a case initiated by a 15-year-old girl who, after becoming pregnant as a result of sexual abuse by her stepfather, requested an abortion. The ruling established the correct interpretation of Article 86, paragraph 2, of the Penal Code, holding that it establishes that abortion is not punishable in all cases of rape, regardless of the mental or cognitive state of the woman or pregnant person.

abused.

It also established that Article 86 did not violate the Convention on the Rights of the Child and that the United Nations Committee on the Rights of the Child even censured the Argentine State for not guaranteeing timely access to

2 - CSJN, F. 259. XLVI. F., AL s/ self-satisfactory measure.

non-punishable abortions, as a matter of public health, without interference from the judiciary (paragraph 26).

The Supreme Court took another step in defining the scope of non-punishable abortion as provided for in Article 86 of the Penal Code. In light of the principle of privacy, it held that this provision applies when the procedure is performed by a healthcare professional with the consent of the woman or pregnant person, as clearly stated in the law. Consequently, any additional requirements
—whether judicial, administrative or professional— is legally inadmissible, as it introduces restrictions not foreseen by the legislator and that directly affect the
exercise of a legally recognized right.

The Court affirmed that such undue interventions constitute an impediment incompatible with the rights at stake, insofar as they render meaningless the permission granted by the legal system and reproduce practices of guardianship and control over bodies and reproductive decisions. From this perspective, judicialization, unjustified delays, or extraordinary requirements not only lack a legal basis but also operate as mechanisms of institutional discipline.

Furthermore, the Court held that these practices are contrary to the international commitments assumed by the Argentine State in the area of human rights, in particular the Inter-American Convention to Prevent, Punish and Eradicate Violence Against Women.

and Eradicate Violence against Women. In that context, she warned that the refusal or obstruction of access to legal abortion can constitute institutional violence under the terms of articles 3 and 6 of Law 26.485 on Comprehensive Protection to Prevent, Punish and Eradicate Violence against Women, since it is the State itself, through its agents, that produces a specific and aggravated violation of the rights of women and pregnant people in the health field.

Cartography of a disputed right

Our national context is currently part of a

unrestricted import opening scheme, indebtedness-accelerated growth and devaluation of the local currency have created a deeply recessionary scenario.

The response to this crisis has focused almost exclusively on adjusting “social spending,” which has led to a marked deterioration in living conditions and a deepening of the poverty and the dismantling of protection structures social action, both in terms of security and assistance.

This is compounded by the rollback of inclusive public policies and integrals and a worrying weakening of values of-democratic systems, where repression begins to be legitimized as a mechanism to maintain a supposed “order”, restricting increasingly the “civic space”.

In this scenario, practices and discourses that evoke the specters of the dictatorship resurface, now reconfigured under the notion of a supposed “need for security.” Thus, democracy is limited both in terms of individual freedoms and in the social and community fabric. The social question then becomes more complex and painful: collective bonds fragment, the social loses value in public discourse, and inequality becomes so evident that, paradoxically, it risks becoming normalized. We find ourselves facing a new historical period in which the economic

The monkey decisively conditions the political, the social and the cultural aspect.

Another characteristic that runs through this national context today is uncertainty: political, due to the loss of trust and identification with state institutions; economic and social, due to the increase in structural inequalities in society; and cultural, in the face of the numerous ideological antagonisms that hinder dialogue.3

It is clear that there is a crisis in the spaces of socialization, which has led to the gradual loss of the collective as a fundamental axis. This can be seen when social duties are transformed into individual ones, generating a loss of belonging to the collective. In other words, duty and needs become linked to the sphere of the individual, detached from the maintenance of society. This contributes to the increase in individualism and ephemeral relationships that fuel the loss of local, common, and collective sense.

However, these tensions take on a particular configuration in the current political and economic context of Argentina. The government's orientation towards reducing public spending, deregulation, and redefining the role of the State in social areas can be analyzed in light of the notion of neoliberal rationality developed by Wendy Brown (2015). 3 - Álvarez, M. (2025). *Anti-gender language: hate speech vs. freedom of expression.* Mujeres x Mujeres; Tucumán.

For the author, neoliberalism is not merely an economic program, but a form of political rationality that profoundly reconfigures social life, transforming rights into commodities and citizens into human capital. From this perspective, rights cease to be conceived as universal guarantees and become mediated by market logics, efficiency, and cost-benefit analysis, which redefines their very meaning and shifts their foundation toward an ethic of individual responsibility.

When this rationale penetrates the field of health, the right to voluntary termination of pregnancy, for example— Therefore, it ceases to be considered an undeniable obligation of the State and is instead reconfigured under neoliberal logic. This is evidenced by budget cuts, defunding of sexual and reproductive health programs, and the weakening of Comprehensive Sexuality Education (CSE) and the precariousness of interdisciplinary teams, and the reconfiguration of new masks of conscientious objection.4

When rights are transformed into finite and distant resources, we enter a logic of consumption where few can compete in a reduced market.

It is important to understand those who are excluded from access to rights in terms of what Florencia Luna (2008) conceptualizes as “layers of vulnerability”: it is not about

4 - Deza, S. (2020). *The masks of objection.* Women x Women; Tucumán.

not subjects vulnerable by nature, but from overlapping layers—age, poverty, rurality, disability, ethnicity, prior violence, lack of transportation, institutional conscientious objection—which make the effective exercise of a formally recognized right and access more difficult

real citizenship.

Here Simone de Beauvoir's warning in her book The Second Sex5 gains strength : “A political, economic crisis will suffice
mica or religious so that women's rights return
to be questioned.” Budgetary and discursive setbacks show that no achievement is irreversible. What
It seemed like a battle won, but it can be up for debate again.
sion when the force correlations change.

Along these same lines, Nora Britos (2003) argues that women have historically been part of groups whose incorporation into full citizenship was conflictive, gradual, and always partial. The author reconstructs this process based on various normative milestones: towards the end of the 19th century, married women were legally considered in terms of their subordination to their husbands, who acted as head of the family with control over property and legal rights. It was only in 1907 that the first laws appeared addressing working women, recognizing them in relation to the world of work. In 1926, their civil status was modified, granting legal capacity to older single women and widows.

5 - de Beauvoir, S. (1949). *The Second Sex.* Gallimard.

women, although this right was lost upon marriage. In 1947, the right to vote and to be elected was recognized, and by 1970 progress had been made in recognizing their full civil capacity.

Although political citizenship in Argentina was configured early on around secret and compulsory suffrage, this overview shows that women's citizenship was cons-
being built unevenly. In this sense, citizenship is not exhausted by the formal recognition of civil and political rights, but also implies the effective possibility of
to exercise them under conditions of material equality.

Reproductive autonomy constitutes a central dimension of social citizenship: without the real capacity to decide on reproduction, equality becomes abstract. Beauvoir's warning about the reversibility of rights thus resonates with Britos's notion of incomplete citizenship. When access to abortion is restricted—whether due to administrative obstacles, underfunding, or dilatory institutional practices—not only is a health service affected, but a constitutive dimension of the citizenship of women and pregnant people is restricted.

Citizenship is not only a legal status, but also real access to civil, political, and social rights. Within this framework, abortion can be considered a condition of citizenship: without reproductive autonomy, there is no substantive equality. From a historical perspective of Argentine feminism, and following Dora Barrancos (2007), it has been shown that control over the

Reproduction was a central axis in the organization of the patriarchal order and in the state regulation of bodies. The disputes surrounding abortion reveal the persistence of a cultural matrix that associates women with motherhood as their destiny and social function. This matrix does not disappear with legal reform; it continues to operate in institutional practices, professional resistance, and moral discourses.

At this point it is enlightening to recall Nelly Minyersky's reflection in the introduction to Checkmate to the Queen6 ▪ Over there It points out that the legalization of abortion represented a "checkmate" to the patriarchal legal order, by questioning motherhood as an obligatory destiny. However, this advance does not imply a "checkmate": the validity of the right depends on its implementation. effective motivation and the ability to sustain it in the face of political, cultural, and economic resistance.

Along the same lines, the work of Soledad Deza, Alejandra Iriarte, and Mariana S. Álvarez highlights the need to continue contesting the law as a field of struggle, where women have a key voice in dismantling the barriers that still persist. Today, those barriers are being reconfigured, and the question becomes more specific: What is happening with abortion in Tucumán?

Tucumán presents a trajectory marked by intense disputes surrounding sexual and reproductive rights. 6 - Deza, S., Iriarte, A., & Álvarez, MS (2014). *Checkmate to the Queen: Health, Autonomy and Reproductive Freedom in Tucumán.* Cienflores Publishing House.

judicialization of cases, institutional resistance, and the
The strong influence of conservative sectors has conditioned
Access to legal abortion (ILE), even after the FAL ruling, and more recently, to voluntary termination of pregnancy (IVE) provided for in Law 27.610, has been restricted. In the current context, marked by cuts and regressive rhetoric, these inequalities are deepening: access to this right becomes more uncertain, more dependent on individual will than on clear public policies and

sustained.

Thus, the right exists, but its exercise is eroded by multiple layers of vulnerability and restrictive institutional practices. The challenge is no longer merely to uphold the norm, but to guarantee the material, budgetary, and symbolic conditions that allow for its effective implementation.

Because abortion is not a privilege or an exceptional concession: it is a human right, a condition of citizenship, and a social good. As Beauvoir points out, its validity always depends on the collective capacity to defend it.

Within this framework, the present input aims to show experiences recorded, systematized and analyzed in our intervention device — Community Clinic
tario MxM— between February 2025 and February 2026. In
During that period, we recorded 102 barriers and obstacles faced by people with the capacity to gestate in the Tucumán public health system when trying to access voluntary termination of pregnancy .

taria or legal of pregnancy.

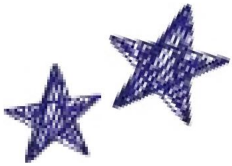
Far from promoting a break with public institutions, our intervention seeks to strengthen their appropriation as spaces that belong to the citizenry, promoting the active exercise of claiming and demanding rights.

Along these lines, we promoted actions aimed at guaranteeing comprehensive, high-quality, accessible, effective, and available healthcare. Among these, we carried out a declaratory action to demand that SI.PRO.SA provide the missing medication7 in hospitals, strengthened the network of professionals built in the "Empalme" project, and developed Comprehensive Sexuality Education workshops in schools and primary healthcare centers.

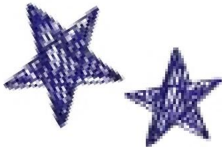
This document invites us to delve into these concrete experiences, into the narratives where the law is strained, contested, and also made possible. Because understanding how barriers operate today not only allows us to grasp the scale of the challenges, but also to identify the collective strategies being developed to confront them. Reading it is, ultimately, a way to continue thinking about ways to dismantle and dismantle the barriers.

red wine.

7 - This refers to Misoprostol and Mifepristone.



Here we are



The community clinic is established as a space for active listening and collective knowledge building, where the effects of a neoliberal state and public administration are clearly expressed, which, through cuts in health policies, persistent misinformation and the reproduction of conservative and hateful discourses, continue to hinder the full exercise of rights.

