

A fertility citizenship – women’s health policies as technologies of sex and gender production

Uma cidadania da fertilidade – as políticas de saúde da mulher como tecnologias de produção do sexo e do gênero

Hevelyn Rosa^a

 <https://orcid.org/0000-0002-2778-1690>

E-mail: hevelynconceicao@gmail.com

Cristiane da Silva Cabral^a

 <https://orcid.org/0000-0003-3025-2404>

E-mail: cabralcs@usp.br

^aUniversidade de São Paulo, Faculdade de Saúde Pública, Departamento de Saúde, Ciclos de vida e Sociedade. São Paulo, SP, Brasil.

Abstract

This article analyzes how the main public policies on Brazilian women’s health, since 2000, define and characterize their target group. Marking an articulation between different sets of agents, disciplinary fields, and government technologies, public policies operate by representing and conforming the subject to whom they are intended. In women’s health field, this process is also made possible by modulating sex and gender, specifically reiterating codes responsible for designating the “nature” of women. This is a documentary research conducted via the anthropological perspective of documents analysis, which investigated the documentary pieces of the *Política Nacional de Atenção Integral à Saúde da Mulher* (2004) and *Rede Cegonha* (2011) and related documents. The themes of fertility and reproduction have been persistent in the set of actions in women’s health, making up the core areas that concentrate state efforts and funds. The woman embraced by health policies has greater chances of accessing her citizenship rights from her role as a potential reproducer. The complex construction of a subject of rights is identified, even when this construction was imbued with a certain emancipatory ideology, in the interstices of the State.

Keywords: Public Policies; Women’s Health; Gender; Reproductive Rights; State.

Correspondence

Hevelyn Rosa Conceição

Av. Dr. Arnaldo, 715. São Paulo, SP, Brasil. CEP 01246-904

Resumo

Este artigo analisa como as principais políticas públicas brasileiras de saúde da mulher, desde 2000, definem e caracterizam seu público-alvo. Marcando uma articulação entre distintos conjuntos de agentes, campos disciplinares e tecnologias de governo, as políticas operam representando e conformando o sujeito a quem se destinam. No campo da saúde da mulher, essa operação também é viabilizada mediante a modulação do sexo e do gênero, especificamente a reiteração de códigos responsáveis por designar a “natureza” da mulher. Trata-se de uma pesquisa documental realizada através da perspectiva antropológica de análise de documentos, que investigou as peças documentais da Política Nacional de Atenção Integral à Saúde da Mulher (2004), da Rede Cegonha (2011) e documentos correlatos. Os temas da fertilidade e da reprodução têm se mostrado persistentes no conjunto de ações em saúde da mulher, formando os núcleos que concentram esforços e verbas estatais. A mulher constituída pelas políticas de saúde tem maiores chances de acessar seus direitos de cidadania por meio de sua função como potencial reprodutora. Identifica-se a complexidade da construção de um sujeito de direitos, mesmo quando esteve imbuída de um certo ideário emancipatório, presente nos interstícios do Estado.

Palavras-chave: Políticas Públicas; Saúde da Mulher; Gênero; Direitos Reprodutivos; Estado.

Introduction

Throughout the 20th century, until the early 1980s, the Brazilian National Health Policies for women were mainly focused on issues related to pregnancy and care for the newborn. The policies operationalization was marked by the verticalization of actions and isolation from other health issues – such as mental health and neoplasms (Villela; Monteiro, 2005).

From the 1980s onwards, other narratives about women emerged in the formulation of health policies in Brazil, seen as more comprehensive as they advocate for comprehensiveness, a paradigm that considers the complexity of women’s health needs (Costa, 2013). Among these norms, we could mention the Program of Comprehensive Women’s Health Care (*Programa de Assistência Integral à Saúde da Mulher*, PAISM) in 1983 and, later, the National Policy for Comprehensive Women’s Health Care (*Política Nacional de Atenção Integral à Saúde da Mulher*, PNAISM), in 2004. This arc formed by these policies, however, is not linear. In parallel to admittedly progressive proposals, others have also emerged intended to emphasize maternal and child health, such as the *Rede Cegonha* (RC), of 2011.

In the Brazilian experience, the area of women’s health stands out as an exemplary case by highlighting the complexity of the health and disease process, criticizing biologicism and integrating popular participation, especially when we consider the intertwining between social movements and political propositions in this field. This is how specific demands of the health system have been historically combined with the problematization of the paradigm that drives health care practices and professional training. Criticism of the society’s organization has also been guided by women’s and feminist social movements in the field of women’s health, especially those linked to anti-racism (Carneiro, 2003), when they report social inequities and work to articulate different elements such as rights, health, and living conditions.

Policies such as PAISM and PNAISM are marked by this emancipatory ideology, whose foundations

are based on the defense of participatory democracy and the fight against inequalities as part of the struggle of activists for the expansion of rights. This shows that public policies are perceived as strategic tools, with the potential to affect people's living conditions and health. Although in a contradictory way, given the low implementation and partial incorporation of the activist agenda (Costa, 2013), these are frameworks that aim at extending citizenship to people who have historically been subalternized.

Observing the public health policies directed to women enacted since 2000, we have propositions in which the prioritized issues and the look aimed at women are very distinct. The PNAISM lists women's health actions according to the guidelines of comprehensiveness, equity, and universality, comprising prevention, diagnosis, treatment, and recovery of health in all life cycles. In turn, the *Rede Cegonha* contains guidelines for the building of a care network focused on prenatal, childbirth, and puerperium, under the perspective of humanization of women's and children's healthcare.

