MSc Dissertation

Social Policy with Tunnel Vision: The 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 1989 and 2010 have shaped social policy addressing adolescent pregnancy. This was examined based on policy documents and public health indicators concerned with adolescent pregnancy. According to this data, adolescents were initially seen as a homogenous group vulnerable to pregnancy as a health risk. While parts of the government began to perceive adolescents as more heterogeneous individuals with agency and responsibility in the 2000s, health indicators lagged behind. 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 often ignored. Moreover, adolescent pregnancy was largely medicalised. This led to narrow social policy approaches to adolescent pregnancy which ignored the wider social contexts of diverse adolescents in Brazil. Based on two examples, I show how this unidimensional focus ignores the lack of opportunities offered to disadvantaged adolescents by the Brazilian education system and labour market, which make pregnancy more attractive than desired by the state. My second example highlights how the invisibility of the father in health indicators contributes to the idea that adolescent pregnancy only affects adolescents, instead of highlighting gendered inequalities that affect Brazilian society as a whole, including other age groups.

Key words: adolescent pregnancy, sexual citizenship, legibility, health indicators, medicalisation

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Introduction

Background

Brazil's adolescent fertility rate is above the regional average 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 higher income groups (Fontoura & Pinheiro, 2010). These are shortcomings of the sexual and reproductive health strategies targeting adolescents that the Brazilian government has been implementing since the last century (Jager, et al, 2014).

Created in 1989, the Adolescent Health Care Programme (PROSAD) was based on the principle of universal rights to health. It defined adolescence as the age between 10 and 19 years and set the aim of curbing adolescent pregnancy. PROSAD's strategies were the facilitation of access to contraception at healthcare facilities, as well as increasing adolescents' confidential access to health professionals and information on sexual and reproductive health (Coordenação da Saúde da Criança e do Adolescente, 1989). In 1995, other programmes to teach sexual education at schools were implemented (Ministério da Saúde, et al, 2007b). Years later, new policies were created to address adolescent sexual and reproductive health: the Health and Prevention in Schools Project (SPE) from 2003, which was incorporated in the Health in Schools Programme (PSE) from 2007. The state continued to address adolescent pregnancy at schools (Departamento de Atenção Básica, n.d.; Russo & Arreguy, 2015).

Throughout the years in which these policies were implemented, Brazil's democracy and society changed. The 1990s saw Brazil starting to democratise, and citizenship and universal rights became dominant concerns (Parker, 1999). At the same time, neoliberalism influenced the state's relationship to citizens, questioning whether it should intervene in the market and in people's lives (Giffin, 1994). More than a decade later, new ideas of social justice questioned neoliberalism and universalism (Caldwell, 2017). Given these developments, the PROSAD and SPE/PSE conceptualised adolescent citizenship and adolescent pregnancy in distinct ways. In order to further understand how Brazil's high adolescent fertility prevails, an analysis of the relationship between the state and adolescents in a period of changing ideas about citizenship is a significant contribution.

This paper therefore examines how the Brazilian state's conceptualisation of adolescents and adolescent pregnancy in the 1990s and 2000s has impacted its approach to adolescent pregnancy. I will argue that the way in which the Brazilian state constructs adolescence and adolescent pregnancy does not allow for a holistic policy approach, ignoring major societal factors that hinder the behavioural change the state desires in order to curb adolescent fertility.

Relevance and Outline

In order to substantiate this position, I will explore the state's approach to adolescent pregnancy using theories on governance, citizenship and sexual behaviour. I will analyse what about adolescent pregnancy and adolescents' lives is made visible and will show how meanings attributed to them ignore some and focus on other aspects of these citizens' 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 ignores adolescents' varying social contexts. My second example regards the invisibility of the father in public health indicators, and therefore lack of consideration for social factors that may lead to adolescent girls being impregnated by adult men. As these examples will show, by ignoring wider societal factors, adolescents become responsible for marginalised life styles that they may not be able to change or that contribute more to their wellbeing than normalised behaviour.

This paper builds on past research analysing the PROSAD and SPE/PSE (Ruzany, et al, 2002; Russo & Arreguy, 2015; Jager, et al, 2014; Horta & de Sena, 2010). These authors analysed policy documents and children's rights laws, and focussed on adolescent health in general. My study, on the other hand, will not only analyse policy documents but also public health indicators used to make adolescents legible. Therefore, 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 describing state-citizen relations like the past studies. By focussing on the legibility of adolescent pregnancy as a problem and how it is addressed, I offer a more detailed account of the impacts of legibility on adolescents' lives.

This paper hence contributes to the field of Social Policy by showing how the promotion of behavioural change without a holistic focus on people's lives can make policy recommendations unfitted for certain groups.

Theoretical Framework

Central to my research are therefore theories regarding the relationship between citizens and the state, as well as how governments create, normalise and legitimise ideas of what is normal and abnormal sexual conduct.

Simplifying Identities

This subsection articulates my theoretical framework for analysing how the state apparatus simplifies the identities of and attributes meanings to groups of people. The theories presented below are necessary for my analysis of the relationship between the Brazilian state and adolescents. It is also the base for understanding why certain sexual behaviours are accepted and others not, which I will elaborate upon in subsections 2.2. and 2.3.

