

Youth, gender and reproductive justice: health inequities in family planning in Brazil's Unified Health System

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Abstract *Sexual initiation is a gradual process of experimentation and learning the cultural repertoire of gender, reproduction, contraception, sexual violence and other topics surrounding youth sociability. Unlike sexual abstinence-based approaches promoted as a panacea for reducing “early pregnancy” in Brazil, reproductive justice is posited as a framework for addressing health inequities in family planning. This article discusses the challenges faced by public health policies in supporting adolescents and young people in their sexual and reproductive trajectories, drawing on the concept of intersectionality. We focus on public institutional initiatives providing long-acting reversible contraceptives (LARC) on the Brazilian Unified Health System (SUS) implemented over the last decade. We conducted a documentary anthropological study drawing on empirical data on contraceptive technologies in order to problematize what we call the “selective provision” of these devices and discriminatory and stigmatizing practices. Advocating the expansion of the provision of contraception on the SUS, with universal access to LARC for all women, distances itself from what we call “contraceptive coercion” among specific social groups.*

Key words *Youth, Long-acting reversible contraceptives, Intersectionality, Reproductive health*

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Introduction

Sexual initiation is a gradual process of experimentation and learning the cultural repertoire of gender, reproduction, contraception, sexual violence and other topics surrounding youth sociability. Unlike sexual abstinence-based approaches promoted as a panacea for reducing “early pregnancy” in Brazil¹, reproductive justice is posited as a framework for addressing health inequities in family planning.

The theme of adolescent pregnancy regained prominence in a recent public debate in Brazil^{2,3}. Most analysts agree that theoretical and sociopolitical perspectives affirming and guaranteeing adolescents’ and young people’s sexual and reproductive rights – secured over decades of feminist and LGBT+ social activism, arduous diplomatic efforts during United Nations conferences, and formulation of youth health policies^{4,5} – should prevail as a parameter of respect for human rights.

However, an important shift has taken pace over recent decades towards the *problematization* of the structural obstacles to protecting these rights, especially those of poor black women living in contexts of extreme inequality⁶. Advocacy underpinned by the legal principles underlying sexual and reproductive rights is essential to guaranteeing the autonomy of subjects (men and women) in making sexual and reproductive choices. However, the link between the right to sexual and reproductive autonomy and the individualistic liberal paradigm obscures the structural racism in so-called democratic societies, which imposes often-insurmountable obstacles to the right to choose and to access medical products and health services among specific groups. In dialogue with *intersectionality*^{7,8} – the overlapping of social hierarchies such as class, race, gender, sexuality, ethnicity, age, nationality, magnifying existing and producing new complex forms of discrimination – reproductive justice advocates for social justice for traditionally excluded groups of women. This includes the state guaranteeing other social rights, such as education, housing, employment, food and other basic needs that are fundamental to a dignified life. The reproductive justice approach seeks to broaden the struggle for the right to abortion – a central element of the pro-choice movement in the United States – to include the right to have and parent a child with dignity, in the case of imprisoned and homeless women for example^{9,10}.

Reproductive health issues affecting young black women include major difficulties in access-

ing health services, undignified conditions during childbirth¹¹, suffering and maltreatment during post-abortion care¹², as well as a myriad of legal, judicial and social care procedures that, despite supposedly protecting their interests, deny their sexual and reproductive freedom, criminalizing reproductive practices and coercively interfering with their bodies. Government technologies control their bodies, punish their reproductive decisions and confiscate their children, among other arbitrary actions¹³⁻¹⁵.

This discussion is by no means new. Respected feminist intellectuals and black activists^{16,17} have done research on this topic, raising awareness and drawing attention to the need to identify institutional racism as a driver of certain public policies.

Drawing on the understanding of reproductive justice, this analysis of family planning in Brazil seeks to show how the expansion of medicalization in exclusionary and highly unequal societies is socially stratified, gendered and racialized¹⁸⁻²⁰. To this end, we take hormonal long-acting reversible contraceptives (LARC) as an object of study to reflect upon the necessary expansion of the provision of contraception through Brazil’s Unified Health System, the *Sistema Único de Saúde* (SUS), and how these methods are provided.

This article discusses the challenges faced by public health policies in supporting adolescents and young people in their sexual and reproductive trajectories, focusing on public institutional initiatives providing LARC through the SUS over the last decade. We seek to problematize what we call the “selective provision” of these devices, and the discriminatory and stigmatizing practices among certain social groups that we denominate “contraceptive coercion”.

