Social Policy with Tunnel Vision: Problems of State Efforts to Curb Adolescent Pregnancy in Post 1988 Brazil

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Abstract

This paper examines how conceptualisations of adolescence and adolescent pregnancy by the Brazilian state between its democratisation and 2018 have shaped social policy addressing adolescent pregnancy. It aims to understand the legibility of this demographic group as specific types of citizens, and the construction of this supposedly apolitical public health problem. In doing so, this paper explores the construction and visibility of sexual citizens and their problems and how the ways in which they are seen justify measures of social control in Brazil. A Foucauldian discourse analysis of policy documents and a content analysis of public health indicators and registries concerned with adolescent pregnancy between 1989 and 2018 show that adolescents' intersecting identities, characteristics of the men and boys who impregnate girls and the extent to which adolescent pregnancies were planned or not were key social factors that were ignored for many years. Moreover, adolescent pregnancy was largely medicalised and notions of adolescents as citizens in development were used to justify corrections of their sexual conduct for many years. This led to narrow social policy approaches to adolescent pregnancy which ignored the wider social contexts of diverse adolescents in Brazil. The results of this paper indicate that the state itself consists of various actors that can construct citizens and problems in different ways. They also show that defining an issue as apolitical and oversimplifying citizens' lives during data collection can lead to inadequate social policies attempting to control citizens' conduct that are incompatible with their realities.
Key Words: adolescent pregnancy, sexual citizenship, legibility, medicalisation

Introduction

Background

Brazil's adolescent fertility rate (68.4) is above the regional average (65.5) and is an indicator for the country's inequalities (UN Brazil, 2018). In 2010, 18% of adolescent girls from lower income groups had children, compared to 1% in more affluent groups (Fontoura and Pinheiro, 2010). Further, it may undermine educational attainment and is associated with greater health risks and poverty for both adolescent mothers and their children (UN Brazil, 2018). It is also one of the issues tangled into Brazil's current political turmoil. With the newly elected government at the forefront of a shift in approach to citizenship and sexuality, adolescents' sexual autonomy and rights have become contentious issues during the rise of moral conservatism (Anon, 2018; Família Bolsonaro, 2020). In the end of 2019, the Ministries of Health and of Women, the Family and Human Rights suggested using sexual abstinence as one strategy to curb adolescent fertility (Sassine, 2020; MDH, 2020). Studying past state approaches to adolescent sexual citizenship and the governance of their behaviour in Brazil highlights potential ways in which the current administration may impact adolescent sexual and reproductive health in the near future.

To address adolescent pregnancy, the Adolescent Health Care Programme (PROSAD) was created in 1989. It defined adolescence as the age between 10 and 19 years and set the aim of curbing adolescent pregnancy. PROSAD's strategies included access to health professionals, contraception and information on sexual and reproductive health (CSCA, 1989). To address this issue at school, the Health and Prevention in Schools Project (SPE) was created in 2003 and was incorporated in the Health in Schools Programme (PSE) from 2007 (MS et al, 2007a). In 2010, the National Guidelines for Comprehensive Healthcare for Adolescents and Youth in Promotion, Protection and Recovery of Health (abbreviated here as National Guidelines from 2010) were added to these measures (Schaefer et al, 2018).

Throughout this period, Brazil's democracy and society changed and citizenship and universal rights became dominant concerns (Parker, 1999). At the same time, neoliberalism questioned whether the state should intervene in the market and in people's lives (Giffin, 1994). More than a decade later, new ideas of social justice probed neoliberalism and universalism (Caldwell, 2017). Since the wave of protests in the 2010s, Brazil finds itself in a period marked by conflicting ideas about rights and citizenship. Given these developments, social policies have conceptualised adolescent citizenship and adolescent pregnancy differently. To understand the prevalence of Brazil's high adolescent fertility and the potential impact of the current shift in state-led approach to citizenship and sexuality, an analysis of the relationship between the state and adolescents in previous periods of changing ideas about citizenship is a significant contribution.

I therefore examine how the Brazilian state's conceptualisation of adolescents and adolescent pregnancy from 1989 to 2018 has impacted its approach to adolescent pregnancy. I will argue that the way in which the Brazilian state constructed adolescence and adolescent pregnancy did not allow for a holistic policy approach, ignoring major societal factors that hinder the behavioural change the state desired in order to curb adolescent fertility.

Outline and relevance

To substantiate this position, I will analyse what about adolescent pregnancy and adolescents' lives was made visible and will show how meanings attributed to them ignored some and focussed on other aspects of their lives. I will use two examples to illustrate how social policy serves as a tool to govern behaviour, and how the lack of consideration of social factors attempts to normalise behaviour that is either unattractive or not suitable for those who are meant to adopt it. My first example will show how the medicalisation of adolescent pregnancy in Brazil ignored adolescents' varying social contexts. My second example regards the invisibility of the

father in public health registries, and the resulting negligence of social factors that may lead to adolescent girls being impregnated by adult men. As these examples will show, the negligence of societal factors makes adolescents responsible for marginalised behaviours that they may not be able to change or that contribute more to their wellbeing than normalised ones.

This paper builds on past research analysing the PROSAD and SPE/PSE (Ruzany et al, 2002; Russo and Arreguy, 2015; Jager et al, 2014; Horta and de Sena, 2010). These authors analysed policy documents and children's rights laws and focussed on adolescent health in general. My study will not only analyse policy documents, but also public health registries and indicators used to make adolescents visible. I will examine not only discourses surrounding adolescence, but also what about it was kept invisible from state officials. Finally, I intend to contribute with a deeper analysis of one public health issue instead of generally describing state-citizen relations like in past studies. By focussing on the problematisation of adolescent pregnancy as a problem and how it was addressed, I offer a more detailed account of the impacts of legibility on adolescents' lives. This paper hence contributes to the field of health policy by showing how the promotion of behavioural change without a holistic focus on people's lives can make policy recommendations ill-fitting. My contribution can also serve as a foundation for further social policy research and analyses of the impact of Bolsonaro's government onto citizenship and rights, as I explore state-citizen-problem relations.