The aforementioned policies are structured in different formats, with different legal statuses, since PNAISM is designated as a National Policy and the *Rede Cegonha* is instituted through an ordinance that omits its position in the federal normative framework. Nevertheless, both are State policies and configure the main governmental initiatives in relation to women's health since the turn of the 21st century, either by the concentration of greater resources - human and financial - in the Technical Area of Women's Health (*Área Técnica de Saúde da Mulher*) of the Ministry of Health and in the period of their implementation (Carvalho, 2017; Atenção..., 2011); or by what they represented in terms of collective ageing, considering the mobilization of actors such as social movements, research institutions, and government sectors (Conceição, 2021).

The PNAISM presents the resumption of the PAISM principles, an agenda raised by social movements of women and feminists before 2003. A notable milestone in this process is the publication of the Feminist Political Platform, which came out of the National Conference of Brazilian Women

(*Conferência Nacional de Mulheres Brasileiras*, CNMB) in 2002. Promoted by the organized civil society, notably the efforts of the Articulation of Brazilian Women (*Articulação de Mulheres Brasileiras*), based on dialogue with black women's movements (Silva, 2016), the CNMB brought together nearly five thousand women to debate a diversity of issues, including health (CNMB-PPF, 2002). The Feminist Political Platform records the demand for comprehensiveness to guide actions in women's health, the defense of sexual and reproductive rights, and the reporting of other inequalities beyond gender, such as those of race, class, and region (CNMB-PPF, 2002).

In addition to drafting a document intended to promote public policies, throughout the 2000s these groups invested in expanding their presence in the legislative and executive branches of the Brazilian government through the practice of advocacy, engagement in spaces of institutionalized participation, and the direct occupation of positions in the so-called second and third levels of ministries (Editorial..., 2005; Pitanguy; Barsted, 2011). This process is reflected in the formulation of the PNAISM through the systematic dialogue between the Ministry of Health and representatives of women's and feminist social movements, such as: Feminist Network for Health and Reproductive Rights (*Rede Feminista de Saúde e Direitos Reprodutivos*); Articulation of the Brazilian Women (*Articulação de Mulheres Brasileiras*); National Articulation of Rural Working Women (*Articulação Nacional das Mulheres Trabalhadoras Rurais*); and National Network for the Humanization of Childbirth and Labor (*Rede Nacional pela Humanização do Parto e Nascimento*) (Brasil, 2004a).

The *Rede Cegonha* (RC) gained visibility when it was announced in the government plan proposal during the presidential campaign, still in 2010, even before it was formulated (Castro, 2012). Promulgated in June 2011, the RC ordinance establishes as one of its milestones the Millennium Development Goals, especially the goal regarding reduction in maternal and infant mortality rates (Brasil, 2011a). Between 2004 and 2011, six other federal norms were also concerned with tackling maternal and infant

mortality rates, evidencing the relevance of this theme in the period¹.

Externally to the Federal Executive circuit, maternal and child health has been on the agenda in scientific and academic circles by producing research and sponsoring events (Diniz et al., 2018). Institutions such as the Oswaldo Cruz Foundation and the International Center for Health Equity (*Centro Internacional de Equidade em Saúde*) (Federal University of Pelotas) established partnerships with the Ministry of Health to fund research in this area, producing scientific evidence for instructing public policies (Barros; Victora; Wehrmeister, 2019; Rattner; et al., 2010).

The social movement for the humanization of childbirth and labor played a strategic role in the articulation between the Ministry of Health and the Academy. The only civil society organization listed as a partner in the RC implementation document, the Network for the Humanization of Childbirth and Labor (*Rede pela Humanização do Parto e Nascimento*, Rehuna), played a significant role in that time, also reaching the occupation of positions in the Ministry of Health, including the coordinator of the Technical Area of Women's Health at the time of formulation of the ordinance.

A comparison between both leads us to ask: What agenda for what target public does each of these propositions have? How do they designate who is a woman? We can think that the definition of woman in one policy does not coincide entirely with the other, just as their health needs are not the same. Both women and their health are not found in the policies as a simple representation of something homogeneous and stable, but as something multiple and always related, because it is articulated to a network that grants its sustainability.

This paper discusses in what ways the major national women's health public policies of the 2000s define and characterize who women are. Our argument is that there is a series of conceptions

about what it means to be a woman, informing the outline of a target-subject of public policies, manifested both in the description of the population to which the rules are addressed, and in the construction of the priority agenda of actions and the criteria for distribution of resources. Problematizing the subject represented and produced by governmental policies in the recent period in Brazil can contribute to understand the path of recrudescence of rights that we have been experiencing, especially in what concerns the anti-gender offensive and the disputes around the role of women in society.

Public policies and the State manufacturing

Public policies are often defined as administrative tools of the State, through an instrumental approach that enforces to them an objective and apolitical character (Castro, 2012). The assumption that public policies are responses of the State to demands of society has led to technicist studies, which are limited to investigating the linear cycle of development of a policy, its level of implementation, effectiveness and efficiency (Souza Lima; Castro, 2008). One of the effects of such an arrangement is the invisibilization of the fruitful interaction of interests, languages, and players that surrounds the production of regulations (Bandeira; Almeida, 2013).

