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Gender between judgements of rights and deservingness: framings about reproductive health on the frontline of public services

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This article analyzes the connection between framings on gender and reproductive health issues and the narratives operated by frontline workers in public services, seeking to answer the questions: how do framings on gender and reproductive health appear in the work context of these actors? To what extent do implementing agents' narratives reproduce or confront these frameworks? We selected a case of implementation of reproductive health care in a policy in which there is close and recurrent contact between agents and users. Methodologically, the research was constructed by i) mapping of the main framings on reproductive health and ii) semi-structured interviews with 32 frontline agentes of the Family Health Strategy (doctors, nursing professionals, community health workers and multidisciplinary professionals). The frameworks mapped were: natalism; population control; maternal and child health; comprehensive care for women's health; individual rights; individual and social rights. The results show that these repertoires are present among agents, but they are not exclusive or presented linearly and navigate between judgments based on rights and judgments based on deservingness. These are predominant and blame women for deviating from social expectations of gender. The work contributes to studies that connect the street level with broader sociological issues, by demonstrating the reasonings present in the front line of the State on gender and reproductive health and how they are operated.
Keywords: frontline work; judgements; framing; gender; reproductive health issues.

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Gênero entre julgamentos de direitos e merecimento: enquadramentos sobre saúde reprodutiva na linha de frente dos serviços públicos

Este artigo analisa a conexão entre os enquadramentos sobre as questões de gênero e saúde reprodutiva e as narrativas operadas pelas trabalhadoras da linha de frente de serviços públicos, buscando responder às questões: como enquadramentos sobre gênero e saúde reprodutiva aparecem no contexto de trabalho desses atores? Em que medida as narrativas de agentes de implementação reproduzem ou confrontam esses enquadramentos? Selecionamos um caso de implementação da atenção à saúde reprodutiva em uma política em que há contato próximo e recorrente de agentes com usuários. Metodologicamente, a pesquisa foi construída por i) levantamento dos principais repertórios socialmente disponíveis (enquadramentos) sobre saúde reprodutiva e ii) entrevistas semiestruturadas com 32 agentes da linha de frente da Estratégia de Saúde da Família (médicas, profissionais de enfermagem, agentes comunitárias de saúde e profissionais multidisciplinares). Os enquadramentos mapeados foram: natalismo; controle populacional; saúde materno-infantil; atenção integral à saúde da mulher; direitos individuais; direitos individuais e sociais. Os resultados mostram que esses repertórios estão presentes entre as agentes, mas não são exclusivos ou apresentados linearmente, e navegam entre julgamentos fundados em direitos e julgamentos fundados em merecimento. Estes são predominantes e culpabilizam mulheres por desviar de expectativas sociais de gênero. O trabalho contribui com os estudos que conectam o nível de rua com questões sociológicas mais amplas, ao demonstrar quais são e como são operadas as racionalidades presentes na linha de frente do Estado sobre gênero e saúde reprodutiva.
Palavras-chave: trabalho da linha de frente; julgamentos; enquadramentos; gênero; saúde reprodutiva.

Género entre juicios de derechos y merecimiento: encuadres sobre salud reproductiva en primera línea de los servicios públicos

Este artículo analiza la conexión entre los encuadres sobre cuestiones de género y salud reproductiva y las narrativas operadas por trabajadores de primera línea en los servicios públicos, buscando responder las preguntas: ¿cómo aparecen los encuadres sobre género y salud reproductiva en el contexto de trabajo de estos actores? ¿En qué medida las narrativas de los agentes implementadores reproducen o confrontan estos marcos? Seleccionamos un caso de implementación de la atención a la salud reproductiva en una política en la que existe un contacto cercano y recurrente entre agentess y usuarios. Metodológicamente, la investigación fue construida por i) levantamiento de los principales repertorios socialmente disponibles sobre salud reproductiva y ii) entrevistas semiestructuradas con 32 agentes de primera línea de la Estrategia Salud de la Familia (médicas, profesionales de enfermería, agentes comunitarias de salud y profesionales multidisciplinarias). Los marcos mapeados fueron: natalismo; control de la población; Salud maternal e infantil; atención integral a la salud de la mujer; derechos individuales; derechos individuales y sociales. Los resultados muestran que estos repertorios están presentes entre los agentes, pero no son exclusivos ni presentados linealmente y navegan entre juicios de derecho y juicios de mérito. Estos son predominantes y culpan a las mujeres por desviarse de las expectativas sociales de género. El trabajo contribuye a estudios que conectan el plano de la calle con cuestiones sociológicas más amplias, al demostrar qué son y cómo se operan las racionalidades presentes en la primera línea del Estado sobre género y salud reproductiva.
Palabras clave: trabajo de primera línea; juicios; encuadres; género; salud reproductiva.

1. INTRODUTION

Part of the field of public policy analysis has been dedicated to studying how values and discourses are linked in policy formulation (Stone, 2012; Yanow, 2015). One of the central debates in this approach concerns framing: that is, how political actors socially portray what constitutes problems and public policy issues, in order to suggest potential solutions and seek to implement them within institutional spaces (Marcondes & Farah, 2022; Rein & Schön, 1996).

The discussion on beliefs, values, ideas, and preferences, however, is not limited to the macro-level, or only to the policy formulation phase. Considering the highly interactive and transformative nature of the implementation phase (Faria, 2012; Lotta, 2018), and the central role played by frontline workers (Brodkin, 2015; Lipsky, 2010), some of the literature has been dedicated to understanding how these elements influence practices (Epp et al., 2017; Harrits & Møller, 2014; Kern & Holbein,

2021; Lotta & Pires, 2020; Maynard-Moody & Musheno, 2022; Møller, 2009; Møller & Harrits, 2013; Pfaff et al., 2021).

In this article, we propose an approach that connects the literature on framing and implementation in order to understand how socially available frames resonate with frontline workers of public services. This proposal is justified because these agents are the face of the State that is most visible to citizens, since they are the ones responsible for implementing public policy on a daily basis (Dubois, 1999; Lipsky, 2010). In this task, they exercise discretion when interpreting the situations they are presented with and proposing outcomes and courses of action for them (Hupe, 2013; Lipsky, 2010; Molander et al., 2012; Wallander & Molander, 2014)

But this does not always result in fair and impartial treatment. Discretion is influenced by various factors (Lotta, 2018), and exercising it may be the result of the behavioral responses of frontline workers to organizational stimuli and constraints (Brodkin, 2015; Lipsky, 2010), or influences that result from the social and cultural integration of frontline workers (Dubois, 1999; Maynard-Moody & Musheno, 2022). In short, inequalities in implementation are not limited to the potential effects of discretionary action, but constitute the decision, insofar as the repertoires that socially reproduce inequalities can inform the exercise of discretion (Lotta & Pires, 2019; Pires, 2019).

It is important, therefore, to understand the reasoning of frontline agents with regard to those social issues that involve inequalities, since this logic guides their practices, which potentially (re)produce unequal treatment. Judgments are mental frames that agents navigate around, taking into account the various social and organizational influences to which they are exposed. They do so in order to construct and justify their discretionary decisions, which are always expressed as a type of reasoning (Maynard-Moody & Musheno, 2022; Molander et al., 2012; Møller, 2022; Wallander & Molander, 2014). Judgments can be based on rights (in other words, who has the right to receive what), or on deservingness (i.e., who deserves to receive what based on a moral assessment by the agents in relation to the people they serve) (Maynard-Moody & Musheno, 2022; Møller, 2009).

In this text, we will specifically address gender inequality, which is a structural issue that has been receiving increasing attention in the field of public policy analysis (Farah, 2004), including analyses of gender framing, but is still little studied in works dealing with frontline workers (Durose & Lowndes, 2024; Marcondes et al., 2018; Marcondes & Farah, 2022; Rasmussen, 2011). The justification for this study is a concern with regard to the (re)production of gender inequality in the implementation of public policies.

The case we analyzed deals with reproductive health care in the implementation of the Family Health Strategy (*ESF*), a program in which there is close and recurrent contact between agents and patients. In reproductive health, the main areas of action of the *ESF* are contraception, the control of sexually transmitted infections (STIs), and prenatal care. The case is suitable for discussion because it addresses reproduction, which is a central theme in the debate on gender. It also deals with the Unified Health System (*SUS*), which covers about 70% of the Brazilian population and is fundamental when it comes to poor and black women having access to reproductive health (Berquó & Lago, 2016; Olsen et al., 2018)white and black women accounted respectively for 40% and 54% of the total sample. Health care during pregnancy and child bearing were assessed by six indicators: attendance to at least one antenatal care visit, having attended to at least six antenatal care visits, attendance to at least one health care visit after child bearing, type of delivery, having received pain relief during a vaginal birth and having someone (relative or friend.

The objective of this article, therefore, is to analyze the connection between the frames of gender and reproductive health issues that are present in society and public debate, and the discourse and practices adopted by frontline workers of the public services. Our main questions are: *How do these discourses appear in the work context of these actors?,* and *How and to what extent do the narratives of implementing agents reproduce or challenge these broader frames?*

Our main effort is to demonstrate which rationales about gender and reproductive health inform the State's actions when it comes to implementing public policies, and how they do so. We start from the idea that macro-issues can be detected by an analysis that is carried out at the micro-sociological level (Dubois, 1999). To this end, we undertook: i) a survey of the main frames of reproductive health by analyzing documents and publications on the subject; and ii) semi-structured interviews with implementing agents of the Family Health Strategy (ESF) in São Paulo: physicians, nursing professionals, Community Health Workers (ACS), and members of the multidisciplinary teams of a Family Health Support Center (NASF).