Reproductive justice and LARC

The use of biomedical technologies (contraceptive and other) in clinical studies with populations considered “vulnerable” is not new in Brazil^{21,22}. Almost always the appeal used by health professionals, public health managers and pharmaceutical companies to promote initiatives that seek to mediate access to new biomedical technologies (generally costly for wide-scale use) to specific groups focuses on sexual and reproductive rights, encapsulating a hegemonic political discourse that aims to guarantee young women’s fundamental rights. The consumption of certain biomedical devices is promoted as a kind of passport to citizenship and modernity, without the

contribution of social policies to transform living conditions.

Although LARC are recommended by medical associations and international organizations^{23,24} as highly effective, their wide-scale utilization should not be seen as the only way of tackling reproductive health inequities. In a recent editorial in the *American Journal of Public Health*²⁵, renowned scholars from the field of social studies of science, gender and reproduction discuss the American Academy of Pediatrics recommendation stating that LARC should be “first-line contraceptive choices” for adolescents and young adults. The authors criticize the reduction of teen pregnancy prevention efforts to individual level behavior interventions, perpetuating structural injustices. They suggest caution in adopting the recommendation of LARC for adolescents, drawing attention to the race and class biases that these apparent solutions may give rise to by limiting reproductive autonomy. They go on to advocate for “an approach to LARC informed by reproductive justice and predicated on the equal value of all lives”²⁵(p.18).

Contraceptive coercion: a fundamental sociological category for examining public policies

Seeking to unravel the genealogy of the term “contraceptive coercion” in family planning programs in the post-Cairo era, Senderowicz²⁶ shows the sophistication that the category can acquire when it distances itself from a simplistic understanding that equates contraceptive coercion with an act of violence perpetrated by one person against another. Drawing on the reproductive justice framework, the author points to a hidden dimension of structural processes related to health systems and state agents (such as quotas, targets, indicators, costs, calculations and estimates) mediated by apparently neutral individual technical interventions.

The author posits that contraceptive coercion gains a bi-directional force that can be exerted to influence women to use methods they may not want or keep them from accessing wanted methods, commonly known as “barriers to access” or “provider bias”. These are often more apparent in the stigmatization of unmarried adolescents and young people in relation to the exercise of their sexuality.

Senderowicz²⁶ warns of a range of practices that we commonly fail to recognize as coercive, but which limit female reproductive autonomy,

such as the restricted provision of contraceptive methods, failing to consider the needs of women in different relational, sociocultural and generational contexts. According to the author, there is a spectrum of structural and interpersonal practices, such as the provision of only partial medical information (advantages of the method without mentioning side-effects), biased or directive counseling, limited method mix, insistence on the use of the method offered, threats to women about future care if they decline the method, insertion of methods without women’s consent or knowledge, especially in the postpartum period, refusal to remove LARC, among others²⁶.

Reflecting on the institutional strategies that prevail in family planning in the country and the nuances of “contraceptive coercion”, we question whether health inequities, class, race and gender inequalities are taken into account in the provision of contraceptive methods on the SUS, respecting the specific characteristics and needs of young people living in extreme poverty and reproductive (in)justice. Our argument is underpinned by the observation that the choice of alternative contraceptive methods available on the SUS, such as tubal ligation, is restricted and that services take a directive approach to the provision of LARC for certain groups of women, going against the principle of universal access to contraception, regardless of age.

Method

We conducted a documentary anthropological study using open-access sources available on the internet. This study is part of a project titled “Sexual and reproductive rights in debate: unravelling meanings and the social uses of biomedical devices for female contraception and sterilization”, in dialogue with the project “Youth, sexuality and reproduction: a study of changes and permanence in the sexual and reproductive trajectories of young Brazilians in the context of social relations mediated by social media”, coordinated by the authors. In this first phase of the research, we looked at electronic media news about LARC devices and reviewed empirical data, such as legal and institutional documents addressing the availability of these devices in public health services (bills, decrees, protocols, etc.), academic papers and position papers issued by civil society organizations, among others.

LARC methods are still not widely available on the SUS for all women. Here we refer to sub-

dermal etonogestrel implants (known as generically as Implanon®), which last up to three years, and the *levonorgestrel*-releasing *intrauterine system* (Mirena® IUD), which is effective for five years. This article analyzes the data collected from the above sources focusing especially on specific groups selected to receive these devices through public initiatives, denominated by the categories “adolescents”, “vulnerable women” and “women at risk” to configure what we call the “selective provision” of these contraceptive methods on the SUS. We do not intend to examine the operationalization of each initiative, but rather seek to show how public managers promote these methods by only emphasizing their benefits and advantages for users.