Theoretical framework

Simplifying identities

Fundamental for the interaction between states and citizens, and a necessity for a state to grant rights and distribute resources, is the making visible of citizens in a simplified, governable manner (Scott, 1998). For this to be possible, state officials need information - such as census data and health indicators - to create simplified images of those who ought to be governed

(Scott, 1998; Rose and Miller, 2008). This information is gathered based on what the state *needs* to see, based on its programmatic goals for society (King, 1999). Hence while people's identities are simplified for them to become governable, other aspects of their lives are purposely made invisible, as they are found irrelevant (Scott, 1998; Hoppe, 2011). This leads to the invisibility of aspects of people's contexts that may be fundamental parts of their lives (Scott, 1998; Brown, 2009). Moreover, if a person is not seen as relevant for a state's programmatic goals, they may themselves remain invisible in the eyes of the state (Scott, 1998). (In)visibility and what is made legible by the state has repercussions for the access to rights and resources. If something remains invisible to the state, it cannot be addressed by policy (Scott, 1998; Brown, 2009; Chemmencheri, 2015; Hildebrandt and Chua, 2017). The concept of rhetorical silence clarifies the link between legibility and redistribution: the absence of someone's identity from government data does not mean that it is not there, but that it is being ignored (Brown, 2009). However, visibility does not necessarily translate into redistribution and the *way* in which one is legible also affects one's access to rights and resources (Chemmencheri, 2015; King, 1999; Li, 2007). Being seen as undesired or incapable of being an agent may restrict such access (King, 1999; Li, 2007). Research on Brazil shows a history of differentiated citizenships. Different groups have been given different rights and means to access them as some are seen as more deserving or capable of agency than others (Holston, 2009; Caldwell, 2017). Those whose identities or behaviour are deemed undesired are addressed with illiberal policies to correct their conduct based on the state's ideals, often denying these citizens' rights and services (Caldwell, 2017; Rodrigues and Almeida, 2015).

Such ideals can be shaped by governments' programmatic goals for society (Scott, 1998; Rose and Miller, 2008). A state has a certain aim for which it needs certain - but not all - of its citizens to be seen and subsequently shaped into individuals that behave accordingly (Ansoms and Cioffo, 2016). This may be economic development, for which the creation of certain ideal

citizens is necessary. In the case of Brazil, Jones (2016) suggests that an idealised adolescence is one where adolescents stay in education until reaching an acceptable age to work as high skilled labour.

Adolescent sexual citizenship

The extent to which one is made legible as capable of governing oneself is a fundamental part of the construction of adolescence and sexual citizenship (Ericsson, 2005; Schaffner, 2005). Amuchástegui (2007: 6) conceptualises sexual citizenship as 'notions of rights related to bodies and their pleasures', such as one's right to decide on the timing of sexual intercourse. This definition is most appropriate for my analysis as its focus on pleasure can include both identity and sexual practices. By including pleasure in the definition of sexual citizenship, this theoretical framework includes the right to sexuality as something that adolescents may pursue for their physical and emotional wellbeing and for the expression of their identities (Tambling, et al, 2012). Another central aspect of this concept is that it grasps to what extent the state controls a citizen's sexual conduct (Amuchástegui, 2007; Richardson, 2015).

Government officials may deem certain people as *not ready* to reproduce (Kim, 2010). The extent to which a state tries to control a group's sexual conduct depends on how the group is made legible and what its ideal image for that group is (King, 1999; Carabine, 2001). In Brazil, previous research has posited that there has been a paradigm shift from treating adolescent sexuality as violence against 'children' to normalising it in a biological and heteronormative manner, with some consideration of pleasure and agency (Jimenez, Assis and Neves, 2015; Faleiros, 2013). Other studies claim that perceptions of adolescents as vulnerable risk groups have inspired targeted public health policies such as the PROSAD to address their so-called 'vulnerability' for contracting venereal diseases and becoming pregnant (Jager et al, 2014; Horta and de Sena, 2010). Another example is how teachers at public schools in Brazil may see

adolescents as unprepared to have sex, justifying constraining their sexual agency by controlling access to condoms at schools (Russo and Arreguy, 2015).

Normalisation of sexual conduct

Because sex is linked to reproduction and, therefore, the creation of new citizens, the construction of desired and undesired sexual conduct is political (Jeffreys, 2009; Carabine, 2001). Based on concerns regarding what kind of citizens should or not reproduce, it is in the interest of the state to use social policy to shape sexuality (Carabine, 2001). This is done via intertwined channels of power (Brickell, 2009): By defining different categories of sexual behaviour and establishing which should (not) be allowed, governing actors have the power to normalise certain types of sexual conduct while marginalising others. This process of normalisation and marginalisation creates what can be called sexual scripts: influenced by notions of acceptable and unacceptable behaviour, subjects constrain themselves by choosing between the 'options' available to them to avoid punishment and shame. Some subjects are thus discouraged to reproduce, and some sexualities are deemed 'risky' (Carabine, 2001).