The anthropological perspective of document review advocates that public policies integrate a series of artifacts that constitute the process of State formation, acting as key pieces for its existence, and also of those who will be designated as its population (Aguião, 2018). In other words, public policies operate as one of the tools through which the State produces itself, while also producing the subjects it governs.

Investigating policy documents thus corresponds to putting under analysis the framework of intelligibility that supports the arrangement in which

¹ These are: PNAISM, 2004; National Pact for the Reduction of Maternal and Neonatal Mortality (*Pacto Nacional pela Redução da Mortalidade Materna e Neonatal*), 2004; the regulation of maternal death surveillance through two ordinances in 2004 and 2008 (Ordinance GM/MS No. 1.172 of 2004 and Ordinance GM/MS No. 1.119 of 2008); Pact for the Reduction of Infant Mortality in the Northeast and in the Legal Amazon (*Pacto pela Redução da Mortalidade Infantil no Nordeste e na Amazônia Legal*), 2009; Health Pacts, including the Pacts for Life, in Defense of the SUS, and for Management, 2006, in which the operational priorities include reducing maternal and infant mortality.

the very terms are found, identifying “a complex mesh of regulations and idealizations” (Vianna; Lacerda, 2004, p. 10) in what has been taken for a fixed appearance, in our case, the woman. The discourses of public policies assume, therefore, the character of active producers, regarding what they postulate, with emphasis on their ability to conceive and manage spaces, objects and people (Vianna, 2014).

The assumption of a fixed subject has been pointed out as one of the grounds of public policies linked to social recognition and expansion of rights, within the scope of States (Aguião, 2018; Preciado, 2018). In this dynamic, delimiting a target audience to some extent necessarily requires affirming who can be legitimized by the State, access rights, and compete for citizenship.

We allude to a complex chain of discursive and non-discursive practices, responsible for defining what woman means, making women, as we conceive them, acquire form, position, and meaning. The arrangements articulated by the characterization of women are composed by public policies and also by cinema, literature, medicine, psychoanalysis, and law, among others. These fields participate in the production of sex and gender through both the representation of figures, and the definition of woman and man in accordance with a binary sexual regime (Preciado, 2017).

According to Preciado (2017), sex and gender should be understood as “complex sociopolitical technologies” through which the body is hierarchically fragmented into high-intensity zones that confer the nature of femininity or masculinity. These zones consist of particular parts of the body - especially the so-called reproductive organs - whose function is to become natural, anatomical markers of sexual difference. The logic of sexual difference is allied to anatomophysiology, but it also overlaps it, since the ordering of the body - its parts and functions - starts to correspond to re-presentations of a social ideal (Laqueur, 2001). What this system puts to work is an understanding that the differences imprinted on the bodies organize the differences in social places and functions between women and men.

To speak of the construction of a category that is so naturalized in the everyday life, as is the case

of “woman”, is not to refer to a supposed falsity - as if the experiences of people so designated were not real - but rather to evidence the operation through which a multiplicity assumes the contours of a subject that pretends to be coherent in itself. We argue that health policies are inserted in this process and start participating in the production of sex and gender, especially of the figure of the woman.

Methods

This is a documentary research driven by the premises of document ethnography (Vianna, 2014). Working with documents from this perspective consists of going beyond an informational and instrumental dimension of records, to understand them as central technological tools both for state institutions and for those who interact with the state, especially in the pursuit of rights (Ferreira, Lowenkron, 2020).

The corpus of this work is composed of a wide range of documents related to the two main national public policies on women’s health since the early 2000s in Brazil - PNAISM and RC. It is an extensive set, made up by: official documents from the federal government, such as letters of principle, ordinances, laws, reports, edicts and manuals; documents from social movements and other civil society organizations; and those arising from the academic and scientific production by players directly involved with the policies under analysis.

We started from the ethnographic study of the inaugural documents of PNAISM and RC (Brasil, 2004a, 2004b, 2011a, 2011b), following the trail of their form and content, in order to map all the argument, information and symbols inscribed in them. For each policy document investigated, a series of other documents were imposed to the investigation, integrating the collection of pieces to be reviewed. This procedure responded to the need to identify other layers of articulations that act in the production of a given text known as an official State document, making visible the complex network of relationships that shape a public policy on women’s health (Vianna, 2014). Such process gave the corpus a multiple character, since it contained

records whose legal status, institutional affiliation, format and platform of insertion differed from each other. Despite being a methodological challenge, such configuration contributed complexity and depth to the research.

The study of each of the policies was done in a comparative way, around two complementary axes: the study of the document wording and the study of the context. In the first axis, we analyzed the content and format of the official documents that promulgated the policies. The objective was to approach the policy in what it lets us see, i.e., how it produces its discourse, what language it uses, what priorities it sets, what inclusions and deletions it promotes. In the second axis - study of the context - we outlined the social, historical, and political conditions that made possible the advent of the elected policies. This second axis is subdivided into three dimensions: social movements, state institutionality, and promotion of scientific knowledge production. The discussion presented in this article privileges results referring to the study of documents and the relationship between Academia and the State.

Handling with the documents related to health policies as artifacts that order, name, associate, segment, exclude and include the elements they hold, makes visible a territory densely populated by multiple players, languages and rationalities in the production of the State.