The categories that emerge from the empirical data make us wonder whether there is an underlying social classification simplistically associated with high rates of maternal morbidity and mortality, adolescent or unplanned pregnancy, sexually transmitted infections and poverty, and the inability of certain women to take care of themselves, thus avoiding pregnancy. In the face of female indiscipline, government technologies are used to transfer responsibility to the state and its biomedical apparatus.

We adopt the concept of “contraceptive coercion”²⁶ to analyze the subjection identified in the publicity for these initiatives, which systematically target young black poor and socially excluded women, while enthusiastically announcing the initiatives as measures that promote the “care” and “protection” of users.

Results

Institutional initiatives providing LARC on the SUS

We have repeatedly witnessed through media coverage institutional initiatives providing LARC through public health services. Developed mainly at state and local level, these initiatives are sparse and have a peculiar feature: they target specific groups of women considered “apt” to use this contraceptive method. In general, they are adolescents or young people who are homeless, drug users or chemically dependent, incarcerated or with HIV.

Three public LARC initiatives exemplify our argument: an initiative in the State of Ceará, in the Northeast of Brazil, which has been promoting the insertion of these methods in the capital

and small towns since 2010; an initiative in the City of São Paulo, which recently introduced a municipal law governing LARC; and an initiative implemented in 2018 in the State of Rio Grande do Sul, involving adolescents in residential care (which had national repercussions).

The following headline published in the regional newspaper, the *Diário do Nordeste*, on 22 September 2010 is noteworthy: “CE is the first [state] in Brazil to use contraceptive implants”²⁷. With an enthusiastic tone, the article reports the provision of subdermal implants through the state health department (SESA) “special family planning” program, highlighting that “it” helps avoid “unwanted pregnancy and, primarily, maternal death”. The text says that “initially, the medication is being used in women receiving treatment at the Dr. César Cals General Hospital, part of the state high-risk pregnancy care referral network”, but will be gradually distributed throughout the state via regional health offices.

Although family planning is always presented with a *consensus justification that is difficult to contest*, such as the reduction of maternal mortality, an examination of a public statement made by the program coordinator reveals ulterior intentions:

According to the obstetrician responsible for Women’s Health at the SESA [...], the administration of these medications to these adolescents is important, since they often forget to take daily contraceptives and are more prone to unwanted pregnancy. “The Implanon offered by SESA is targeted mainly at adolescents, women with sexually transmitted diseases, chemically dependent persons and prisoners”²⁷.

In July 2016, two other reports highlighted the provision of contraceptive implants to women in Ceará “at social risk”^{28,29}. In one of the reports, the supervisor of the Women’s Health Unit used arguments like forgetting to take the contraceptive pill or lack of proper self-care, which results in “clandestine abortions or leaving school to look after the baby”. He goes on to emphasize: “In addition, this is one of the best methods for them, because it’s continuous and adolescents don’t use condoms”²⁸.

A partnership between the State Justice Department and Special Secretariat for Drug Policy with the support of the Ceará Society of Obstetrics and Gynecology, the program in Ceará targets “vulnerable women”, more specifically, adolescents aged between 15 and 19 years, women of reproductive age deprived of liberty and chemically dependent women.

The state government's website defends the use of LARC for "vulnerable populations" or groups that encounter difficulties in accessing health services, particularly in the postpartum period, ensuring a "reduction in unplanned pregnancies and safe *interpregnancy intervals* (more than 18 months)"; and also for "adolescents and users of alcohol and/or other drugs"; who leave "the maternity facility with their family planning [problem] already resolved"²⁹.

In December 2017, the City of São Paulo's legislature approved a Bill governing LARC (No.467/2015) presented in 2015 by the city councilor P. Bezerra (PSDB)³⁰. On 19 January 2018, the mayor of São Paulo sanctioned Law 16.806 that "Governs the *policy for the protection of vulnerable women* by the public health care network with the use of etonogestrel long-acting reversible contraceptives and other provisions" (emphasis added)³¹. The justification for this initiative is based on health indicators such as a reduction in the number of unplanned pregnancies and infant and maternal mortality rates. "Chemically dependent persons, the homeless and adolescents will be given priority in the free distribution [of the contraceptive] through both the conventional public network and contracted organizations"³².