One way in which sexual behaviour is marginalised or normalised without exposing the state's stake in this is through medicalisation (Seckinelgin, 2007). This concept describes 'a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness or disorder' (Conrad, 1992: 209, as quoted in Seckinelgin, 2007: 72). Understood as a legitimate form of improving society - as it makes issues seem technical and therefore apolitical - medical science can be used to separate *normal* from *abnormal* behaviour and legitimise interventions to correct the latter (Seckinelgin, 2007; Li, 2007). Medicalisation can justify, for example, the sanctioning of promiscuity under the explanation that it spreads venereal diseases, which is different from the more morally loaded idea that promiscuity is simply *impure*. Moreover, the targeting of risk groups may not only associate them with certain

medical risks and so-called risk behaviour, but also make them responsible for their condition. Information about certain *risk behaviours* and how to prevent forms of *ill health* is accompanied by a moral weight on those who receive this information, and assumptions that patients are capable of avoiding whatever causes them ill health (Seckinelgin, 2007). Hence medical prescriptions can contribute to the normalisation of behaviour and simultaneously make those who engage in such behaviour responsible, legitimising their condemnation while ignoring structural factors that made them *ill* (Seckinelgin, 2007; Li, 2007).

As explained by Seckinelgin (2007), medicalisation results in the depoliticisation of social control. It is in the interest of governing actors such as the state to present the problems that they construct as technical. This simplifies complex problems with multiple stakeholders, making them more intelligible and manageable by attracting less resistance (Hoppe, 2011). Problematisation thus entails the creation of narratives about reality, with the aim to make them as simple and uncontroversial as possible, hiding whatever power imbalances between groups may have caused a problem to occur (Hoppe, 2011; Li, 2007).

Methodology

The theoretical framework above is the basis for how I intend to analyse adolescent fertility policies in Brazil, which I will describe in this section.

Data collection and analysis

As the PROSAD and SPE are two major adolescent health programmes, they are the focus of this research (MS et al, 2007a). Further, the National Guidelines from 2010 and other technical documents written by the Ministry of Health in the 2010s were included. In total, thirteen federal level policy documents between 1989 (year PROSAD was created) and 2018 (year of Bolsonaro's election) were analysed to understand the construction of adolescence and the state's justifications for addressing adolescents' sexual conduct. I focused on how adolescents

are framed, how they are put into categories of meaning, and what meanings are attributed to different groups of adolescents. Similarly, I analysed how adolescent pregnancy is conceptualised and framed as a problem, and how the state has justified perceiving it as such. I focussed on whether it was desired or undesired, what actions were suggested to govern it, and what aspects of its social context were (not) paid attention to.

Given this focus on the creation of meaning, I conducted a Foucauldian discourse analysis. Here, discourse is conceptualised as a practice through which reality is constructed. It is comprised of statements which are not mere linguistic units such as sentences, but functions where meaning is created (Pedersen, 2009; Garrity, 2010). In this sense, subjects are not authors of statements, but are defined by them. Hence the discourse analysis I conducted for this paper adheres to Foucault's notion of archaeology, where discourse is not interpreted, but described (Garrity, 2010). My type of discourse analysis therefore implies that reality is shaped by statements, including the attribution of meaning to people and their actions (Pedersen, 2009). The policy documents I analysed can be understood as communicative acts and texts that include statements, which produce knowledge by attributing meanings to adolescents and adolescent pregnancy (Fairclough, as quoted in Pedersen, 2009; Garrity, 2010). Because I am interested in the establishment of state-citizen contracts and the normalisation of behaviour via the creation of meaning, these are the most adequate definitions of discourse and discourse analysis for this paper. Nevertheless, this definition has its limitations, as I will elaborate in the next subsection.

I also analysed health indicators and surveys from health registries used for the state to *see* adolescent pregnancy. These included state databases with indicators on adolescent pregnancy from 1994. Some indicators have been retrieved from the Indicators and Basic Data (IDB), a compilation of health indicators from nine different public health databases compiled by the Interagency Health Information Network (RIPSA) covering the years 1996 to 2011. I also

analysed registry sheets from the SIAB, SISAB, CadSUS and SISPRENATAL published up to 2018. The indicators and registries analysed up to 2010 were recommended by the Ministry of Health via the Electronic System of the Citizen Information Service (e-SIC). For the period between 2010 and 2018, I also based my search for data on an email exchange with the Department of Strategic Programmatic Actions within the Secretariat of Primary Health Care (DAPES/SAPS).

To learn how exactly adolescence and adolescent pregnancies are made legible, I conducted a content analysis of the health indicators and registry questions. I was not interested in the values shown by the indicators, but rather what kind of questions health professionals asked to or about adolescents. As health professionals at the SUS are part of the state apparatus, the questions they ask their patients represent what the Brazilian state is interested in knowing about them (Scott, 1998; Rose and Miller, 2008). I paid attention to what was not assessed or asked to determine what was kept invisible by the state (Brown, 2009). Indicators and surveys used by think tanks, universities and other research institutions have been excluded from my analysis, as my research only focuses on the data gathered by the state and the documents produced by the relevant line ministries. The reason for this is that I am interested in how certain state officials see adolescents (Rose and Miller, 2008). Adolescents within the private health and education systems were also excluded, as these are also subjected to governance by non-state actors.

To support my conclusions from primary data, I use previous studies on adolescent reproductive and sexual health that have analysed the PROSAD and the SPE/PSE. Although none have explicitly addressed my research question, I have found that most have agreed with my findings on citizenship and approach to adolescent fertility (Ruzany et al, 2002; Russo and Arreguy, 2015; Jager et al, 2014; Horta and de Sena, 2010).

Limitations

The main limitation of my discourse analysis is that statements are not clearly distinguished linguistic units, so a certain amount of interpretation is required to recognise them. This entails deciding when a piece of language is actually contributing to the discourse I am describing (Garrity, 2010). This is subjective and susceptible to my own interpretations, which are constrained by my own discursively constructed reality (Fiss and Hirsch, 2005). Other researchers could therefore read the same documents and identify other statements even if they apply the same methodology (Garrity, 2010).