Our intervention device plays a key role in detecting the barriers and obstacles faced by people with the capacity to gestate within the public system
health in Tucumán at the time of accessing the IVE/ILE. A

Through daily support and ongoing exchange between those experiencing these situations and those of us who accompany them from this space, the “paths” and “labyrinths” that many women and pregnant people must navigate to access legal, safe, and free abortion services repeatedly become visible. Identifying these barriers is the result of collective work: from those who say enough is enough and articulate the violence and inequalities they have experienced, and from those of us who accompany them, record, systematize, and together transform these experiences into political action.

co-socials oriented towards change.

In this sense, the removal of barriers from the doctor's office

It is not a welfare action, but rather a preventive, educational and health promotion intervention, which in turn is profoundly political: a practice that challenges meanings, strengthens knowledge and the exercise of rights, and promotes effective access to comprehensive health from a community, feminist and reproductive justice perspective.

As an organization, we assume the responsibility to listen to, support, and respond to those voices that express a collective social demand and that highlight violated rights, committing to a comprehensive, intersectional, and interdisciplinary view of health as a right, oriented towards
to guarantee freedom and real equality of opportunity, for that abortion should no longer be a privilege.

8 - Mónaco Rodríguez, MF (2024). *Feminist lace: weaving urgent stories.* Women x Women Foundation.

How is it built

the labyrinth?

The labyrinth is described as the winding, confusing, and exhausting path that women and pregnant people must travel to try to exercise their right to abortion. It is not a linear path, but a trajectory marked by uncertainty, where the person is led from one place to another without clear solutions, a paradox between being

“derivative” and to be “adrift”.

- Construction of the labyrinth: It is built by means of Persistent misinformation, lack of adequate guidance, and fragmentation of care, forcing people to go through multiple offices and hospitals.

- Impact: This process produces physical and emotional exhaustion that aims to make the person abandon their decision or become worn down in the process. Crossing the labyrinth often depends more on the “individual will” of professionals or the support of organizations than on clear public policies.

The **barriers:** the barriers to accessing health care are obstacles specific policies, restrictive practices and institutional mechanisms that limit or prevent the effective exercise of the right to comprehensive health.

According to the framework developed by the Organization World Health Organization and Pan American Health Organization Health, health systems must guarantee four fundamental dimensions: availability, accessibility, acceptability and quality9

.

These dimensions constitute criteria for evaluating the functioning of health systems and allow for the identification of obstacles that limit effective access to healthcare services. When these conditions are not met, barriers emerge that hinder or prevent the full exercise of rights, including access to voluntary and legal abortion.

In turn, as we mentioned earlier, in our country, the identification of these obstacles was also pointed out by the Supreme Court of Justice of the Argentine Nation in the ruling: “FAL s/ Self-satisfactory measure”, where the court warned that women and pregnant people face various administrative, institutional and judicial obstacles that hinder access to abortions permitted by law.

In this sense, the analysis of barriers allows us to understand the tensions that exist between the regulatory framework that recognizes rights and the concrete conditions of access in the health system, thus becoming a fundamental tool to strengthen support strategies.

9 - Committee on Economic, Social and Cultural Rights. (2000). *General Comment No. 14: The right to the enjoyment of the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights).* United Nations.

to guarantee effective access to benefits and promote rights-based health practices.

BARRERAS

bureaucratic-administrative

In this context, barriers can include obs-
tasks: administrative, material, institutional or
cultural factors that restrict timely access to care
health.

- Bureaucratic-administrative barriers: affect primarily accessibility to health services. These include a lack of appointments, appointments with excessive delays, incorrect referrals, unnecessary administrative procedures, or the requirement of documents not included in current regulations (such as judicial authorizations, signatures from directors, or medical boards). These practices generate delays that can hinder timely access to care.

These barriers have a parallel in the real and everyday lives of users who experience them firsthand:

-Experiences with bureaucratic-administrative barriers in access to IVE/ILE (case of Valentina, Camila and Paula)

Valentina:10

On November 7, 2025, Valentina enters a hospital specializing in gynecology and obstetrics. She requests a voluntary termination of pregnancy. She speaks clearly, certain of her decision, but the response from the other side of the counter is bureaucratic and curt: “Appointment for December 17.” More than a month away. For her, time is not a detail: it is pressure, it is anguish, it is feeling that her body no longer entirely belongs to her. She asks at other hospitals. They all refer her to the same one. “That’s where the specialty is,” they tell her. But that word no longer sounds like a guarantee to her, but rather a trap.

This isn't the first time she's been through this; a year earlier, she wanted to terminate a pregnancy, and they sent her from doctor's office to doctor's office and through hallways until they finally gave her an appointment. Then, a doctor told her she needed an ultrasound and that she didn't usually do "that" [referring to the abortion procedure]. The hospital didn't perform ultrasounds, so Valentina went to a private clinic. There, without asking her, they made her listen to the fetal heartbeat. She felt they wanted her to doubt herself, to break down. And she did: she didn't change her mind, but she was exhausted.

She gave up and continued with the pregnancy.

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10 - In order to protect the confidentiality of the people involved, the names used in the cases have been changed.

11 - This document does not identify the specific hospitals involved in the cited cases. This decision reflects the fact that the objective of this resource is primarily communicative and educational, prioritizing the understanding of the situations and the rights involved by people from different backgrounds, especially those who do not reside in the province, rather than the individualization of the institutions.

Now she doesn't want it to happen again. She leaves the hospital angry, but also clear-headed. She takes out her phone and looks up the MXM Foundation. Valentina isn't asking for permission.
She is seeking: that this time she be allowed to decide without being pushed, without being tired, without her right depending on how much she can resist.

Case analysis

The case of Valentina personifies the critical gap between current legality (FAL Ruling and Law 27.610) and in-
obstructive institutional framework. By linking its history to the framework
From a regulatory standpoint, we observe how the health system transforms a right into an administrative “trap” that seeks to exhaust the pregnant person: Let's analyze what happens
here...

1. Systematic violation of the legal deadline (Art. 5 - Law 27.610) The law is CLEAR: the maximum period to guarantee the interruption of pregnancy is 10 consecutive days.

- In Valentina's case: when requesting the IVE on November 7th-
  In November 2025, the hospital gave him an appointment for December 17, that is, 40 days later.
- Legal link: This delay is not a scheduling error, but an unjustified administrative obstacle that the “FAL” ruling explicitly prohibits, since it “renders meaningless the permission granted by the legal system.” This forced delay turns time into a tool of psychological and physical pressure on Valentina’s body.

2. The referral as a “trap” (Art. 10 inc. B - Law 27.610) the regulations require a referral in good faith, temporary and without delays.

- In Valentina's case: she visited other hospitals bus-

looking for a solution, but they all systematically referred her to the same center that had already denied her timely access, claiming that the "specialty" was there.

•Legal link: this practice distorts the spirit of the law. Instead of being a bridge to the law, the derivative-Vation is used as a recirculation mechanism within the labyrinth, forcing it to return to the original point of obstruction. This contradicts the Supreme Court's mandate to eliminate any requirement that introduces restrictions not foreseen by the legislature.

3. Exhaustion as a disciplinary mechanism: the “FAL” ruling warns that delays operate as mechanisms of institutional discipline.

•In Valentina's case: her story is marked by a prior vulnerability (in 2024 she was forced to listen to fetal heartbeats, which led her to abandon her decision to terminate a pregnancy due to exhaustion). The system uses current bureaucracy to reactivate that exhaustion.

•Legal link: the lack of appointments and the “pilgrimage” between hospitals are not logistical failures, but a form of institutional violence (Law 26.485). The State, through its agents, produces a specific violation by attempting to make the person, in the face of desperation and mistreatment, abandon the decision to exercise their reproductive autonomy.

4. Incomplete citizenship and legal insecurity: as already noted, without the real possibility of deciding, equality becomes abstract. Valentina did not arrive at the hospital from confusion, but from the experience of having been violated before; however, the system responds to her again with a bureaucratic “denial disguised as an argument.”

In conclusion, Valentina's case demonstrates that the legal "check" to patriarchy is not yet a "checkmate," since institutions in Tucumán use appointments and referrals to restore motherhood as a mandatory destiny through attrition.

Camila:12

Camila is 25 years old and her life story is marked by violence. She was sexually abused and became pregnant, a pregnancy she never chose. At 18 weeks pregnant, on December 3, 2025, she went to a hospital specializing in obstetrics and gynecology to request a legal abortion. They didn't listen to her. They told her to come back "when you're ready."

9 months old."

She arrived at the victim assistance office of the Judiciary, where she was referred to the Women for Women Foundation. Accompanied, she returned to the hospital, but began a long journey of waiting, referrals, and rejections: medical tests that were delayed, a laboratory that sent her from one place to another, and even a signature from an administrator that wasn't necessary to access the medication and which was denied to her twice. Every step was an obstacle.

She only gained access to legal abortion on December 15, 2025. Not because the system had guaranteed her right, but because she wasn't alone in navigating a path that should never have been a labyrinth.

12 - In order to protect the confidentiality of the people involved, the names used in the cases have been changed.

Case analysis

Camila's case is one of the most critical, as it involves a legal abortion resulting from rape, a right recognized in Argentina since 1921 and ratified by the FAL ruling. Her story allows us to delve deeper into how the healthcare system not only creates barriers but also perpetrates institutional violence and revictimizes victims.

extreme miization.

- Denial of rights and institutional revictimization: When Camila went to a specialized gynecology and obstetrics hospital at 18 weeks pregnant after suffering abuse, the staff's response was to tell her to come back "when she's 9 months pregnant, when she's already had the baby." This refusal is not just a barrier; it is an act of institutional discipline that seeks to impose motherhood as a mandatory destiny, ignoring the urgency of a victim of sexual violence.

- The administrative "ping-pong" labyrinth: once she managed to be seen thanks to her persistence and that of This Foundation , She was subjected to an exhausting ordeal between the laboratory and the emergency room. This constant movement, where she was treated as if her emergency were just another bureaucratic procedure, was intended to physically and emotionally wear the pregnant person down so that she would give up on the pregnan process.

- Requirement of non-existent requirements: the hospital so-

The company contracted a firm from the administration to deliver the medication, a requirement that was not necessary. According to the FAL ruling, any additional requirement—judicial or administrative—is legally inadmissible, as it introduces restrictions not provided for by law and renders the law meaningless. the content of the right.

•Failure to comply with deadlines (Art. 5 - Law 27.610): Camila initiated her request on December 3rd and was only able to access the procedure on December 15th. Although she finally succeeded, the process exceeded the 10-day period established by law, demonstrating that even in cases of legal abortion due to rape, the State fails to guarantee “timely and appropriate” care.

The importance of the collective: the outcome of Camila's case underscores that access to our rights requires a collective effort to fight for answers. In this context, where the very territory becomes unexpected, assuming public space as a contested territory means rewriting the outcome, crafting a narrative that works in our favor and resolves Camila's demands. As a foundation, we supported her, and together with her and her mother, we were able to ensure she received the care she needed.

Paula13

Paula knew from the very beginning what decision she needed to make. Her pregnancy was the result of sexual violence, and, protected by law, she requested a legal abortion within the public health system. She believed she would find a quick, respectful response that aligned with her rights. However, the path turned out very differently.