The study is original in that it addresses the issue of gender when implementing public policies, and contributes, first and foremost, by offering an empirical map of judgments on the subject at the front line of public services. The analysis also showed that frontline agents make judgements based on rights and judgements based on deservingness that largely echo the frames on gender and reproductive health that we mapped. Like other analyses, therefore, the article shows that frontline workers make judgments that reproduce existing inequalities.

But judgments do not occur in a delimited and coherent way, as rhetorical frames do. Agents navigate between judgments of rights and deservingness; that is, the same agents who argue in defense of the rights of choice and freedom condemn women because of the number of children they have, or the number of partnerships they have been involved in, and other aspects. This reveals the coexistence of the perspectives to which agents are exposed socially and organizationally, and which can influence their discretionary decisions. This work is an advance in that it identifies that these agents are not driven exclusively by one type of reasoning in (re)producing inequalities. The theoretical lenses of framing help throw light on how these ideas are presented and intricately linked on the front line, as practical frames are.

2. IDEAS, BELIEFS AND PERCEPTIONS IN THE FORMULATION AND AT THE FRONTLINES

Starting from a critique of the rational model of decision-making in public policies, some literature has argued that "facts" and "absolute truths" are contestable, and that the power of persuasion and the ability to shape discourse are important as interested groups construct and communicate meanings in public debate (Yanow, 2015). In this process, the identification and definition of issues and problems become central: this is not just a reflection of lived experiences, but of social and political constructions (Stone, 2012; Yanow, 2015).

These constructions are cognitive and classificatory, that is, they need to be "framed" by political actors. Frames are belief, perception, and appreciation structures that can be tacit, implicit, and intentionally advocated (Rein & Schön, 1996). They are part of the human experience, insofar as they serve to organize and select how we perceive the world and, thus, make it intelligible and explicable.

Frames typically originate from broader institutional or metacultural frames, and it is important to understand them in rhetorical terms (rhetoric framing), that is, in an ideal and coherent format;

and in practical terms (action framing), which derives from concrete situations of practice in public policies: for this reason, they are more opaque, diffuse, and mixed (Rein & Schön, 1996). In other words, to understand or shape a particular situation, there are often several possible frames that conflict or complement each other.

Using these concepts, Rasmussen (2011) illustrates the dispute over whether or not to classify contraception as a matter of health care in the United States: including it was defended from the perspective of medical care and gender and class equity; while excluding it was constructed by market interests, and religious or moral agendas. This example shows that an important task is to identify, name, and classify the frames that compete in a given public policy theme in order to understand how they are presented in rhetoric and in practice.

More recently, the debate about perceptions, beliefs, and values has moved beyond understanding just the scope of agenda setting and public policy formulation to analyze also the phenomena that are related to the implementation of these policies. This occurs concomitantly with recognition that implementation is not merely the execution of previously formulated goals and objectives, but a highly interactive process in which decisions are made (Faria, 2012; Lotta, 2018).

Key agents in implementation, frontline workers – or street-level bureaucrats (SLB) – interact directly with citizens and have substantial power in doing their work (Lipsky, 2010). Frontline agents effectively *make* public policies by exercising discretion, which comprises their freedom to act. Discretion is limited and influenced by various individual, organizational, and systemic elements (Hupe, 2013; Lipsky, 2010; Lotta & Santiago, 2017).

Literature has shown that, over and above the commands imposed and incentives offered by official rules, and working and management conditions (Brodkin, 2015), frontline workers use their discretion based on socially and culturally acquired repertoires, as well as their professional knowledge and social conventions (Harrits & Møller, 2011, 2014; Lotta, 2018; Maynard-Moody & Musheno, 2022; Musheno, 2022; Møller, 2009, 2016; Pfaff et al., 2021). Sometimes, these repertoires lead to the (re)production of inequalities (Pires, 2019), because frontline workers are socially embedded agents, and their decisions bear the marks of their social and professional trajectories (Dubois, 1999). In other words, their decisions do not simply lead to social inequality (Brodkin, 2015; Lipsky, 2010), but they themselves are informed – influenced, guided – by the inequalities that exist in society (Lotta & Pires, 2019).

This being so, we highlight a central aspect of the exercise of discretion for this work: the epistemic dimension, which suggests that discretion be understood as a type of reasoning; that is, it will be expressed here and analyzed as a type of reasoning used on the front line (Molander et al., 2012; Wallander & Molander, 2014). Thus, to a greater or lesser extent, frontline workers use rules, personal knowledge, professional knowledge, and social conventions to interpret and make sense of what they encounter in their daily work (Molander et al., 2012; Møller, 2022; Wallander & Molander, 2014). These agents operate by making *judgments* based on these different repertoires, and on the conditions they have for carrying out their work (Maynard-Moody & Musheno, 2022).

An epistemic, judgmental character, therefore, is central to frontline work. Judgments are "frames" or "mental maps" used to navigate the uncertainties and tensions between rules, values, beliefs, and social expectations – and to categorize and value the users of the services (Harrits & Møller, 2011;

Maynard-Moody & Musheno, 2022; Møller, 2009; Pfaff et al., 2021). In this interpretive task, frontline agents can operate by making judgments based on both a logic of "deservingness" and a logic of "rights" (Maynard-Moody & Musheno, 2022; Møller, 2009).

These logics are related to what is considered most, or carries the most weight for the frontline agent when justifying and constructing their discretionary decisions: the formal rules and commands of the public policy they implement, or the moral evaluations they make regarding the identities and behaviors of service users, based on their socially acquired repertoires (Harrits & Møller, 2011; Maynard-Moody & Musheno, 2022; Pfaff et al., 2021). In this sense, depending on the logic used by frontline agents to judge users, the policy that is implemented has the potential to either confront or (re)produce inequalities, and may even move in the opposite direction to that originally intended by the public policy (Pires, 2019).

To the extent that the reasoning of frontline agents can be influenced by different logics, they can be permeated by different elements, such as class stereotypes (Harrits, 2019), racial prejudice (Epp et al., 2017), social conventions about behavior and normality (Harrits & Møller, 2014; Møller & Harrits, 2013; Ziegler & Bozorgmehr, 2024), gender issues (Bisgaard & Pedersen, 2022; Pedersen & Nielsen, 2020) and professional logic (Møller, 2022). In this article we will analyze just one of these processes: gender issues. The literature shows that in frontline work, gender issues generate practices of moral differentiation, and construct social expectations of behavior for men and women (Bisgaard & Pedersen, 2022; Pedersen & Nielsen, 2020; Siblot, 2006a). These traits are socially anchored in double standards for men and women, or in stereotypical behavioral expectations (Bisgaard & Pedersen, 2022; Pedersen & Nielsen, 2020; Siblot, 2006a)

Although some studies have looked at the issue of gender on the front line, this field is still quite nascent and has various gaps (Durose & Lowndes, 2024). The first is a lack of empirical studies that look at understanding how gender issues permeate daily work on the front line. The second is understanding how such issues form the basis of the judgments of frontline workers, and to what extent they are based on professional and public policy standards or on socially structuring patterns.

In this sense, looking at the framing literature in more depth is beneficial, as it helps us understand how broader social issues have repercussions in everyday micro-processes. Mapping competing perspectives is quite common in framing analyses, including on the topic of gender (Marcondes et al., 2018; Marcondes & Farah, 2022; Rasmussen, 2011).

This literature can also help us understand how the judgments of frontline agents are formed, because by comparing them with broader social frames we will understand whether these agents reproduce or contest these views and how they do so. Echoing the notion of rhetorical and practical framing, we can qualify their relationship with these worldviews (complete, partial, ambiguous, coherent, contradictory, etc.) (Rein & Schön, 1996).

3. CONTEXTUALIZING REPRODUCTIVE HEALTH IN THE FAMILY HEALTH STRATEGY

To understand the gender judgments of frontline agents, we chose to analyze reproductive health care in the family health strategy (ESF), a program that is part of primary health care (APS), whose provision is mainly the responsibility of municipalities, although there is both federal regulation and funding. APS focuses on prevention and health promotion in caring for outpatients, and performing low-complexity procedures, in accordance with the guiding principles of universality, equity, and comprehensiveness. Each Basic Health Unit (UBS) – a unit in the network that implement APS – has a defined territorial coverage area. The idea is to promote links between teams and the population in the territory. As the main entry point to the health network, APS should cover most of the population's health problems, refer people for specialist and more complex care (referral), and provide a follow-up after procedures at other levels of care (counter-referral).

According to the National Primary Care Policy (Portaria nº 2.436, de 21 de setembro de 2017), the ESF is a priority for expanding, consolidating, and organizing primary health care and the Unified Health System (SUS). This program seeks to draw together the health policies of the various social contexts in the territory, by having ESF teams actively seek out those who use the system. Each team is responsible for a subdivision of the unit's coverage area considering population density criteria, which, on average, assigns 200 families to each of them.

The team is multidisciplinary and includes at least one physician (a general practitioner who is an ESF physician), a nurse, a nursing assistant or technician, and four to six community health workers (ACS). They all live in the communities where they work and have the most frequent contact with families in the territory. In some primary health care units (UBS), such as those we contacted in this research, there is also an NASF, a multidisciplinary and interdisciplinary team, which is complementary to the ESF, and comprised of different specialists from various areas such as psychology, occupational therapy, physical education, social work, and others.