The fragmentation of Brazil's public health data gathering systems also affects the validity of my study (Ripsa, 2008a). To compensate for the lack of overview and availability of all indicators used to monitor adolescent fertility in Brazil since 1989, I used IDB data, and the registries and documents suggested to me via e-SIC and DAPES/SAPS. However, the compiled data may have excluded relevant information.

Discussion of findings

In the following, I will argue that the way in which adolescents and adolescent pregnancy were made legible prevented the state from addressing adolescent pregnancy as part of a wider social reality. To illustrate this point, I will use the two aforementioned examples.

Adolescent sexual citizenship in Brazil

This section explores to what extent the constructed category of 'adolescence' allowed for holistic approaches to adolescent pregnancy. This will be the base for understanding the developments presented in my two examples.

According to policy documents from the 1990s and studies about the PROSAD, adolescents were - at that time - seen as a relatively homogenous group in a stage of 'development

characterised by anatomical, physiological, psychological and social transformations'[1], who were more vulnerable to sexual and reproductive health risks (CSCA, 1996: 5; MS et al, 1993a; 1993b; Horta and de Sena, 2010). Any mention of inequalities between adolescents was vague, and the documents implied that, adolescence was 'an evolutionary stage of great vulnerability', regardless of social class, sexual orientation or race (MS et al, 1993b: 23; Jager et al, 2014).

Similarly, health indicators and registries in the 1990s also ignored adolescents' intersecting identities. This contributed to the homogenisation of adolescents as one category (Jager et al, 2014). While questions regarding socio-economic status and geographical area could be used to grasp some aspects of structural inequalities affecting adolescent pregnancy, other key aspects of their realities were kept invisible. Only in the mid-1990s did the first health indicators in Brazil begin to include self-reported race, and whether pregnancies were planned not until the 2010s (compare to Caldwell, 2017). Moreover, no health registry regarding adolescent pregnancy asked anything about the fathers. Therefore, while the discourse surrounding adolescents included vague statements about their 'regional particularities' or 'individual and social differences', the data gathered about them only allowed for a generalised approach to adolescent pregnancy (CSCA, 1989: 11; Scott, 1998).

This laid the foundation for the construction of adolescents' sexual citizenship and the extent to which any sexual and reproductive health policy could consider inequalities between adolescents' realities. The absence of race and gender from these policy documents meant that these aspects of adolescents' realities, which are not purely medical or merely based on income, could not be addressed by policy (Caldwell, 2017; Brown, 2009; Chemmencheri, 2015). By not recognising these social factors, policy makers working on the PROSAD did not consider possible social factors that would hinder adolescents from following governmental guidelines

[1] All quotes from government documents are translations from Portuguese by the author.

to prevent them from reproducing (Hildebrant and Chua, 2017; Horta and de Sena, 2010). The effects of this will be elaborated upon in later subsections.

While briefly acknowledging that there are differences, these documents speak of adolescents as citizens with sexual and reproductive rights, but who, due to being in a phase of *development*, require more information in order to *be ready* for their sexual life (CSCA, 1989, 1996). This is another crucial point in the construction of adolescent sexual citizenship because of the agency that was (not) attributed to them. This idea that adolescents may not be ready for sex created a notion that the state ought to teach them how to exercise their sexual citizenship (King, 1999; Li, 2007; Ericsson, 2005). Seen as a group that *required* state intervention for the *correct* exercise of sexual citizenship, the state could justify interventions in adolescent sexual conduct. In 1990s Brazil, this discourse implied that adolescents *needed* information about sexuality, to make the presumably *right* choices which, as I will elaborate later, meant opting against pregnancy (CSCA, 1989; 1996; MS et al, 1993a; 1993b; King, 1999).

This perception of adolescents prompted the state to advocate for more information on sex, privacy in health facilities and campaigns for the use of contraception (Horta and de Sena, 2010; Jager et al, 2014). However, the idea that providing information and free or cheap treatment could be enough to change the sexual behaviour of adolescents was based on insufficient information. The state was ignorant about the extent of adolescents' desire and ability to follow their guidelines for sexual behaviour (Scott, 1998; Seckinelgin, 2007; CSCA, 1989; 1996; Ripsa, 1997; 1998; 2000). Such factors are often related to structural inequalities in Brazil, such as the lack of other opportunities. The way in which adolescent pregnancy was seen also relates to this problem, which I will explain in the next subsection.

The state-citizen contract in which adolescents found themselves changed in the 2000s. Certain state officials began to view adolescents as heterogeneous citizens with rights and responsibilities (MS et al, 2007b; 2007a). Adolescence remained seen as a phase of

development, but there was an awareness that this was a social construct liked to expectations of 'educational attainment and professional preparation' (MS et al, 2007b: 87). These government actors concluded that as individuals with agency and diverse backgrounds, some adolescents would have more capacity and will to follow public health directives than others (MS et al, 2007b; 2007a). On the other hand, this agency and respect for own decisions were coupled with a discourse of responsibility: while it remained the role of the state to ensure that adolescents could claim their rights to health equitably, the state would also '[stimulate] their responsibility towards their own health' (MS et al, 2007b: 84).

One example of this are the Adolescent Health Booklets from 2010 and 2012. In these educational documents for adolescents, the section on contraception proceeds to address what happens if contraceptives fail: the adolescent boy and girl must prepare for parenthood. It lists what kind of medical care a future adolescent mother has to take and urges boys to assume the responsibility for their children (MS, 2010a; 2012). At the same time, the goal to curb adolescent fertility remained, but with an emphasis on 'reducing adolescents' vulnerability towards [...] unplanned pregnancy' (MS et al, 2007a: 7). The notion of responsibility as the flip side of agency in the 2000s therefore became an important part of adolescents' new sexual citizenship: It was a tool to ensure that they would govern themselves according to the sexual scripts desired by the state. Governmental intervention in adolescents' lives could be replaced with their self-governance (Rose and Miller, 2008; Brickell, 2009; Carabine, 2001).