Each consultation ended in a new referral. Each professional seemed to send her somewhere else. Days passed, and the procedure she had requested still hadn't materialized. Adding to the delays were contradictory answers and the feeling that no one was taking responsibility for resolving her situation.

The hardest part wasn't just waiting. Instead of receiving rights-based care, Paula had to endure repeated interrogations. Throughout this ordeal, twelve different professionals interviewed her, questioned her decision, and tried to dissuade her from continuing.

with the procedure she had requested. In each meeting, she explained again that the pregnancy was the result of sexual violence, answered questions about deeply intimate aspects of her life, and relived a traumatic event.

13 - In order to protect the confidentiality of the people involved, the names used in the cases have been changed

which I had already recounted on numerous occasions. What should have been a process of support ended up becoming a profoundly revictimizing experience.

Meanwhile, her life went on. She was a mother and primary caregiver to a ten-year-old girl with ADHD, she was unemployed, and she was trying to support her household amidst the uncertainty. The lack of answers not only prolonged the pregnancy she had decided to terminate, but also It deepened the anguish, anxiety, and feeling of despair protection.

When members of a foundation learned of her case, they understood that Paula didn't just need information: she needed someone to walk alongside her. They listened to her story, analyzed the situation, and began taking steps to ensure the healthcare system guaranteed the right that the law already recognized.

The support was not limited to phone calls. It was necessary to visit the hospital twice. During the first visit, a formal administrative note was submitted outlining the case history, the delays experienced, and the need to guarantee immediate access to the requested procedure. Since this action was insufficient to obtain a concrete response, a second intervention was organized.

On that occasion, members of the foundation attended along with their legal team to hold a meeting with the

The meeting included top hospital authorities, legal advisors, and healthcare professionals. During the meeting, the serious human rights violations Paula had suffered were discussed, the unjustified delays were questioned, and the hospital was urged to guarantee, immediately, a legal abortion in accordance with current regulations.

Finally, the joint effort paid off. As a result of the actions taken and that institutional meeting, it was agreed that Paula would be admitted to the Hospital to undergo the indicated medical procedure, with the intervention of the appropriate equipment and the necessary professional support. Days later, the legal termination of the pregnancy was carried out under safe conditions, within the public health system.

That ruling did not erase the pain or the difficulties Paula had endured. Nor did it compensate for the weeks of waiting, the unnecessary referrals, the interrogations, the attempts to dissuade her, or the situations that violated her dignity. But it did mean that, finally, the State fulfilled its obligation to guarantee a right that Paula had requested from the beginning.

Case analysis

Paula's story reminds us that behind every file
There is a person. It also teaches us that access to a right should not depend on the perseverance of the person claiming it.
nor the extraordinary intervention of organizations that should demand their fulfillment. Rights exist to be guaranteed in a timely, humane, and respectful manner, especially when those who need them are going through a difficult situation.
tion of such vulnerability.

1. Revictimization through repeated interrogations (FAL Ruling; Law 26.485; Law 27.610)

Paula's pregnancy was the result of sexual violence.
sexual, a scenario contemplated by article 86 paragraph 2 of the Penal Code, the FAL Ruling and subsequently by the Law
27,610.

- In Paula's case: during the process she was interviewed by twelve different professionals. In each meeting she had to recount the sexual violence she suffered, answer questions about intimate aspects of her life, and justify a decision that Argentine legislation re-
known as a right.

- Legal link: the FAL Ruling established that victims of sexual violence should not go through-
to implement procedures that involve new forms of violence or suffering. The unnecessary repetition of

Interviews constitute a form of institutional revictimization, also prohibited by Law 26.485, by forcing the person to repeatedly relive the traumatic event in order to access a benefit that does not require
additional re-accreditations.

2. The fragmentation of responsibilities as a mechanism-mode of obstruction (Law 27.610; FAL Ruling)

Access to legal abortion requires that the health system guarantee a comprehensive, coordinated, and timely response.

•In Paula's case: no professional assumed responsibility-
The resolution of the case. Each consultation will determine-
naba with a new branch, creating a circuit where responsibility was diluted among different services and teams.

•Legal link: This practice contradicts the principle of accessibility established in Law 27.610 and the mandate of the FAL Ruling, which requires the elimination of unnecessary administrative obstacles. The proliferation of referrals transforms the institutional organization into a barrier to access, causing the very functioning of the system to impede the exercise of the right.

3. Unjustified delay as a form of institutional violence (Art. 5 Law 27.610; Law 26.485)

Law 27.610 establishes that the practice must be guaranteed within a maximum period of ten consecutive days from its request.

citude.

•In Paula's case: although she finally agreed to the In practice, this only happened after many weeks of waiting and following the direct intervention of a civil society organization that submitted administrative notes, held institutional meetings and demanded compliance with the regulations.

•Legal link: When access depends on extraordinary measures to obtain a state response, the system fails to fulfill its obligation to guarantee timely care. The delay ceases to be a simple administrative deficiency and becomes institutional violence, since it unnecessarily prolongs the pregnancy, increases suffering, and places the burden on the pregnant person to enforce a right that the State should guarantee ex officio.

4. Institutional distrust and oversight of autonomy (Law 27.610; Law 26.529)

Law 27.610 recognizes that the sole will of the pregnant person is sufficient to access the practice within the legal assumptions.

•In Paula's case: far from respecting that autonomy, numerous professionals repeatedly questioned her decision and tried to persuade her to give up the requested procedure.

•Legal link: these attempts at dissuasion violate the principle of autonomy recognized by both Law 27.610 and Law 26.529 on Children's Rights
patient. The role of the healthcare system is to provide
clear information and support, not exerting moral pressure on the reproductive decisions of users.

5. Inequality in access to rights: when compliance depends on collective support

Paula's experience demonstrates that, even though the legal framework fully recognizes the right to legal abortion, its effective exercise continues to depend, in many cases, on people's ability to mobilize external resources.

•In Paula's case: only sustained intervention by
The Women for Women Foundation —through accompaniment, administrative presentations and meetings with hospital authorities — made it possible to unblock a procedure that the State itself had the obligation to guarantee from the beginning.

•Legal link: the right to access health must
to be guaranteed under conditions of equality. When only those with legal advice, supporting organizations, or support networks manage to overcome institutional barriers, unequal citizenship arises, where rights cease to be

universals to depend on the social, legal or political capital of each person.

Paula's case demonstrates that barriers to accessing legal abortion are not always manifested through explicit refusal. Sometimes, the system
It deploys more subtle strategies: it multiplies interviews, fragments-
It assigns responsibilities, delays decisions, and subjects people to a process of attrition that seeks to test the persistence of their will. Institutional violence no longer operates solely by saying “no,” but by making the law seem unattainable. Paula’s story demonstrates that the greatest obstacle was not the absence of laws, but the institutional resistance to applying them, forcing a victim of sexual violence to navigate a bureaucratic labyrinth to access a right that the Argentine legal system guaranteed her from the outset.

BARRERAS

materials and economic

•Material and economic barriers: these affect the availability and quality of healthcare. Among them are shortages of supplies.

The availability of medications (misoprostol, mifepristone), limitations in the availability of professionals with specific training, the insufficiency of human resources in health centers and the lack of health supplies or technical equipment (such as ultrasound machines) necessary to guarantee safe care.

Experiences of material and economic barriers: in access to abortion (the cases of Mariana and Florencia)

Mariana:14

Mariana has two children and one certainty: she cannot have another. With that decision, she goes to a primary health care center (CAPS) to request a voluntary termination of pregnancy (VTP), but they tell her they don't have the medication and send her to a more complex hospital, without more guidance.

She arrives at a hospital specializing in gynecology and obstetrics. A receptionist whispers to her that it's her right, even though they won't give it to her there. When the gynecologist sees her, she finds not support but fear: that the pregnancy is "very advanced," that "the baby is already quite big." Mariana is 11 weeks pregnant. They talk to her about risks vaguely and warn her that if "something happens" to her, they can't guarantee her good treatment in the emergency room, and furthermore, they can only offer her a prescription, since they don't have any free medication.

She feels pressured and explains that she can't wait any longer and that the medication is expensive, but she receives no solutions, only warnings. Mariana leaves distressed, but without a doubt, her decision is firm.

14 - In order to protect the confidentiality of the people involved, the names used in the cases have been changed.

Case analysis

The analysis of Mariana's case allows us to identify that
Drug shortages are not an administrative accident.

administrative, but a direct consequence of a policy of

State based on “neoliberal rationality” and fiscal adjustment
lime.

This link manifests itself in the following ways:

1. Shortages as a barrier to entry into the system-

issue:

Mariana begins her journey at a Primary Care Center

Maria de la Salud (CAPS), where the official response is material lack: they
inform her that "they do not have medication".
This lack of supplies is the result of underfunding.

of public policies and key programs such as “Remediar”, which should
function as the “bridge” for real access
to health.

The shortages that affected Mariana are not an isolated incident, but a systematic pattern that runs through almost the entire territory of Tucumán. This was also reflected in the monitoring carried out by the MxM Foundation, which reveals that the State has ceased to fulfill its role as guarantor of the right to health, turning the lack of supplies into a structural barrier that is particularly acute in the interior departments of the province.

After completing our Empalme Verde15 project, key departments such as Trancas, Burruyacú, Tafí del Valle, Simoca, Cruz Alta, Monteros, La Cocha, Río Chico, Leales and Graneros, among others, did not have medication to guarantee the IVE (Voluntary Interruption of Pregnancy). Even in the capital, San Miguel de Tucumán, cases were recorded same material lack.

- The shortage is not limited to abortion; it affects the provision of condoms and contraceptive methods in various municipalities such as El Chañar, El Naranjito and San Pedro de Colalao. In El Siambón, the director of the CAPS even declared that they deliver anti-expired prescriptions due to the population crisis "terrible".

This material lack is not an administrative error, but a form of institutional violence against reproductive freedom. By defunding public policies, the State pushes people with the capacity to gestate into a labyrinth of recirculation where, as in Mariana's case, access to sexual citizenship depends on "how much fear they are willing to endure" or on whether they have the financial resources to resort to the private sector to buy medication.

2. The transformation of law into a commodity:

In the story, Mariana explains that “the medication is costly-"sa" and that it cannot wait any longer. Here we see what

15 - https://mujeresxmujeres.org.ar/wp-content/uploads/2023/07/EM-PALME-VERDE-DIGITAL_11zon-1.pdf

Wendy Brown defines this as “neoliberal rationality”: the state ceases to conceive of health as a universal guarantee and shifts it toward a logic of individual responsibility and cost-benefit analysis. By not providing medications, the state forces individuals to resort to the private market, transforming a legal right into a commodity accessible only to those with economic resources.

“So, we ask ourselves: are we returning to a logic in which those who can afford it have access to voluntary termination of pregnancy, while those who cannot afford it do not?”
Those with economic resources are exposed to clandestine practices.
"Do you intend?"

3. Production of material inequality:

Cuts in “social spending” are not neutral; rather, they produce socio-material inequality. Mariana's case illustrates this.
This gap:

- For those with resources: they can avoid an under-supplied public health system by paying for private consultations or medications.
- For Mariana: the lack of state provision exposes her to delays and mistreatment in more complex hospitals, which constitutes a “new way of returning to clandestinity” within the public system itself.