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 & Miller, 2008). Key here is that the information is gathered based on what the state *needs* to see, hence 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 about a citizen is made legible by the state has repercussions for the access to rights and resources (Scott, 1998; Brown, 2009; Hildebrandt & Chua, 2017; Chemmencheri, 2015). If an aspect of a citizen's life remains invisible to the state, it cannot be addressed by policy (Brown, 2009; Chemmencheri, 2015; Hildebrandt & Chua, 2017). The concept of rhetorical silence is helpful in understanding 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). One example is how, until the mid-1990s, the Brazilian government did not gather data on patients' self-reported ethnicity. This kept racial inequalities in access to healthcare invisible, and no policies were implemented to address them. Only after former president Cardoso officially acknowledged racism as an issue did health data begin to regularly include the ethnicity of patients. Following that, affirmative action and universalist policies aiming at improving the non-white populations' access to health care have been considered (Caldwell, 2017).

However, visibility does not necessarily translate into redistribution (Chemmencheri, 2015). In the case of residents of the peripheries of São Paulo, for example, despite the recognition of Brazilians' universal rights in the 1988 Constitution, this recognition did not translate into equal access to urban spaces, practically denying the rights of the urban poor to the city (Holston, 2009; Fausto & Fausto, 2014). Moreover, the way in which one is legible also affects one's access to rights and resources. 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 where different groups have been given different rights and means to access them (Holston, 2009; Caldwell, 2017). These studies show that, in Brazil, those whose identities or behaviour are deemed undesired are addressed by illiberal policies aimed at 'correcting' their conduct based on the state's ideals, often denying these citizens' rights and services (Caldwell, 2017; Rodrigues & Almeida, 2015).

Such ideals can be shaped by governments' programmatic goals for society (Scott, 1998; Rose & Miller, 2008). A state has a certain aim for which it needs certain - but not all - of its citizens, based on which it will try to make them legible, and shape them into ideal citizens that behave according to the state's goals (Ansoms & Cioffo, 2016). One major goal, for example, is economic development, for which the creation of certain ideal citizens is necessary. In the case of Rwanda, as part of a programme to increase the production of cash crops, social policy was used to turn farmers into 'exemplary citizens' who would be rewarded for harvesting crops the government required, without questioning new guidelines. Those who objected were met with repression, for breaching the state-citizen contract determined by the state (Ansoms & Cioffo, 2016). 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. Again, social policy is used as a tool to turn them into ideal citizens: conditional cash transfers (CCTs) are used to ensure that this group does not discontinue education (Lomelí, 2008).

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 adolescents' 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. Amuchástegui's (2007) definition is most appropriate for my analysis as its focus on pleasure includes both identity and sexual practices. While this concept may imply a subject's individual choice and entitlement to it, it is important to keep in mind that choice may be mediated through kinship and other communal relationships (Richardson, 2015). For my analysis, the 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). This affects what kind of policies are designed to control their sexual and reproductive behaviour. Certain meanings attributed to people may justify illiberal interventions aimed at preventing them from reproducing (Li, 2007).

While the extent to which a state tries to control a group's sexual conduct depends on how this group is made legible by the state, it also depends on what that state's ideal image for that group is (King, 1999; Carabine, 2001). A study on 19th century Norway, shows, for example, how adolescent girls from lower socioeconomic backgrounds were seen as promiscuous subjects with little self-control, who threatened society for their alleged lack of morals and supposed risk of carrying diseases (Ericsson, 2005). Framed as incapable of governing their sexual conduct, it was justifiable for the Norwegian state to deny them liberty and institutionalise them, until their behaviour was 'corrected'. Hence, in order to turn them into idealised citizens who behaved according to Norwegian sexual norms, their agency and sexual citizenship were constrained (Ericsson, 2005).

Additionally, as states and other governing authorities are part of a specific historical and cultural context, societal norms constructed by previous dominant actors and policies also influence how a group is seen and targeted by their contemporary governments (Brickell, 2009). Schaffner (2005) shows how different discourses surrounding gender norms making under-age girls and boys legible in different ways inspire different laws to target them in the United States. US American gender norms make girls legible as less capable "to choose to have sex" than boys (Schaffner, 2005: 190). On the other hand, boys are framed as more willing to become sexually active; less likely to be seen as victims when engaging in sexual contact with older women. This leads to regulations calling for the protection of girls from both men and boys (Schaffner, 2005).

In terms of the construction of adolescence and their sexual citizenship 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 & 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 & 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 & Arreguy, 2015).