In February 2016, after the implementation of a pilot project in a municipal maternity hospital, the city health department (SMS-SP) announced the purchase of 1,000 contraceptive implants aimed at expanding distribution through the public health network, signaling the savings these devices could provide.

In a statement published by the SMS-SP, the recurring argument for recommending this method reappears³³: the fact that they are long-acting means they offer long-term (three years) protection against pregnancy and "do not require discipline because they are not used on a daily basis". Although the statement emphasizes that the contraceptives can "be interrupted at any time if there is a desire to get pregnant, quickly restoring fertility soon after removal", it fails to explain that removal is doctor-dependent, meaning that the user has to find a doctor who will perform the procedure free of charge.

Little more than a year after its introduction (January 2018), Decree N° 58.693 (2 April 2019)³⁴ was published to regulate Law N° 16.806. Article 1 provides:

Vulnerable women in the City of São Paulo receiving treatment through the public health network in direct or contracted centers will have the right to the insertion of etonogestrel long-acting

*reversible contraceptive implants free of charge, in accordance with the city health department protocol and respecting their freedom of choice*³⁴ (emphasis added).

Article 2 goes on to specify that "vulnerable women" include chemically dependent persons, homeless women and "adolescents living in regions with a very high level of social vulnerability, as defined by the São Paulo Social Vulnerability Index (IPVS 2010), developed by the Fundação SEADE (state data analysis foundation)". Finally, Article 3 seems to redress any potential distortions or misinterpretations that the law leaves open when it provides that "Users should be informed by qualified professionals from referral health facilities belonging to the municipal health care network about the benefits, risks, side-effects and duration of this contraceptive method". The original bill from 2015 contained a sole paragraph with an exhaustive list of categories of women considered to be "socially vulnerable" (sex workers, women with HIV, adolescents aged under 17 who have had previous pregnancies or with "low adherence to health services", etc.). The list was vetoed by the mayor when he sanctioned the law.

The last example is a recent initiative in Porto Alegre, capital of the State of Rio Grande do Sul, which sparked uproar among civil society organizations, feminists, the Municipal Health Council, and other actors involved in health policy making. The State Public Prosecutor's Office publicized a "Cooperation Agreement" between Porto Alegre City Council's Department of Health^{35,36}, two public hospitals – one of which a university hospital – and the pharmaceutical company Bayer to insert 100 five-year *intrauterine systems* (SIU-LNG) in adolescents in state residential care.

The news triggered a series of protests and criticism, signaling that the "Cooperation Agreement" had gone over social control agencies/organizations that debate on population health issues^{37,38}. The two-year agreement envisaged check-ups 45 days after insertion, but failed to outline how the follow-up of the adolescents would be carried out over the five-year period (period of effectiveness of the device) or how they would get the method removed at the end of this period, especially considering that they only remain in care until the age of 18. In April 2019, the Regional Federal Court suspended the agreement³⁹.

This event brings up an earlier initiative (2006) in Porto Alegre – also with the Department of Health's stamp of approval – involving the insertion of 2,500 contraceptive implants in

adolescents aged between 15 and 18 years in 10 underprivileged neighborhoods⁴⁰. At the time, political leaders, feminist organizations and groups defending the rights of children and adolescents joined forces to discuss the intervention, questioning its legitimacy by claiming that it violated the adolescents' rights⁴¹. The initiative was implemented despite a public debate on the city's adolescent health care policies, being suspended the following year by court order.

The category "socially vulnerable women" tends to be the "magic key" or "free pass" used to justify family planning actions based on the logic of the state, specifically targeting adolescents and young people. The appropriateness of the term, which serves various political interests and is open to subjective interpretations, is at the very least questionable. For example, why are women who experience intimate partner violence not mentioned as targets of these programs? Are they not at social risk? Why is reproduction on the fringe of the periphery such a major concern? Shouldn't the fact that there are people who live their whole life in social exclusion cause greater indignation on the part of the state?

Discussion

"Selective provision" of LARC: the fine line between expansion and violation of rights

Although LARC initiatives are supported by health indicators, the coercive face of these initiatives appears evident to us: actions target specific groups of women (adolescents, homeless persons, chemically dependent persons, etc.) that find themselves in precarious living conditions and too fragile to stand up to medical/state power if they do not want to use LARC.