As mentioned above, another shift in the 2000s was the increased awareness of inequalities among adolescents (MS et al, 2007b). However, health indicators lagged behind this more intersectional legibility of adolescents by years. The planning of pregnancies was only enquired about in the 2010s and fathers remained invisible. In the case of adolescents in the 2000s, it is clear from the comparison between the policy directories of the SPE and the health indicators

and registries of the same period that, while some state officials had one image of the group, others had another (Russo and Arreguy, 2015).

Documents from the 2010s show the Ministry of Health attributing even more diversity, complexity and autonomy to adolescents, culminating in a conscious effort to see adolescent sexuality free of normal value judgements and applying a pleasure approach to their sexuality (Amuchástegui, 2007). Inequality in Brazil and the social determinants of health are often mentioned in these Ministry of Health documents and it seems clear to the government actors involved that adolescents' realities are complex (DAPES/SAPS, 2010; 2016). This autonomy is still frequently tied to responsibilities. Especially the National Guidelines from 2010 repeatedly state that adolescents 'must be regarded as a rich potential, capable of influencing the Country in a positive manner' (DAPES/SAPS, 2010, p.5). These Guidelines also reflect other ideas of adolescent citizenship from the 2000s, such as the notion that an adolescent is still 'on the path of becoming a socially sane person' (p.53). At the same time, new themes that are found more often later that decade can also be found in 2010. Adolescents are seen as subjects with their own opinions, values and views on life that are affected by socioeconomic status and culture. To 'help adolescents and youth to build their autonomy', a goal similar to the previous decade, one solution was to include adolescents in decisions that affect them (p. 52).

By 2016, adolescents are constructed with even more autonomy and their sexual citizenship is met by the Ministry of Health with a pleasure and rights-based approaches to sexuality – acknowledging adolescents' right to their sexuality and as something that contributes to their wellbeing (DAPES/SAPS, 2016; Amuchástegui, 2007). Health professionals receive instructions to respect adolescents' life goals and notions that this demographic ought to go to school and be the future of the nation become less prominent. Instead, the Ministry instructs health professionals that, if an adolescent wants to become pregnant, they have the right to be

assisted in this endeavour. There is a clear emphasis on ensuring that adolescents have the information and the means to make their own choices (DAPES/SAPS, 2016). The Ministry is aware that adolescents are a diverse group with diverse goals and complex lives, and that their choices are not only mediated by their position in Brazilian society, but even 'independent of their parents and or relatives and of the very State' (p.12).

Nevertheless, this awareness of heterogeneity and granting of autonomy observed within the Ministry of Health is not reflected in health indicators and health registries about adolescent pregnancy in the same time period. While gendered power imbalances are highlighted in Ministry guidelines and health registries included a question about planned pregnancies from 2014, no patient survey sheet used to gather data about pregnant women and girls asked any question about the potential father (SAS, 2014; MS, 2018; n.d.-a; n.d.-b; DAB, 2016; 2018; CNSH, 2016). Although the Partner's Prenatal, where pregnant women's partners are asked to take medical exams and accompany the pre-natal process, was included into health registries in 2011, no data is gathered about them unless they voluntarily comply (Cofen, 2017; SAS, 2014; MS, 2018; n.d.-a; n.d.-b; DAB, 2016; 2018; CNSH, 2016). The Adolescent Health Booklets from 2010 and 2012 (MS, 2010a; 2012) still preached responsibility linked to autonomy, reflecting the idea that the group is the future of the country rather than that they are completely free to choose. Hence, during the 2010s, the same fragmentation witnessed in the 2000s prevailed: awareness of adolescents' complexities among state officials writing guidelines was not reflected into recognition by those picking health indicators (Rose and Miller, 2008; Chemmencheri, 2015). As such, regardless of the information held among decision-makers that allowed them to be aware of such complexities, major aspects of adolescents' lives remain invisible (Brown, 2009).

In the subsections below, I will explore how these shifting state-citizen contracts and (fragmented) legibilities have affected the state's approach to adolescent pregnancy in more

detail. In the next subsection I will first analyse how adolescent pregnancy was problematised; part of the basis for my examples.

Adolescent pregnancy as health risk

Adolescent pregnancy was medicalised, especially in the 1990s, making the state ignore structural inequalities behind it (Seckinelgin, 2007). It was primarily seen as a health risk for adolescents in the policy documents up to 2000 and in health indicators during the 2000s (MS, 2000; DAB, 2003). As federal guidelines for the treatment of pregnant adolescents from 2000 show, health professionals were preoccupied with pregnancy between the ages 10 and 19. The main concern was the higher maternal mortality ratio among that age group. This document also states that the undesirability of adolescent pregnancy is a social construct linked to the expectation that adolescents in modern Brazil go to school instead of reproducing (MS, 2000). However, this often is framed as a cultural peculiarity (MS, 2000; MS et al, 2007a).