Results

The first paragraph of the PNAISM introduction is dedicated to discussing who women are (Brasil, 2004a). The document answers this question by stating that women constitute the majority of the Brazilian population and of the Brazilian National Health System (SUS) users. In a section especially devoted to reflecting on what it calls the “gender approach”, the policy introduces the idea of gender as a social and historical construction that cuts across women and men, although it does not make explicit that it is women and their bodies who are the main targets of investigation, intervention, and regulation.

Even though the document addresses a historical approach to the contingencies that revolve around women, this look is not extended to the dimension of sex and sexual difference. According to the PNAISM argument, culture (gender) is imposed over the body (sex), defining behaviors, beliefs, and roles in which power is unequally distributed, causing an imbalance between women and men.

In the ordinance enacting the RC, the woman that emerges in the presentation of the policy background is implied through reference to terms such as gestation, childbirth, and maternal mortality, since there is no direct citation of woman as a noun and subject. The RC (Brasil, 2011a, 2011b) refers to gender a few times; however, in none of the official documents is there an explanation of what the “gender approach” means, nor how it will be operationalized, causing this perspective to lose strength in the normative horizon. In other platforms linked to the RC, such as the launch and dissemination events of the policy (Brasil, 2014, 2015), the mention to gender appears in allusion to the violence suffered by women in health services, notably in labor care.

The “life cycles” play a core role in the structure of actions envisaged by the policies, being established as the starting point to get closer to its target subject. The PNAISM develops more content about the different “life cycles” of women, offering proposals for women from puberty to “old age”. The RC, on the other hand, enunciates more briefly the category of its interest: women of reproductive age.

Mortality is the main statistical criterion used in both rules for the analysis of women’s health status. The RC elects maternal mortality as a priority, and its reduction is among the main objectives of the policy. The PNAISM focuses on data related to deaths of women considered to be of “fertile age”, i.e., between the ages of 10 and 49 years.

However, in the PNAISM the association with the paradigm of comprehensiveness in women’s health care strains the unrestricted prominence of the reproductive perspective, bringing experiences linked to mental health, aging, homosexuality, and work, for example. In order to promote

comprehensiveness in dialogue with a gender and race perspective, the PNAISM documents (Brazil, 2004a, 2004b) cover specificities in their target audience, identifying subgroups including: rural women, women with disabilities, black, indigenous, lesbians, and women in prison.

In discussing these difference markers, the PNAISM approaches the relationship between social inequality and living and health conditions, citing references linked to social movements and civil society meetings, announcing the coordination with players beyond the jurisdiction of the MoH (Brasil, 2004a). It highlights, above all, contributions from groups of black women, rural workers women, and women from popular classes.

Several references to women's health listed among the priority actions of the PNAISM and RC orbit around the reproductive potential of the female body from a biomedical point of view, such as: menopause, puberty, fertility, pregnancy, and puerperium. Together with the abundant use of other terms, such as fertile age, reproductive organs, contraception, fecundity, maternal health and maternal morbimortality, a grammar is made explicit in the documents that seeks the production in the body of a causal point of the definition of woman.

Once we conceive the discourses of the official texts not only as a mere vehicle to represent what would be the facts, but also as "practices that systematically form the objects of which they speak" (Foucault, 1997, p. 56, free translation), it is interesting to observe which terms and adjectives accompany the category woman. The ability to update the statements gives the neighborhood of the concept of woman a status of a field in dispute, as the many articulations produced carry their own projects and alliances about what it means to be a woman. Such dynamics gains light as we understand that concepts are more than linguistic phenomena, as they immediately indicate something that "lies beyond language" (Koselleck, 1992).

Whether in what it effectively says or in what it does not say - in other words, in what it includes and what it excludes - the way these documents approach the category of woman expresses the regime of its dispersion and regularity. Therefore,

in view of what has been exposed in the previous paragraphs, we notice that the systematically constituted neighborhood for the policies' woman is strongly marked by the recurrence of the claim of the reproductive organs as the nucleus that issues meaning and coherence of the body as a whole.

The approach to sexually transmitted infections (STIs) in the policies also reveals the meanings imbued in the designation of the female body. The issue of prevention, diagnosis, and treatment of STIs is located in the PNAISM and RC documents, in reference to the pregnancy-puerperal cycle, and in a perspective of diagnosis and treatment of symptoms. The opportunity to discuss STIs is found in the prenatal care, puerperium, family planning, and newborn care, actions that are justified by the contribution of STIs to the increase in maternal mortality rates and fetal health complications. However, such infections seem to be prominent as they threaten the healthy evolution of pregnancy and the child, reinforcing the association between sex and procreation. Thus, STIs are excluded from the policy horizon as events that can also be present in the experience of sexuality without reproductive purposes, as well as non-heteronormative sexual practices.

The incidence of greater attention and resources in the actions around pregnancy and childbirth, compared to other points raised by the policies, can be identified in the PNAISM and the RC. In the RC, this topic is the main objective of the set of normative proposals, excluding other subareas of women's health. The PNAISM, on the other hand, presents a broader thematic list, in which care for pregnancy and childbirth is among several topics, such as care related to issues of violence, cancer, and minority groups.

However, the discrepancies in the development of the PNAISM specific objectives are significant and are expressed, for example, in the more detailed and lengthy description of the objective of promoting obstetric and neonatal care in relation to the other sub-items. Actions aimed at women in the climacteric period, as well as indigenous women and women in prison situation, are presented in a

brief and unqualified way, counting only on a combination of the following words: expand and qualify comprehensive care to this group.