4. Shortages as a trigger for the “labyrinth”

The lack of medication at the CAPS was the first step towards

to construct an institutional labyrinth. Being referred without guidance-

With the lack of supplies, Mariana was left at the mercy of individual whims. In the more complex hospital, the material shortage was compounded by ideological barriers: the gynecologist used time to her advantage to instill fear (claiming that the pregnancy was “very advanced”) and warning of possible mistreatment in the emergency room “if anything happens” to that pregnancy.

5. Failure to fulfill the duty of guarantor

The FAL ruling established that the State, as administrator of public health, has the obligation to provide the necessary medical conditions quickly, accessibly, and safely. By defunding sexual health programs, the State fails in its role as guarantor, rendering the legal authorization meaningless and subjecting Mariana's autonomy to "however much fear she is willing to endure."

In conclusion, the shortages Mariana experienced are a tool of institutional violence. It is a policy that uses budget cuts to restore control over bodies, making true equality of opportunity—
data is “abstract” if the material conditions do not exist
to exercise it.

Florence:16

Florencia entered the healthcare system seven weeks pregnant. When she decided to seek information, she thought the process would be relatively simple: make an inquiry, receive advice, and find an answer… but that path soon began to transform into something else entirely.

The first place she went was the primary healthcare center in her neighborhood. There, she asked if they could advise her on the possibility of having a voluntary termination of pregnancy. The gynecologist who saw her told her that she was a conscientious objector. She didn't explain her rights or how she could access the procedure. She simply told her, briefly, to go to a hospital specializing in obstetrics and gynecology.

Florencia left there with more questions than answers, but she kept trying. She made an appointment with a gynecologist at a hospital and waited for the day of the consultation.

When she finally arrived, the experience was not what she expected. Not only did she feel treated with hostility, but the response closed another door: she was told there was no medication. There were no pills at the hospital. Nor, she was informed,
in pharmacies.

After going to those two healthcare providers, Florencia decided to try somewhere else. She went to another hospital. At the reception desk, she asked about the procedure, but they told her that

16 - In order to protect the confidentiality of the people involved, the names used in the cases have been changed.

It wasn't done there. As he was leaving, a hospital worker who had overheard the conversation approached discreetly and wrote down the health hotline number for him on a piece of paper.
sexual. Florencia called that number. On the other end they gave her
A shift at a polyclinic. The journey continued...

When she finally arrived at the consultation, the answer was different. incomplete time: there they could give her advice and a prescription, but not free medication. At that moment, in this
There were no pills available at the health service.

Florencia then began another search, this time in pharmacies. She asked at several. The answer was always the same: yes, they had the medication, but the price was around $200,000 pesos or more. The figure was too high.

In Florencia's case, the shortage of medication in public services shifted the cost of the procedure to the patient, not the pharmaceutical market. The cost of the pills—around 200,000 pesos17— represents approximately 57% of the current monthly minimum wage in Argentina, which in May 2026 was 363,000 pesos. In concrete terms, this means that a person earning the minimum wage would have to allocate more than half of their · monthly salary to access the medication, making the lack of supplies a significant economic barrier to the effective exercise of the right to access care.

17 - According to the Wage Council/Ministry of Human Capital, the SMVM (Minimum, Vital and Mobile Wage) and according to INDEC, the CBT (Total Basic Basket) is $1,469,768

voluntary termination of pregnancy.

In a context where many incomes are well below that amount, paying 200,000 pesos for a meal-
Dedication represents a difficult economic barrier to overcome. Meanwhile, time continued to pass.

What had begun with a seven-week gestation turned into a journey of consultations, incomplete referrals, fragmented answers, and personal searches that stretched over weeks.

When Florencia finally arrived at the foundation to ask for advice, she was already eleven weeks pregnant.

Their journey reveals something that is sometimes hidden behind protocols and regulations: when the health system fails to guarantee clear information, effective referrals, and availability of supplies, people are not truly cared for.
derivatives.

Case analysis

Florencia's case illustrates how various institutional, material, and economic barriers can overlap, transforming access to voluntary termination of pregnancy into a fragmented and exhausting journey. Although Florencia entered the healthcare system at seven weeks pregnant and with a clear decision, the lack of information, incomplete referrals, and medication shortages meant she arrived at the Foundation at eleven weeks.

pregnancy.

1. Conscientious objection without an effective referral

A professional's conscientious objection cannot become a barrier to accessing medical practice. When faced with a request for a voluntary termination of pregnancy (VTP), the healthcare system must guarantee clear information and a referral that allows for continued care in a timely manner.

In Florencia's case: the first place she went was the primary healthcare center in her neighborhood. There, the gynecologist informed her that she was a conscientious objector, but did not explain her rights or how she could actually access the procedure. The only instruction she received was to go to a hospital specializing in gynecology and obstetrics.

Conscientious objection cannot result in abandonment, misinformation, or interruption of the care circuit.
When a person has to rebuild on their own

The path to accessing legal benefits, the referral ceases to function as a guarantee and becomes a new
barrier.

2. Shortages as a material barrier

The formal recognition of a right requires the existence of the necessary material conditions for its exercise. In the case of access to voluntary termination of pregnancy (VTP), this implies, among other things, the effective availability of the necessary medication.

In Florencia's case: after being referred, she went to various public healthcare facilities. At one, she was told there was no medication; at another, they simply said the procedure wasn't performed. Finally, she arrived at a polyclinic where they could provide her with advice and a prescription, but they also didn't have any free medication.

When health services can advise on or prescribe a practice but lack the necessary supplies to
Without guaranteeing it, the right remains incomplete. The lack of medication shifts the responsibility to the pregnant person to resolve, by their own means, a deficiency that belongs to the family.
to the health system.

3. When the lack of supplies becomes a ba-
economic race

The shortage doesn't just create a material hardship. When the only available alternative is to acquire medication on the private market, the ability to practice medicine is compromised.

The right begins to depend on each person's economic capacity.

After visiting various health services without finding the medication, she began looking for it in pharmacies. There she found that the price was around $200,000 or more, an amount she could not afford and which represented a significant portion of her minimum monthly income.

Shifting the cost of the procedure to the user creates a concrete inequality in access. The right is no longer guaranteed under equal conditions and begins to depend on available economic resources. In this way, a material barrier also becomes an economic barrier.

4. System fragmentation and time as an obstacle ass

Accessibility depends not only on the existence of a place where the practice can eventually take place. The system must offer a clear, well-structured, and timely pathway that prevents people from being sent from one facility to another.
to another without an effective response.

In Florencia's case: she entered the healthcare system at seven weeks pregnant. She went to a primary care center, a hospital specializing in gynecology and obstetrics, another hospital, a sexual health hotline, a polyclinic, and various pharmacies. When she finally arrived at the Foundation seeking advice,

She was already eleven weeks pregnant.

Incomplete referrals, lack of information, and shortages caused time to pass while Florencia tried to resolve individually what the system should have guaranteed. Thus, institutional fragmentation ends up creating its own labyrinth: the person moves through different spaces, but no institution takes responsibility for her needs.
generally the responsibility to guarantee access.

In conclusion

Florence's tour shows how barriers don't work
in isolation. Conscientious objection without adequate guidance, incomplete referrals, medication shortages and their high cost in the private market accumulated until they prolonged for weeks a process that should have been accessible and timely.

Florencia didn't arrive late to the system: she entered at seven weeks pregnant. It was the institutional process itself that consumed time and placed the burden of finding information, locating providers, and obtaining medication on her shoulders. Her experience shows that a right is not guaranteed simply because it is recognized by law: it also requires information, resources, institutional coordination, and the material conditions that allow it to be effectively exercised.

Its journey reveals something that is sometimes hidden behind protocols and regulations: when the health system

It fails to guarantee clear information, effective referrals, and availability of supplies; people are not truly derivatives.

BARRERAS

from the health team

•Barriers related to the healthcare team: these primarily impact the acceptability and accessibility of services. They manifest as mistreatment, stigmatization, or moral judgments towards individuals requesting the procedure, misuse of conscientious objection, or the dissemination of false or misleading information about current regulations or access conditions.

This is the opposite of what the rights-based approach to health proposes: dignified and respectful treatment for all people who access the service.

Experiences of barriers related to the health team in accessing voluntary termination of pregnancy (case of Rocío and Luján)

Rocío:18

Rocío arrived at a hospital in the capital of Tucumán with a decision made: she wants an abortion. She didn't arrive confused; she arrived informed, knowing that there is a law that supports her request. But on the other side, she finds not care, but invented boundaries. They tell her they can't treat her because she lives at Burruyacú 19, which is "outside the operational area." As if her address carried more weight than her urgency. As if her body were subject to jurisdiction.

Then they tell her they are “in favor of saving lives.” That, regardless of the existence of a law, “what the law says isn’t true.” One doctor goes even further: she assures her that the law is no longer in effect.

Rocío is not only frustrated, she also feels disoriented.
Not because I doubt their decision, but because those who should be guaranteeing their rights treat them as if they were mere opinions. As if legality were up for debate in a hospital corridor.

Rocío leaves there with the feeling of having crashed into
Something invisible but firm: the refusal disguised as an argument. And he understands, perhaps without putting it into words, that sometimes the biggest obstacle is not the distance to a hospital,

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18 - In order to protect the confidentiality of the people involved, the names used in the cases have been changed.

19 - **Burruyacú** is a department located in the northeast region of the province of Tucumán.

but the distance between the law and those who decide whether it is enforced or not.

Case analysis

Rocío's case illustrates the "health team's obstacles," where the refusal to guarantee a right is not due to a lack of material resources, but to the imposition of ideological barriers and deliberate misinformation.

1. Invented territorial borders

Upon arriving at a hospital in the capital of Tucumán, Rocío was denied care on the grounds that she lives in Burruyacú and is “outside the operational area.” This is described as “obstructive georeferencing,” a practice where the patient’s address is used as a bureaucratic barrier to prevent service provision, treating the woman’s body as if it were under “jurisdiction.” This contravenes the public policy nature of Law 27.610, which is mandatory throughout the national territory, and violates the universal principle of health, which establishes that all people must have access, without discrimination or economic barriers, to comprehensive, quality, safe, and affordable health services (promotion, prevention, treatment, and rehabilitation) when they need them. Furthermore, as a tertiary care hospital, it has the capacity to provide the service.

2. Disinformation as a blocking tool

The healthcare staff assured Rocío that “what the law says is not true.” This conduct flagrantly violates the right-

Right to health information (Art. 6 of Law 27.610), which requires that the information provided be truthful, up-to-date and based on scientific evidence, not on personal opinions or fake news.

3. The refusal disguised as an argument:

The medical team used phrases like “in favor of saving life” to invalidate Rocío’s decision. According to Deza (2020), this is a “mask of conscientious objection,” where ideological positioning is presented as a medical argument to dissuade the patient, which constitutes undignified and disrespectful treatment.

4. Institutional violence and disorientation:

Although Rocío arrived informed and certain of her decision, the healthcare team's discourse sought to disorient and emotionally break her. Since state agents obstructed her access to public policy through lies and mistreatment, this constituted a case of institutional violence.
(Law 26.485), since the State, through its agents, produced a specific violation of the person's rights pregnant.