Moreover, in the 1990s, by framing pregnancy as a health risk to adolescent bodies, adolescent pregnancy was assumed to be inherently unplanned. None of the PROSAD documents analysed considered that adolescents could become pregnant on purpose (CSCA, 1989; 1996; MS et al, 1993a; 1993b). The question of whether pregnancies were planned was only added to the health registries in 2014 (DATASUS, 2008a; 2008b; SIAB, n.d.-a; n.d.-b; n.d.-c; Ripsa, 2000-2012; SAS, 2014; e-SUS Atenção Básica, 2016). Additionally, as explained in the previous section, adolescents were made legible in a homogenised manner, seen as vulnerable with little capacity for agency, so it was assumed that they could not plan to become pregnant, like *adults*. Pregnancy was seen as inherently undesired by and for all adolescents and – without their agency being acknowledged – their homogenisation as a group in the eyes of the state implied that no adolescent could possibly plan or desire a pregnancy (Schaffner, 2005; Horta and de Sena, 2010; Jager et al, 2014).

Moreover, adolescent pregnancy was treated as a public health rather than a societal issue linked to the availability of opportunity, sexual scripts and gendered norms. This is explicit in the guidelines for treatment of pregnant adolescents in 2000 where the Ministry of Health states that 'adolescent pregnancy, [...] undeniably contributed to the perpetuation of a cycle of poverty and deprivation' (MS, 2000: 8). Instead of addressing adolescent pregnancy as a symptom of structural inequalities, it was addressed as the main problem (see Seckinelgin, 2007). Even in government documents pertaining to the SPE from the late 2000s, the reduction of adolescent pregnancy was stated as one of the main goals in itself (MS et al, 2007b; 2007a).

Assumptions regarding this 'public health problem' gained nuance by 2007, with the Professional Training Guide for Health and Education Professionals acknowledging social factors that make pregnancy desirable for some adolescents. This document shows that there were government officials by that time who were aware of societal reasons for adolescents to disregard pregnancy-related recommendations. There was also more awareness of the role of structural inequalities, like the lack of opportunities among lower income groups (MS et al, 2007b). However, adolescent pregnancy remained seen as a risk for adolescents' health, and other documents ignore planned adolescent pregnancies (MS et al, 2007a). This was reflected in health indicators: In 2003, the SIAB's survey sheet for pregnancy included being 20 years old or younger as a risk during pregnancy (DAB, 2003).

Hence while the government occasionally admitted that adolescent pregnancy was *made* undesired due to a perception of adolescents in which they were ascribed to obtain education and not seen as ready for childbirth, it focused on preventing adolescent pregnancy as a health risk to adolescents. Adolescent pregnancy was therefore medicalised (Seckinelgin, 2007). On the other hand, the Brazilian government itself admitted that perceiving adolescent pregnancy as undesired per se was a social construct based on the modernisation of Brazilian society and the ideal where adolescents would go to school (MS et al, 2007b). The Brazilian government

therefore made it clear that the society to which it belonged was interested in preventing adolescent pregnancies. This unidimensional manner of addressing adolescent pregnancy was a consequence of medicalisation, as the notion of health risks replaced concerns about social roots of now medical problems (Seckinelgin, 2007). However, as public health approaches to social issues are regarded as apolitical, they are more legitimate (Seckinelgin, 2007; Li, 2007; Hoppe, 2011).

Adolescent pregnancy became less medicalised by the mid-2010s. In 2016, the Ministry of Health advised health professionals to support adolescents who wish to become pregnant and not judge their choices (DAPES/SAPS, 2016). However, within the same Ministry, this decade saw conflicting stances on adolescent pregnancy which reflect how changes in problem construction work within the state apparatus (Rose and Miller, 2008; Hoppe, 2011; DAPES/SAPS, 2010; 2016). A technical manual for high risk pregnancies from 2010 stated that 'adolescence, in itself, is not a risk factor for pregnancy' (MS, 2010b, p.12). The National Guidelines from 2010 still reflected the idea that pregnancy during adolescence should be treated as a health risk, though (DAPES/SAPS, 2010).

This highlights how a state is fragmented, what may change once it begins to see new aspects of citizens' lives and how fragmentation influences the state's construction of citizens and problems (Scott, 1998; Rose and Miller, 2008; Hoppe, 2011). Given that, in 2014, the state started gathering data to see planned adolescent pregnancies, it is not surprising that the Ministry of Health's stance on it by 2016 was more aware of its social and not purely medical nature (DAPES/SAPS, 2016; Scott, 1998). Note that more nuanced stances on adolescent pregnancy were first observed in 2007, data gathering was only adapted from 2014, and adolescent pregnancy was only explicitly described as a socially mediated choice rather than a medical problem by 2016 (SAS, 2014; MS, 2018; n.d.-a; n.d.-b; DAB, 2016; 2018; CNSH, 2016; DAPES/SAPS, 2016).

The examples below illustrate how the medicalisation of adolescent pregnancy for most of the time period analysed in this paper has undermined the role of society in adolescent sexual and reproductive health.

Education as alternative to pregnancy

Below I consider the notion that some adolescents choose pregnancy over education due to it looking like the most attractive alternative (Fontoura and Pinheiro, 2010). I will argue that the way in which adolescents and adolescent pregnancy were seen until the mid-2010s justified social policies that (1) marginalised the behaviour of some adolescents, and (2) allowed the state to ignore its responsibility in increasing adolescents' access to opportunities.

A major reason for the Brazilian state to discourage adolescent pregnancy was the idea that adolescents should go to school. As shown in the policy documents from the 1990s to 2010, regardless of how much agency is attributed to them, adolescents were made legible as citizens in a phase of development (CSCA, 1989; 1996; MS et al, 2007b; 2007a; DAPES/SAPS, 2010). Other documents linked that with the idea of adolescents as the future of the country (MS et al, 2007b; DAPES/SAPS, 2010). Not only did the Health Ministry acknowledge that in Brazilian society education was expected from that age group, but that was also evidenced in the assumptions and goals of other policies (MS et al, 2007b; Jones, 2016). As explained by Jones (2016), there is an assumption that adolescents' lives are part of a linear progression from childhood to successful adulthood via education. Moreover, as evidenced by the logic of Brazil's *Bolsa Família* programme, education was assumed to help adolescents and their families lift themselves out of poverty. Adolescents therefore were perceived as a group that needs education to become successful adults. This assumes that education will benefit all adolescents, allowing them to get better employment that translates into social mobility (Jones, 2016; Lomelí, 2008). However, this has not been the case: the quality of education has not been

good enough to make poor adolescents become more productive, and even if they become more skilled, the country's economy has not offered enough jobs for them to employ those skills and earn more (Jones, 2016).