The focus on reproductive health is one of the various possible areas of care in primary health and ESF in São Paulo. We use the term "reproductive health" to mean the various aspects related to human reproduction and the care that surrounds it. According to the items of Article 3 of Law No. 9263/1996 (Lei nº 9.263, de 12 de janeiro de 1996), this comprises: advice with regard to conception and contraception; prenatal care; assistance with childbirth, the postpartum period, and with the newborn child; the control of sexually transmitted diseases; and the control and prevention of cervical, breast, and penis cancers. In other words, the choice of the reproductive health case is understood here as "crucial" for understanding gender narratives and judgments (Gerring, 2008).

In this work, we primarily studied conception and contraception, the control of STIs, and prenatal care, since care during childbirth typically occurs in a hospital setting. Issues related to cancer prevention appeared infrequently in our field research, and were generally part of broader "women's" and "men's" health initiatives. Narratives about childcare and vaccinating children were also considered, since they involve reproductive rights related to motherhood and fatherhood. Some specific topics were also covered, such as abortion and adoption, which are topics on which primary health care in São Paulo is expected to provide support and guidance.

4. METHODOLOGY

The first part of the research involved analyzing documents and productions from various fields of knowledge – population and demographic studies, feminist authors, human rights, and health – to map some of the frames of reproductive health. The documents we analyzed included laws, protocols, booklets, and guidelines that focus on sexual and reproductive health in primary health care (Appendix A). We chose the production, on the other hand, based on our reading of some of the key articles and chapters on the subject, which led to other important references for understanding the main debates on reproductive health. All the material we analyzed is referenced in the following section, in which we describe the mapped frames.

Document analysis allowed us to contextualize sexual and reproductive health in primary health care, and the room for action of frontline agents in this area. During this process we noted that there are some vague or ambiguous contents in the guidelines; for example, generic commands that do not specify the conduct or those responsible (Matland, 1995). The commands "inform," "guide," and "educate," are very frequent in regulations dealing with contraception, prenatal care, and STI prevention. They do not, however, specify formats and content, but only state that they can be done individually or in groups. Furthermore, they are commonly directed "at teams" or "at any health professional linked to the *SUS*," without specifying who is responsible for each task. This aspect leaves significant margin for agents, using their discretion, to fill in [*according to their own interpretation*] what it means to "inform," "guide," and "educate".

By addressing discussions and reports on the construction of public policies on reproductive health, especially in Brazil, the production we analyzed helped us understand where this vagueness and ambiguity come from. According to these texts, these public policies are the result of the disputes between the following frames: i) population control; ii) religious natalism; iii) feminist struggles for reproductive rights (perspectives on individual rights, and individual and social rights); and iv) health (perspectives on maternal and child health and comprehensive women's health). These expressions are mentioned by the various authors we studied to explain the main disputes and conflicts between the ideas, values, and courses of action advocated – that is, between *frames* – on issues related to sexual and reproductive health.

We carried out the second part of the research in the field by way of semi-structured interviews that were conducted in two primary health care units in different regions in the city of São Paulo, although we draw no comparison between them. One of the primary health care units (UBS A) is located in the central-west region, and has good socioeconomic indicators. The other is located in a district in the far south, where the socioeconomic indicators are very poor. But both have implemented the family health strategy (*ESF*), which means that both have a significant impact on their respective vulnerable populations. We interviewed thirty-two agents, whose characteristics are detailed in Appendix B.

We highlight that, of the people we interviewed, thirty-one were women, and only one was a man. Their racial composition was white (17), black or brown (14) and yellow (1). After authorization from the Research Ethics Committee of the Municipal Health Department of São Paulo (Substantiated Opinion No. 5,372,298), and from the managers of the UBSs, we selected the people to be interviewed. This was based on their availability to participate in the research, and considered the previously established criterion of speaking to people who have different occupations. All interviews were

consented to by way of a Free and Informed Consent Form (TCLE), lasted about an hour, were recorded using a recording app. and transcribed manually.

The method we employed made it possible to access narratives related to their daily work with sexual and reproductive health and the rationales they used related to gender. The questions were designed to encourage experience sharing, that is, situations that had happened to them and were related to the topic. This strategy draws inspiration from other works that use narratives to study bureaucracies and frontline workers (Lotta & Pires, 2020; Maynard-Moody & Musheno, 2022). Working with narratives helps reveal the values, the reasoning employed, and the motivation behind the actions of frontline agents. We thus adopted the perspective of narratives as agency, insofar as they contain claims about how things are and how they should be (Maynard-Moody & Musheno, 2022). The script we used (Appendix C) was based on the authors' experience in other research involving primary health care and street-level bureaucracy, and served as a preliminary field research tool. By adopting a broad approach to the investigation, the script also addressed organizational aspects that are not discussed in this article (Miranda, 2021).

For this analysis, we initially mapped all the content that contains considerations about users of health services, and topics that are relevant in reproductive health. Although our goal was to compare the initially mapped frames with the content of the interviews, we only carried out this comparison in the final stage of coding, so the analysis process was abductive. In short, we used open coding and, after successive groupings, we were able to understand if and how the content of the frontline narratives aligned with the frames (Charmaz, 2006).

We first performed open coding to understand the valuable content that emerged from the agents' words and reflections. The codes resulting from this stage were not limited to describing the content, but to understanding the meaning, and the values conveyed by the agents. This was an interpretive coding strategy, in other words, to understand the imperatives underlying the narrative (Maynard-Moody & Musheno, 2022; Soss, 2015). For example, in a narrative in which the agent disapproves of the attitudes of a teenager who goes to a funk party to meet potential partners with whom to have relations, the coding was "*Judgment – teenagers shouldn't have a sex life*."

Seventy-five judgment subcodes were recorded in total, which we first grouped according to their content. For example, judgments such as "*Women should choose their method of contraception,*" and "*The State should not decide on the criteria for women to undergo tubal ligation*" were grouped under the code "*Judgment – defense of women's choice and autonomy*." There were 13 grouping codes in all. Using an axial coding strategy, we then grouped these codes according to the mapped frames. At this stage, we noted that almost all the frames were present in the agents' words, and that two groups of judgments also had outlines that were different from those we initially mapped. This is when we identified that there were two other broader perspectives on reproductive health, which were added to the frames: *behavior ideal* and *social position*.

Finally, the last coding stage involved analyzing the frames (and emerging perspectives) as judgments of rights or deservingness, in a dialogue with our theoretical lenses that discuss judgments with reference to street-level bureaucracy. The entire coding process is recorded in Appendix D. In the following sections, we present and discuss the results arising from this analysis.

4.1 Bringing frames and judgments together

4.1.1 Reproductive health frames

Our analysis of the documents and production resulted, as mentioned, in four types of frames: religious natalism; population control; reproductive rights; and health, the latter two being subdivided into two, as we will later explain. The first was *natalism*. Historically, religious positions reinforce the ideal of family, which emerged in the modern era, and was traditionally preached by hegemonic Christian groups, particularly by Catholics and Protestants (Baxandall & Gordon, 2005).

Always defending "*the family*," this frame alludes to a traditional family model: heterosexual, monogamous, and procreative. We call it "natalist" because the defense of compulsory motherhood is one of its core arguments. Another important justification is the "*defense of life*," a notion that gained strength in the late 1970s with the rise of conservative governments worldwide, in a reaction to the gains made by women's groups in matters of contraception and abortion in previous decades (Baxandall & Gordon, 2005). Natalist positions are found in both public and legislative debate on contraception and abortion: for example, in the 1987-1988 National Constituent Assembly, which brought us to the current scenario, some rights were recognized, but there are still significant gaps (Ávila, 2019; Barsted, 1992; Pitanguy, 2019; Rocha, 1993).

The second frame we found is that of *population control*, which derives from the debate on population policies. Inspired by neo-Malthusian thought in the aftermath of the Second World War, it translated as pressure being exerted on poor countries to adopt policies to reduce fertility. Such an attitude was justified by the argument that high population growth made the economic development of "underdeveloped" nations unfeasible (Osis, 1994; Rocha, 1993).

Population control framing is frequently eugenic and racist in character, and creates a hierarchy in populations of those that are either capable or incapable of raising their children and developing fully. This was not only directed at poor countries, but also at "incapable" populations within countries (Davis, 2016). Examples of this include the massive interventions resulting in the forced or poorly informed surgical sterilizations of black and migrant women in Brazil and the United States (Ávila, 2019; Barsted, 1992; Davis, 2016). This framing advocates making women individually responsible for family size, as if those who belong to the poorest strata in society had a moral obligation to have fewer children.

For Ávila (2019, p. 165), controlism and natalism are "two sides of the same coin," in the sense that both undermine *women's freedom of choice*, which is another important frame in the debate on reproductive health as part of the sexual and reproductive rights claimed by feminist movements. This framing centers on the demand for voluntary motherhood and the right to sexual abstinence in the first wave of feminism. Another fundamental aspect is the discussions that took place and the proposals that were made in the 1960s and 1970s about alternatives to childbirth and the medicalization of pregnancy, the fight against domestic and sexual violence, and the campaign for reproductive rights, with demands for the right to abortion and contraception in the broadest sense (Baxandall & Gordon, 2005). Framing also involves combating the exaltation of femininity and the struggle for reproductive autonomy, as a way of demanding that women should be able to study, work, and make choices about their own bodies.