The approach to the pregnancy-puerperal cycle made by the documents is driven by references to maternity, indicating that both policies assume an inherent link between pregnancy and maternity. In the official RC documents, despite the alliance with the supposedly impartial discourse of a certain science in the effort to characterize pregnancy and labor, many elements emerge that escape this framework of neutrality, such as the assumption of heterosexuality, the focus on the cisheteronormative nuclear family, and the equivalence between sex and reproduction.

The documents use terms that not only match pregnancy with maternity, re-emphasizing the role of the mother as an inherent characteristic of the female body, but also produce a moral valuation of this condition. This grammar is evoked mainly by the RC. We highlight some expressions used to refer to pregnancy and labor: “such a special moment”, “rite of passage”, “pure transformation”, “power in the body”, “special experience”, “labor is part of the woman”, and “experience of strong positive potential” (Brasil, 2011b, 2014, 2015). Referring to the inseparability between pregnancy and motherhood and childcare, there are: “mother-newborn binomial”, “mother-child binomial”, and “mother-baby dyad” (Brasil, 2011b, 2014, 2015).

Regarding the promotion of scientific knowledge production, the survey showed that most of the calls for proposals from the Department of Science and Technology (*Departamento de Ciência e Tecnologia*, Decit) of the Ministry of Health concerned pregnancy and labor, in the period close to the PNAISM; and prematurity and child development, in the period around the RC. In formulating the women’s health sub-agenda of the National Agenda for Health Research Priorities (*Agenda Nacional de Prioridades de Pesquisa em Saúde*, ANPPS) in 2006, the topic “pregnancy, labor and puerperium” was the most extensive, with a total of 14 topics. This set of priority objects for investment in research represents twice as many items compared to other objects in the women’s health sub-agenda, such as

“STD/AIDS” and “breast cancer”. In relation to “mental health”, “abortion”, and “race/ethnicity”, the difference is even more expressive, since these contain only two topics each.

In the set of research supported by the MoH, we identify the prevalence of children among the most studied population groups, which persists throughout the period covered by the PNAISM and RC. In a Decit report on total research funded in 2004 and 2005, the three main population groups investigated are: in first place “children and adolescents”, followed by “women” and, ranked third, “children and women” (Brasil, 2007). The establishment of the category “child and woman” in Decit’s vocabulary evidences the effort to fix the maternal and child ideology at the interface between healthcare and the production of scientific knowledge.

In the context of the RC, the ANPPS was passed over in favor of a new agenda of research priorities called “Strategic research for the health system” (*Pesquisas estratégicas para o sistema de saúde*, PESS). Smaller in scope, the PESS had only one strategic objective that directly addressed issues traditionally recognized as belonging to the area of women’s health (Brasil, 2011c). Dedicated to the RC, the objective was to promote studies related to comprehensive healthcare for women and children and the RC implementation.

Discussion

Reproductive anatomy in the production of the category “woman”

Simultaneously represented and made up in the ordering of rules, the woman that emerges from the public health policies of the 2000s is characterized based on a fundamental assumption: reproductive anatomy. Both the PNAISM and the RC show that a woman is a person whose sexual and reproductive organs correspond to those designated as female. Although neither policy formally announces this, one can conclude that the reference used is established from a “structural place between the production of gender identity and the production of

certain organs as sexual and reproductive organs” (Preciado, 2011, p. 12, free translation).

The stability of this subject who inhabits the PNAISM and the RC is forged in the anatomical truth of organs, in a linear coherence between sex and gender, especially through the naming of the ability to become pregnant. Functioning as a guiding axis of the gaze on women, the quintessence of pregnancy organizes the path of life, bringing out categories of compartmentalization of life based on before, during and after the “potentially” reproductive period. They are: puberty, fertile/reproductive age, and climacteric.

The fertile or reproductive age category is not of exclusive use in public policies, since it is a denomination established in health disciplines and also in the interface between these and demographic studies. However, the systematic presence of this category in the PNAISM and RC evidences that the qualification of a woman’s life is subordinated, above all, to the virtual possibility of reproduction.

In its document of principles and guidelines, the PNAISM (Brasil, 2004a, p. 44, free translation) locates the fertile age as the central core of women’s lives, with adolescence and climacteric defined as transitional phases of “changes, transformation and adaptation”. This description is consistent with the frame of reference used by medicine to treat menopause and climacterium as markers of disruption of the primordial female system: fertility (Martin, 2006). The scarcity of proposals and budget for actions aimed at older women in the PNAISM may point out to one of the effects of the hierarchy triggered by this system.

“Maternal mortality” is another interesting case to be considered, since it is a coefficient that calculates the proportion of individuals who die due to some event related to pregnancy and the puerperium. Even a statistical rate is full of politics from its conception, since it equates pregnancy with maternity.

The pre-existence of a parental bond given between the parenting body, especially the female one, and the newborn body has defined parenting as a predominantly female issue (Robles, 2013). The systematic presence of the

issue of infant mortality in women’s health public policies may indicate that the success of the “fetal outcome” and the healthcare of newborns concern the woman. According to this regime, the person who carries female reproductive organs would find in her biological conformation the abilities to gestate and give birth, as well as those to educate and love children (Robles, 2013). The woman is thus presented not only as the avenue of generation of new humans, but as the avenue that enables the sustaining of the maternal and familial institution, as well as child survival.

