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ORIGINAL ARTICLE

Sociodemographic characterization of adolescents who accessed to services related to voluntary termination of pregnancy due to rape. Chile: 2018 - 2020

Caracterización sociodemográfica de adolescentes que tuvieron acceso a las prestaciones vinculadas con la interrupción voluntaria del embarazo por violación. Chile: 2018 - 2020

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What do we know about the subject matter of this study?

Although there are studies on sexual violence and its implications for minors, there is little information on the interruption of pregnancy due to rape in adolescents, making this a pioneer study in systematizing the data since the enactment of Law 21,030.

What does this study contribute to what is already known?

It shows the main sociodemographic variables related to the voluntary interruption of pregnancy due to rape in adolescents. It is expected to contribute to the evaluation and follow-up of the rape crime of Law 21.030, within the public policy framework that guarantees the exercise of sexual and reproductive rights in adolescents.

Abstract

Ground N°3 of Law 21,030 allows for the termination of a pregnancy due to rape, with the woman's consent, establishing a gestational age limit of 14 weeks for adolescents under 14 years of age and 12 weeks for those over 14 years of age. **Objective:** To describe, between the period 2018-2020, the main sociodemographic and other variables linked to ground N°3 in minors under 14 years, adolescents

Keywords:
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aged 14 years or older and under 18 years, and women aged 18 years or older. **Patients and Method:** Cross-sectional, descriptive, and population-based design. National data was obtained from the official registry of the Ministry of Health and through the Transparency Law. Measures of central tendency (median), dispersion (interquartile range), absolute frequencies, and percentages were used. **Results:** 31.6% of the women with rape-related pregnancies were under 18 years of age. Women under 14 lived mainly in the regions of the country, had a higher gestational age at the time of the ground factor, and 31.2% decided to continue the pregnancy. Adolescents aged 14 or older and under 18, had a higher multidimensional poverty index. Women aged 18 or older were most frequently foreigners, lived mainly in the Metropolitan Region, and decided to terminate the pregnancy. 57.4% of those who reported the rape and 11.1% who failed to establish the ground were under 18. **Conclusions:** Sexual violence is a public health problem. Pregnancy due to rape in adolescents is a social reality. There should be permanent evaluation and monitoring of the implementation of Law 21,030, guaranteeing timely, efficient, and nondiscriminatory access to benefits.

Introduction

Violence against women constitutes a serious violation of human rights, becoming a public health problem with short, medium and long-term consequences on physical, sexual, gynecological, and mental health, affecting the quality of life of survivors[1].

Although the actual prevalence is probably underestimated due to social stigma and repercussions associated with disclosure or reporting, in 2018, it was estimated that between 736 million and 852 million women over the age of 15 years (almost 1 in 3 women) have ever experienced physical, sexual, or psychological violence by the intimate partner or sexual violence perpetrated by family members, acquaintances, or strangers, confirming its pervasiveness in women's lives[1]. Violence against women increased globally during the SARS-CoV-2 pandemic[1]. Chile was no exception, registering an exponential increase in calls for help to emergency numbers, and decreasing formal reporting, mainly in the period of confinement where the victims were living with the aggressor, unable to go in person to file a complaint[2].

According to the IV Survey on Violence Against Women (2020), 2.1% in 2017 and 2.8% in 2020 of women aged 15 to 65 years suffered in the last year sexual violence by intimate partner. The low proportion of complaints and its decrease in 2020 (16.3%) compared with 2017 (23%) stands out. The main causes for not reporting were shame (13%) and fear (11%)[3]. The Undersecretariat for Crime Prevention, in 2019 reported 12,641 complaints of sexual crimes, increasing to 14,056 in 2021[4]. In both periods, the victims were mostly women, concentrated in children under 18 years of age. The perpetrators were predominantly men aged 30 to 64 years[5]. In 2017, the Forensic Medical Service reported 2,119 forensic examinations for rape, affecting women in 88.6%. In the Metropolitan Region, 89.6% of the victims were women. Of these, 49.2% were adolescents between 10 and 19 years old. In 25.4%, the perpetrator was a family member; in 42.2% it was other non-relative acquaintances, and 32.4% it was unknown or undetermined[6].