One of the criticisms is that the movements around this frame are predominantly white, both in their composition and in their lack of sensitivity to the needs of poor, black, and migrant women (Baxandall & Gordon, 2005; Biroli, 2018; Biroli & Miguel, 2015; hooks, 1984). Unlike compulsory motherhood, they have been the target of eugenic and population control campaigns throughout history (Ávila, 2019; Barsted, 1992).

In addition, for poor and black women, abortion often does not represent an expression of freedom over their own bodies, but a desperate alternative to the lack of social protection and support for motherhood, given their extremely adverse socioeconomic conditions and exposure to violence (Davis, 2016). This is also why young, black women from working-class backgrounds suffer the most from health problems that are the result of unsafe abortions (Lima & Cordeiro, 2020; Ribeiro, 2020).

Generally speaking, the reflections constructed by black feminism about reproductive rights seek to place the issue of women's choice and autonomy within socioeconomic and racial dynamics. In simplifying, therefore, the countless positions of feminist thought and movements, we mapped two main frames for women's rights: one that focuses on the individual dimension of choice and autonomy, with a focus on freedom and the right to one's own body; and another that incorporates the social dimension by considering the impositions of the socioeconomic position and of racism on women's sexual and reproductive health and in demanding "*reproductive justice*."

Finally, we also find the framing of the issue in the area of health, the main axis that informs the discussion on reproduction within the scope of the SUS (Brazilian Unified Health System). A first focus, and one that was predominant in the 20th century, is on actions and interventions for women-mothers, which echo concerns about childhood poverty, and results in health programs for women that have a "*maternal and child*" approach (Osis, 1994). From a critical perspective, this frame refers to a social identity that is built around motherhood, unlike that of men, who are considered for their value as individuals (Osis, 1994). The logic is that women's health only deserves any attention because of their reproductive function.

From the 1960s and 1970s onwards, there was a shift in focus from maternal and child health towards "*comprehensive women's health care*," an approach that stopped focusing exclusively on reproduction, and paid attention to all the possible health problems of women, which may or may not be related to gynecology and obstetrics (Correa, 1993; Osis, 1994). A landmark in this regard was the Comprehensive Women's Health Care Program (PAISM), which was launched in 1983 with the support of women's movements.

BOX 1 MAPPED FRAMES OF REPRODUCTIVE HEALTH

Frame	Summary of the main content
Christian natalism	Compulsory motherhood in defense of "life" and "family,"; against contraception and abortion.
Population control	Ideas based on racism, eugenics, and elitism; some people are less apt to have children than others.
Women's rights	An individual right; the right to freedom, and autonomy over one's own body.
	In addition to aspects of freedom, there is consideration of the differences in the social position of women and reinforcement of the social justice component in the realization of these rights, taking into account, for example, dimensions of race and class.
Health	Maternal and child health: prioritizing the rights and best interests of the child. Viewing the woman-mother as a reproducer and responsible for the child's health.
	Comprehensive Women's Health Care (AISM): integrating reproductive health issues into the broader context of women's health, encompassing not only biomedical aspects but also psychological and social factors.

Source: Research data.

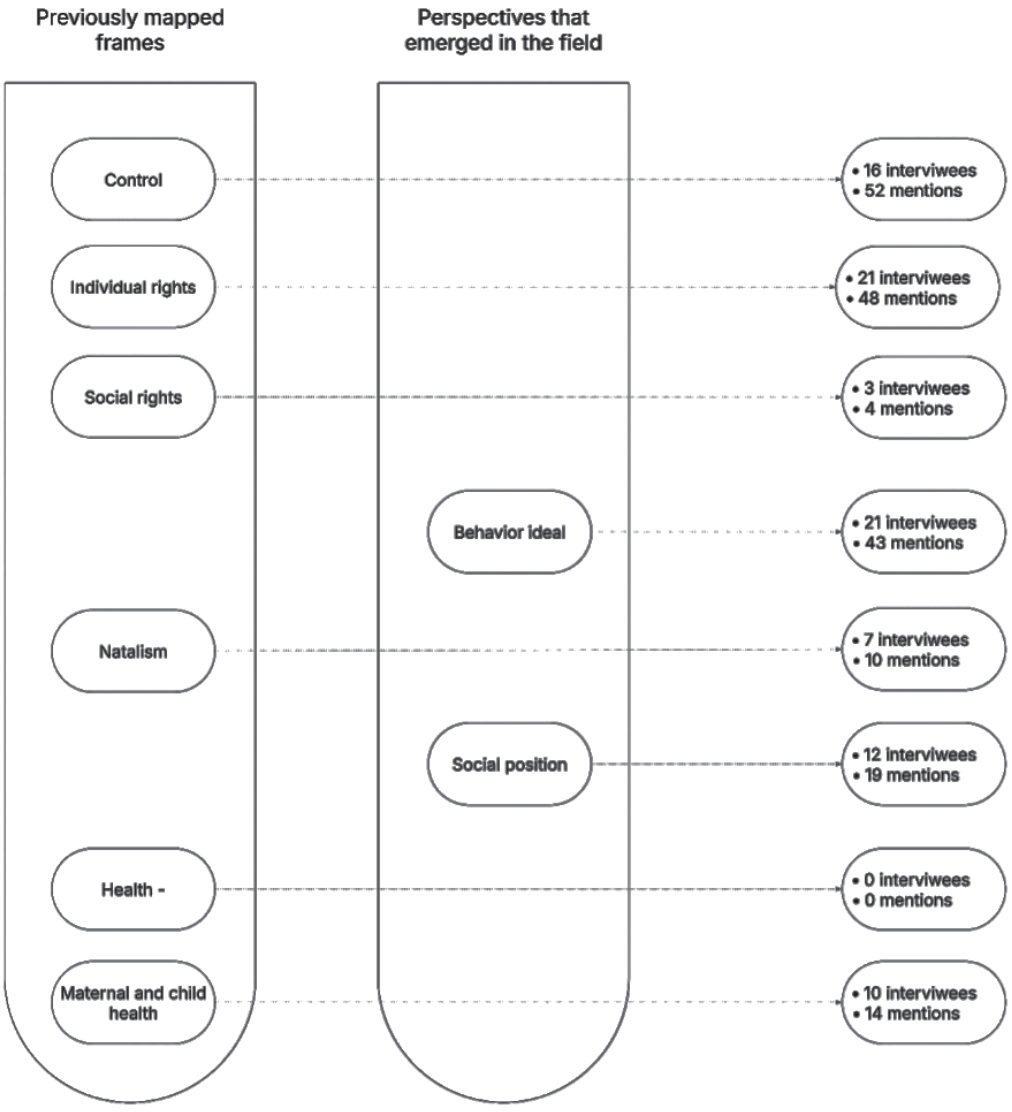
Documentary analysis reveals that laws and public policies directed at reproductive health primarily incorporate the frames of women's rights and health as a result of demands from women's movements worldwide (Barsted, 2001; Baxandall & Gordon, 2005; Pitanguy, 2019), even though they cannot always be considered "gender policies" in the sense of having an explicit commitment to transforming gender relations (Marcondes et al., 2018). Obviously, the rules are not free from negotiation and conflict, and so they express the possible consensus for the different frames being disputed (Ávila, 2019; Barsted, 1992; Matland, 1995; Osis, 1994; Pitanguy, 2019; Rocha, 1993). It is important to highlight the fact that frames are interrelated and often intertwined within a broader discourse (practical frames). Our analysis sought to highlight the core argument (theoretical frames) of each in order to enable mapping and a subsequent comparison with frontline judgments.

4.1.2 Judgements on reproductive health expressed in local narratives

We now present the extent to which, based on our interviews with frontline workers, we see a reproduction of the more general frames that were described earlier. Analysis of the interviews shows that the frames we mapped on reproductive health are present in the judgments of frontline workers, with the exception of those dealing with comprehensive women's health care. This does not mean that comprehensive health care provision is not being offered, since protocols and standards of comprehensive care are put into practice on a daily basis. It reveals, however, that this is not a belief or a value that frontline workers hold as motivation for their practices and in a way that stands out from the rules and protocols.

Other frames were identified among the workers, with a particular emphasis on the large number of mentions by interviewees of the perspectives of control and individual rights. The others appear less frequently. We also recorded two new perspectives, which we highlight separately because they were not foreseen in the framing survey: behavior ideal, –quite frequent – and social position, as shown in Figure 1.

FIGURE 1 INTERVIEWEES AND MENTIONS BY MAPPED FRAMES AND EMERGING PERSPECTIVES



Source: Elaborated by the authors based on data codification using NVivo (2022) software.

The quantities are not intended to be used in any general way and serve only to illustrate the relevance or recurrence of the perspectives. We are primarily interested in discussing their content: *how* they appeared in the field.

In the case of the *control* perspective, the agents seem to believe that some people are more suited to motherhood than others. The main areas of unsuitability are adolescence and poverty. Regarding the former, the predominant view is one of generalized irresponsibility and the need for guardianship and using specific contraceptives – such as the quarterly injection, or *Implanon* –, or parents limiting the sexual life of teenagers. Regarding the latter, agents deplore the "lack of planning" of poor women, especially those who *already have a lot of children,* are *disorganized*, or who only *have children to increase their child benefit payments* (M3B).