The absence of the theme of abortion in the RC exemplifies the recitation of codes linked to the regulation of the female body within the framework of maternal nature. By electing as one of its goals the reduction of maternal mortality, without addressing one of the main causes of preventable deaths of pregnant people - abortion - the RC action plan exhibits an original flaw. It is in this sense that feminist activists’ criticisms of the policy argue that the RC is especially dedicated to women who become pregnant and wish to have children, representing a reductionism in understanding women’s health needs (Castilhos, 2011; Negrão, 2011).

RC: Harbinger of anti-gender offensives by the State

The power of the reproduction issue in both policies is not enough to make the charter of principles and the scope of proposals of each of them indistinct. On the horizon of the PNAISM, the policy plane is contested by other interests and issues. Added to this is the fact that the drafting of the PNAISM went through an extensive process of popular participation, involving several sectors of women’s and feminist social movements, whereas the RC is considered a “cabinet decision” (Werneck, 2012).

The many points that distinguish the PNAISM from the RC indicate the singularities of the public policy-making process for women on both occasions. The difference between what is worked on in the body of the PNAISM and what is not in the body of the RC -such as comprehensiveness, racism, gender, abortion, homosexuality - in addition to signaling the

priorities of each Federal Executive's administration, makes visible a new arrangement of forces in the sense of what can be officially documented and, with that, recognized and legitimized on the field where State and gender are built.

The funds allocated to the PNAISM were drastically reduced after the enactment of the RC causing, on the one hand, the de-funding of women's comprehensive healthcare actions and, on the other, a centralization of resources in the care of pregnancy and labor (Carvalho, 2017). The commitment of funds is thus established as another index of the overlap between norms. Understood as a loss of rights, the emptying of the PNAISM also unfolds in the exclusion of the dimension of comprehensiveness, and in the silencing of the gender and race perspective in public policies for women's health (Atenção..., 2011).

The intensification of a conservative tone in the documents observed in the RC points to a tightening of control over female bodies associated with an offensive against gender by the State. Although the approach to gender in the policies is one that designates it as a category predominantly of the feminine, failing to problematize masculinity and preserving the natural character of sex under the regime of sexual difference, there is an undeniable and growing polemic in this debate.

One can glimpse different effects of the anti-gender crusade in the undermining of the PNAISM and in the strengthening of the RC, especially in the dissemination of a praise to the figure of the woman-mother. It is about the relevance of the disputes around gender with regard to the processes of continuity and discontinuity of rules. The abandonment of the comprehensiveness paradigm can be understood as an aspect of this fight, in which sexual and reproductive rights are central. The vectors of the offensive against gender participate in the territory where the formulations of women's rights pass through, including health policies, and influence the way negotiations take place.

The discourses of the policies operate a re-naturalization of women, simultaneously evoking more recognizably biological data - hormones and physiology of birth - and more recognizably moral data - rite of passage and special moment.

We can say that motherhood designed as a peculiar experience of femininity aims to present itself, also, as a claim of biology and morality on that body (Preciado, 2017). Nothing in the official documents linked to the analyzed policies is as adjectivized as child birth, labor, and motherhood. There is no "fullness", "beauty", "special", or "celebration" for sexuality or maturity.

Discourses of moral nature collaborate in the constitution of scientific language in order to grant the "purified and neutral point of view of science" to its formulations (Foucault, 1988, p. 61, free translation). Even though there are no anatomical or physiological elements that account for motherhood as it is enunciated by the documents, mothering emerges as part of "feminine nature", a direct product of the condition of being a body susceptible to pregnancy. We understand that the grammar that designates organs, functions and parameters does not have a merely descriptive function, since it also functions as a producer of the categories it only presumes to enunciate, assuming a prescriptive performance in relation to sex and gender. After all, gender constitutes a "sophisticated technology that manufactures sexual bodies" (Preciado, 2017, p. 29).

Epidemiological and statistical data are central devices in the modulation of the public health agenda, from the way they are elaborated, to the way in which they are distributed, recognized and used (Adams, 2016). With regard to the policies analyzed, we see indicators and other metrics contextualizing the target audience of the actions (the emphasis on "women of childbearing age"), and justifying the need for the proposed measures (the reiteration of high infant and maternal mortality rates). By articulating governmental agendas to scientific evidence and fragments of the language of activisms, women's health metrics define and sustain priorities in official documents, from a self-declared neutral and universal position (Adams, 2016).

The circulation of codes that are in alliance with the hierarchical classification imposed by the regime of sexual difference contributes to the reproduction of patterns that subordinate women in the universe of health, including the dimensions of education, research, management and formulation

of public policies. By promoting this set of articulations, policies operate as mechanisms that insert women again in the circuit of heterosexual conjugality, the nuclear family, motherhood, and reproductive sex.

Final considerations

The discourse found in the PNAISM, the RC, and associated documents manifests the ways in which policies make up who is a woman, drawing on classifications and hierarchies. The emerging grammar not only delimits a type, a subject, but also reveals the set of attributes through which public health policies in Brazil have designated women. In this way, we understand that public health policies for women function simultaneously as guardians and manufacturers of sex and gender under the cisheteronormative matrix.

What insists on composing the actions directed to women's health, between one rule and another, reveals what has not been abandoned over time, i.e., what has conquered greater stability in the field of references in which women and health intersect. The reiteration of the primacy of reproductive organs in the definition of measures and of fertility as its organizing axis prevail in the women's health agenda, also influencing the governmental promotion of knowledge production. Thus, it is mainly from her function as a potential breeder that women in health policies can access their citizenship rights.