This coercive face is cloaked in terms such as "protecting the health" of socially vulnerable women. The documents analyzed in this study fail to mention training of technical and professional staff in sexuality education, including issues of gender and sexual violence. Training is only provided for device insertion. The focus appears to be promoting the use of LARC to save spending resources on "risky motherhood"¹³. There is an assumed greater need for intervention and the instrumentalization of these women's bodies to reduce greater harm associated with reproduction between poor black people.

A previous study discusses a request made by the Brazilian Federation of Gynecology and

Obstetrics Associations (FEBRASGO) to the Ministry of Health in 2015 to incorporate these contraceptive technologies into the SUS for use with "special populations" (young women aged between 15 and 19 years)⁴². The request was denied at that time. One of the underlying justifications for the request was that these young women were unable to control their fertility and take care of themselves, meaning that it would be more effective to transfer this responsibility to doctors, for a reasonable length of time (three to five years), through the insertion of these methods.

The analysis of the initiatives presented here reveals a context in which adolescents and young people are at the mercy of the discernment of health professionals, their values and moral judgments and racial and class prejudice towards these women and their "deviant" sexual and reproductive behavior. It is therefore necessary to reveal what is hidden in such initiatives: some "types of motherhood are possible", while others are not.

In Brazil we therefore oscillate between stopping teenage sex (see the public debate mentioned above) or proposing measures to prevent adolescent pregnancy dressed up as measures to "protect vulnerable adolescents", in which the selective provision of LARC is the most pragmatic path. The simple provision of informed consent (by the adolescent or young woman and/or parent/guardian) to guarantee "voluntary adherence" to LARC and other important ethical questions need to be problematized, in view of the difficulties encountered by people without formal scientific education in understanding technical terms and the methods used by health professionals to convince women to use these methods, often taking advantage of patient-provider power hierarchies. This ethical debate seems to be rather silenced in this country.

It is impossible not to add the demographic debate surrounding the juvenilization of reproduction in Brazil to this context and its implications over the last two decades stemming from the Family Planning Law⁴³. The demographic transition in Brazil has not resulted in the postponement of parenthood, but rather the country has maintained a young fertility profile (20-24-year and 15-19-year age groups)⁴⁴. Alongside this phenomenon, the high rate of unplanned pregnancies prevails, together with the problem of *untimely pregnancies*. The regulation of voluntary sterilization by the Family Planning Law established criteria for performing surgeries in

the country (women aged over 25 years or with at least two children). However, this action has been accompanied by some unexpected developments.

On the one hand, the initiative was considered as an important step forward in terms of the democratization of access to procedures (expanding availability for men and curbing the “tubal ligation epidemic” among women). However, the fall in the number of female sterilizations has raised questions as to whether the criteria stipulated for performing tubal ligations has led to new barriers to access, especially among younger women. Unfortunately, up-to-date information on contraceptive behavior among the population is severely lacking, given that the latest national demographic and health survey was conducted in 2006.

We might wonder whether there is a certain gap in the availability of contraceptives due to this unexpected dynamic in relation to female sterilization, potentially being bridged gradually by the “selective provision” of LARC. A frequent outcome among women who begin parenthood early, sterilization tends to be an appealing contraceptive method – especially for those who have quickly reached the “number of desired children” – and has been proposed countless times as a solution to end the reproductive trajectories of “abject women”. Currently, LARC represent the “ideal method” for postponing (and spacing) pregnancy, but may also constitute a potential artifact for ending reproductive trajectories in certain groups of women.

Perceived as being in a latent state of “uncontrol” and therefore in a permanent state of potential reproduction, women’s bodies “require” intervention. These questions lead us back to the debate about “social Malthusianism”, not only on the part of health professionals, but also in certain interventions and policies put in place “in the name of” the health of women and/or their reproductive rights⁴⁵. The coercive proposition of LARC to specific groups of women has been added to the historic selective provision of tubal ligation. Similarities in these processes make us wonder whether strategies are underway to facilitate the governmentality of bodies.

Final considerations

Sexual, family *planning and reproductive health* care for adolescents provided by public health

services should uphold the ethical principles of respect for personal integrity and autonomy, without the imposition of constraints by health professionals. As a public health policy, family planning with a specific focus on adolescents and young people cannot be done without debate on gender, sexuality, and racism and gender-based violence in schools, universities and the media. It also requires the wide-scale distribution of condoms in places where young people socialize, the provision of other contraceptive methods (the oral contraceptive pill, emergency contraceptives, injectable contraceptives, copper IUDs), access to safe abortion, tubal ligation and vasectomy, without spouse/partner approval, and supporting young people in their decisions.

