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

Beatriz Burattini

Social Policy Department, The London School of Economics and Political Science, London, United Kingdom[1]

E-mail: beatriz.burattini@ipc-undp.org or beatriz.brt@gmail.com

Twitter: @BeatrizBrttn

Linkedin: www.linkedin.com/in/beatriz-burattini

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[1] This was the author's affiliation at the time in which this research was conducted. The author is now affiliated to the International Policy Centre for Inclusive Growth, Brasília, Brazil.

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The current moralistic take on adolescent sexuality in Brazil raises the importance of sexual citizenship when examining adolescent fertility policies. Literature on the capacity contract lends a useful lens for understanding the ramifications of the construction of adolescents as sexual citizens. This paper investigates how the conceptualisation of adolescents within the capacity contract may relate to the problematisation of adolescent pregnancy in Brazil. To investigate this, I conduct a Foucauldian discourse analysis of federal level documents. These pertain to adolescent sexual and reproductive health programmes, guidelines and a campaign between 1989 and 2020. To examine the visibility of adolescents and adolescent pregnancy, I conduct a content analysis of health indicators and surveys from health registries from the same period. My evidence shows that adolescents found themselves in contradictory and dynamic positions within the capacity contract. Notably, when adolescents were attributed less agency, they were governed more paternalistically. Their choices and vulnerabilities regarding adolescent fertility seemed then more likely to be ignored. I conclude that this way in which adolescents were constructed as sexual citizens may have hindered a holistic policy approach to adolescent pregnancy. This highlights how the capacity contract falls short of protecting those deemed incapable.

Keywords: adolescent pregnancy, sexual citizenship, legibility, medicalisation, capacity contract

Introduction

Brazil's adolescent fertility rate (68.4) is above the regional average (65.5) and is an indicator for the country's inequalities. It may undermine educational attainment and is associated with greater health risks and poverty for both adolescent mothers and their children (UN Brazil 2018). This suggests that policies have inadequately addressed this matter. It is also an important issue in Brazil's current political turmoil (Anon 2018; Tokarnia 2019; Sassine 2020). The recent emphasis on the importance of the family,

combined with a more paternalistic approach to teenage sexuality, raises the question of how state approaches to adolescent sexual citizenship and pregnancy have affected policies that address adolescent fertility.

At the same time, the concept of *capacity contract* has recently been explored within citizenship scholarship, albeit mostly theoretically (Clifford 2014; Kymlicka and Donaldson 2017, 2018). Based on a group's perceived ability to make and express rational choice, the capacity contract determines who may govern themselves and who must be governed by others. It establishes that some are equal citizens capable of self-governance and political participation. Those deemed less cognitively capable are awarded fewer rights and responsibilities and need protection by the capable. The latter, thus, may be governed paternalistically by the former (Clifford 2014; Kymlicka and Donaldson 2017). However, while some groups, like young children, are attributed a clearer position within this contract, others, like adolescents, are in a more ambiguous position (Kymlicka and Donaldson 2017; Bauböck 2018; Rollo 2020; Schaffner 2005). By growing up, children can be seen as citizens-in-waiting, implying a more dynamic position within the capacity contract (Kymlicka and Donaldson 2017). This paper contributes to this literature by comparing the ambiguous positions of adolescents within the capacity contract and by examining their key ramifications. My findings show that the capacity contract does not fulfil its purpose. The desires of the 'incapable' must be taken seriously, although the mere visibility of those desires is not enough to be translated into political action.

This paper analyses the conceptualisation of adolescents within the capacity contract. Building on that, it examines the resulting problematisation of adolescent pregnancy. It then analyses how these have shaped policies addressing adolescent fertility in Brazil. Regarding the Brazilian context, this paper offers a deeper

understanding of the governance of adolescent fertility. Further, it contributes to the literature by examining the operationalisation of the capacity contract and building on adolescents' shifting positions within it to highlight why it is an inadequate means to organise citizenship.

Various shifts in Brazil's approach to citizenship between its re-democratisation and today make it a relevant case. Since the creation of a new constitution in 1988, citizenship and universal rights have become dominant concerns (Parker 1999). At the same time, neoliberalism questioned whether the state should intervene in the market and in people's lives (Giffin 1994). More than a decade later, new ideas of social justice probed neoliberalism and universalism. This shifted social policy towards a more social democratic approach (Caldwell 2017; Fausto and Fausto 2014). Brazil currently finds itself in a period marked by the questioning of certain rights, emphasis on obligations and a more conservative and moralist approach to sexuality (Tokarnia 2019; Sassine 2020; Harris and Schipani 2020). Given these developments, policies have conceptualised adolescent citizenship and adolescent pregnancy differently. To understand the potential impact of the current shift in state approach to citizenship and sexuality, an analysis of the relationship between the state and adolescents in previous periods of changing ideas about citizenship is a significant contribution.

The next section summarises the theoretical framework for this paper by explaining how adolescent sexual behaviour is governed. It highlights how legibility is crucial for constructing the adolescent as a sexual citizen. Further, it explains the role of legibility in determining what it is about sexual behaviour that governing actors may wish to control. This is followed by the methodology section detailing how I conducted my analyses of the construction of adolescents as sexual citizens and of the problematisation of adolescent pregnancy.