The deletion of themes such as gender, race, and social inequalities with the promulgation of the RC coexists with an advance of conservatism, which forced a retreat in the guideline of comprehensiveness and in the feminist agenda for women's health. This dynamic unveils the fragile institutionality of policies such as the PNAISM, and also the disputes around the role of women in society, which place sex and gender at its heart.

In addition to the setbacks in the guidelines and scope of policies observed at the beginning of this century, we highlight the loss of expanded popular participation, indicating a weakening of the democratic dimension in the development of public health policies for women. The centralization

of decisions related to sexual and reproductive rights in the government, experienced in the RC, seems to restate the position of women as subjects to be regulated, limiting their access to government technologies and, thus, disfavoring the constitution of new subjects of rights. Such aspects become relevant in face of the current scenario of women's rights recrudescence experienced especially in Brazil.

Research has shown that in the scope of public policies in the 2000s, the conquests of rights in women's health were possible under the natural determination of sex, making explicit the forcefulness of this mechanism as a regulator of citizenship and the possibility of becoming a political subject for those who are under the insignia of woman. Faced with such a composition of assumptions, questions such as: Would it be possible for any health policy to escape from a concentration of efforts and resources on the pregnancy-puerperal cycle or on the dimension of female fertility? Wouldn't this be a limit of the very conception of subject that guides the policies?

The technology of production of female-bodies and male-bodies installs its machinery in the various disciplinary fields that make up Public Health, hiding politics in discourses of science and nature. The citizenship of fertility necessarily excludes many people from coverage of rights, with some being directly ignored - such as transvestites, transsexuals, and prostitutes - and others being poorly accommodated - such as the elderly and lesbians. The implications of the struggles in the field of representational politics indicate the complexity of building a subject of rights within the State, even when this construction is imbued with an emancipatory ideology.

References

- ADAMS, V. Introduction. In: ADAMS, V. (Org.). *Metrics: what counts in global health*. Durham: Duke University Press, 2016. p. 1-17. DOI: 10.1215/9780822374480-001
- AGUIÃO, S. *Fazer-se no "Estado": uma etnografia sobre o processo de constituição dos "LGBT" como sujeitos de direitos no Brasil contemporâneo*. Rio de Janeiro: Eduerj, 2018.

- BANDEIRA, L.; ALMEIDA, T. A transversalidade de gênero nas políticas públicas. *Revista do CEAM*, Brasília, DF, v. 2, n. 1, p. 35-46, 2013.
- BARROS, A.; VICTORA, C.; WEHRMEISTER, F. (Org.). *Desigualdades em saúde materno-infantil no Brasil: 20 anos de progresso*. Pelotas: UFPel, 2019.
- BRASIL. Ministério da Saúde. *Política Nacional de Atenção Integral à Saúde da Mulher: princípios e diretrizes*. Brasília, DF: Ministério da Saúde, 2004a.
- BRASIL. Ministério da Saúde. *Política nacional de atenção integral à saúde da mulher: plano de ação 2004-2007*. Brasília, DF: Ministério da Saúde, 2004b.
- BRASIL. Ministério da Saúde. *Relatório de Gestão 2005 do Departamento de Ciência e Tecnologia (Decit)*. Brasília, DF: Ministério da Saúde, 2007.
- BRASIL. Ministério da Saúde. *Portaria nº 1.459 de 24 de junho de 2011*. Institui, no âmbito do Sistema Único de Saúde - SUS - a Rede Cegonha. Brasília, DF: Ministério da Saúde, 2011a.
- BRASIL. Ministério da Saúde. *Manual prático para implementação da Rede Cegonha*. Brasília, DF: Ministério da Saúde, 2011b. Disponível em: <http://saude.mppr.mp.br/arquivos/File/kit_atencao_perinatal/rede_cegonha/manual_pratico_rede_cegonha.pdf>. Acesso em: 10 mar. 2020.
- BRASIL. Ministério da Saúde. *Pesquisas estratégicas para o sistema de saúde - PESS*. Brasília, DF: Ministério da Saúde, 2011c.
- BRASIL. Ministério da Saúde. *Cadernos HumanizaSUS: humanização do parto e do nascimento*. V. 4. Brasília, DF: Ministério da Saúde; Itaperi: Universidade Estadual do Ceará, 2014.
- BRASIL. Ministério da Saúde. *Simpósio Internacional de Redes de Atenção Integral à Saúde da Mulher e da Criança/Rede Cegonha*. Brasília, DF: Ministério da Saúde, 2015.
- CARNEIRO, S. Mulheres em movimento. *Estudos Avançados*, São Paulo, v. 17, n. 49, p. 117-133, 2003.
- CARVALHO, L. *Da esterilização ao Zika: interseccionalidade e transnacionalismo nas políticas de saúde para as mulheres*. 2017. 212 f. Tese (Doutorado em Ciência Política) - Faculdade de Filosofia, Letras e Ciências Humanas, Universidade de São Paulo, São Paulo, 2017.
- CASTILHOS, C. “Senhora presidenta, ouça as mulheres”. *Viomundo*, [S.l.], 2 abr. 2011. Política.
- CASTRO, M. *A integralidade como aposta: etnografia de uma política pública no ministério da saúde*. 2012. 344 f. Tese (Doutorado em Antropologia) - Departamento de Antropologia, Universidade de Brasília, Brasília, DF, 2012.
- ATENÇÃO Integral à Saúde da Mulher ficou fragilizada. *Jornal Fêmea*, ano XIV, n. 171, Brasília, DF, out. 2011.
- EDITORIAL - As causas feministas e o Plano Nacional de Políticas Públicas para as Mulheres. *Jornal Fêmea*, ano XIII, n. 140, Brasília, DF, jan. 2005.
- CNMB-PPF - CONFERÊNCIA NACIONAL DE MULHERES BRASILEIRAS. Plataforma política feminista. Brasília, DF, 6 a 7 de junho de 2002.
- CONCEIÇÃO, H. R. M. *As mulheres nas políticas públicas de saúde dos anos 2000: tecnologias de produção do sexo e do gênero no imbricamento entre Estado e movimentos sociais*. 2021. 361 f. Tese (Doutorado em Saúde Pública) - Faculdade de Saúde Pública, Universidade de São Paulo, São Paulo, 2021.
- COSTA, A. M. *Saúde integral da mulher: quo vadis 30 anos depois? Cebes*, Rio de Janeiro, 7 mar. 2013. Opiniões.
- DINIZ, C. et al. Disrespect and abuse in childbirth in Brazil: social activism, public policies and providers’ training. *Reproductive Health Matters*, London, v. 26, n. 53, p. 19-35, 2018. DOI: 10.1080/09688080.2018.1502019
- FERREIRA, L.; LOWENKRON, L. Encontros etnográficos com papéis e outros registros burocráticos. In: FERREIRA, L.; LOWENKRON, L. (Org.). *Etnografia de documentos: pesquisas antropológicas entre papéis, carimbos e burocracias*. Rio de Janeiro: E-papers, 2020.
- FOUCAULT, M. *História da sexualidade I: a vontade de saber*. 13. ed. Rio de Janeiro: Graal, 1988.
- FOUCAULT, M. *Arqueologia do saber*. Rio de Janeiro: Forense Universitária, 1997.