Sociodemographic profile and abortion

Every year, 29% of all pregnancies and 61% of unwanted pregnancies worldwide are terminated, with an estimated 73 million abortions. 45% of these occur in unsafe conditions, especially in developing countries, causing 4.7%-13.2% of maternal deaths. In Latin America, 3 out of every 4 abortions are performed under unsafe conditions[7].

In adolescents, there are few national and international reports. In Uruguay, between 2013 and 2017, adolescents between 15 - 19 years accounted for 16% of the total annual abortions[8]. The 2016 National Research on abortion in Brazil, regarding the last abortion, reports a frequency of 29% in adolescents aged 12 - 19 years[9]. In Mexico City, between 2007 and 2021, 5.5% of women under 18 years of age have had access to legal abortion[10]. In Chile, the 2022 X National Youth Survey reveals that 3.1% of young women aged 15 - 29 years had an abortion. In 83.2% was by personal decision and only 10.9% was within the three current legal grounds[11].

According to socioeconomic level, there is a similar percentage of pregnancies that end in abortion in high-income countries (43%) and low-income countries (40%)[12]. The higher abortion rate would be related to partial or total legal restriction and the lowest rates occur in countries whose legislation permits abortion and guarantees its safe access. In countries with highly restricted abortion, the rates are 3-5 times higher[13].

In Brazil, abortion is more frequent in women of African descent, Asians, and indigenous peoples. The rates are higher in women who have had children, who live in urban areas, have less schooling level, and have

lower family income[9]. Huneeus A. et al., based on information from 2015, showed that in Chile, women aged 15-29 years with higher socioeconomic status were more likely to have induced abortion. In this study, there was no correlation according to urban or rural residence, identification with indigenous peoples, age at first sexual activity, use of contraception at first intercourse, teenage pregnancy, and political or religious affiliation[14].

Pregnancy due to rape

This serious consequence of violence affects women's physical, social, sexual, and existential integrity[15]. A study carried out in Colombia among 121 women who got pregnant because of rape, revealed that 63% decided to terminate the pregnancy[15]. In Chile, the IV Survey on Violence Against Women reported 7% of pregnancies because of sexual violence[3].

During the legislative process of Law 21,030[16], despite the lack of knowledge of the actual prevalence of sexual violence and pregnancy as a consequence[17], an annual figure of 2,000 pregnant women as a result of rape was estimated[18].

That Law, enacted on 09/14/2017, contemplates the termination of pregnancy mediated by the will of the woman when: there is vital risk to the pregnant woman (ground 1); the embryo or fetus suffers from an acquired congenital or genetic lethal pathology, incompatible with independent extrauterine life (ground 2), and in pregnancy due to rape (ground 3). For this last ground, it limits the gestational age to 12 weeks in those older than 14 years and 14 weeks in those younger than 14 years[16].

Considering the national context, after 28 years of absolute prohibition of abortion[19] and five years after the enactment of Law 21,030, the objective of this article is to describe in the period 2018 - 2020, the main sociodemographic variables and others linked to ground 3 in adolescents under 14 years of age, adolescents aged between 14 years and under 18 years, and women aged 18 years or older. This systematization expects to contribute to the monitoring of this public policy, evidencing what happened with the voluntary interruption of pregnancy at the national level, specifically in minors due to their greater vulnerability, allowing to take measures that strengthen their growth and development and guarantee the exercise of their sexual and reproductive rights.

Patients and Method

Design

Cross-sectional, descriptive, and population-based study.

Data collection

The information for the country was collected in May 2021 from the anonymized databases available on the website of the Ministry of Health[20] and from anonymized records provided by Transparency Law from the Undersecretariat of Public Health and the SEREMI[a] of Metropolitan Health. A guideline was prepared to collect information by transparency, including the main variables and categories detailed in the corresponding item.

Population

The population under study is made up of all women in the country who had access to ground 3 (pregnancy due to rape), whose information was entered into the databases described above. Data was obtained from 415 women with access to benefits linked to ground 3 of Law 21,030, from January 2018 to December 2020. Specifically for the variable complaint, data from 200 women was available during the period from January 2019 to June 2020, while for the variable constitution of grounds, data was collected from 355 women from January 2018 to June 2020.