Normalisation of Sexual Conduct

As seen above, social policy is used as a tool to shape subjects' conduct in order to turn them into idealised citizens (Ansoms & Cioffo, 2016; Elias, 2009). And because reproduction is linked to the creation of new subjects, social policy has an important role in the construction of desired and undesired sexual conduct (Jeffreys, 2009; Carabine, 2001). When under the guidance of improving society, authorities try to indirectly or directly manage life itself. Here sex is key, as it is through sex that life is created and new citizens are born (Jeffreys, 2009). 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, as explained by Brickell (2009): By defining different categories of sexual behaviour, and regulating which should not be allowed and which should, governing actors such as the state have the power to normalise certain

types of sexual conduct while marginalising others as wrong (Brickell, 2009). 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 if they do not wish to be punished or shamed (Carabine, 2001). This means that some subjects are discouraged by the state or other governing actors to reproduce, and some sexualities are deemed 'risky', such as in the case of the demoralisation of lone motherhood in Britain around the 19th century. Triggered by financial concerns about men having to provide for their 'illegitimate' children based on women's words, regulations were enforced to construct lone mothers as immoral, hence 'undeserving poor' (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, cited 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' (Seckinelgin, 2017). Moreover, as argued by Seckinelgin (2007), the targeting of risk groups not only associates them with certain 'medical risks' and 'risk behaviour', but also responsibilises them for their condition: especially health promotion activities that give a target group information about certain 'risk behaviours' and how to prevent 'ill health' deposit a moral weight on those who receive this information, portraying patients as capable of avoiding whatever causes them ill health (Seckinelgin, 2007). Hence, enjoying legitimacy for being supposedly apolitical, 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', and without questioning to what extent they are actually 'abnormal' (Seckinelgin, 2007; Li, 2007).

As explained by Seckinelgin (2007), medicalisation therefore 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 and therefore apolitical. Such problems are complex and may be contested by various stakeholders. They must therefore be simplified in order to become intelligible and manageable by attracting less resistance - which can be achieved by framing them as technical (Hoppe, 2011). Problematisation thus entails the creation of narratives about reality, with the aim to make them as simple and uncontroversial as possible (Hoppe, 2011; Li, 2007). It is hence in the interest of authorities to simplify issues to the extent where tackling such problems appears to be a technical, and not political, process - hiding whatever power imbalances between groups may have caused a problem to occur (Hoppe, 2011).

Past research in Brazil has shown that the state has been trying to frame their policies as technical solutions to apolitical problems (Rocha & Barbosa, 2018). Recent political debates in Congress, for example, are about the alleged need for a 'depoliticisation' of the school curriculum, which, for conservatives, justifies and entails the removal of 'gender ideology' from schools. Under the justification to make education more technical and less 'politically biased', morally-guided changes in the way in which sexual conduct is taught and addressed by schools are suggested (Gava & Villela, 2016). This shows how, in the Brazilian government, the idea that apolitical technical interventions are more legitimate than their true political nature is prevalent, and that technical ways to frame them are applied.

Framework Summary

This section demonstrates that the state uses social policy to constrain the agency of individuals, determining what is seen as good or bad behaviour, finally 'conducting their conduct' (Brickell, 2009; Ostrom, 2011). Part of this process entails the legibility of citizens - hence the making visible of their identities and needs - for the state or other governing actors to be able to address or control them (Scott, 1998). Additionally, governments have their own notions of what kind of behaviour is desired from certain citizens, hence different groups of people are framed and governed in different ways based on what purpose they ideally ought to serve (King, 1999; Li, 2007). For adolescent sexual citizenship this means that, depending on what is expected from the ideal adolescent citizen and how much agency is attributed to them, they may enjoy more liberal or constrained sexual citizenship (Ericsson, 2005; Schaffner, 2005). These ideas matter for understanding how the Brazilian government tackled adolescent pregnancy. As the reproduction of citizens is in the interest of the state, policies to control who gets to reproduce and when become crucial (Jeffreys, 2009). This theoretical framework is the basis for how I intend to analyse adolescent fertility policies in Brazil, which I will describe below.

Methodology

Data Collection and Analysis

As the PROSAD and SPE are two major adolescent health programmes, I focused on them to guide my research (Ministério da Saúde, et al, 2007b). These two programmes yield ten federal level policy documents between 1989 and 2010, which I analysed in order to understand the construction of adolescence as well as 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, as well as how the state has justified perceiving it as a problem. Here, I focussed on whether it was seen as desired or undesired, what actions were suggested to govern it, and what aspects of its social context were paid attention to.

Given this focus on the creation of meaning, I conducted a Foucauldian discourse analysis. Here, discourse was conceptualised as a practice through which reality is constructed (Pedersen, 2009; Garrity, 2010). Discourse is therefore 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 (Garrity, 2010). Hence the discourse analysis I conducted for this paper can be seen as 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). Hence 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, cited 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, I believe that 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 subsection 3.2.

Additionally, I also analysed health indicators used for the state to 'see' adolescent pregnancy. Based on my access to governmental databases, I have analysed ten databases with indicators on adolescent pregnancy from 1994. The databases chosen for my analysis belong to Brazil's public and unified health care system (SUS). Moreover, some indicators have been retrieved from the Indicadores e Dados Básicos (IDB), a compilation of health indicators from different public health databases compiled by the Rede Interagencial de Informações para a Saúde (RIPSA). The IDB indicators analysed come from nine databases and cover the years 1996 to 2011. These databases and indicators that I included in my research were recommended to me by the Ministry of Health via the Sistema Eletrônico do Serviço de Informação ao Cidadão (e-SIC), Brazil's online system for citizens' enquiries and transparency. I used this system to solicit information regarding what indicators were used to assess adolescent health. In order to learn how exactly adolescence and adolescent pregnancies are made legible, I conducted a content analysis of the health indicators retrieved from the different databases. I was not interested in the values shown by the indicators per se, but in what kind of questions health professionals asked to or about adolescents. As health professionals at the SUS are part of the state apparatus, the survey questions they ask their patients represent what the Brazilian state is interested in knowing about them - hence what they wish to make legible (Scott, 1998; Rose & Miller, 2008). Applying the notion of rhetorical silence, I paid particular attention to what was not measured by health indicators, in order to determine what was made invisible by the state (Brown, 2009).