> The challenge is for people to become more careful. There are women who have four or five children, are minimally financially literate, and are having more children. So it seems like they don't get it: it's not them who suffer, it's the children. This is the challenge. We schedule an appointment for the person, we fit them into the family planning program, and she just disappears. A little while later she shows up for a pregnancy test. It's positive, and I say: "Do you see? Just look what happened [*because*] you didn't come in (AE2A).

Another focus is on the perspective that emphasizes *social position* as a problem. In this case, the workers articulate the lack of education of patients, especially of women, and supposedly deliberate misinformation – caused by a lack of interest in finding out more about the body and reproduction – and a consequent refusal to continue using the service. Very occasionally, not using the service [*correctly*] is attributed to "wealthy patients" or "pregnant women with health insurance," because they do not value the SUS (Brazilian Public Health System) and its agents.

> They often use it [*contraception*] incorrectly. They go three days without using it, and then say, "Oh, I can keep using it," "Oh, I can take two a day." You know what I mean? Some things that […] a more informed person, with a better level of education, wouldn't have […] because they'd get hold of the package insert and read it. Sometimes we come across some really absurd things (M3B).

> The vaccination room doesn't have any problems, but the patients are mostly those rich patients who come here full of airs. They come with their health plan card and doctor's prescription, and say, "I want this vaccine and the other." Then you look at your calendar and there's a bunch of overdue vaccines and those that you have to give. "No, I don't want to. The pediatrician didn't let me." That really annoys me (AE1A).

Not using the service also appears as an important element of the *maternal-child* perspective. This expresses the view that the women's health service primarily addresses the needs of pregnancy, and criticizes *pregnant women who do not take care of themselves,* especially pregnant teenagers, and so harm their children. An example of this is the statement of a community health worker (ACS), who was shocked by the fact that a pregnant woman wanted to give her child up for adoption and was not receiving prenatal care in line with the service guidelines:

> I think she was a patient who had some kind of mental disorder; she was bipolar, or something like that. She hadn't been diagnosed, because she didn't consider herself that way, but every time I visited her she always contradicted herself. And then she got pregnant [...] and didn't start her prenatal care. I monitored her as a pregnant woman, but she didn't register for prenatal care.

> She didn't do anything right; she did everything that was not normal. I used to see her and ask her if she was having tests and things, but she was very evasive, and didn't give straight answers [...] and she never showed any affection or wish for me to see her and help her. I think she had a few ultrasounds at the request of the family that was going to adopt the child, but she didn't talk to me about the baby. She had no love for it. She didn't want it at all. I tried to talk to her, I said: "Look, it's important for you to have prenatal care, even if you don't want to - because the child has nothing to do with it - so that the child is born healthy. And what are you going to do with it if you don't want it? I believe that however much you don't want to… you had ways of preventing it, but since it happened, and if you want to give it away, it's better that you give it to someone who'll take care of it than you mistreat it. So make a proper plan. Have prenatal care." But she didn't… She said some things [...].That was the most unusual case, because never, in the six years I've been working, had anyone ever wanted an abortion. In fact, everyone was always happy to know they were pregnant because it was something they wanted. But hers was the most astonishing case I ever had (ACS3B).

Regarding the *pro-natalist* perspective, the main focus is on condemning – either expressly or by implication – abortions that they were aware of, or believe had been induced.

> One of my patients was very frank with me. She said, "I think I'm pregnant." And she already has two daughters from her first marriage. And she said, "I'm going to abort this child because I don't want to have it. I didn't want to get pregnant and I'm going to abort this child." Then we did a really good job with this girl. We explained everything that could happen to her. We also explained that the child had nothing to do with it, because she could have prevented getting pregnant because we've got several forms of prevention here. If she doesn't want to use protection, or if her partner doesn't want to use a condom, we've got female condoms. We've got them here at the health center. They don't need to worry. "Oh, I don't have money to buy condoms," but we've got them here. "I don't have the money to buy the pill," but we've got it here. She could have done family planning, but she didn't want to (ACS1B).

At this point, a related and quite recurrent perspective is that which conveys an *ideal of appropriate behaviors* for women and girls, especially with regard to leisure, the number of partners they have throughout life, and also the role of caregivers or those solely responsible for contraception and prevention.

> But I think that one of the problems today is these pregnant women who end up not getting the proper prenatal care, even with the whole team keeping on at them; the agents, the assistants, the nurses, the doctors, everyone who's looking after them. With some of them, but not all, it's even sometimes a bit related to drugs. Unfortunately, they sometimes go to a funk party and that's when it happens [...] some of the mothers get pregnant there. And I don't know if they don't accept the pregnancy, or they didn't want it, but they also didn't use contraception, did they? Because many of them say: "Oh, I'm not going to use a condom," but then they have more than one partner (ACS 1B).

We distinguish this frame from the natalist one because, although both relate to the roles expected of each gender, the expectations of natalism are related to family structure and the "defense of life,"

which mainly translates into an accusation that women have no right to choose regarding the question of motherhood. In the case of the behavior ideal, expectations relate to the female role in caring for children and their responsibility with regard to contraception and preventing STIs. In this sense, many of the narratives blame women and girls for becoming pregnant and contracting a disease, and do not consider the men's responsibility and the limitations of public prevention policies, as emphasized in the words of a nurse:

> I think that [...] that's the biggest difference between us. I think that's it. I've always had this paranoia about "No, I can't get pregnant. I'll always take care of myself, I don't want to get pregnant, I just don't want to." It's something I keep thinking about: "Wow, how can people not take care of themselves? Everyone knows how it happens. How could it have been unintentional? How could they not have taken care of themselves? Don't they know that having sex without a condom will lead to pregnancy?" You know what I mean? So I see myself as different in that respect, which is something I've always worried about (E1A).

Finally, we also identified narratives in the field that express *adherence to women's rights,* as exemplified in the following:

> There's one thing I think should be emphasized more in relation to this; we see a lot about women, but not so much about men. As if only the woman's body is responsible for getting pregnant, or for looking after the child after she's had it, or for sexually transmitted diseases. They're still stigmatized in this regard. I think we should also raise the men's flag; [*we have to*] break this sexist taboo (ACS2A).

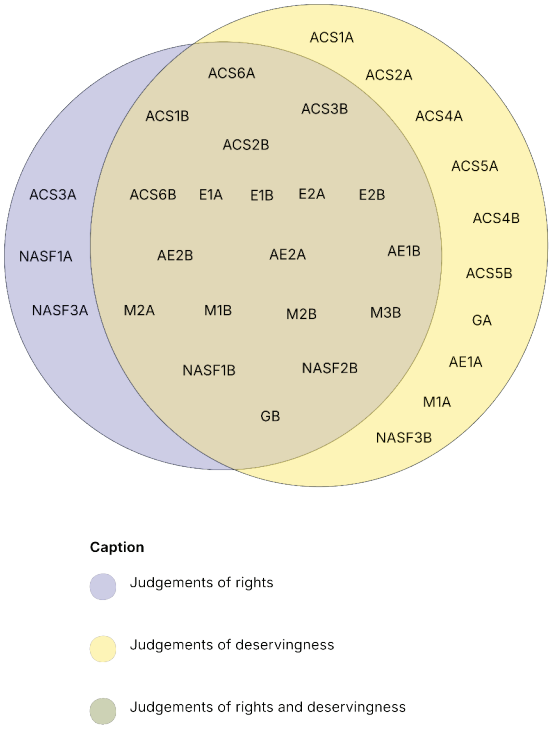
But the words about the *individual perspective* – which primarily focus on women's autonomy and freedom of choice, and also include gender equality within families and denouncing social and religious taboos – were far more frequent than narratives that put women's *socioeconomic needs* at the center. At this point, it is important to emphasize that the interviews did not map perspectives that take into account the women's racial profile.

4.2 Navigating between judging rights and judging deservingness

The broader social notions about gender and reproductive health were, for the most part, identified in the judgments of the *ESF* agents, albeit with varying incidence; that is, rhetorical framings echo and are reproduced in the daily practice of providing reproductive health care.

If we divide the frames between perspectives that are either more or less committed to rights – that is, judgments based on rights or judgments based on repertoires of deservingness (Maynard-Moody & Musheno, 2022; Møller, 2009) – we have, on the one hand, individual rights, social rights and *comprehensive women's health care*, and on the other, control, natalism, ideal gender behaviors, and maternal and child health. As can be seen from the diagram below, most of the interviewees mentioned both types of judgment: three interviewees make judgements based on rights; ten make exclusively based on deservingness and 19 mentioned both types of judgment.

FIGURE 2 JUDGING RIGHTS AND JUDGING DESERVINGNESS DIAGRAM



Source: Elaborated by the authors based on data organized using NVivo (2022) software.

The number of interviews we conducted does not allow for more detailed comparisons regarding the differences in judgment by occupation and profession of those we interviewed, and neither was this the objective of the research. Nevertheless, in Box 2 we list the number of interviews we conducted with agents from each occupation and their types of judgment. We would point out that around half of the community health agents (ACS), assistants, and nurses are black or brown. Physicians, members of the family health support center (NASF) team, and managers are all white.

BOX 2 TYPES OF JUDGMENT BY INTERVIEWEE OCCUPATION

OCCUPATION	INTERVIEWEE	JUDGMENT OF DESERVINGNESS	BOTH	JUDGMENT OF RIGHTS
ACS	12	6	5	1
Physician	5	1	4	0
Nasf	5	1	2	2
Nurse	4	0	4	0
Nursing assistant (technician)	4	1	3	0
Manager	2	1	1	0

Source: Research data.