In conclusion, Rocío's case demonstrates that the biggest obstacle is not always physical distance, but the distance between the written law and the will of the professionals in charge of complying with it, who transform legality into something "debatable" in a hospital corridor.

Luján:20

Luján was twenty-six years old and going through difficult circumstances in her life when she decided to terminate an unwanted pregnancy. She went to a hospital specializing in gynecology and obstetrics. This happened twice. In both cases, they told her the same thing: that they couldn't do it there, that they needed a "highly specialized gynecologist." The phrase sounded medical, but to her it seemed like an excuse.

She finally found medical attention at another hospital. There, they listened to her, explained the procedure, and treated her with respect. She thought it was all over.

But soon after, she suffered a hemorrhage. Frightened, she returned to the first hospital where she was turned away. In the emergency room, she told the truth: that she was recovering from an abortion. No one rushed to help. They made her wait while the blood continued to flow. The minutes stretched on until her body no longer responded and she fainted.

They put her on a stretcher, and she managed to wake up, while the doctor and nurse said, “This is unnecessary,” as if they were angry with Luján because of her situation. They gave her medication that caused intense contractions, a deep pain that no one had warned her about or explained. During the transfer through the corridors, she saw the doctors' eyes, bent over the stretcher: gestures of discomfort, of disapproval.

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20 - In order to protect the confidentiality of the people involved, the names used in the cases have been changed.

They made her lie down without changing the sheets, on
his own blood.

Then came the procedure. The doctor took some forceps.
and began to work inside her body, without any explanation
She was told what they were doing to her. There was no anesthesia.
Luján screamed and writhed in pain as they told her to stay still.
When it was over, the doctor said she had saved her from surgery.
Ten minutes later, they sent her home. Without observation, without
painkillers, without instructions—
clear ones.

Over time, Luján began to say that what she had experienced wasn't just a poorly handled medical emergency. It had been something else: a form of silent punishment, as if the healthcare system had decided to discipline her for making a decision about her own body. Since then, every time she remembers that day, a shudder runs through her body, and she finds it hard to imagine that she will ever fully trust the healthcare system again.

Case analysis

The Luján case (February 2026) exposes one of the most extreme forms of institutional, obstetric and medical violence recorded in the health system: a situation in which physical pain appears to be used as a form of moral punishment against someone who exercised their right to terminate a pregnancy.

1. Access barriers and deterrence strategies:

Before being able to access the procedure, Luján encountered obstacles at the hospital she initially went to. There, she was denied care on the grounds that the procedure required a “highly specialized gynecologist,” a requirement that does not exist in Law 27.610.

This type of additional requirement constitutes a practice deterrent. As established by the FAL ruling of the Court Supreme Court, the imposition of requirements not provided for by law functions as an inadmissible administrative obstacle that effectively restricts the exercise of the right.

Furthermore, this practice also violates the right to timely and adequate health care, one of the central principles of Law 26.52921.

21 - “National Law 26,529 on Patient Rights” (enacted in 2009, amended by Law 26,742) regulates the relationship between patients and healthcare professionals/institutions in Argentina. It guarantees fundamental rights such as dignified treatment, confidentiality, access to medical records, and informed consent to accept or refuse treatment.

2. Violence in post-abortion emergency care

When Luján later went to the emergency room due to bleeding, honestly reporting that she was going through a post-abortion period, the institutional response was marked by negligence and undignified treatment.

- Neglect in the emergency room: she remained waiting for about twenty minutes while she bled until she fainted, which contradicts the obligation to provide immediate care in an obstetric emergency.

- Stigmatization: During the transfer, health professionals made derogatory gestures and comments, which constitutes a violation of the right to dignified treatment guaranteed by Law 27.610 and contemplated in Law 26.529.

- Physical humiliation: she was forced to lie down on a stretcher covered with his own blood, ignoring his warning and seriously affecting his dignity.

3. The punitive use of pain: a curettage without anesthesia

One of the most critical moments was the realization of a Manual curettage without anesthesia. From a legal perspective, this implies multiple violations:

- Obstetric violence: Law 26.485 on Comprehensive Protection against Violence against Women recognizes such as obstetric violence, the dehumanizing treatment in the

reproductive health care.

•Lack of informed consent: medication

The previously administered and subsequent procedure were carried out without explaining to the patient what was being done to her or what its effects would be, which violates the right to informed consent, one of the pillars of Law 26.529.

•Right to pain relief: subjecting a patient to an invasive procedure without adequate pain management contradicts basic medical standards and the right to receive safe and humane treatment.
Performing a curettage without anesthesia or analgesia constitutes, in the opinion of international human rights protection bodies, cruel, inhuman and degrading treatment (See: A/HRC/31/57 and A/74/137, among others).

4. Institutional neglect and consequences

Following the procedure, Luján was sent home just ten minutes later, without medical observation or instructions.
clear ones.

This directly affects other patient rights:

•Right to health information: the patient did not receive explanations about her health status or about subsequent care.

•Right to continuity of care: the absence of

Medical monitoring and medication constitute a form-

ma of institutional abandonment.

•Right to safety in medical care: immediate discharge after an obstetric emergency implies an avoidable risk to health.

Covert objections:

What is the objection and how is it disguised?

Conscientious objection manifests itself in the health system such as the refusal of professionals to perform abortion procedures based on their per-
personal and moral. In fact, authors like Luna (2008) describe it as one of the “layers of vulnerability” that overlap to hinder real access to rights already
legally recognized.

It is used as a barrier in the following ways:

- Refusal disguised as an argument: objection is often presented not as a right of the professional, but as a “refusal disguised as an ideological argument.” Instead of guaranteeing care, objectors use moral or religious discourses to invalidate the pregnant person’s decision.

- Disinformation about the law: some professionals use their position to spread false information, claiming that the law is not in force or that "what the law says is not true", in order to mislead the patient and prevent her from accessing the practice.

- “Institutional conscientious objection”: the law regulates individual conscientious objection, but does not contemplate “institutional conscientious objection,” since, whether people like it or not, institutions do not have a conscience. In the

In fact, there is a kind of "institutional conscientious objection" that operates as a systematic block in certain hospitals or areas, forcing people to go through multiple institutions without getting a response.

•Failure to fulfill the duty of referral: Law 27.610 requires that the objecting professional must "refer in good faith" the patient temporarily and without delay. However, conscientious objection is used as a barrier when this referral does not occur in a timely manner, or when it is carried out with undue delays or mistreatment, such as forcing the person to listen to the fetal heartbeat to induce guilt and exhaustion.

•Professional resistance and patriarchal matrix: it is described as a form of professional resistance that reveals the persistence of a cultural matrix that necessarily associates women with motherhood, questioning their reproductive autonomy even in the face of a legal right.

In summary, **conscientious objection ceases to be an individual right of the physician when it is used to invalidate current legislation, delay care times, or exert institutional violence** on those seeking access.
to an IVE/ILE.

BARRERAS

sociocultural and symbolic

• Sociocultural, symbolic, and everyday life barriers: From the perspectives of collective health and social determinants of health (WHO/PAHO), social, cultural, and symbolic conditions directly impact the real possibilities of exercising the right to health. These dimensions are expressed in the experiences of women and pregnant people through fears, doubts, and conflicts that influence their search for care, consultation times, and conditions.
access.

The stigma surrounding abortion, societal expectations regarding motherhood, and family or community sanctions often lead to silence or delays, creating additional barriers to accessing legal abortion services. Thus, sociocultural factors act as a key determinant in the trajectories of access to the healthcare system.

In this context, health promotion is fundamental: it not only improves access to services, but also strengthens autonomy, access to information, and

capacity to exercise rights, contributing to transforming stigmatizing representations and generating more favorable conditions for the effective exercise of the right to health.

Experiences of sociocultural, symbolic and everyday life barriers (Diana and Malena).

Diana:22

Diana arrived at the foundation one morning on November 22, 2025, seven weeks pregnant. Before she started asking questions, she wanted to explain why she was there: she didn't want the same thing to happen to her as happened to her sister.

Some time ago, her sister went through a pregnancy she didn't want to continue. She explored various aspects of the healthcare system in Tucumán, but found neither clear answers nor timely support. The lack of information, the delays, and the uncertainty caused time to pass, and what at first seemed like a possible decision became increasingly difficult to sustain. Ultimately, she continued with the pregnancy.

That experience didn't just remain a memory; it became a constant warning in Diana's daily life. The idea that "there's nowhere to go" or that "no one will help you" was built from that story, through conversations, silences, and shared fears.

Furthermore, the previous year, Diana had tried to get a tubal ligation, but her request was denied because she was young and had no children. This refusal left her feeling that her reproductive decisions were not taken seriously within the healthcare system.
of the health system.

That's why, when she found out she was pregnant, one of her

22 - In order to protect the confidentiality of the people involved, the names used in the cases have been changed.

My main concern was not to repeat that journey. I didn't want misinformation, fear, or the passage of time to affect me. will influence their decision.

He arrived in space with a clear decision, but also with the expectation— and the need—to find, this time, a different path.

Case analysis

1. The intertwining of institutional and socio-cultural barriers: Diana's story demonstrates that the health system often fails even before the user arrives at the hospital.

- Narratives of exclusion: the traumatic experience of her sister, who was forced into motherhood due to a lack of timely responses, served as a "warning" that conditioned Diana's access to the health system.

- Layers of vulnerability: these shared fears add to the "layers of vulnerability" described by Florencia Luna (2008), where misinformation and social stigma act as invisible obstacles that make exercising citizenship an odyssey.

2. Violation of Law 26.130 and protection over bodies: the prior rejection suffered by Diana when requesting a tubal ligation under the argument of being "too young" and "not having children"
It is an illegal practice with no legal basis.

- Legal framework violated: Law 26.130 (the surgical contraception law guarantees access to tubal ligation and vasectomy as a right of all people) is explicit: any adult can access surgical contraception free of charge, without needing to have had children or to have had a child.

to be with third-party authorization.

• Biomedical criteria as a barrier: denying this right
cho based on age or the absence of maternal

Previous age reveals the persistence of a cultural matrix that associates women with motherhood as an obligatory destiny, exercising a guardianship over the body that the law seeks to eradicate.

3. Autonomy as a condition of citizenship

The narrative directly links reproductive autonomy with substantive freedom.

•"Incomplete Citizenship": without real capacity to decide on their own reproductive processes, equality-
Dad becomes an abstraction.

•Violence against reproductive freedom: the refusal to perform a legal practice (such as ligation or IVE) constitutes violence against reproductive freedom according to Law 26.485, since it prevents freely deciding on the number of pregnancies or the interval between them.

4. The praxis of the "Feminist Randa" in the case of Diana

In the face of misinformation and fear, Diana's approach to the MxM Foundation represents the search for a "praxis between seams".

•Listening to subjective urgency: the co-community clinic addressed Diana's anguish —marked by

the fear of repeating her sister's story—as a subjective urgency that requires an effective response to what erupts as "the unbearable."

•Legal literacy: by making visible that the medical arguments used to deny her the ligation were illegal, Diana was transformed from a disoriented victim into a sovereign subject capable of demanding quality healthcare free from violence.