In order to support the 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 has 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 & Arreguy, 2015; Jager, et al, 2014; Horta & de Sena, 2010). My research therefore uses these studies to support my claims and add more evidence to my discourse analysis. Nevertheless, this paper has several limitations.

Limitations

The main limitation of my discourse analysis concerns the reliability and validity of its results. Because statements are not clearly distinguished linguistic units, 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 therefore subjective and susceptible to my own interpretations, which are constrained by my own discursively constructed reality (Fiss & 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, 2008b). In order 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 databases suggested to me via e-SIC. However, the compiled data may have excluded relevant information.

Furthermore, indicators 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 SUS and the documents produced by the Ministry of Health and of Education (in the case of the SPE). The reason for this is, on one hand, the time and scope available for my research, but also the fact that

I am interested in how certain state officials see adolescents. Had I included data from non-state actors in this analysis, it would have not been equally possible to tell what Brazilian state officials from the Ministry of Health and Education *want* to know (Rose & Miller, 2008).

Moreover, I have excluded the more recent health policy for adolescents in conflict with the law (PNAISARI) from 2014 from my analysis (Ministério da Saúde, n.d.). Because the distinct targeting of these adolescents calls for a study of its own, I have decided to exclude this topic. I have also excluded the most recent political debates surrounding gender and sex education; particularly plans for a programme called *Escola Sem Partido* (School Without a Party) (see Gava & Villela, 2016). This programme and the PNAISARI are both from the mid-2010s and were found too recent to be adequately analysed.

Next to those limitations, there is the problem that I could not conduct research in Brazil for financial and time constraints. It was therefore not possible to compare policy guidelines to their implementation. I use secondary literature to counter this limitation. Related to this point is the additional limitation that I could not analyse what these policies mean for adolescents within the private health and education systems, as these are also subject to governance by non-state actors.

Finally, as my findings will show, my research has identified certain shifts in ideas about citizenship that relate to broader contextual changes in Brazil. Yet it is not the aim of this paper to explain changing conceptualisations of citizenship and rights in Brazil in general. For such discussions, I would suggest reading different literature (see Fausto & Fausto, 2014; Parker, 1999).

Discussion of Findings

Below, I will argue that the way in which adolescents and adolescent pregnancy are made legible prevents the state from addressing adolescent pregnancy as part of a wider social reality. In order to illustrate this point, I will use two case studies: First, by addressing adolescent pregnancy as a medical problem, the government ignores how it may be a symptom of widespread lack of opportunities for many adolescents, hence an indicator for Brazil's structural inequalities. Second, I will show how, by ignoring fatherhood in in health indicators, the state ultimately ignores how exactly gender relations are linked to adolescent pregnancy.

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 case studies.

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 (Coordenação da Saúde da Criança e do Adolescente, 1996: 5; Ministério da Saúde, et al, 1993a; 1993b; Horta & de Sena, 2010). Any mention of inequalities between adolescents was vague, and the documents implied that, generally, adolescence was "an evolutionary stage of great vulnerability"[2], regardless of social class, sexual orientation or race (Ministério da Saúde, et al, 1993b: 23; Jager, et al, 2014).

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[1] Translation: See Appendix 1 for original
[2] Translation

Similarly, health indicators in the 1990s also ignored adolescents' intersecting identities (DATASUS, 2008a; 2008b; SIAB, n.d.-a; n.d.-b; n.d.-c; Ripsa, 1997; 1998; 2000). This contributed to the homogenisation of adolescents as one category described by 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 began to include self-reported race, and whether pregnancies were planned not until the 2010s (Caldwell, 2017; DATASUS, 2008a; 2008b; SIAB, n.d.-a; n.d.-b; n.d.-c; Ripsa, 1997; 1998; 2000-2012). Moreover, no health survey regarding adolescent pregnancy ever asked anything about the fathers (DATASUS, 2008a, 2008b; SIAB, n.d.-a; n.d.-b; n.d.-c; Ripsa, 1997; 1998; 2000-2012). Therefore, while the discourse surrounding adolescents included vague statements about considering their "regional particularities"[3] or "individual and social differences"[4], the data gathered about them only allowed for a generalised approach to adolescent pregnancy and sexual health (Coordenação da Saúde da Criança e do Adolescente, 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 take structural inequalities and adolescents' various realities into account. Employing the concept of rhetorical silence, it is clear that the absence of concepts such as race and gender from these policy documents has a meaning in itself: these aspects of adolescents' realities, which are not purely medical or merely based on income, cannot be addressed by policy (Caldwell, 2017; Brown, 2009; Chemmencheri, 2015). By not recognising these social factors, health policy makers working on the PROSAD, did not take into account possible social factors that would hinder adolescents from following governmental guidelines to prevent them from reproducing (Chemmencheri, 2015; Hildebrant & Chua, 2017; Horta & de Sena, 2010). The effects of this will be elaborated upon in subsections 4.3 and 4.4.