Sociodemographic variables

For the age variable, the age ranges established in Law 21,030[b] [16] were considered, which distinguishes between minors (under 14 years of age; over 14 years of age and under 18 years), and women over 18 years of age. Therefore, in this study, women in ground 3 were divided into: under 14 years of age; adolescents 14 years or older and under 18, and women 18 years or older (N = 414). This last group comprises all women, adolescents, and adults aged 18 years or older.

The other variables correspond to: Nationality (foreign/Chilean; N = 412); Zone of residence (North, regions: I, II, III, IV, XV / Metropolitan Region, region: XIII / Center, regions: V, VI, VII, XVI / South, regions: VIII, IX, X, XI, XII, XIV; N =4 11); Healthcare insuran-

[a] *Regional Ministerial Secretariat* (Secretaría Regional Ministerial, in Spanish).

[b] Distinctions on age in Law 21,030: 1) Gestational age in ground 3: 14 weeks in minors under 14 and 12 weeks in those over 14 years of age; 2) Decision-making: in minors under 14, the authorization of the legal guardian or the Family Court must be obtained. In children over 14 and under 18, only the legal guardian or adult/responsible family member indicated by the adolescent must inform. In women over 18, the decision is autonomous without the need to inform third parties; 3) Reporting: in minors under 18, the authority of the public or private health institutions will make the complaint according to the Criminal Code and the Code of Criminal Procedure, and the National Service for Minors must be notified. In those older than 18 years, who have not reported the rape, they will inform the Public Prosecutor's Office to investigate *ex officio*[16].

ce (FONASA[c]/ISAPRE[d]/Armed Forces/No health insurance; N = 413); FONASA level (A/B/C/D; N = 368); Percentage of multidimensional poverty; N = 409.

To compare the degree of vulnerability of those who were on ground 3, the multidimensional poverty index proposed by Alkire and Foster[21] was incorporated in 2015 through the Chile National Socioeconomic Characterization Survey (CASEN). This index measures the deprivations suffered by households in different dimensions relevant to the well-being of the population. For its measurement, it considers the dimensions of education, health, work, and social security; housing and environment, and networks and social cohesion[21], making visible the households requiring a greater focus from public policies[22]. Each dimension, made up of dichotomous indicators, has an impact on the well-being of the population, determining whether a household has overcome its deprivations, which are weighted by a relative weight assigned to each indicator, allowing to identify those households that are in a situation of multidimensional poverty[23]. Thus, multidimensional poverty is defined as a methodology for measuring poverty, which considers areas that, in addition to income, determine the incidence and intensity of the deprivations and lack of households and therefore the poverty level in which they are[22,23].

For our analysis, the percentage of people living in multidimensional poverty in the municipality was obtained from the value already formulated and calculated by the Ministry of Social Development and Family, available in the Ministry's database[24].

Variables related to the constitution of the ground

Referral level: private medical consultation, medical center/1st level of care (PHC)/ 2nd level of care/3rd level of care (gynecology-obstetrics emergency) / 3rd level of care (hospitalization); N = 411.

Gestational age: weeks of gestation at ground constitution N = 414 and at termination N = 381.

Woman's decision: she decides to terminate (yes/no), N = 414; Accepts psychosocial support (yes/no), N = 412.

Complaint: report (yes/no), N = 200.

Constitutes ground: (yes/no), N = 355.

Statistical analysis

For the descriptive analysis, the women were grouped by age as indicated. Measures of central tendency (median) and dispersion [interquartile range (IQR)], absolute frequencies, and percentages were used. The statistical software STATA v 12 (StataCorp LP, Texas, USA) was used.

[c]National Health Fund (Fondo Nacional de Salud in Spanish); public social security health insurance.

[d]Private social security health institutions.

Ethical evaluation

Corresponds to the 1st stage of the *Fondecyt Regular Project* nº 1200374, approved by the Human Research Ethics Committee, Faculty of Medicine, University of Chile (Act nº 009 - 2020).