Malena:23

Malena arrived at the foundation when she was ten weeks pregnant. When he entered, he didn't speak right away. He sat down first, like someone who needs to adjust their body after having gone through too many things in a short time.

Two weeks earlier she had been there. At that time, she was eight weeks pregnant and had many questions. She had heard that there was the possibility of terminating the pregnancy, that there were places where she could be accompanied, but she still wasn't sure she could do it. It wasn't just a personal decision; all around her were stares, words, and silences that weighed heavily.

Before returning, she tried to find answers elsewhere. She went to a hospital. She waited in line, asked at one window and then another. Finally, they told her there were no appointments available. The response was brief, almost automatic. Malena left with the feeling that her question had been left hanging in the air, without any support.

The days passed. At home, news of the pregnancy began to circulate. First as a rumor, then as a certainty. When her family learned that Malena was considering terminating the pregnancy, the conversation ceased to be calm. The words became harsher, more definitive. In the midst of that argument came a phrase that changed everything: she had to

23 - In order to protect the confidentiality of the people involved, the names used in the cases have been changed.

leave home.

Leaving home was not a decision, it was a consequence. Suddenly, Malena found herself gathering some things, trying to figure out where she was going to sleep that night. It was her friends who then appeared, opening doors and offering her a place to stay. They were also the ones who offered to accompany her, to listen to her, to to be close during those confusing days.

During that time, the decision that had previously seemed distant began to take shape. Not because it was easy, but because circumstances forced her to resolve it.

Two weeks after her first visit, Malena returned to the foundation. This time she arrived ten weeks pregnant and with a recent history marked by family arguments, moving house, and the need to rely on other support networks to get through the process.

She performed the procedure accompanied by her friends and her sister. They were there, holding silences, fetching water, asking questions when Malena couldn't find- ba the words.

With some of her family, however, the relationship became difficult. The distance was no longer just physical; it was also made up of recriminations, broken expectations, and a decision that, for some of them, remained impossible to accept.

Case analysis

The analysis of Malena's case allows us to understand that access to reproductive health depends not only on the existence of medical services, but on a complex web of social, cultural, economic, political, and relational conditions that permeate the daily lives of people.

pregnant women.

1. The institutional labyrinth: the refusal to grant appointments:

Malena tried to find answers at a hospital. There she faced one of the most common bureaucratic barriers of the

“Labyrinth,” the brief and automatic response that “there were no appointments available.” This lack of adequate guidance left her request in a state of uncertainty, demonstrating how the health system can disregard its role as guarantor of the right to health, leaving the user “adrift.”

2. Social and family stigma as a barrier to access:

Malena's story highlights that reproductive decisions are also shaped by cultural mandates and moral norms that operate both in discourse and in social practices. In her case, the decision to terminate her pregnancy led to rejection and exclusion from her family, demonstrating how stigma also constitutes a barrier to the effective exercise of sexual and reproductive rights.

• Family sanction and exclusion: The decision to terminate the pregnancy triggered a rejection response from her family, culminating in her expulsion from the home. This form of sanction demonstrates how gender mandates and moral norms can translate into exclusionary practices that deepen women's vulnerability and complicate their timely access to health services. This family sanction acts as an additional layer of vulnerability that conditions their trajectory of access to health care.

•Motherhood as a mandate: its history shows

How the cultural matrix that associates women with motherhood as an obligatory destiny can lead to reproaches and the breaking of bonds when autonomy is exercised, and the decision is made to have an abortion.

3. The time factor as a structural dimension: in the case of pregnancy interruptions, time is not a neutral variable; it is a limited resource that conditions the possibilities of access, this factor operates transversally in all the stories mentioned.

•Induced delay: between her first consultation and the final resolution, two weeks passed (from week 8 to week 10 of gestation) due to the refusal of appointments at the hospital and family conflicts.

•Disruption of daily life: following Ágnes
Heller (1977), time is a factor in measuring the

life, where it has its character of “irreversibility” and in this case the unintentional pregnancy altered the daily organization of Malena's life, requiring reorganization of spaces and relationships in a time frame of urgency.

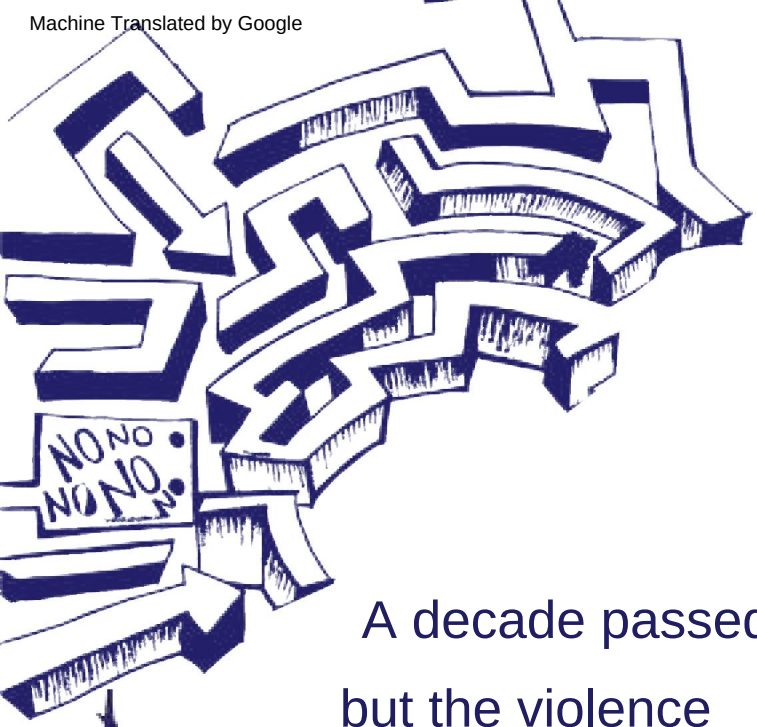
4. The support network: a “Randa”24 of accompaniment.

Faced with state and family neglect, the resolution of Malena's case was made possible thanks to community and affective networks, which translate into support and containment networks.

•The role of friends: it was her friends who offered her accommodation and support, becoming the fundamental resource to sustain her decision-
Zion.

•Collective praxis: Malena underwent the procedure accompanied by her friends and her sister, who “maintained silence” and provided the support that the institution denied her. This external support functions like the weaving of a feminist lace, where the union of wills allows the unraveling of the knots of violence imposed by the system.

24 - It is an ancient technique of handmade weaving, very characteristic of the province of Tucumán.



A decade passed

but the violence

They

persist: **Mary Magdalene today...**

Concepción25

Concepción is eighteen years old and has just finished high school. She lives with her grandfather and her sister, and while she thinks about starting to study to enter the Federal Police, she helps her cousin with a small food business.

One afternoon she started with a sharp pain in her stomach. She thought It was one of the ovarian pains she usually had, but this time it was different. When she went to the bathroom, she felt something coming out of her body and got scared. She called her sister and they decided to go to the hospital because the bleeding wouldn't stop.

At the hospital, they made her wait. They asked her if she was pregnant. Concepción said she didn't know. They examined her several times and, after a while, told her they had to take her to the operating room for a dilation and curettage (D&C). She signed a consent form without them clearly explaining what they were going to do to her.

In the operating room, she was given anesthesia from the waist down. She was awake during the procedure, watching her pulse monitor as they worked.

When the procedure was over, they took her to a re- room recovery. Two police officers entered and began asking her questions about her house, her family, and where she lived. Concepción didn't understand why they were there and thought it might be part of the procedure.

25 - In order to protect the confidentiality of the people involved, the names used in the cases have been changed.

It wasn't until the next day that a social worker and a psychologist listened to her attentively. They themselves told her that it wasn't normal for the police to have come in and asked her questions.

Concepción left the hospital without much explanation about what had happened to her or clear instructions for what to do next.
What she remembers most is not just the pain, but the feeling
of having gone through something very big without anyone noticing-
He had to explain what was really happening. The case
Concepción constitutes a clear manifestation of the “labe-
"Institutional" rinto, where obstetric violence, institutional violence and a serious violation of the duty of confidentiality converge.

Case analysis

The following is a detailed analysis of the case based on the legal framework and patients' rights:

1. Violation of the right to information and consent informed lie:

Concepción underwent a dilation and curettage (D&C) procedure after signing a consent form “without them clearly explaining to her what they were going to do.” do it."

- The flawed process: according to the law, informed consent is not a mechanical signature, but a dialogue process in which health personnel have the obligation to provide clear, truthful and complete information about the risks and benefits of the procedure

- Lack of alternatives: by not receiving explanations, he was deprived of knowing possible therapeutic alternatives or understanding his own state of health, which is an obligation of the doctor.

2. Violation of privacy and confidentiality (professional secrecy):

The fact that two police officers entered the recovery room to interrogate her represents the most serious violation of her rights:

- Breach of professional secrecy: Healthcare personnel have an obligation to maintain secrecy

especially regarding everything they know within the context of healthcare. Introducing the police into the healthcare sector is a crime of breach of confidentiality (Art. 156 of the Penal Code).

- Prohibition against reporting: health personnel cannot report a patient, even if they suspect that the abortion was induced.

- Post-abortion care must be guaranteed without prejudice to the legality of the previous act

- Institutional Violence: This act sought institutional discipline and moral punishment, using the penal system to intimidate the patient in
a moment of vulnerability.

3. Obstetric and Institutional Violence

Concepción recalls the feeling of having gone through something big without anyone stopping to explain it to her, which is defined as dehumanizing treatment:

- Dignified treatment: the law requires respectful treatment that respects uphold human dignity.

- Ignoring Concepción's subjectivity and treating her body- to treat it as a mere administrative procedure is a way of obstetric violence.

- Leaving the hospital without clear instructions for post-surgical care is a breach of quality standards.

data set by the WHO that the State must guarantee.

4. Parallels with Criminalization in Tucumán

The situation in Concepción (2026) is similar to the cases of “María Magdalena” (2012) and “Belén” (2014), where health personnel violated professional secrecy by allowing the police to enter the operating room or care rooms, initiating criminal proceedings for common obstetric events that are part of reproductive health.

As already pointed out in Tucumán, the violation of professional secrecy continues to be a mechanism of moral and penal punishment.

Conclusion: Concepción was the victim of an institutional machine-
A policy that prioritizes police surveillance over assistance
Humanized healthcare. The healthcare staff failed to fulfill their duties of confidentiality, information, and dignified treatment, which gives rise to administrative, civil and criminal liabilities (Art. 156 and 85 bis) of the Penal Code.

To retrace the labyrinth

Unraveling this labyrinth is an urgent and collective task. Throughout these pages, we have seen that the right to abortion in Argentina—won in the streets and recognized in law—continues to face multiple forms of obstruction that render it meaningless in practice.

The labyrinth is a concrete architecture of bureaucratic, material, ideological and symbolic barriers that operate simultaneously on the bodies and autonomy of women and pregnant people.