While briefly acknowledging that there are differences, all of 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 (Coordenação da Saúde da Criança e do Adolescente, 1989, 1996). This is another crucial point in the construction of adolescent sexual citizenship because of the agency that is (not) attributed to them. This idea that adolescents may not be ready for sex creates 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 in subsection 4.3, meant opting against pregnancy (Coordenação da Saúde da Criança e do Adolescente, 1989; 1996; Ministério da Saúde, 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 & 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 to which adolescents actually could and wanted to follow their guidelines for sexual behaviour (Scott, 1998; Seckinelgin, 2007; Coordenação da Saúde da Criança e do Adolescente, 1989; 1996; Ripsa, 1997; 1998; 2000). This probably resulted in certain planned and unplanned pregnancies that the state could not prevent. Such factors are often related to structural inequalities in Brazil, such as the lack of other opportunities, on which I will

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[3] Translation
[4] Translation

elaborate in section 4.3. The way in which adolescent pregnancy was seen also relates to this problem, which I will explain in subsection 4.2.

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 (Ministério da Saúde, et al, 2007a; 2007b). Adolescence remained seen as a phase of development, but the fact that it was a social construct related to expectations of "educational attainment and professional preparation"[5] was acknowledged (Ministério da Saúde, et al, 2007a: 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 (Ministério da Saúde, et al, 2007a; 2007b). On the other hand, this agency and respect for own decisions was coupled with a discourse of responsibility: while it remained perceived as 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"[6] (Ministério da Saúde, et al, 2007a: 84).

One example of this are the *Adolescent Health Booklets*. 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 (Ministério da Saúde, 2010; 2012). At the same time, the goal to curb adolescent fertility remained, but with an emphasis on "reducing adolescents' vulnerability towards [...] unplanned pregnancy"[7] (Ministério da Saúde, et al, 2007b: 7). The notion of responsibility as flip side of agency in the 2000s therefore became an important part of the adolescents' 'new' sexual citizenship: It was a tool to ensure that adolescents 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 & Miller, 2008; Brickell, 2009; Carabine, 2001).

As mentioned above, another shift in the 2000s was the increased awareness of inequalities among adolescents (Ministério da Saúde, et al, 2007a). 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, for example (DATASUS, 2008a; 2008b; SIAB, n.d.-a; n.d.-b; n.d.-c; Ripsa, 2000-2012). This disconnect between one government body's discourse about adolescents, and others' indicators about them illustrates how fragmented states can be and that awareness about subjects' intersecting identities does not necessarily translate in their recognition (Rose & Miller, 2008; Chemmencheri, 2015). 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 of the same time period, that while some state officials had one image of the group, others did not. This is supported by evidence on how public school teachers in Rio de Janeiro denied students access to condoms based on their own perceptions that adolescents should not be 'promiscuous' (Russo & Arreguy, 2015). Hence, in the 2000s, the fragmented awareness of inequalities and agencies within adolescence is a key aspect to consider when analysing the state's approach to adolescent pregnancy.

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[5] Translation
[6] Translation
[7] Translation

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 subsection 4.2. I will first analyse how adolescent pregnancy was problematised, as it also serves as the bases for my case studies.

Adolescent Pregnancy as Health Risk

As this subsection will argue, adolescent pregnancy has been medicalised, especially in the 1990s, making the state ignore structural inequalities behind adolescent pregnancy (based on Seckinelgin, 2007).

Adolescent pregnancy was primarily seen as a health risk for adolescents in the policy documents up to 2000 and in the health indicators in the 2000s (Carneiro, et al, 2000; Departamento de Atenção Básica, 2003). As federal policy guidelines for the treatment of pregnant adolescents from 2000 show, health professionals were preoccupied with pregnancy between 10 and 19 years of age. The main concern described in this document was the higher maternal mortality ratio among that age group. Moreover, other biological explanations were given, concerning girls between the ages of 10 and 15 (Carneiro, et al, 2000). This document also briefly 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 (Carneiro, et al, 2000). However, this often is framed as a cultural peculiarity (Carneiro, et al, 2000; Ministério da Saúde, et al, 2007b).

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 for this paper considered that some adolescents might become pregnant on purpose (Coordenação da Saúde da Criança e do Adolescente, 1989; 1996; Ministério da Saúde, et al, 1993a; 1993b). Neither did any of the health indicators ask pregnant women and girls whether their pregnancies had been planned, until 2016 (DATASUS, 2008a; 2008b; SIAB, n.d.-a; n.d.-b; n.d.-c; Ripsa, 2000-2012; e-SUS Atenção Básica, 2016). Additionally, because at that time adolescents were made legible in a homogenised manner, seen as vulnerable with a dubious capacity for agency, it seemed justifiable to assume that they could not plan to become pregnant, like 'adults' (Schaffner, 2005; Horta & de Sena, 2010; Jager, et al, 2014).