Results

From January 2018 to December 2020, 2,207 women were registered with access to benefits linked to the 3 grounds of Law 21,030. In 2,189, the age was recorded, corresponding to 161 women under 18 years of age (7.4%). In this group, there were 7 in ground 1 (4.3%), 23 in ground 2 (14.3%), and 131 in ground 3 (81.4%).

Specifically in ground 3, in 414 women, the age was recorded. 15.5% were under 14 years of age, 16.2% were adolescents 14 years or older and under 18, and 68.4% were women 18 years of age or older. 97.6% were seen in public hospitals.

Children under 14 years of age

A total of 7.8% were foreigners; 36.5% resided in the central zone of the country and only 11.1% in the Metropolitan Region. 98.4% were users of FONASA, with 58.7% in level A (Table 1). For constitutes ground, 42.2% came from primary health care (PHC), and 28.1% were admitted due to gynecological-obstetric emergencies (Table 2). The median gestational age was 8 weeks at the time of ground constitution and at termination (Table 3). 68.8% decided to terminate the pregnancy and 89.1% accepted psychosocial support (Table 4).

Adolescents 14 years or older and under 18

11.9% were foreigners and 40.9% lived in the Metropolitan Region. 91% of the patients were users of FONASA, with 59% in level A (Table 1). 17.9% came from PHC and 50.7% were admitted due to gynecological-obstetric emergencies (Table 2). The median gestational age was 7 weeks at the ground constitution and 8 weeks at the termination (Table 3). 94% decided to terminate and 91% accepted psychosocial support (Table 4).

Women 18 years of age and older (adolescents and adults)

26.7% were foreigners and 47.5% resided in the Metropolitan Region. 86.5% were users of FONASA, with 38.9% in level A (Table 1). 54.6% were admitted due to gynecological-obstetric emergencies (Table 2). The median gestational age was 7 weeks at the ground constitution and 8 weeks at the termination (Table 3). 96.8% decided to terminate and 92.5% accepted psychosocial support (Table 4).

Under 14 years old v/s adolescents 14 years or older and under 18

Regarding the area of residence, adolescents aged 14 years or older and under 18 years live mainly in the Metropolitan Region and those girls under 14 years of age live mostly in the other regions of the country (Table 1).

For the variable healthcare level of referral, those under 14 years of age came mainly from PHC, unlike adolescents between 14 years or older and under 18, who were admitted in a higher percentage due to gynecological-obstetric emergencies (Table 2).

In adolescents under 14 years of age, there is a higher median gestational age at the ground constitution

Table 1. Distribution of sociodemographic variables by age of the woman and ground 3 of voluntary interruption of pregnancy in Chile

Variables	Categories	Total n(%)	Age of woman (years)			
			< 14 n = 64 n (%)	14 a < 18 n = 67 n (%)	< 18 n = 131 n (%)	18 or older n = 283 n (%)
Nationality	Foreign	88 (21.4)	5 (7.8)	8 (11.9)	13 (9.9)	75 (26.7)
	Chilean	324 (78.6)	59 (92.2)	59 (88.1)	118 (90.1)	206 (73.3)
	Total	412 (100)	64 (100)	67 (100)	131 (100)	281 (100)
Zone of residence	North	72 (17.5)	15 (23.8)	10 (15.2)	25 (19.3)	47 (16.7)
	Metropolitan Region	168 (40.9)	7 (11.1)	27 (40.9)	34 (26.4)	134 (47.5)
	Center	80 (19.5)	23 (36.5)	13 (19.7)	36 (27.9)	44 (15.6)
	South	91 (22.1)	18 (28.6)	16 (24.2)	34 (26.4)	57 (20.2)
	Total	411 (100)	63 (100)	66 (100)	129 (100)	282 (100)
Health care Insurance	FONASA	368 (89.1)	63 (98.4)	61 (91.0)	124 (94.7)	244 (86.5)
	ISAPRE	19 (4.6)	1 (1.6)	2 (3.0)	3 (2.3)	16 (5.7)
	Armed Forces	1 (0.2)	---	---	0 (0)	1 (0.3)
	No Health Insurance	25 (6.1)	0 (0)	4 (6.0)	4(3.0)	21 (7.5)
	Total	413 (100)	64 (100)	67 (100)	131(100)	282 (100)
Level FONASA	A	168 (45.6)	37 (58.7)	36 (59.0)	73 (58.9)	95 (38.9)
	B	114 (31.0)	16 (25.4)	13 (21.3)	29 (23.4)	85 (34.8)
	C	39 (10.6)	6 (9.5)	5 (8.2)	11 (8.9)	28 (11.5)
	D	47 (12.8)	4 (6.4)	7 (11.5)	11 (8.9)	36 (14.8)
	Total	368 (100)	63 (100)	61 (100)	124 (100)	244 (100)
Percentage multidimensional poverty by the municipality	Median (IQR) n:409	20.9 (8.4)	19.9 (11.0)	21.9 (9.1)	20.3 (10.9)	20.9 (8.6)