The stories in this book show that rape-
Negligent behavior doesn't always manifest itself explicitly. Sometimes it takes the form of an appointment that never arrives, a pointless referral, a lie told in a medical tone, a puer-
that closes without explanation or a silence that leaves
Someone adrift. Other times it's direct, raw, disciplinary: pain as punishment, humiliation as a response, the police in a recovery room. In all cases, it's
It deals with the same logic: that of a system that, even while recognizing rights, continues to dispute who can exercise them.
really.

This work demonstrates that barriers are expressions of a broader structure where underfunding-

The deterioration of public health, the persistence of patriarchal mandates, and the advance of a neoliberal rationality that transforms rights into privileges. At this crossroads, reproductive autonomy emerges as a terrain of permanent dispute, where every obstacle not only delays a practice but also restricts citizenship.

However, here too the plots become visible that They resist. The community clinic, support networks, legal strategies, and spaces for listening and information are part of a collective effort that insists on opening paths where the system erects walls. Where the State arrives late, practices emerge that not only resolve urgent needs but also challenge established meanings and reconstruct law as a lived experience.

Because if the labyrinth is built from a position of power, it can also be dismantled collectively. Naming the barriers, systematizing them, and making them public is a way of intervening upon them. It is transforming what is often experienced in isolation into a political, social, and structural problem.

This book concludes with one certainty: the right to abortion is not guaranteed solely by its legal recognition, but by the capacity to sustain it, defend it, and make it effective in every territory, in every institution, and in every body. Unraveling the labyrinth thus implies continuing to weave strategies, strengthen networks, and contest the material and

symbolic that make true autonomy possible.

Abortion cannot depend on chance, money, support, or individual resistance. Abortion must cease to be an uncertain journey and become, definitively, an accessible, dignified and violence-free right.

Glossary

Key concepts in public health, gender and rights

Manual Vacuum Aspiration (MVA): A safe, low-complexity medical procedure that involves evacuating the uterine contents by creating a vacuum with a handheld device. It is primarily used for early pregnancy termination and the treatment of incomplete miscarriages. It is an outpatient procedure of short duration and is recommended by the World Health Organization for its effectiveness and low risk of complications.

Medical abortion: A method of pregnancy termination that uses medication—misoprostol, alone or in combination with mifepristone—to induce the evacuation of uterine contents. It is a safe and effective practice recommended by the World Health Organization, which can be performed on an outpatient basis and, under certain conditions, in a self-managed manner with access to adequate information and health services.

Reproductive autonomy: children and adolescents. Children and adolescents are recognized by law as true subjects of rights, not merely objects of protection. This implies acknowledging that they possess a degree of autonomy that must be respected, especially when it comes to reproductive decisions that directly impact their lives and health, always taking into account their age and level of maturity.

In this regard, the Argentine Civil and Commercial Code incorporated the principle of “progressive autonomy” in 2015, applicable to health-related decisions. Under this approach, it is recognized that children and adolescents possess sufficient maturity to understand their situation—including what pregnancy entails, its effects on health, the risks associated with their age, and the available medical alternatives—and are therefore capable of making informed and autonomous decisions about their own bodies and life plans.

This criterion was already present in Law No. 25,673 on Sexual Health and Responsible Procreation, although the current Code adjusts the age from which this capacity is presumed, setting it at 13 years.

Article 26 of the Code establishes who can decide and how that decision is expressed through informed consent. Thus, from the age of 16, they have the same rights as adults to decide autonomously about their health, without the need for intervention.

tion or authorization of third parties, which includes the possibility of interrupting a pregnancy or continuing it.

Between the ages of 13 and 16, adolescents are presumed to have the capacity to decide for themselves regarding practices that are not invasive or pose a serious risk to their health or safety. In cases where the intervention is invasive or compromises their safety, the decision must be supported by their parents or legal guardians. However, if

Those who are required to attend object; another person may intervene. no affective reference to guarantee consent.

In the event of any disagreements between the will of the adolescent-

The response, for the child and their representatives, should not be judicialization, but rather an evaluation of what decision is most appropriate for their health, always under the principle of the best interests of the child and respect for their autonomy.

Layers of vulnerability: According to Florencia Luna (2008), this concept posits that people are not vulnerable by nature.
nature, but they can go through different conditions that overlap and hinder the exercise of rights.

These layers may include poverty, age, rurality, violence, or lack of resources.

Health grounds: Legal grounds that allow for the termination of pregnancy when its continuation may affect the health of the

pregnant person. In Argentina, it is recognized in article 86 of the Penal Code —in force since 1921— and reaffirmed by Law 27,610 on Access to Voluntary Interruption of Pregnancy, which guarantees access to legal interruption of pregnancy when health or life is at risk.

According to the definition of the World Health Organization, health comprises a state of comprehensive physical, mental and social well-being, so this cause should be interpreted broadly and without requiring severity or imminence of the risk.

Rape grounds: Legal assumption that allows the interruption of pregnancy when it is the result of rape.

In Argentina, it is provided for in Article 86 of the Penal Code and reaffirmed by Law 27,610 on Access to Voluntary Termination of Pregnancy, which guarantees access to legal abortion in these cases without the need for judicial authorization. Access is based on the sworn statement of the pregnant person, without requiring a prior criminal complaint. This framework was clarified by the FAL ruling on self-executing measures of the Supreme Court of Justice of the Nation, which established standards to eliminate barriers to access and ensure prompt, confidential, and respectful care.

petulant

Citizenship: It is a status, a social and legal recognition.

Citizenship is the concept by which a person has rights and duties by virtue of belonging to a community in general, based on territory and culture. Citizenship accepts difference, not inequality.
Dad.

According to Nora Aquín26 (2003) there is a political citizenship, which is understood as a legal structure that regulates the relationships between people, who are first and foremost individuals.
In the political sphere, it refers to participation in matters pertaining to the political community.

From a sociological perspective, Elizabeth Jelin 27 attributes to citizenship a relational character linked to a conflictive practice connected to power, reflecting the struggles over who will be able to define what the common problems will be and how they will be addressed.28

26 - AQUÍN, N.: "On Citizenship" Page 15. In "Essays on Citizenship Reflections from Social Work": Aquín, Nora (compiler) Espacio Editorial. Buenos Aires, 2003.

27 - JELIN, E.: How to build citizenship? A view from below.
European Journal of Latin American and Caribbean Studies No. 55. Amsterdam, Netherlands. (1993: 25).
Extracted from the text: "Health and Community Participation - Module 7. Pp 40 – 42. Postgraduate Course in Social and Community Health - Ministry of Health of the Nation - 2006).

28 - Text: Health and Society - Modules 1 and 7 Postgraduate Course in Social and Community Health - Ministry of Health of the Nation - 2010).

Right to health:

Health: According to the World Health Organization (WHO)29
It defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” It is a universal and fundamental human right.
mental.

This definition, in force since 1948, emphasizes a holistic and comprehensive vision that encompasses quality of life and social relationships.

Furthermore, it is the right of all people to access timely, quality, and non-discriminatory health services, as well as living conditions that allow them to maintain their well-being. This is not limited to medical care, but also includes social factors such as housing, food, education, and

healthy environment.

It is guaranteed by international standards, by
our National Constitution through article 75, paragraph
22, which ratifies relevant Treaties, Pacts and Conventions.
Also, as a human right, it focuses on the dignity of people and is binding on States.
interrelates with other rights.

Public health: “The science and art of preventing disease, prolonging life, and promoting health and efficiency

29th *International Conference on Primary Health Care, Alma-Ata, USSR, September 6-12, 1978.* Available at: https://www.paho.org/es/documentos/declaracion-alma-ata

through the organized efforts of the community for: environmental sanitation, control of communicable infections, education of individuals in personal hygiene, and the organization of medical and nursing services for the preventive treatment of diseases." It is the development of a social mechanism that ensures everyone a standard of living adequate for the preservation of health, so that every citizen is able to enjoy their natural right to health and longevity. (Winslow, 1920).

Health system organization:

Health system: The health services system is the re-
result of successive political, economic, social and technological influences that have occurred in a country over the years.
This means that each country's health system has its own unique characteristics. One cannot speak of "one health system" but rather of specific systems for each country at each historical moment.30

The organization of the health services system in our

30 - Moreno, Elsa: Organization and structure of Health Systems-
Public Health Volume II - Chair of Public Health Faculty of Medicine
na-1996

The country is represented by different subsectors:31

- Public services: financed by national, provincial, or municipal governments through taxes. They have their own installed capacity, are based on universality and equity, and their operational units are represented by: health centers, polyclinics, and hospitals. They have national coverage in remote areas of the territory and constitute the subsector with the greatest installed capacity.
- Social security services: financed by employer and employee contributions. A few social welfare organizations have their own installed capacity, but in general they contract diagnostic and hospitalization services in the private subsector.
- Private health services: represented by clinics, diagnostic institutes, sanatoriums, polyclinics, hospitals, and private practices. They are financed voluntarily by patients.
  Payments can be made directly or indirectly through the purchase of a health insurance policy with prepayment: prepayments
  doctors.

Levels of care in the public health system: the or-

31 - Delgado, Lucía and Ricco, Rosa Magdalena: Health Services System - Public Health Volume II - Chair of Public Health Faculty of Medicine - 1996 - Pages 129 to 141

The organization of health systems by levels of care is based on the fundamental principle that there is a direct relationship between the complexity of illnesses and the methods and resources needed to resolve them. Using the primary health care framework as a paradigm, medical care should be delivered according to levels of complexity.

growing.

This way of grouping problems and service responses is based on reasons of rationality between supply and demand and the proper use of the resources available to society.

There are 3 levels of care recognized, of which the least complex, the 1st level of care, includes the most basic and undifferentiated actions of the system and constitutes the point of contact with the community.

The 2nd and 3rd levels correspond to services with different degrees of specialization and increasing complexity that generally act as referral centers for 1st level care services based on organizational mechanisms for patient referral and counter-referral between levels to ensure care in the appropriate place for their problems.

more health.

Reference and counter-reference system: “Reference and

counter-referral”32: for the health services network to be such, a referral system must function in such a way that people are attended to at the levels of lower complexity, and based on the complexity of the health problem that afflicts them, they can be attended to at a level of greater complexity, that is, one that has the required resolution capacity.

On the other hand, the patient can, after this care, be referred back to the health service closest to their home.

that has the operational capacity to continue its care and follow-up until its proper restoration.

The system as proposed is rational and seeks to avoid overburdening the most complex establishments; likewise, it will allow not only offering the service to people in the establishments closest to their place of residence, but also decongesting the establishments with regional and national coverage and using high-tech resources more rationally.”

Primary Health Care (PHC): The Declaration

32 - Delgado, Lucia and Ricco, Rosa Magdalena: Health Services System - Public Health Volume II - Chair of Public Health Faculty of Medicine - 1996 - Pages 129 to 141

Alma-Ata (1978)33 defines Primary Health Care (PHC) as essential health care, based on practical, scientifically sound and socially acceptable methods and technologies, made universally accessible to all individuals and families in the community through their full participation, at a sustainable cost, constituting the core of national health system.

Health promotion: According to the Ottawa Charter (1986), health promotion consists of actions aimed at improving living conditions and strengthening people's ability to care for their health.

It is not limited to preventing diseases, but seeks to empower communities to exercise their rights and improve their well-being.