Many of the judgments we recorded were triggered when agents were recounting stories about patients they care for, which draws attention to the fact that these are action-oriented values (Maynard-Moody & Musheno, 2022). Unlike practical framing, this is not an action in the institutional field of formulating public policy rules and commands. The action, in these cases, is immediate and, as we have warned, has the potential to reinforce gender, race, and class inequalities (Biroli, 2018; Lima & Cordeiro, 2020; Ribeiro, 2020).

From the point of view of combating or (re)producing inequalities, we would point out that most of the agents refer to judgments based on rights. This is indicative of the fact that repertoires consistent with commitments to equity in the *SUS* are not restricted to regulations and are, to some extent, the basis of the discretionary action of *ESF* agents. Three agents, in fact, exclusively formulate judgments of rights, but these judgments are primarily centered on a perspective of individual rights, which is important, but does not encompass issues of race and class, which are important themes for understanding and combating gender inequalities (Biroli, 2018; Lima & Cordeiro, 2020; Ribeiro, 2020). In other words, perspectives that take women's rights into account are not marked by an intersectional approach on the front line of public services.

When judgments that take into account the socioeconomic dimension appear, they categorize women as undeserving. In particular, they condemn women's choice or ability to be mothers due to a lack of money (e.g., *judgment – poor women shouldn't have a lot of children*). At this point, we highlight how, within the scope of moral narratives and the identification of problems, individual accountability is central, as typically discussed in the literature on the reproduction of inequalities on the front line(Harrits & Møller, 2014; Møller & Harrits, 2013; Pfaff et al., 2021). Patient-users are frequently identified as the cause of the problem or of the demands the agents face, which stem primarily from the women's social origins and because of disapproval of their behavior (Lotta & Pires, 2020; Pfaff et al., 2021).

In the context of gender and reproductive health, this has to do with blaming women for behaviors that deviate from societal expectations regarding their choice to become mothers or not, the ideals of family and motherhood, and gender norms of behavior (Bisgaard & Pedersen, 2022; Pedersen & Nielsen, 2020)". The agents we interviewed categorize the women they attend based on the behaviors they perceive as immoral and inappropriate. Siblot (2006a, 2006b) condemns their resistance to service, irresponsibility, and lack of planning. Their judgments frequently simplify the "types" of women, and reduce all their characteristics to the negative stereotypes surrounding teenagers, mothers who change partners, poor women who have a lot of children, etc. This simplification exercise is based on reproductive health and gender frames (Harrits, 2019; Rasmussen, 2011).

Our results, therefore, reinforce the findings in the literature that frontline agents reproduce inequalities when they make judgments about the deservingness of people who use the services (Lotta & Pires, 2020; Møller, 2009; Pfaff et al., 2021). The study makes advances, however, because it relates these judgments to broader gender and reproductive health frames. It also offers something new when it emphasizes the intricate nature of the judgments of rights and deservingness. As with the practical dimension of these frames (Rein & Schön, 1996), we found most of the judgments were not coherent and well-defined, but quite intertwined, overlapping, and ambiguous; that is, the same agents swung between protective judgments and narratives that do not recognize rights.

It follows that judgment processes on the front line are not coherently watertight. They reveal the disputes and multiple influences that reach the agents, and mark the exercise of discretion in

the cognitive dimension (Maynard-Moody & Musheno, 2022; Molander et al., 2012; Møller, 2022; Wallander & Molander, 2014). The competition of judgments reveals that the reproduction of inequalities on the front line is not driven by any strong discourse or convictions that go against women's rights. In fact, when articulating the judgments of rights, agents recognize the existence of inequalities and the need to combat them. However, over and above the fact that this perspective is not sensitized by an intersectional approach, they themselves end up reproducing these inequalities in their judgments and daily practices (Pires, 2019).

5. FINAL CONSIDERATIONS

In this article we have sought to discuss *whether* and *how* framings on gender and reproductive health are *reproduced* or *confronted* by frontline agents of the family health strategy (EISF). Based on the results discussed above, we were able to draw conclusions about the reasoning expressed by the State regarding gender and reproductive health in encounters on the front line of public services, based on the types of judgment made and their characteristics; that is, the content, the way the services operate, and implications for the exercise of discretion.

We first identified that judgments of rights and deservingness occur simultaneously. ESF agents are not unfamiliar with framing based on women's rights. But in addition to moral judgments being more numerous, most judgments of rights are expressed by agents who also make judgments about deservingness. This concurrence of judgments echoes the notion of practical framing and reflects the broader disputes over gender inequalities and reproductive health that occur in day-to-day life on the front line.

In addition to the practical contribution of mapping repertoires on gender on the front line, therefore, the drawing together of theoretical lenses that address ideas, beliefs, and values in public policies at different analytical levels contributes to the debate on frontline agents, by helping us understand the findings regarding the overlaps and conflicts of ideas of the implementing agents.

Regarding the scope of the judgments, we note that the content of those based on rights focuses on the dimension of individual rights and gives little consideration to the racial and socioeconomic aspects that intertwine with gender, which means that the intersectional perspective is missing. Judgments on deservingness, on the other hand, are based on socially shared expectations about women's roles in reproduction, family and care, and sexual behavior.

In view of our concerns about the production and reproduction of inequalities, we draw attention to how deservingness judgments have the potential to include or exclude women, by marking the exercise of discretion and potentially resulting in material and symbolic inequalities.

Although this empirical case deals with health, in which issues involving reproductive health are more salient, our results point to judgments based on socially shared frames. Reflections on combating or reproducing gender inequalities on the front line, therefore, can be drawn from agents in other sectors – or even from other areas of health.

Therefore, this article contributes to efforts to fill the gap on the (re)production of gender inequalities on the front line of public service. Understanding the phenomenon is central to the proper shaping of strategies to combat inequalities and for training frontline agents on issues of gender.

We would point out, however, that this article is somewhat limited in that it does not analyze in any great depth some of the relevant dimensions, such as differences between professions, differences

in agent profiles, and differences between implementation territories. For now, we can say that there are no significant differences in these dimensions when we group together all the judgments of rights and deservingness. Future analyses, however, should pay attention to these issues.

We also draw attention to the "silences", or absences in the narratives during the interviews. Little emerged, either spontaneously or by way of in-depth questioning regarding men in reproductive health care, or the LGBTQIAPN+ population. Future analyses should pay attention, for example, to issues of masculinity and reproductive health and to sexual and reproductive health care for transgender and transvestite groups, such as pregnancy in trans men, hormone therapy processes, follow-up after sex reassignment surgery, etc.

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AVAILABILITY OF DATA

The dataset that supports the results of this study is not publicly available.

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APPENDIX A

BOX 3 LEGISLATION RELATED TO SEXUAL & REPRODUCTIVE HEALTH WITHIN THE CONTEXT OF PRIMARY HEALTHCARE – AT THE FEDERAL LEVEL

	DOCUMENT	DESCRIPTION
LEGISLATION	Law No. 9263, January 12, 1996	Law that regulates Paragraph 7 of Article 226 of the Federal Constitution, which deals with family planning.
	Decree-law No. 2848, December 7, 1940 (Art. 128, Items I and II)	Penal Code. Legal permission for the practice of abortion.
JUDICIAL DECISION WITH THE FORCE OF LAW	ADPF 54 (Federal Supreme Court, 2004)	Abortion in cases of fetal anencephaly.
SUB-LEGAL RULES AND OTHER DIRECTIVES	Ordinance No.48, February 11, 1999	Operating guidelines and oversight mechanisms for the implementation of family planning and surgical sterilization actions by the managing bodies of the Brazilian Unified Health System (SUS).
	Ordinance No. 1555, July 30, 2013	Establishes the rules for financing and implementing the Basic Component of Pharmaceutical Assistance within the scope of the SUS.
	Ordinance No. 2436, September 21, 2017	Approves the National Primary Care Policy, which establishes a revision of the guidelines for the organization of primary care within the scope of the SUS.
	Consolidation Ordinance No. 2, September 28, 2017	Consolidation of rules of the national health policies of the SUS.
	Ordinance No. 2234, July 23, 2018	Establishes the "Agenda for Greater Access, Care, Information and Respect for Women's Health", and provides for the transfer of operating funds to Municipal Health Funds in the 2018 fiscal year, subject to compliance with requirements established in a public call for proposals.
	Ordinance No. 3265, December 1, 017	Amends Appendix XXVIII of Consolidation Ordinance No. 2/GM/MS, of September 28, 2017, which provides for the expansion of access to the TCU 380 Intrauterine Device (copper IUD) within the scope of the SUS.
	National Policy for Comprehensive Women's Healthcare (Ministry of Health, 2004)	General guidelines for women's health care.
	Primary care notebooks: Sexual and reproductive health (Ministry of Health, 2013a)	General guidelines for sexual and reproductive health care in primary care.

(Continue)

	DOCUMENT	DESCRIPTION
SUB-LEGAL RULES AND OTHER DIRECTIVES	Primary care protocols: Women's Health (Ministry of Health, 2016)	Protocols for providing primary healthcare for women.
	Guide for health professionals on Pre-Natal advice for partners (Ministry of Health, 2023)	Guidelines for health professionals on prenatal advice for partners.
	Clinical protocol and therapeutic guidelines for the prevention of vertically transmitted HIV, syphilis and viral hepatitis (Ministry of Health, 2022)	Guidelines on managing women and their sexual partners regarding STIs that have the potential for vertical transmission, with special attention to addressing sexual and reproductive health for those living with HIV. Guidelines on the use of antiretrovirals and other anti-infective agents for preventing and treating STIs, especially syphilis, viral hepatitis (B and C), and HIV infection, in pregnant women and exposed children.
	Men's Health Guide for Community Health Workers (Ministry of Health, 2024)	Guidelines on men's health for community health workers.
	The rapid pregnancy test in primary care: a technical guide (Ministry of Health, 2013b)	Care guidelines in light of the different results of rapid pregnancy tests.
	Low-risk prenatal care – Primary Care Notebook No. 32 (Ministry of Health, 2012)	Guidelines for providing low-risk prenatal care.