IQR: interquartile range. Source: In–house elaboration from anonymized databases available on the website of the Ministry of Health and from anonymized records provided by Transparency Law

Table 2. Distribution of the variable level of referral to constitute ground, by the age of the woman and ground 3 of voluntary interruption of pregnancy in Chile

Variables	Categories	Total n(%)	Age of woman (years)			
			< 14 n = 64 n (%)	14 a < 18 n = 67 n (%)	< 18 n = 131 n (%)	18 or older n = 283 n (%)
Referral level	Private medical consultation, medical center	8 (1.9)	0 (0)	1 (1.5)	1 (0.7)	7 (2.5)
	1st level of care (PHC)	98 (23.8)	27 (42.2)	12 (17.9)	39 (29.8)	59 (21.1)
	2nd level of care (HOR)	73 (17.8)	12 (18.8)	15 (22.4)	27 (20.6)	46 (16.4)
	3rd level of care (gynecology-obstetrics emergency)	205 (49.9)	18 (28.1)	34 (50.7)	52 (39.7)	153 (54.6)
	3rd level of care (hospitalization)	27 (6.6)	7 (10.9)	5 (7.5)	12 (9.2)	15 (5.4)
	Total	411 (100)	64 (100)	67 (100)	131 (100)	280 (100)

PHC:1st level of care; HOR: High Obstetric Risk. Source: In–house elaboration from anonymized databases available on the website of the Ministry of Health and from anonymized records provided by Transparency Law

Table 3. Distribution of gestational age at ground constitution and at termination, by age of the woman and ground 3 of voluntary termination of pregnancy in Chile.interrupción voluntaria del embarazo en Chile

Variables	Categories	Total	Age of woman (years)			
			< 14 n = 64	14 a < 18 n = 67	< 18 n = 131	18 or older n = 283
Gestational age at ground constitution	Median (IQR) n = 414	7 (3)	8 (4)	7 (3)	7 (3)	7 (3)
Gestational age at termination	Median (IQR) n = 381	8 (3)	8 (3)	8 (3)	8 (4)	8 (3)

IQR: Interquartile range. Source: In–house elaboration from anonymized databases available on the website of the Ministry of Health and from anonymized records provided by Transparency Law

Table 4. Distribution of the woman's decision variable by age and ground 3 of voluntary interruption of pregnancy in Chile

Woman´s decision	Categories	Total n (%)	Age of woman (years)			
			< 14 n = 64 n (%)	14 a < 18 n = 67 n (%)	< 18 n = 131 n (%)	18 or older n = 283 n (%)
Decides termination	No	33 (8.0)	20 (31.2)	4 (6.0)	24 (18.3)	9 (3.2)
	Si	381 (92.0)	44 (68.8)	63 (94.0)	107 (81.7)	274 (96.8)
	Total	414 (100)	64 (100)	67 (100)	131 (100)	283 (100)
Accepts psychosocial support	No	34 (8.2)	7 (10.9)	6 (9.0)	13 (9.9)	21 (7.5)
	Si	378 (91.8)	57 (89.1)	61 (91.0)	118 (90.1)	260 (92.5)
	Total	412 (100)	64 (100)	67 (100)	131 (100)	281 (100)

Source: In–house elaboration from anonymized databases available on the website of the Ministry of Health and from anonymized records provided by Transparency Law

(Table 3). In this group, one-third choose to continue the pregnancy (31.2%), in contrast to adolescents 14 years or older and under 18, who mostly decide to terminate the pregnancy (94%) (Table 4).