Our findings clearly show that, unlike other moments in history in which the formulation of women’s and young people’s care policies involved the active participation of users’ representatives in the discussion of their interests, currently the main protagonists are medical associations, public managers and pharmaceutical companies. It is no coincidence that in 2016 the non-governmental organization SisterSong Women of Color Reproductive Justice Collective – a cradle of debate on reproductive justice in the United States – and the National Women’s Health Network published the LARC - Statement of Principles, endorsed by numerous women’s rights organizations⁴⁶. The statement advocates for the freedom of women and necessary conditions so that the choice of which contraceptive method to use can be made “in a medically ethical and culturally competent manner”.

Finally, the concept of “contraceptive coercion” enabled us to demonstrate how much the provision of LARC to specific population groups reifies a modus operandi of reproductive control by various agents of the state across multiple levels. It is important to remember that the phenomenon of contraceptive coercion did not come about due to the “badness” of health professionals. Rather it obeys a broader scheme of policy formulation and health service organization – often using fiscal incentives, international funding and other forms of support – that ends up subordinating reproductive autonomy as a basic principle of contraceptive programs.

Dressed up in the language of rights, this game not only deepens social inequalities among women, but also reinforces racism and stigma by ignoring the vital need for debate on reproductive justice.

Collaborations

ER Brandão contributed to study conception, data collection and analysis and writing the article. CS Cabral contributed to the discussion of the data and writing the article.