Source: Elaborated by the authors.

BOX 4 LEGISLATION RELATED TO SEXUAL & REPRODUCTIVE HEALTH IN THE CONTEXT OF PRIMARY HEALTHCARE – AT THE MUNICIPAL LEVEL

	DOCUMENT	DESCRIPTION
LEGISLATION	Law No. 11,621, July 14, 1994	Establishes the Family Planning Program.
	Law No. 11,821, June 26, 1995	Amends Article 1 and Paragraph 2 of Law No. 11,621, of July 14, 1994.
	Law No. 16,806, January 19, 2018	Establishes a policy for protecting women in vulnerable situations by way of the Public Health Network, using the long-acting reversible contraceptive, etonogestrel, and provides other measures.
	Law No. 13,211, November 13, 2001	Establishes the Program for the Protection of the Health of Pregnant Women and Newborn Infants in the municipality, and other measures.
	Law No. 16,540, August 31, 2016	Establishes the Municipal Policy for Comprehensive Men's Health Care, and other measures.

(Continue)

	DOCUMENT	DESCRIPTION
SUB-LEGAL RULES AND OTHER DIRECTIVES	Decree-law No. 35,867, February 7, 1996	Regulates Law No. 11,621, of July 14, 1994, as amended by Law No. 11,821, of June 26, 1995, which establishes the Family Planning Program.
	Decree-law No. 58,693, April 2, 2019	Regulates Law No. 16,806, of January 19, 2018, which provides for a policy of protection for women in vulnerable situations by the Public Health Network, with the use of the long-acting, reversible contraceptive, etonogestrel.
	Municipal Health System (SMS) Ordinance No. 295, May 17, 2004	Protocol for the provision of reversible contraceptives in the Primary Care Network of the municipality of São Paulo.
	Municipal Health System Ordinance No. 497, March 25, 2006	Guidelines for carrying out the Family Planning Program.
	Municipal Health System Ordinance No. 760, May 4, 2016	Guidelines for prescribing and use of the long-acting reversible contraceptive, a 68 mg etonogestrel subdermal implant, in the SMS service network.
	SMS (Municipal Health System) Protocol	Guidelines for comprehensive sexual and reproductive health care for teenagers using health services in the municipality of São Paulo.
	SMS Protocol	Protocol on hypertensive syndrome in pregnancy.
	SMS Protocol	Sulfate administration protocol.
	SMS Protocol	Protocol of basic prenatal care routines for highly vulnerable pregnant women (the homeless, drug users, immigrants, socially excluded individuals).
	SMS Protocol	Protocol for requesting a morphological ultrasound – Women's Health – SMS-SP, 2016.
	SMS Protocol	Protocol for regulating the provision of barrier contraceptive methods in primary healthcare services in the municipality of São Paulo.
	SMS Protocol	Calcium supplements during pregnancy – WOMEN'S HEALTH – SMS-SP, 2016.
	Prenatal care protocol for routine (low-risk) patients.	Establishes guidelines for routine low-risk prenatal care.
	SMS Ordinance No. 2117, July 22, 2010	Establishes the integration and organization of services for the maternal and child healthcare in the municipality of São Paulo, according to the reference framework of the São Paulo Mother Protection Network.
	SMS Ordinance No. 1187, December 26, 2019	Establishes a new designation for the Health Program for Pregnant Women and Newborn Infants in the municipality of São Paulo, and includes complementary actions to Decree No. 46,966/2006.
	Decree-law No. 46,966, February 2, 2006	Regulates Law No. 13,211, of November 13, 2001, sand structures the São Paulo Mother Protection Network, for managing and operating the network of obstetric and neonatal healthcare services in the municipality of São Paulo.

Source: Elaborated by the authors.

APPENDIX B

BOX 5 PROFILE OF THOSE INTERVIEWED

INTERVIEWEE'S CODE	UBS	GENDER	RACE	AGE	OCCUPATION	EDUCATIONAL BACKGROUND
GUBSA	BHU A	F	White	59	Manager	Nursing
M1UBSA	BHU A	F	White	31	Physician	Medicine
0M02UBSA	BHU A	F	White	28	Physician	Medicine
E1UBSA	BHU A	F	White	39	Nurse	Nursing
E2UBSA	BHU A	F	Yellow	31	Nurse	Nursing
AE1UBSA	BHU A	F	Black	37	Nursing Assistant	Higher education (currently enrolled) – Engineering
AE2UBSA	BHU A	F	White	40	Nursing Assistant	Higher education (currently enrolled) – Nursing
ACS1UBSA	BHU A	F	Brown	30	Community Health Worker - CHW	High school
ACS2UBSA	BHU A	F	White	24	CHW	Higher education (currently enrolled) – Nursing
ACS3UBSA	BHU A	F	White	63	CHW	High school
ACS4UBSA	BHU A	F	Brown	53	CHW	High school
ACS5UBSA	BHU A	F	Brown	55	CHW	High school
ACS6UBSA	BHU A	F	White	58	CHW	High school
NASF1UBSA	BHU A	F	White	40	Psychologist – Family Health Support Center	Psychology
NASF2UBSA	BHU A	F	White	51	Physical Education – Family Health Support Center	Physical Education
NASF3UBSA	BHU A	F	White	50	Social Worker – Family Health Support Center	Social Services
GUBSB	BHU B	F	White	39	Manager	Nursing
M1UBSB	BHU B	F	White	26	Physician	Medicine
M2UBSB	BHU B	F	White	33	Physician	Medicine
M3UBSB	BHU B	M	White	33	Physician	Medicine
E1UBSB	BHU B	F	Brown	37	Nurse	Nursing
E2UBSB	BHU B	F	Black	36	Nurse	Nursing
AE1UBSB	BHU B	F	Brown	31	Nursing Assistant	High school
AE2UBSB	BHU B	F	Black	40	Nursing Assistant	High school
ACS1UBSB	BHU B	F	Black	33	CHW	High school
ACS2UBSB	BHU B	F	White	52	CHW	High school

(Continue)

INTERVIEWEE'S CODE	UBS	GENDER	RACE	AGE	OCCUPATION	EDUCATIONAL BACKGROUND
ACS3UBSB	BHU B	F	White	33	CHW	Higher Education (course not informed)
ACS4UBSB	BHU B	F	Brown	45	CHW	High school
ACS5UBSB	BHU B	F	Brown	25	CHW	High school
ACS6UBSB	BHU B	F	Brown	33	CHW	High school
NASF1UBSB	BHU B	F	White	31	Therapist – Family Health Support Center	Occupational Therapy
NASF2UBSB	BHU B	F	White	34	Nutritionist – Family Health Support Center	Nutrition
NASF3UBSB	BHU B	F	White	36	Social Worker – Family Health Support Center	Social Services

Source: Elaborated by the authors.

APENDIX C

INTERVIEW SCRIPT

The interviewee

- What's your name and how old are you?
- What's your educational background? How did you decide to become a BNR?
- How long have you been working in this Basic Health Unit (BHU)? Is this the first time you've worked in primary care?
- Where do you live?
  - *How close to or far from your work is it?*
  - *Have you always lived in the region?*
- Are you religious? Which religion?
  - *Do you go to a church in the neighborhood where you work?*
- And what about a community association, club, etc.?
- Which race/color do you identify with (white, brown, black, yellow, or indigenous)?

Your work with reproductive health

- Describe your typical workday.
  - *In this works, what do you have to do with family planning, contraception methods, prenatal care, pregnancy, or controlling STIs?*
- Can you tell me what type of care you provide regarding the above?

Potential content to be explored, depending on the above replies:

- *Contraception*
- *IUDs*
- *Condoms (male and female)*
- *Prenatal care*
- *Sterilization (tubal ligation and vasectomy)*

  - *Diaphragms*
  - *Subcutaneous implants*
  - *Family planning meetings*
  - *How does the prenatal card work? Who completes it?*
  - *Birth plan*
  - *STIs*
- What do you normally come across in your day-to-day work when dealing with these matters? What is not normal?
  - *How do you deal with situations like that?*
  - *What type of patient do you see for such matters [Try and explore if the work is directed towards individuals, or families, and if it focuses more on men or women]?*
  - *Do you like them?*
  - *Do you think they are like you or different from you?*
- With regard to these topics, which patients are the easiest and which are the most difficult to care for or deal with?
  - *Why?*
  - *Can you give me an example of a case of an easy patient?*
  - *Can you give me an example of a case of a difficult patient?*
- What is your relationship like with the other services in the network that deal with this subject?
  - *Is there good communication?*
  - *Do you know of any other initiatives in the region whose purpose is to give information about reproductive health (other services, NGOs, schools, etc.)?*
- What are the main problems and challenges you foresee regarding reproductive health?