There were no major differences according to nationality, health insurance, FONASA level, gestational age at termination, and acceptance of psychosocial support. For the multidimensional poverty variable, there was a higher median in the group of adolescents aged 14 years or older and under 18 (Table 1).

Adolescents under 18 years old vs. women 18 years old or older

Women 18 years of age and older have a higher proportion of foreigners and a higher percentage of residence in the Metropolitan Region. Adolescents under 18 years of age are concentrated in level A of FONASA. The median of multidimensional poverty by municipality was similar (Table 1).

According to referral for ground constitution, when compared, adolescents under 18 years of age come mainly from the first and second level of care, in contrast to women 18 years of age or older, who are admitted in a higher percentage due to gynecological-obstetric emergencies (Table 2).

The gestational age at the ground constitution and termination of the pregnancy were similar in both groups (Table 3).

A higher percentage of women 18 years of age or older decide to terminate the pregnancy. In both groups, there is a high percentage who accept psychosocial support (Table 4).

Complaint

Among 200 women, only 36.5% had reported at admission to the ground constitution, with a higher frequency of reporting among those under 18 years of age (Table 5).

Ground constitution

Of 355 women, 92.7% were able to establish the ground, with a higher percentage of women 18 years of age or older. Of 26 women in whom it was not constituted, 6 were younger than 14 and 8 were adolescents aged 14 years or older and under 18 (Table 5). The main reason for adolescents was due to exceeding the gestational age limit.

Discussion

Sexual violence is a social reality and a public health problem. In girls and adolescents, it is usually intrafamilial, and repeated, with late disclosure and reporting[25]. Pregnancy due to rape constitutes a critical period for women, placing them in a moment of great vulnerability when deciding on motherhood, aggravated by the stigma, and the probability of suffering legal sanctions[15]. In Chile, there is also the time limit established in the legal norm, limited to 12 or 14 weeks depending on the woman's age[16].

Contrary to what was estimated during the legislative debate on Law 21,030, the low number of women who had access to the benefits related to the third ground of abortion[18] stands out in the total sample, which may be due to obstacles that have not yet been fully elucidated. According to the Social Monitoring Report, the main barriers are: lack of knowledge of the Law among the population, particularly among women; insufficient training of the healthcare teams; lack of protocols, and conscientious objection[26]. Similar findings come from Argentina, highlighting the request for unnecessary requirements and/or studies to establish the grounds for abortion, the lack of counseling for minors under 15 years of age, in whom the possibility of sexual violence is not considered, and the late access of women with pregnancies caused by rape[27].

On all the grounds, we observed a lower frequency of adolescents under 18 years of age. In ground 1, this could reflect an underestimation or underreporting of pathologies associated with the vital risk of the pregnant girl. In ground 2, it could be explained by the malformations of the embryo/fetus that would correlate with an older chronological age of the woman. However, in ground 3, considering the characteristics and implications of sexual violence, 66% of adolescents were expected[28].

Although minors under 18 years of age who get pregnant as a result of rape are a particularly vulnerable group, those under 14 years of age reflect this social vulnerability even more starkly. Considering that the Chilean Penal Code typifies as rape any penetrative sexual activity in minors under 14 years of age, pregnancy at this age will be a consequence of rape[29]. Therefore, if during 2018 - 2020 there were at least 88 births in minors under 14[30], regardless of their decision to continue or terminate the pregnancy, all of them should have been identified in PHC and referred promptly to constitute a ground.

In our results, out of the 64 minors under 14, there were 20 who decided to continue the pregnancy, therefore, it possible to supposes that 68 that did not constitute a ground for termination of pregnancy, which shows the lack of access. This is compatible with the findings of qualitative research, which shows insufficient PHC screening and referral of violence in general and rape pregnancy in particular, mainly because of exceeding the gestational age limit, by assuming an implicit acceptance of maternity, or assuming that pregnancy in minors under 14 was with sexual consent[31].