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References

- Cabral CS, Brandão ER. Gravidez na adolescência, iniciação sexual e gênero: perspectivas em disputa. *Cad Saude Publica* 2020; 36(8):e00029420.
- Federação Brasileira das Associações de Ginecologia e Obstetrícia (FEBRASGO). *Posicionamento da FEBRASGO sobre a campanha de prevenção da gravidez na adolescência "Adolescência primeiro, gravidez depois"* [Internet]. 2020 [acessado 2019 maio 15]. Disponível em: <https://www.febrasgo.org.br/pt/noticias/item/939-posicionamento-da-febrasgo-sobre-a-campanha-de-prevencao-da-gravidez-na-adolescencia-a-adolescencia-primeiro-gravidez-depois>.
- Pitanguy J, Barroso C. *Sexo e gênero, a fabricação do perigo* [Internet]. Folha de São Paulo; 2020 [acessado 2019 maio 15]. Disponível em: <https://www1.folha.uol.com.br/opiniaio/2020/02/sexo-e-genero-a-fabricacao-do-perigo.shtml>.
- Brasil. Ministério da Saúde (MS). Secretaria de Atenção em Saúde. Departamento de Ações Programáticas Estratégicas. *Cuidando de Adolescentes: orientações básicas para a saúde sexual e a saúde reprodutiva*. Brasília: MS; 2015.
- Brasil. Ministério da Saúde (MS). Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. *Marco teórico e referencial: saúde sexual e saúde reprodutiva de adolescentes e jovens*. Brasília: MS; 2006.
- Ross L. What Is Reproductive Justice? In: *Reproductive Justice Briefing Book*. s/d. p. 4-5.
- Vigoya MV. La interseccionalidad: una aproximación situada a la dominación. *Debate Feminista* 2016; 52:1-17.
- Crenshaw K. Documento para o encontro de especialistas em aspectos da discriminação racial relativos ao gênero. *Rev Estud Fem* 2002; 10(1):171-188.
- Price K. What is Reproductive Justice? How Women of Color Activists Are Redefining the Pro-Choice Paradigm. *Meridians Fem Race Transnat* 2010; 10(2):42-65.
- Luna Z, Luker K. Reproductive Justice. *Annu Rev Law Soc Sci* 2013; 9:327-352.
- Leal MC, Gama SGN, Pereira APE, Pacheco VE, Carmo CN, Santos RV. A cor da dor: iniquidades raciais na atenção pré-natal e ao parto no Brasil. *Cad Saúde Pública* 2017; 33(Supl. 1):e00078816.
- Goes EF, Menezes GMS, Almeida MCC, Araújo TVB, Alves SV, Alves MTSSB, Aquino EML. Vulnerabilidade racial e barreiras individuais de mulheres em busca do primeiro atendimento pós-aborto. *Cad Saude Publica* 2020; 36(Supl. 1):e00189618.
- Faya-Robles A. Da gravidez de "risco" às "maternidades de risco": biopolítica e regulações sanitárias nas experiências de mulheres de camadas populares de Recife. *Physis* 2015; 25(1):139-169.
- Fernandes C. Figuras do constrangimento: as instituições de Estado e as políticas de acusação sexual. *Mana* 2019; 25(2):365-390.
- Sarmento C. Mulheres em situação de rua e tecnologias de governo. In: Mendes N, Merhy E, Silveira P, organizadores. *Extermínio dos excluídos*. Porto Alegre: Rede Unida; 2019. p.89-102.
- Carneiro S. *A construção do outro como não-ser como fundamento do ser* [tese]. São Paulo: Universidade de São Paulo; 2005.
- Werneck J. O belo ou o puro? Racismo, eugenia e novas (bio)tecnologias. In: Rotania AA, Werneck J, organizadoras. *Sob o signo das Bios: vozes críticas da sociedade civil*. Rio de Janeiro: E-papers Serviços Editoriais; 2004.
- Clarke A, Shim J. Medicalization and biomedicalization revisited: technoscience and transformations of health, illness and American medicine. In: Pescosolido BA, Martin JK, Mcleod JD, Rogers A, editors. *Handbook of the sociology of health, illness, and healing*. New York, Dordrecht, Heidelberg, London: Springer; 2011. p.173-199.
- Valdez N, Deomampo D. Centering Race and Racism in Reproduction. *Med Anthropol* 2019; 38(7):551-559.
- Rapp R. Race & Reproduction: An Enduring Conversation. *Med Anthropol* 2019; 38(8):725-732.
- Pimentel ACL, Jannotti CB, Gaudenzi P, Teixeira LAS. A breve vida do Norplant® no Brasil: controvérsias e reações entre ciência, sociedade e Estado. *Cien Saude Colet* 2017; 22(1):43-52.
- Manica D, Nucci M. Sob a pele: implantes subcutâneos, hormônios e gênero. *Horiz Antropol* 2017; 23(47):93-129.
- Federação Brasileira das Associações de Ginecologia e Obstetrícia (FEBRASGO). *Contraceção reversível de longa ação*. São Paulo: FEBRASGO; 2016.
- Ponce de Leon RG, Ewerling F, Serruya SJ, Silveira MF, Sanhueza A, Moazzam A, Becerra-Posada F, Coll CVN, Hellwig F, Victora CG, Barros AJD. Contraceptive use in Latin America and the Caribbean with a focus on long-acting reversible contraceptives: prevalence and inequalities in 23 countries. *Lancet Glob Health* 2019; 7:e227-e235.
- Gubrium AC, Mann ES, Borrero S, Dehlendorf C, Fields J, Geronimus AT, Gómez AM, Harris LH, Higgins JA, Kimport K, Luker K, Luna Z, Mamo L, Roberts D, Romero D, Sisson G. Realizing Reproductive Health Equity Needs More Than Long-Acting Reversible Contraception (LARC). *Am J Public Health* 2016; 106(1):18-19.
- Senderowicz L. "I was obligated to accept": A qualitative exploration of contraceptive coercion. *Soc Sci Med* 2019; 239:112531.
- Diário do Nordeste. *CE é o 1º do Brasil a usar implante contraceptivo* [Internet]. 2010 [acessado 2019 nov 18]. Disponível em: <https://diariodonordeste.verdesmares.com.br/editorias/metro/ce-e-o-1-do-brasil-a-usar-implante-contraceptivo-1.536907>.
- Diário do Nordeste. *Método contraceptivo para mulheres em risco* [Internet]. 2016 [acessado 2019 nov 18]. Disponível em: <https://diariodonordeste.verdesmares.com.br/editorias/metro/metodo-contraceptivo-para-mulheres-em-risco-1.1588729>.
- Governo do Estado do Ceará. *Mulheres em situação de risco terão alternativa de implante anticoncepcional* [Internet]. 2016 [acessado 2019 nov 18]. Disponível em: <https://www.ceara.gov.br/2016/07/19/mulheres-em-situacao-de-risco-terao-alternativa-de-implante-anticoncepcional/>