Social determinants and inequality in health: The WHO (2003) defines the determinants of health as follows: "(…) adverse social and economic circumstances that affect health throughout life. Material and psychological causes and their effects extend to almost all causes of illness and death. If policies fail to address these factors, they not only ignore the most powerful determinants of health, but also fail to meet one of the most important challenges of modern societies: social justice."

33rd International Conference on Primary Health Care, Alma-Ata, September 1978

Recognizing social determinants allows us to identify health inequalities.

Therefore, social determinants of health are understood to be the social conditions in which people live and work and that impact health.

The mechanisms of socioeconomic stratification are the

These are called structural determinants of health inequity, and they shape better or worse opportunities for health and well-being, depending on differences in vulnerabilities, exposures to agents, and access to basic services.
cos.

Intersectionality34 It is a perspective that analyzes how different social inequalities combine and produce specific experiences of discrimination or vulnerability.

For example, gender inequalities can be combined with those of class, age, or territory.

34 - Kimberlé Crenshaw “Demarginalizing the intersection of race and sex: a critique from black feminism of anti-discrimination doctrine, feminist theory and anti-racist policies”, translated by Cecilia Ezpeleta, in “Legal Feminisms. Interpellations and debates”, by Mal-ena Costa Wegsman and Romina Lerussi Compilers, Bogotá, Siglo del Hombre and Universidad de los Andes, pp. 43-68, Year 2020.

Interdisciplinarity35: A theoretical, methodological, and practical approach that promotes collaboration between different disciplines to address complex problems that cannot be understood or addressed in a fragmented way. It involves a process of dialogue, exchange, and collective construction among diverse fields of knowledge, in which each discipline contributes its conceptual frameworks, methodologies, and tools, but is also challenged and transformed by its encounters with others.

From Roberto Follari's perspective (1992)36, interdisciplinarity involves going beyond the mere juxtaposition of knowledge, giving rise to a critical interaction that questions the limits and assumptions of each disciplinary field. It is not about adding perspectives, but about producing new knowledge from the tension between them.

Along the same lines, Susana Cazzaniga (2008) emphasizes that interdisciplinarity is a situated practice, shaped by power relations, institutions, and specific contexts of intervention. It requires agreements, common languages, and recognition of differences, as well as a work ethic that prioritizes holistic care for individuals.

In the field of health and rights, interdisciplinarity re-

35 - Lic. Susana Cazzaniga (2008) Social Work and Interdisciplinarity - The Question of Health Teams - chapter of the book Health and Intervention in the Social - Editorial Espacio - Buenos Aires Pages: 153-168

36 - 3 FOLLARI, Roberto. Notes from the Epistemology Seminar (mimeo). Faculty of Educational Sciences. UNER. Paraná. 1992.

It is key to ensuring comprehensive, respectful, and people-centered approaches, articulating biomedical, psychological, social, and legal dimensions.

Voluntary Interruption of Pregnancy (IVE): The right of people with the capacity to gestate to decide on and access the termination of a pregnancy within the time limits established by law, without needing to invoke grounds. In Argentina, this right is guaranteed by Law 27.610 on Access to Voluntary Interruption of Pregnancy, which allows access up to and including the 14th week of gestation. It must be performed within the healthcare system free of charge, safely, confidentially, and with dignified treatment, respecting the autonomy and decision of the individual.

pregnant person.

ILE (Legal Interruption of Pregnancy): The right to access abortion when the grounds established by law are met. In Argentina, it is recognized in Article 86 of the Penal Code and guaranteed by Law 27.610 on Access to Voluntary Interruption of Pregnancy.

The reasons are: when pregnancy is the result of a

rape or when it endangers the life or health of the pregnant person. It is not subject to gestational time limits and must be guaranteed under conditions of safe, confidential, prompt and respectful care, without the need for judicial authorization.

Misoprostol: A prostaglandin analogue used in reproductive health for pregnancy termination, treatment of incomplete abortions, and induction of labor, among other uses. It works by causing uterine contractions and cervical dilation, facilitating the evacuation of uterine contents. It is a safe and effective drug, widely recommended by the World Health Organization, both in combination with mifepristone and as a standalone treatment, especially in contexts where other medications are unavailable. Its access and use must be accompanied by adequate information and within current legal and health frameworks.

Mifepristone: An antiprogestin medication used to terminate a pregnancy, usually in combination with misoprostol. It works by blocking the action of progesterone, a hormone necessary for the continuation of the pregnancy, which causes changes in the endometrium and facilitates the subsequent expulsion of the uterine contents. It is a safe and effective drug, recommended by the World Health Organization as part of the medical abortion regimen, especially in the early stages of pregnancy. Its use improves effectiveness and reduces the duration of the procedure compared to using misoprostol

Subjective urgency37: A concept that refers to a form of suffering that erupts as “unbearable” for the subject and cannot wait, demanding an immediate, effective, and situated response. It is characterized by its initial difficulty in being expressed in words and by its inscription in the singularity of each experience.

Unlike medical emergencies—which focus on biological parameters—subjective emergencies are addressed from an interdisciplinary perspective, recognizing the holistic nature of suffering and the need for attentive listening on a case-by-case basis. In this sense, it cannot be separated from the sociopolitical and economic context in which it arises: conditions such as poverty, loneliness, cultural mandates, or institutional barriers can intensify and shape the sense of urgency.

In the field of sexual and reproductive health, particularly in situations of voluntary termination of pregnancy, the subjective urgency is linked to the need to "get rid of" as a response to an experience that goes beyond the physical, involving emotional, social and symbolic dimensions.

Their approach involves creating spaces for shelter, listening, and support that allow for processing this distress, strengthening the person's autonomy and recognizing themselves

37 - Mónaco Rodríguez, MF (2024). *Feminist lace: weaving urgent stories.* Women x Women Foundation.

as a subject of law, desire and speech, in contexts marked by multiple vulnerabilities.

Violence against reproductive freedom: A form of gender-based violence that consists of violating the right of individuals to decide freely and responsibly about their reproductive lives. In Argentina, it is defined in Law 26.485 on Comprehensive Protection to Prevent, Punish and Eradicate Violence against Women as any action or omission that limits or prevents access to information, contraceptive methods, sexual and reproductive health services, or the exercise of autonomous decisions about one's own body.

This form of violence can manifest itself through practices such as the denial or unjustified delay of services, the imposition of contraceptive methods, obstruction of access to abortion, or a lack of adequate information. It constitutes a violation of human and reproductive rights and must be addressed from a comprehensive perspective that guarantees effective access to health and the autonomy of individuals.

Institutional violence: A form of violence perpetrated by officials, professionals, or agents belonging to public institutions—and, in certain cases,

private—through actions or omissions that hinder, restrict, or violate access to rights. In Argentina, it is recognized in Law 26.485 on Comprehensive Protection to Prevent, Punish, and Eradicate Violence against Women.

It manifests itself, among other ways, in the denial or unjustified delay of services, dehumanizing treatment, revictimization, and the demand for requirements not provided for by the regulations. motivating or the lack of adequate information. In the field of health, can be expressed in barriers to accessing services, discriminatory practices, or interventions that are unaware the autonomy of people.

Institutional violence implies a state responsibility, since it compromises the duty to guarantee the effective exercise of rights under conditions of equality, dignity and respect.

Obstetric violence: A form of gender-based violence that occurs in the healthcare setting during pregnancy, abortion, post-abortion, childbirth, and the postpartum period, through practices that dehumanize, over-medicalize, or
They violate the autonomy and rights of pregnant people. In Argentina, this is recognized in Law 26.485.
Comprehensive Protection to Prevent, Punish and Eradicate Violence against Women and also linked to the de-rights established in Law 25.929 on Humanized Childbirth.

It includes behaviors such as depersonalized treatment, lack of information or consent, and the performance of interventions. Unnecessary or medically unjustified procedures, the pathologization of natural processes, and the imposition of practices that disregard the decisions of the pregnant person.

This form of violence affects dignity, integrity, and physical and emotional health, and must be addressed from a rights-based approach, ensuring respectful, informed, and person-centered care.

Rights in healthcare: Patient Rights Law: Law No. 26,529 establishes the fundamental rights of individuals in their relationship with the healthcare system. Among
they:

- Receive clear information.
- Informed consent.
- Dignified treatment.
- Confidentiality.
- Access to medical records.

This law recognizes that people are not objects of medical treatment, but subjects of rights within the system
sanitary.

Informed consent: According to Law 26.529 on patient rights in Argentina, informed consent is the declaration of the patient's will, issued after receiving clear and adequate information from the doctor about their health, the proposed procedure, benefits, risks and alternatives.

It is a mandatory process for all medical acts, guaranteeing autonomy and freedom of decision.

Medical record: Argentine National Law No. 26,529 establishes that the medical record is the mandatory, chronological, paginated, and complete document that contains all information about a patient's health and medical procedures. It belongs to the patient, and the healthcare facility must provide them with a signed copy within 48 hours upon request.

Gender38: A social, historical, and cultural category that refers to the roles, identities, expressions, and power relations constructed around sexual differences. It is not a fact.

biological, but a construct that organizes expectations, norms and hierarchies in a given society.

From Judith Butler's perspective (2004), gender is a performative practice: it is produced and reproduced through ac-

38 - Inverted Subordinations: On the Right to Gender Identity / Laura Saldivia Menajovsky. - 1st ed. - Los Polvorines: National University of General Sarmiento; Mexico City: National Autonomous University of Mexico, 2017. (it is chapter 1 “The role of medicine and law in the binary construction of sex-gender”

Coughs, discourses, and social regulations shape what is understood as "feminine" and "masculine," as well as other possible identities. The same cautions against a biological perspective, asserting that anatomy and sex do not exist without a cultural framework. On the contrary, gender should be understood as a cultural way of configuring the body, which is why it is open to reform.

Within the Argentine regulatory framework, the Micaela Law (No. 27,499) It recognizes gender as a key category for understanding structural inequalities and violence, promoting its inclusion in public policies from a human rights and equality perspective.

Biological perspective in health: This is a view that explains health and disease processes solely based on biological factors, ignoring the social, economic, and cultural.

Critical perspectives in public health indicate that this vision is limited because it makes social inequalities invisible. social.

Hegemonic medical model: The predominant approach in the field of health that interprets health and disease processes from a fundamentally biological perspective, focused on organic and physiological factors. It is characterized by

due to a reductionism that disregards social, economic and cultural contexts, making inequalities and the uniqueness of experiences invisible.

This model tends toward the homogenization of individuals, establishing universal health parameters that disregard diverse life trajectories. Furthermore, it establishes a hierarchical power relationship in which medical knowledge is positioned... na as dominant over other forms of knowledge, and people are frequently treated as objects of intervention rather than as subjects of rights.

In the field of sexual and reproductive health, this can manifest as paternalistic practices that limit autonomy, restrict access to information, or impose decisions, reproducing logics of guardianship over bodies. This perspective reinforces a hegemony of biology that has been challenged by regulatory frameworks such as the Gender Identity Law No. 26,743, as well as by critical approaches that promote a holistic view.

In contrast, approaches from interdisciplinary and situated perspectives propose understanding health as a complex process, traversed by multiple dimensions, which requires recognizing the autonomy, experience and context of each person.

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