Applying this to adolescent pregnancy, it becomes clear that preventing adolescent parenthood for them to stay at school does not automatically translate into them becoming higher skilled workers capable of lifting themselves out of poverty. Further, by assuming that adolescents are developing adults who are either too vulnerable to make their own decisions (in the 1990s) or who need to be made responsible for their decisions (in the 2000s and 2010s) and disregarding much of their heterogeneity and planned pregnancies until the mid-2010, the state's approach against adolescent pregnancy made adolescents responsible by ignoring the social factors that lead to adolescent pregnancy were not being tackled by the Brazilian state. As Jones (2016) shows, race and gender are major factors that influence employment access in Brazil. However, race was only included in health indicators in the mid-1990s (Caldwell, 2017). Moreover, whether pregnancies were planned or not was only asked from 2014 (SAS, 2014). Hence adolescents who chose to become pregnant instead of continuing education were ignored during most of the analysed period. This lack of enquiry about indicators of health inequalities ignored major variables that influence adolescent pregnancy, hiding inequalities in health and opportunities that are difficult to tackle (Hildebrandt and Chua, 2017).

Especially in the 1990s and 2000s, the medicalisation of adolescent pregnancy marginalised motherhood before the age of 20 as a risk behaviour, legitimising its undesirability. Regardless of whether the state was putting enough effort into offering adolescents good education that would bring them better opportunities or not, the medicalisation of adolescent pregnancy offered another legitimate reason why this behaviour was undesired, even if it looked like the best alternative for many young girls who saw no better future by staying at school. Hence the state marginalised the behaviour of the disadvantaged, suggested they were responsible, and

tried to impose a certain script on their sexuality (Seckinelgin, 2007; Carabine, 2001). By medicalising adolescent pregnancy, the state could restrict itself to public health policies teaching adolescents to self-govern instead of confronting the complex interplay of education, employment, and sexism in the whole society (Seckinelgin, 2007).

The invisibility of the father

This section shows how the lack of visibility of fathers has led to an approach to adolescent pregnancy which ignored the role of gender beyond adolescence. As explained above, the health surveys used to record health outcomes of pregnant women and girls have not asked any question about the characteristics of the fathers of their babies to pregnant women themselves (DATASUS, 2008a, 2008b; SIAB, n.d.-a; n.d.-b; n.d.-c; Ripsa, 1997, 1998, 2000-2012; SAS, 2014; MS, 2018; n.d.-a; n.d.-b; DAB, 2016; 2018; CNSH, 2016). Despite the Partner's Prenatal, there is no registry that includes information about fathers unless they willingly accompany their pregnant partners (Cofen, 2017, SAS, 2014; MS, 2018; n.d.-a; n.d.-b; DAB, 2016; 2018; CNSH, 2016). The absence of this information keeps those responsible for impregnating adolescent girls invisible. This not only leaves room for inaccurate assumptions that adolescent girls get impregnated only by adolescent boys, but also hinders adequate policy making (Brown, 2009; Hildebrandt and Chua, 2017; Scott, 1998).

As seen above, in the 1990s, adolescents were seen as homogenous and vulnerable, so state intervention in the form of medical recommendations was a justified and simple way to promote behavioural change (CSCA, 1989; 1996; King, 1999). The invisibility of the father contributed to the disregard of the heterogeneity of adolescence as a category as the different reasons why boys or adult men impregnate girls were ignored. Gendered issues such as the (lack of) agency to negotiate the use of contraception were excluded from policy in the 1990s (MS et al, 2007b; 2007a). Moreover, by seeing adolescents as vulnerable, it was justified to construct adolescents

as the target group for policies curbing adolescent fertility, ignoring the role of adult men (MS, 2000; King, 1999). Combined with the medicalisation of adolescent pregnancy and the idea that by giving adolescents information they could avoid that *problem*, adolescents were made the sole responsible for adolescent pregnancy (Seckinelgin, 2007).

From the 2000s, policy documents did acknowledge that there are adolescent girls that are impregnated by older men and gender issues were supposed to be targeted at school (MS et al, 2007b; 2007a; DAPES/SAPS, 2010; 2016). However, as mentioned above, the health indicators lagged behind and only began to enquire about any characteristic of the father in the 2010s. Even then, their information as fathers would only be gathered once they were willing to see a health professional with their pregnant partner (DATASUS, 2008a, 2008b; SIAB, n.d.-a; n.d.-b; n.d.-c; Ripsa, 1997, 1998, 2000-2012; SAS, 2014; MS, 2018; n.d.-a; n.d.-b; DAB, 2016; 2018; CNSH, 2016). Moreover, while the SPE and the National Guidelines from 2010 advocated for gender to be addressed at schools, SPE indicators did not monitor what exactly was being taught. Adolescents were also made responsible for the consequences of their actions, as they were seen as agents capable of making their own choices (DAB, n.d.; MS et al, 2007a; DAPES/SAPS, 2010; 2016; Rose and Miller, 2008). Therefore, because of the narrow focus on adolescents only, the result of this approach was similar to the one in the 1990s: even if an adolescent girl was taught her rights ad methods to prevent an unwanted pregnancy, she might still not be able to negotiate condom use if her partner is too old to have received similar information or chooses to disregard it.