It should be noted that the referral for any of the grounds, even when not constituted, allows the con-

Table 5. Distribution of the variable reporting and constitution of ground by age of the woman and ground 3 of voluntary interruption of pregnancy in Chile

Variables	Categories	Total n (%)	Age of woman (years)			
			< 14 n = 60 n (%)	14 a < 18 n = 66 n (%)	< 18 n = 126 n (%)	18 or older n = 229 n (%)
Reporting	No	127 (63.5)	19 (52.8)	10 (31.2)	29 (42.6)	98 (74.2)
	Yes	73 (36.5)	17 (47.2)	22 (68.8)	39 (57.4)	34 (25.8)
	Total	200 (100)	36 (100)	32 (100)	68 (100)	132 (100)
Constitutes ground	No	26 (7.3)	6 (10.0)	8 (12.1)	14 (11.1)	12 (5.2)
	Yes	329 (92.7)	54 (90.0)	58 (87.9)	112 (88.9)	217 (94.8)
	Total	355 (100)	60 (100)	66 (100)	126 (100)	229 (100)

Source: In–house elaboration from anonymized records provided by Transparency Law

nection with a specialized psychosocial support team for women, vital to identify their needs and evaluate the support and referral to other institutions or organizations as appropriate.

The proportion of minors under 14 years of age who decide not to terminate a pregnancy stands out, which may reflect less freedom of decision. This could be due to multiple factors, such as social, cultural, and family pressure, abortion stigma, and gender violence[32]. As Skuster P. indicates, the requirements imposed by laws and policies on the participation of the father and/or mother in the decision of young women constitute a significant barrier, forcing them to resort to illegal abortion[33]. This situation could occur in Chile, given that Law 21,030 states that, with the consent of a minor under 14 years of age, the termination must be authorized by her legal representative or the family court[16]. In addition, in this group, we found a higher gestational age at the time the ground was established, which coincides with the late disclosure of violence and the state of pregnancy in adolescents, a matter of concern given the legal time limit imposed for weeks of gestation[16].

Reporting is not a condition to constitute a ground, but it could act as a deterrent to seeking treatment in the health system. Considering that sexual violence in adolescents is usually intrafamilial with late disclosure, it is common for a high percentage not to report the aggression. In addition, other factors such as shame, guilt, fear of being judged, and stigmatization experienced by the victims may also play a role[15,32]. The mistrust of the story by the health teams and the trivialization of the rape context contribute to sanctioning and stigmatizing those who request a termination of pregnancy[34].

The strengths of this study is based in the pioneering description of national data related to the interruption of pregnancy due to rape since the enactment of Law 21,030, allowing for a sociodemographic characterization of the population according to age. As limitations, the quantitative design does not allow a full account of the degree of vulnerability and obstacles faced by pregnant women, especially adolescents, in accessing the health system.

Conclusions

Victims of violence, especially minors pregnant due to rape, require competent, empathetic, and quality care, avoiding the generation of fear, pathologizing, and secondary victimization. However, even though Law 21,030 constitutes an advance in sexual and reproductive rights, there are still barriers to access that have not been fully considered, particularly in ground 3. Therefore, in addition to creating opportunities to disseminate the content of the Law and address the obstacles and stigma associated with abortion, it is urgent to raise awareness of the implications of violence among the general population and health teams in a cross-cutting manner. Sexual, civic, and ethical education at the school level, education and training of professionals, technical and administrative personnel in health, education, and justice, as well as mass campaigns to the community, are strategies to be considered.

Even though civil society has made efforts to highlight and warn about the difficulties in the application of Law 21,030, the State must carry out permanent evaluation and monitoring of its implementation, guaranteeing access to benefits. Simultaneously in its role, along with generating policies to prevent and identify violence, it must implement real actions of accompaniment and reparation to the victims.

Ethical Responsibilities

Human Beings and animals protection: Disclosure the authors state that the procedures were followed according to the Declaration of Helsinki and the World Medical Association regarding human experimentation developed for the medical community.

Data confidentiality: The authors state that they have followed the protocols of their Center and Local regulations on the publication of patient data.

Rights to privacy and informed consent: This study was approved by the respective Research Ethics Committee, which, according to the study's characteristics, has accepted the non-use of Informed Consent.

Conflicts of Interest

Authors declare no conflict of interest regarding the present study.

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