Moreover, adolescent pregnancy was treated as a public health issue, and not a societal issue linked to the availability of opportunity, sexual scripts and gendered norms. This is explicitly stated in the guidelines for treatment of pregnant adolescents in 2000: here, the Ministry of Health states that "adolescent pregnancy, [...] undeniably contributed to the perpetuation of a cycle of poverty and deprivation"[8] (Carneiro, et al, 2000: 8). Hence instead of addressing adolescent pregnancy as a symptom of structural inequalities, it was addressed as the main problem (see Seckinelgin, 2007). Even in more recent government documents pertaining to the SPE, the reduction of adolescent pregnancy is stated as one of the main goals in itself (Ministério da Saúde, et al, 2007a; 2007b).

Assumptions regarding this 'public health problem' became more nuanced by 2007, with the *Guia de Formação* acknowledging social factors that may make pregnancy a desired outcome for some adolescents and their families. This document shows that there were government officials by that time who were aware of societal reasons for adolescents to disregard professionals' recommendations. There was also more awareness of the role of structural inequalities, such as the lack of opportunities among lower income groups (Ministério da Saúde, et al, 2007a). However, adolescent pregnancy remained seen as a risk for adolescents' health, and other documents would

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[8] Translation

frame the issue in a way that seemed to ignore planned adolescent pregnancies (Ministério da Saúde, et al, 2007b). The policy directory for the SPE/PSE, for example, argued that adolescent pregnancy should be associated with "individual and social vulnerability, unplanned pregnancy,

lack of appropriate information and of access to health services and adolescents' and women's status in society"[9] (Ministério da Saúde, et al, 2007b: 12). A similar position was reflected in health indicators: In 2003, the Ficha B-GES - which gathers data on pregnancy - included being 20 years old or below as a risk during pregnancy (Departamento de Atenção Básica, 2003).

Hence while the government occasionally admitted that adolescent pregnancy was *made* undesired due to a perception of adolescence in which they are ascribed to obtain education and not seen as ready for childbirth, it focused on preventing adolescent pregnancy as a public health issue that poses a public 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 notion that, ideally, adolescents would go to school (Ministério da Saúde, et al, 2007a). The Brazilian government therefore made it clear that the society of which it is a part of is interested in preventing adolescent pregnancies.

This unidimensional manner of addressing adolescent pregnancy is a consequence of medicalisation, as the notion of health risks replace concerns about social roots of now medical problems (Seckinelgin, 2007). However, as public health approaches to social issues are regarded as technical and therefore apolitical, they are more legitimate (Seckinelgin, 2007; Li, 2007; Hoppe, 2011). My cases studies below will illustrate how the medicalisation of adolescent pregnancy 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 seeming to be the most attractive life path (Fontoura & Pinheiro, 2010). I will argue that the way in which adolescents and adolescent pregnancy were seen justified social policies that (1) marginalised the behaviour of some disadvantaged adolescents, and (2) allowed the Brazilian government to ignore its responsibility in increasing adolescents' access to opportunities.

A major reason for the Brazilian government to discourage adolescent pregnancy was the idea that adolescents should go to school. As shown in the policy documents from the 1990s and 2000s, regardless of how much agency is finally attributed to them, adolescents were nevertheless made legible as citizens in a phase of development (Coordenação da Saúde da Criança e do Adolescente, 1989; 1996; Ministério da Saúde, et al, 2007a; 2007b). This implies that they are in a process of creation; yet to become the ideal adults who ought to be educated in order to become high skilled workers capable of making Brazil internationally competitive in the global political economy (Ministério da Saúde, et al, 2007a; Jones, 2016). Not only do the Health Ministry's policy documents acknowledge that in current Brazilian society education is expected from that age group, but that is also evidenced in the assumptions and goals of other policies (Ministério da Saúde, et al, 2007a). As explained by Jones (2016), there is an assumption that adolescents' lives are part of a linear progression from childhood to successful adulthood via the attainment of education. Moreover, as evidenced by the logic of Brazil's *Bolsa Família* programme, education is assumed to help adolescents and their families lift themselves out of poverty (Jones, 2016; Lomelí, 2008). Adolescents therefore are perceived as a group that needs education in order to become

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[9] Translation

successful adults - or ideal citizens. This is based on the assumption that education in Brazil will benefit all adolescents and allow them to get better employment which is assumed to translate into social mobility (Jones, 2016; Lomelí, 2008). However, this is not the case: the quality of education is not good enough to make poor adolescents become more productive, and even if they become more skilled, the country's economy does not offer enough jobs for them to employ those skills and earn more (Jones, 2016).

Applying this evidence to the case of adolescent pregnancy, it becomes clear that preventing adolescents from becoming parents at that stage of life in order for them to stay at school will not automatically translate into them becoming higher skilled workers capable of lifting themselves out of poverty. This suggests that the Brazilian state should instead invest in tackling the problems of the education system, employment, and social security, which is more difficult than narrow policies such as CCTs or sexual education for the prevention of adolescent pregnancy (Jones, 2016; Lomelí, 2008).

Moreover, the assumptions above meet (1) the assumptions 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)s, and (2) health indicators that disregarded major inequalities and the question of planned pregnancies (Coordenação da Saúde da Criança e do Adolescente, 1989; 1996; Ministério da Saúde, et al, 2007a; 2007b; DATASUS, 2008a; 2008b; SIAB, n.d.-a; n.d.-b; n.d.-c; Ripsa, 2000-2012; e-SUS Atenção Básica, 2016). Under these circumstances, the state's approach against adolescent pregnancy ignored structural inequalities and made adolescents responsible by ignoring the fact that certain social factors that lead to adolescent pregnancy are not being tackled by the Brazilian state.