- KOSELLECK, R. Uma história dos conceitos: problemas teóricos e práticos. *Estudos Históricos*, Rio de Janeiro, v. 5, n. 10, p. 134-146, 1992.
- LAQUEUR, T. *Inventando o sexo - corpo e gênero dos gregos a Freud*. Rio de Janeiro: Relume Dumará, 2001.
- MARTIN, E. *A mulher no corpo: uma análise cultural da reprodução*. Rio de Janeiro: Garamond, 2006.
- NEGRÃO, T. *Rede Feminista de Saúde alerta: a Rede Cegonha é retrocesso de 30 anos*. Entrevista: Lemes, C. [S. l.]: Viomundo, 2011.
- PITANGUY, J.; BARSTED, L. Um instrumento de conhecimento e de atuação política. In: BARSTED, L.; PITANGUY, J. (Org.). *O Progresso das Mulheres no Brasil 2003-2010*. Rio de Janeiro: CEPIA; Brasília, DF: ONU Mulheres, 2011. p. 15-19.
- PRECIADO, B. Multidões queer: notas para uma política dos “anormais”. *Revista Estudos Feministas*, Florianópolis, v. 19, n. 1, p. 11-20, 2011.
- PRECIADO, P. B. *Manifesto Contrasssexual: práticas subversivas de identidade sexual*. São Paulo: n-1, 2017.
- PRECIADO, P. B. *Texto Junkie*. São Paulo: n-1, 2018.
- RATTNER, D et al. ReHuNa - a Rede pela Humanização do Parto e Nascimento. *Tempus: Actas de Saúde Coletiva*, Brasília, DF, v. 4, n. 4, p. 215-228, 2010. DOI: 10.18569/tempus.v4i4.849
- ROBLES, A. La “police amie des mères” : nouvelles modalités de la régulation sanitaire au Brésil contemporain. *Sociologie*, Paris, v. 4, n. 1, p. 63-79, 2013.
- SILVA, C. *Feminismo popular e lutas antissistêmicas*. Recife: Edições SOS Corpo, 2016.
- SOUZA LIMA, A.; CASTRO, J. Notas para uma abordagem antropológica da(s) política(s) pública(s). *Antropológicas*, Recife, v. 26, n. 2, p. 17-54, 2015.
- VIANNA, A. Etnografando documentos: uma antropóloga em meio a processos judiciais. In: CASTILHO, S. et. Al. (Org.). *Antropologia das práticas de poder: reflexões etnográficas entre burocratas, elites e corporações*. Rio de Janeiro: Contra Capa, 2014. p. 43-70.
- VIANNA, A.; LACERDA, P. (Org.). *Direitos e políticas sexuais no Brasil: mapeamento e diagnóstico*. Rio de Janeiro: CEPESC, 2004.
- VILLELA, W.; MONTEIRO, S. Atenção à saúde das mulheres: historicizando conceitos e práticas. In: VILLELA, W.; MONTEIRO, S. (Org.). *Gênero e Saúde: Programa Saúde da Família em questão*. São Paulo: Abrasco; UNFPA, 2005.
- WERNECK, J. “O governo Dilma está chocando o ovo da serpente”. Viomundo, [S.l.], 10 fev. 2012. Em Pauta.

Authors' contribution

Rosa was responsible for the data analysis and the text production. Cabral contributed to the design of the article and the critical review of its content. Both authors approved the final version of the manuscript.

Received: 10/11/2022
Resubmitted: 10/11/2022
Approved: 11/23/2022