30. Bezerra P. Projeto de Lei nº 467, de 09 setembro de 2015. Dispõe sobre política de proteção às mulheres em situação de vulnerabilidade, pela rede pública de saúde com a utilização do contraceptivo reversível de longa duração de etonogestrel, e dá outras providências. *Câmara Municipal de São Paulo* 2015; 09 set.
31. São Paulo. Lei nº 16.806, de 19 de janeiro de 2018. Dispõe sobre política de proteção às mulheres em situação de vulnerabilidade pela Rede Pública de Saúde, com a utilização do Contraceptivo Reversível de Longa Duração de Etonogestrel, e dá outras providências. *Diário Oficial São Paulo* 2018; 20 jan.
32. Câmara Municipal de São Paulo. *Agora é lei: contraceptivo de longa duração será disponibilizado na rede pública* [Internet]. 2018 [acessado 2019 nov 18]. Disponível em: <http://www.saopaulo.sp.leg.br/blog/agora-e-lei-contraceptivo-de-longa-duracao-sera-disponibilizado-na-rede-publica/>.
33. Prefeitura de São Paulo. *Rede Municipal adquire implantes contraceptivos de longa duração para ampliar gama do Planejamento Reprodutivo* [Internet]. 2016 [acessado 2019 nov 18]. Disponível em: <https://www.prefeitura.sp.gov.br/cidade/secretarias/saude/noticias/?p=211815>.
34. São Paulo. Decreto nº 58.693, de 2 de abril de 2019. Regulamenta a Lei nº 16.806, de 19 de janeiro de 2018, que dispõe sobre política de proteção às mulheres em situação de vulnerabilidade pela Rede Pública de Saúde, com a utilização do Contraceptivo Reversível de Longa Duração de Etonogestrel. *Diário Oficial São Paulo* 2019; 02 abr.
35. Ministério Público do Estado do Rio Grande do Sul. *MP assina termo de cooperação para garantir acesso das adolescentes acolhidas às políticas de saúde da mulher* [Internet]. 2018 [acessado 2019 nov 18]. Disponível em: <https://www.mprs.mp.br/noticias/infancia/46995/>.
36. Ministério Público do Estado do Rio Grande do Sul. Promotoria de Justiça da Infância e da Juventude. *Termo de Cooperação* [Internet]. Porto Alegre; 2018 [acessado 2019 nov 18]. Disponível em: <https://apublica.org/wp-content/uploads/2019/03/termo-de-cooperacao.pdf>.
37. Conselho Municipal de Saúde de Porto Alegre. *Nota Pública Conjunta* [Internet]. Porto Alegre; 2018 [acessado 2019 nov 18]. Disponível em: http://www2.portoalegre.rs.gov.br/cms/default.php?reg=217&p_secao=8.
38. Anjo AB. *Quem decide sobre o corpo das meninas?* [Internet]. Agência Pública; 2019 [acessado 2019 nov 18]. Disponível em: <https://apublica.org/2019/03/quem-decide-sobre-o-corpo-das-meninas/>.
39. Tribunal Regional Federal da 4ª Região. *TRF4 suspende aplicação de contraceptivo em adolescentes acolhidas pela prefeitura de Porto Alegre* [Internet]. 2019 [acessado 2019 nov 18]. Disponível em: https://www.trf4.jus.br/trf4/controlador.php?acao=noticia_visualizar&id_noticia=14345.
40. Negrão T. Uma Ação Sinérgica por Direitos Reprodutivos: uma história sem fim. *Saude Soc* 2012; 21(Supl. 1):164-176.
41. Rede Nacional Feminista de Saúde, Direitos Sexuais e Direitos Reprodutivos. Regional do Rio Grande do Sul e outras. *Implantes hormonais em jovens: a volta do controle da natalidade, uma violação aos direitos humanos* [Internet]. Porto Alegre; 2006 [acessado 2019 nov 18]. Disponível em: <https://www.ufrgs.br/nph/ong/?p=701>.
42. Brandão ER. Métodos contraceptivos reversíveis de longa duração no Sistema Único de Saúde: o debate sobre a (in)disciplina da mulher. *Cien Saude Colet* 2019; 24(3):875-879.
43. Caetano AJ. Esterilização cirúrgica feminina no Brasil, 2000 a 2006: aderência à lei de planejamento familiar e demanda frustrada. *Rev Bras Estud Popul* 2014; 31(2):309-331.
44. Cavenaghi S, Alves JED. The everlasting outmoded contraceptive method mix in Brazil and its legacy. *Rev Bras Estud Popul* 2019; 36:e0103.
45. Cabral CS. Contraception et stérilisation des jeunes femmes au Brésil. *Autrepart* 2014; 70:165-183.
46. Long-Acting Reversible Contraception (LARC). *Statement of Principles*. Atlanta: SisterSong Women of Color Reproductive Health Collective & National Women Health Network; 2016.

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