This is where the medicalisation of adolescent pregnancy and the lack of legibility of inequalities among adolescents become relevant. 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 in the public health system after 2013 (Departamento de Atenção Básica, 2013). Hence whether a particular group of adolescents was choosing to become pregnant instead of continuing education, it was ignored during the entire time period of my analysis. This lack of enquiry about indicators of health inequalities ignores major variables that influence adolescent pregnancy, hiding inequalities in health and opportunities that are difficult to tackle (Hildebrandt & Chua, 2017). By medicalising adolescent pregnancy, the state could restrict itself to public health policies instead of admitting the need for more complex social policies that address education, employment, and sexism in the whole society. Instead, it could focus on teaching a target group how to conduct their own conduct (Seckinelgin, 2007).

Additionally, the medicalisation of adolescent pregnancy marginalised motherhood before the age of 20 as a risk behaviour, legitimising its undesirability (Seckinelgin, 2007; Carabine, 2001). 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 see no better future by staying at school. Hence the consequence was that, instead of tackling social causes for adolescent pregnancy, such as the lack of opportunities, 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).

The Invisibility of the Father

Below I will show how the lack of visibility of the fathers led to an approach to adolescent pregnancy which ignored the role of gender beyond adolescence.

As briefly explained above, the health surveys used to record health outcomes of pregnant women and girls have never asked any question about the characteristics of the fathers of their babies (DATASUS, 2008a, 2008b; SIAB, n.d.-a; n.d.-b; n.d.-c; Ripsa, 1997, 1998, 2000-2012). The absence of this information ignored the males responsible for impregnating adolescent girls. This not only left room for inaccurate assumptions that adolescent girls get impregnated only by adolescent boys, but also hindered adequate policy making (Brown, 2009; Hildebrandt & 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 seemed not only justified but also a simple way to promote behavioural change (Coordenação da Saúde da Criança e do Adolescente, 1989; 1996; King, 1999). The invisibility of the father therefore contributed to the lack of consideration of the heterogeneity of adolescence as a category (based on Brown, 2009; Hildebrandt & Chua, 2017). Not only were the social factors behind why adolescent girls get pregnant ignored, but so were the different reasons why boys or adult men impregnate girls. Gendered issues such as the (lack of) agency to negotiate the use of contraception were, for example, excluded from policy in the 1990s (Ministério da Saúde, et al, 2007a; 2007b). Moreover, by seeing adolescents as vulnerable, it was justified to construct adolescents as the target group for policies curbing adolescent fertility (Carneiro, et al, 2000; King, 1999). Combined with the medicalisation of adolescent pregnancy, and the idea that by giving adolescents information they could avoid that 'problem', adolescents could then be made responsible for adolescent pregnancy (Seckinelgin, 2007).

In the 2000s, on the other hand, policy documents did acknowledge that there are adolescent girls that can be impregnated by adult men and gender issues were supposed to be targeted at school (Ministério da Saúde, et al, 2007a; 2007b). However, as mentioned above, the health indicators lagged behind and, still, do not enquire about any other characteristic of the father (DATASUS, 2008a, 2008b; SIAB, n.d.-a; n.d.-b; n.d.-c; Ripsa, 1997, 1998, 2000-2012). Moreover, while the SPE advocated for gender to be addressed at schools, its indicators did not monitor what exactly was being taught (Departamento de Atenção Básica, n.d.). At the same time, adolescents were also made responsible for the consequences of their actions, as they were now seen as agents capable of making their own choices (Ministério da Saúde, et al, 2007b; Rose & 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 is taught that she has rights and should use contraception and condoms 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.

The targeting of adolescents and the invisibility of the father therefore make adolescent girls responsible for their pregnancy, instead of focussing on gendered social norms that serve as the actual 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 medicalized. Brickell's (2009) idea of channels of power are helpful here. By addressing adolescent pregnancy as a problem pertaining to adolescents, the state ignores how adults may be linked to it - such as by impregnating girls. And as this is seen as an issue of adolescents, public health institutions exert their power by coining the idea that adolescents are the sole group responsible for adolescent pregnancy (Brickell, 2009). The medicalisation of adolescent pregnancy, as I have explained in subsection 4.2, legitimises this

(Seckinelgin, 2007). Then, by regulating adolescents' sexual behaviour, the state institutionalises and promotes 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 root 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 they do also state that the government and society are also responsible for the reproductive and sexual health of adolescents, my analysis of the *Adolescent Health Booklets* unveils contradictions (Ministério da Saúde, 2010; 2012). As explained above, this document tells adolescents that they need to prepare to become healthy parents to healthy babies in the case of their contraceptive methods failing leading to pregnancy. Hence regardless of the discourse about how the state should guarantee adolescents' sexual and reproductive rights, and that it is responsible for their well being, there is 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 and that many unplanned pregnancies could be aborted if the Brazilian government made the *political* decision to decriminalise it (Luna, 2014).