The work

- What do you like about your work? [*feelings, relationship with colleagues, relationship with the manager and the team, etc.*].
- Does management offer you the support you need so you can do your work in the best possible way?
- Have you always had the material you need to do your work [*talk about resources*]? And specifically with regard to reproductive rights?

- Did you receive any training for working in the Basic Health Unit? What training?
  - *Do you have any specific way of dealing with matters linked to family planning, contraception, prenatal monitoring and preventing STIs*?
- Who do you contact when you have any doubts about the best way of proceeding in your work?
- What is your relationship with work colleagues in the unit like? [*physicians, technical assistants, CHWs, Family Health Support Center teams*].
- Do you think you have the autonomy you need to do your work?
- Regarding the rules relating to your work, do you think there are a lot of rules?
  - *Can you mention any?*
  - *Do you think there are any laws or internal regulations that are unfair or wrong?*
  - *Do you remember the rules about reproductive planning?*

APPENDIX D

BOX 6 CODING SCHEME

	Frame/Perspective	Judgement groups	Open interpretation coding	Interviewees	Mentions
JUDGEMENT OF RIGHTS (21 INTERVIEWEES, 51 MENTIONS)	Individual rights (21 interviewees, 48 mentions)	JUDGEMENT – abortion must be in accordance with the law	Judgment - Women should be able to have abortions in line with legal criteria	2	2
		JUDGEMENT – intrafamily support, sharing care tasks, responsibility for contraception	Judgment – teenagers don't need to get married because they get pregnant or have a child	1	1
			Judgment – teenagers who have the support of the family are more committed	1	1
			Judgment – men should get vasectomies because it's easier than tubal ligation	3	3
			Judgment – men should not abandon their children	1	1
			Judgment – men who resist having a vasectomy or using a condom are male chauvinists	6	6
			Judgment – male partners should participate in the pregnancy and support the pregnant woman	5	6
			Judgment – women are made to bear more responsibility for contraception	3	3

(Continue)

	Frame/Perspective	Judgement groups	Open interpretation coding	Interviewees	Mentions
JUDGEMENT OF RIGHTS (21 INTERVIEWEES, 51 MENTIONS)	Individual rights (21 interviewees, 48 mentions)	JUDGEMENT – defending women's right to choose and their autonomy	Judgment – the husband's authorization criterion for tubal ligation is unfair	1	1
			Judgment – tubal ligation criteria are excessive and make the lives of women difficult	1	1
			Judgment – the State should not decide the criteria for women to undergo tubal ligation	1	1
			Judgment – there are no policies for protecting the choice of having an abortion	1	1
			Judgment – men/husbands/ partners should not prevent women from practicing contraception, or oblige them to	2	3
			Judgment – women should decide the method of contraception they wish to us	1	1
			Judgment – women should choose if they wish to have an abortion, or not	5	5
			Judgment – women should choose if they want to get pregnant, or not	1	1
			Judgment – women should feel able to admit they have had an abortion to professionals	2	3
			Judgment – women are afraid to admit they have had an abortion because it is seen in a bad light by society	1	1

(Continue)

	Frame/Perspective	Judgement groups	Open interpretation coding	Interviewees	Mentions
JULDGEMENT OF SERVINGNESS (27 ENTREVISTADAS, 138 MENÇÕES)	Individual rights (21 interviewees, 48 mentions)	JUDGEMENT – the problem of religion and taboos	Judgment – older people are reluctant to talk about preventing STIs	3	3
			Judgment – religion should not influence parents when it comes to talking about sexual education with teenagers	1	1
			Judgment – taboos about sex prevent teenagers from being open with their mothers	2	3
	Social rights (3 interviewees, 4 mentions)	JUDGEMENT – social justice	Judgment – teenagers need to be paid more attention	1	1
			Judgment – mothers who need to hand over their children for adoption have been neglected by the State	1	1
			Judgment – poor women need a support network	1	1
			Judgment – public authorities do not look after poor and vulnerable women	1	1
	Control (16 interviewees, 52 mentions)	JUDGEMENT – control over sexuality and birth control	Judgment – teenagers shouldn't have a lot of freedom; parents need to control teenagers	1	2
			Judgment – teenagers shouldn't hide their sexual relationships from their parents	2	2
			Judgment – teenagers shouldn't have an active sex life	1	1
			Judgment – teenage girls shouldn't agree to take the pill; it's better for them to have a quarterly injection	1	1
			Judgment – teenage girls who want to get pregnant are unaware of the responsibility [*this entails*]	3	3

(Continue)

	Frame/Perspective	Judgement groups	Open interpretation coding	Interviewees	Mentions
JULGEMENT OF SERVINGNESS (27 ENTREVISTADAS, 138 MENÇÕES)	Control (16 interviewees, 52 mentions)	JUDGEMENT – control over sexuality and birth control	Judgment – some women have children in order to receive state income benefit	2	2
			Judgment – people should prevent pregnancy	1	1
			Judgment – reproductive planning difficulties have to do with vulnerability and poverty	1	3
			Judgment – it's better to have an abortion than to abandon the child, or not look after it properly	1	1
			Judgment – structured families use family planning and contraception	5	7
			Judgment – young people have more freedom than they should have	1	1
			Judgment – teenage girls and young men shouldn't have children	1	1
			Judgment – women who [*already*] have a lot of children should never get pregnant again	7	9
			Judgment – mentally disturbed women do not look after their children and should not get pregnant	1	3
			Judgment – forgetful and disorganized women should use injectable contraception	1	1
			Judgment – wealthier and educated women make no mistakes regarding contraception	2	2
			Judgment – very poor women shouldn't get pregnant	3	3
			Judgment – poor women should choose to marry later in life and not have children	3	3

(Continue)

	Frame/Perspective	Judgement groups	Open interpretation coding	Interviewees	Mentions
JULDGEMENT OF SERVINGNESS (27 ENTREVISTADAS, 138 MENÇÕES)	Control (16 interviewees, 52 mentions)	JUDGEMENT – control over sexuality and birth control	Judgment – poor patients who get pregnant have no prospects and are inconsequential	2	2
			Judgment – fathers and mothers who mistreat children should put them up for adoption	2	2
	Behavior ideal and the role of gender (21 interviewees, 43 mentions)	JUDGEMENT – appropriate and inappropriate female behavior	Judgment – the fact that pregnant women do not look after themselves may be because of drug use, funk parties, having more than one partner and not taking contraceptive measures	1	1
			Judgment – mothers need to be strict with their children	1	1
			Judgment – women should spend money on transport to go to consultations and not on buying cigarettes	1	1
			Judgment – women should not go to funk parties	2	2
			Judgment – women shouldn't have more than one partner	4	4
			Judgment – women shouldn't take drugs	1	1
			Judgment – women shouldn't wear short dresses	1	1
			Judgment – mothers shouldn't refuse to have their children vaccinated	2	2
		JUDGEMENT – caring is the responsibility of women; it's the female's role	Judgment – women should look after their children	3	3
			Judgment – women should plan their pregnancies	2	3
			Judgment – women should concern themselves with preventing STIs and not getting pregnant	5	6
			Judgment – women and girls are more open than men and boys to hearing about and practicing contraception and prevention	13	16

(Continue)

	Frame/Perspective	Judgement groups	Open interpretation coding	Interviewees	Mentions
JULDGEMENT OF SERVINGNESS (27 ENTREVISTADAS, 138 MENÇÕES)	Behavior ideal and the role of gender (21 interviewees, 43 mentions)	JUDGEMENT – caring is the responsibility of women; it's the female's role	Judgment – pregnant women easily form bonds with each other	1	1
		JUDGEMENT – LGBTQIAPN+ is the population at risk of catching STIs	Judgment – homosexuals are more exposed to STIs	1	1
	Natalism (7 interviewees, 10 mentions)	JUDGEMENT – defending life and essentialism in relation to motherhood	Judgment – abortion violates the life of a child	2	2
			Judgment – young men shouldn't have a vasectomy	1	2
			Judgment – women shouldn't have an abortion	5	5
			Judgment – women are mothers by nature whereas men have to learn how to be fathers	1	1
	Social position (12 interviewees, 19 mentions)	JUDGEMENT – misinformation is a problem of people with low incomes	Judgment – teenagers do not seek information	2	2
			Judgment –female patients generally look for family planning advice when they are already pregnant	1	1
			Judgment – there's a lot of misinformation about contraception and prevention	8	10
			Judgment – uninformed fathers and mothers hinder the care of teenage patients with regard to their sexual and reproductive health	2	2
		JUDGEMENT – a better income as a problem associated with staying in a job	Judgment – pregnant women who have a health insurance plan do not value their local community health center	1	1
			Judgment – wealthy mothers are the hardest to treat as patients	2	2

(Continue)

	Frame/Perspective	Judgement groups	Open interpretation coding	Interviewees	Mentions
JULDGEMENT OF SERVINGNESS (27 ENTREVISTADAS, 138 MENÇÕES)	Maternal & child health (10 interviewees, 14 mentions)	JUDGEMENT – a woman's health is important because of the health of her child	Judgment – pregnant teenagers are irresponsible and do not attend medical consultations	2	2
			Judgment – teenagers are irresponsible and don't look after themselves	2	2
			Judgment – pregnant teenagers do not commit to have the necessary prenatal care	1	1
			Judgment – pregnant women should look after themselves because of the child they are carrying	1	1
			Judgment – pregnant women shouldn't take drugs	2	2
			Judgment – mothers and pregnant women who don't look after themselves harm their children	3	6

Source: Elaborated by the authors.