The targeting of adolescents and the invisibility of the father therefore made adolescent girls responsible for their pregnancy, instead of focussing on gendered social norms that serve as the underlying causes for their situation (Seckinelgin, 2007). This can be explained by considering the power of social policy in normalising sexual behaviour and relating it to how adolescent pregnancy has been medicalised. By addressing adolescent pregnancy as a problem pertaining

to adolescents, the state ignored how adults may be linked to it. As this was seen as an issue of adolescents, public health institutions exerted their power by coining the idea that adolescents are the sole group responsible for adolescent pregnancy (Brickell, 2009). The medicalisation of adolescent pregnancy explained earlier in this paper legitimised this (Seckinelgin, 2007). Then, by regulating adolescents' sexual behaviour, the state institutionalised and promoted the idea that adolescent pregnancy is a problem of that age group only (Brickell, 2009).

Because the medicalisation of adolescent pregnancy as a problem hides the structural inequalities that serve as its underlying causes, it can make adolescent parents responsible for their situation (Seckinelgin, 2007). Although the documents analysed do not specify what exactly those responsibilities are and state that the state and society are also responsible for the reproductive and sexual health of adolescents, my analysis of the *Adolescent Health Booklets* unveils contradictions (MS, 2010a; 2012). As explained above, this document tells adolescents that they need to prepare to become healthy parents to healthy babies if their contraceptive methods fail. Hence, regardless of the discourse about the state's responsibility for adolescents' sexual and reproductive rights and wellbeing, there was also an effort to make adolescents take family planning into their own hands. This becomes problematic when one considers that many adolescents' agency may be constrained.

Conclusion

In the paper at hand, I have analysed how the way in which adolescents and adolescent pregnancy have been made legible by the Brazilian state between 1989 and 2018 has shaped policy addressing adolescent pregnancy. There were significant shifts in the construction of adolescents' sexual citizenship by the Brazilian state. While they were generally homogenised and framed as vulnerable in the 1990s, the group's legibility changed in the 2000s with adolescents appearing as individuals with agency and responsibilities. However, the idea

prevailed that they are developing citizens following an idealised linear path to becoming educated adults - which is interrupted by pregnancy (CSCA, 1989; 1996; MS et al, 2007b; 2007a; Jones, 2016). By 2016, the awareness about the complexity of adolescents' realities increased and adolescent pregnancy was more accepted by parts of the Ministry of Health (DAPES/SAPS, 2016). However, despite the acknowledgement of the role of society and inequalities by officials from the Ministries of Health and Education, it is evident from the indicators and teachers that this perception of adolescents is not yet dominant in all of the state apparatus (Russo and Arreguy, 2015; DATASUS, 2008a, 2008b; SIAB, n.d.-a; n.d.-b; n.d.-c; Ripsa, 1997, 1998, 2000-2012). Similarly, while the discourse around adolescent pregnancy was not as medicalised in the 2000s as it was in the 1990s, the phenomenon was still addressed mainly as an unwanted public health issue and not a symptom of wider societal problems (MS et al, 2007b; 2007a).

As my two examples have shown, these perceptions of adolescents and adolescent pregnancy contributed to a narrow policy focus which insufficiently addressed the role of inequalities in adolescent pregnancy. The unattractiveness of Brazilian education and lack of opportunities in the labour market were not given enough importance when addressing adolescent pregnancy. Additionally, by focussing on adolescents, the role of adult men and gender relations was kept invisible and remains unaddressed. Finally, these examples not only show the insufficient efforts to tackle society's role in adolescent pregnancy, but also how, by largely ignoring reasons why adolescents get pregnant, social policies promoted a type of behaviour that was not compatible with some adolescents' realities.

These findings have several implications for health policy. First, social issues are intertwined and should be considered when designing health policy. While the SPE's attempt to unite education and health in an intersectoral approach to adolescent health was a significant step, it is also clear that this mind-set had yet to reach other government branches. Moreover,

acknowledging societal issues in policy directories is not enough. While Brazilian health indicators now include the planning of pregnancies and data may be gathered about some men who impregnate adolescent girls, it is alarming that information is only collected about the father when they voluntarily accompany pregnant women and girls for prenatal treatment.

Further, adolescent sexual and reproductive health cannot be addressed as a technical and apolitical public health problem because of how culture and access to resources and opportunities affect sexual conduct. By assuming that one can approach sex without speaking of inequalities, one is bound to design flawed sexual health policies. I have demonstrated that the state cannot adequately promote behavioural change without understanding whether the desired conduct suits citizens' diverse lifestyles and aspirations. The currently rising discourse that aims at 'depoliticising' sexual education and removing conversations about gender from schools therefore either misunderstands how adolescent sexuality relates to society or is being purposely framed as apolitical in order to advance a new political agenda on how to govern adolescents' sexual conduct according to a conservative ideology (see Gava and Villela, 2016; Anon, 2018).

Finally, my findings hint at how the current rise of conservatism and changing ideas about adolescent pregnancy and sexual citizenship may affect this group's sexual and reproductive health and rights. As seen above, the state is fragmented into multiple actors that understand problems in different ways. Thus, the new administration and its stance on adolescent sexuality might permeate different parts of the state apparatus in varying ways. Questions in health registries might be added or removed, while those who write guidelines and policy recommendations at the responsible line ministries and their ideas may influence the current government to varying degrees (Rose & Miller, 2008; Scott, 1998). Essentially, my findings indicate that this administrations' conservative ideals on adolescent sexual citizenship may face

some resistance within the state apparatus while an irregular shift in the control of this group's sexual conduct takes place.

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