In the 1990s, this regulation was justified by the idea of adolescents as vulnerable citizens, incapable of governing themselves, therefore requiring state intervention in the form of information (Coordenação da Saúde da Criança e do Adolescente, 1989; 1996; Rose & Miller, 2008). In the 2000s, the justification was that adolescents had to learn to be responsible for their actions, which entailed being 'good' parents for their planned or unplanned babies (Ministério da Saúde, et al, 2007a; 2007b; Rose & Miller, 2008). The idea that information was enough to not become pregnant made adolescent girls who supposedly 'knew better' responsible for becoming pregnant in the 1990s (Coordenação da Saúde da Criança e do Adolescente, 1989; 1996; Seckinelgin, 2007). In the 2000s, on the other hand, the discourse was that even if contraceptives failed an adolescent should assume responsibility for parenthood (Ministério da Saúde, 2010). Finally, through the promotion of this institutionalised idea that only adolescents are a 'part of the problem', the idea was promoted that it is also only that group that one should 'be worried about' and that it is them who should be responsible for their reproductive health (Brickell, 2009). Therefore, in a scenario where an adolescent girl gets impregnated by an adult male, it is her who had the information on how to prevent that pregnancy, possibly not the man, and therefore she is made responsible (based on Seckinelgin, 2007).

Conclusion

Above I have analysed how the way in which adolescents and adolescent pregnancy have been made legible by the Brazilian state between 1989 and 2010 has shaped social policies addressing adolescent pregnancy. As my findings have shown, there has been a significant shift 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 (Coordenação da Saúde da Criança e do Adolescente, 1989; 1996; Ministério da Saúde, et al, 2007a; 2007b; Jones, 2016). Moreover, despite the acknowledgement of the role of society and inequalities by officials from the Ministries of Health and Education as shown in the SPE documents, it is evident from the indicators and teachers that this perception of adolescents is not yet dominant in all of the Brazilian government (Russo & 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 (Ministério da Saúde, et al, 2007a; 2007b). As my two case studies 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 in planned adolescent pregnancies. Additionally, by focussing on adolescents, the role of adult men and gender relations was kept invisible and remains unaddressed. Finally, these case studies not only show the insufficient efforts to tackle society's role in adolescent pregnancy, but also how, by ignoring reasons why adolescents still get pregnant, social policies promote a type of behaviour that is not compatible with some adolescents' realities.

These findings therefore have important implications for health policy in Brazil and social policy in general. First, social issues are intertwined and should be taken into account 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 has 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, it is alarming that no information is required about the father when pregnant women and girls receive treatment (DATASUS, 2008a, 2008b; SIAB, n.d.-a; n.d.-b; n.d.-c; Ripsa, 1997, 1998, 2000-2012). Another major implication is the problem of addressing adolescent sexual and reproductive health as apolitical. It cannot be addressed as a technical 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 current discourse surrounding the *Escola Sem Partido* project - that aims at 'depoliticising' sexual education and removing conversations about gender from schools - therefore either clearly 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 (Gava & Villela, 2016).

Finally, it was not the aim of this paper to make any normative comments on whether adolescents should or not become parents or be taught sexual education. I have simply argued that, when trying to impose a certain ideal of sexual conduct on a heterogeneous group such as Brazilian adolescents, the state ought to take into account societal factors. While advancing the idea of a modern society where adolescents have safe sex and only become parents during adulthood, the Brazilian state must ensure that these adolescents can actually choose to do so. By expecting a certain behaviour from groups of people who do not benefit from it or lack the agency to comply, the state is merely marginalising sexualities, and not advancing any modern goals. Instead, the state ought to ensure that citizens can use their agency to make sexual choices suitable to them.

Conclusion

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Appendix 1. Supporting Quotes

Footnote Nr.	Original version
1	"desenvolvimento, que se manifesta por transformações anatômicas, fisiológicas, psicológicas e sociais" (Coordenação da Saúde da Criança e do Adolescente, 1996: 5)
2	"uma etapa evolutiva de grande vulnerabilidade" (Ministério da Saúde, et al, 1993b: 23)
3	"particularidades regionais" (Coordenação da Saúde da Criança e do Adolescente, 1989: 11)
4	"desajustes individuais e sociais" (Coordenação da Saúde da Criança e do Adolescente, 1989: 11)
5	"formação escolar e preparação profissional" (Ministério da Saúde, et al, 2007a: 87)
6	"[estimular] a responsabilidade com sua própria saúde. O respeito à sua autonomia faz com que eles passem de objeto a sujeito de direito" (Ministério da Saúde, et al, 2007a: 84).
7	"reduzir a vulnerabilidade de adolescentes [...] à gravidez não-planejada (Ministério da Saúde, et al, 2007b: 7)
8	"É inegável que a gravidez na adolescência, [...] contribui para a perpetuação de um ciclo de pobreza e carências" (Carneiro, et al, 2000: 8)
9	"vulnerabilidade individual e social, gravidez não-planejada, falta de informação apropriada e de acesso aos serviços de saúde e o status das adolescentes mulheres na sociedade" (Ministério da Saúde, et al, 2007b: 12)

Table 1.: Original Supporting Quotes (See content for sources)