In the four empirical sections that follow, I argue that the positions of adolescents within the capacity contract seem linked to a contradictory understanding of adolescence and the invisibility of major vulnerability factors. These prevented the state from addressing adolescent pregnancy holistically. First, I situate adolescents within the capacity contract by examining how they are constructed as sexual citizens. I find that assumptions about adolescents and adolescent pregnancy justified the incomplete legibility of this group and of factors that influence adolescent fertility. The third and fourth empirical sections, respectively, show how this may have led to a lack of consideration of access to other opportunities and non-benevolent adults. Thus, these four empirical sections imply that the more paternalistic the approach, the less the state was able to see factors of vulnerability. This rendered the capacity contract incapable of protecting the vulnerable.

Governance of adolescent sexual behaviour

This section explains the theoretical understanding of governance of adolescent sexual behaviour. It begins by conceptualising sexual citizenship. Then, it explains how the construction of sexual citizens is based on the way in which people are made visible to governing actors. Finally, I explain how sexual and reproductive conduct are normalised and marginalised based on how sexual citizens are constructed.

Here, sexual citizenship is defined rather broadly. It encompasses Plummer's (1995, 17) concept of *intimate citizenship* as 'cluster of […] concerns over the rights to choose what we do with our bodies, our feelings, our identities, our relationships, our genders, our eroticisms and our representations'. Volpp's (2017, 165) notion of *affective citizenship*, which 'draws on feelings of belonging that tie the citizenship subject to multiple communities, including the nation-state' is also included in this definition. Sexuality is viewed as more than merely a factor in granting rights and defining

responsibilities linked to bodies and pleasures. Thus, sexual citizenship encompasses the governing of not just bodies, but also emotions and relationships (Lister 2002; Amuchástegui 2007; Richardson 2015; Mann 2013). This includes the importance of sexuality in adolescents' lives as something they may pursue for their physical and emotional wellbeing and the expression of their identities (Tambling, et al. 2012).

Another central aspect of sexual citizenship is that it grasps to what extent the state controls sexual and reproductive conduct (Amuchástegui 2007; Richardson 2015; Volpp 2017). Feminists emphasise the link between reproduction and citizenship. They highlight the interest of the state in governing mostly female bodies due to their importance in the creation of future citizens (Volpp 2017, 160). Concerned with which citizens should create new ones, government officials may deem certain people as not ready to reproduce. Considering the capacity contract, this means that those deemed incapable of self-governance – but not exclusively – may not be seen as *worthy of* or *ready for* reproduction (Kim 2010; Volpp 2017; Young 1990). Thus, the concept of sexual citizenship highlights the construction of citizens who are granted the right to reproduce and those who are not (Volpp 2017).

The extent to which one is seen as capable of governing oneself is a fundamental part of the construction of sexual citizens (Ericsson 2005; Schaffner 2005). *Legibility* is conceptualised as the making visible of citizens in a simplified, governable manner (Scott 1998). It is fundamental for the granting of rights and distribution of resources, and for the implementation of the capacity contract. For this to be possible, state officials need information to create simplified images of those who ought to be governed (Scott 1998; Rose and Miller 2008). This information is gathered based on what the state needs to see (King 1999). Hence, while people's identities are simplified for them to become governable, other aspects of their lives are purposely made

invisible, as they are found irrelevant (Scott 1998; Hoppe 2011). In turn, this means that other aspects of peoples' lives are ignored, even if they are important to the people in question (Scott 1998; Brown 2009). Moreover, if a person is not seen as relevant, they may themselves remain invisible (Scott 1998).

What is made legible has repercussions for the access to rights and resources. If something remains invisible, it cannot be addressed by policy (Scott 1998; Brown 2009; Chemmencheri 2015; Hildebrandt and Chua 2017). The absence of someone's identity from data does not mean that it is not there, but that it is being ignored (Brown 2009). However, visibility does not necessarily translate into redistribution. Further, the way in which one is legible also affects one's access to rights and resources (Chemmencheri 2015; King 1999; Li 2007). Being seen as undesired or incapable of being an agent may restrict such access (King 1999; Li 2007).

The extent to which a state tries to control a group's sexual conduct depends on how the group is made legible and what its ideal image for that group is (King 1999; Carabine 2001). Those perceived as deviant or incapable may be excluded from this right to reproduction (Volpp 2017; Clifford 2014; Kymlicka and Donaldson 2017, 2018). Consequently, policies are put in place to govern their sexualities such that their reproduction only occurs when the group is perceived as desired or capable. If not, it is impeded completely. By granting and refusing sexual and reproductive rights, the state normalises and marginalises different groups' sexual conduct (Mann 2013).

It is thus in the interest of governing actors to use social policy to shape sexuality (Carabine 2001). By defining different categories of sexual behaviour and establishing which should (not) be allowed, governing actors have the power to normalise certain types of sexual conduct while marginalising others. Influenced by notions of acceptable and unacceptable behaviour, subjects constrain themselves by

choosing between the ‘options’ available to them to avoid punishment and shame (Brickell 2009). Some subjects are thus discouraged from reproducing, and some behaviours are deemed ‘risky’ (Carabine 2001; Volpp 2017). Thus, governing actors may regulate ‘even the most “private” realms of the family, the body, and sexuality through forms of surveillance, self-discipline, and social welfare’ (Volpp 2017, 159). As highlighted by Young (1990, 164), groups associated with non-normalised sexual behaviour are othered as individuals whose ‘exclusion, avoidance, paternalism, and authoritarian treatment’ are justified. Referring back to the concept of capacity contract, this othering may legitimise the already unchecked paternalistic governance of those legible as incapable subjects (Kymlicka and Donaldson 2017; Ericsson 2005).

One way in which sexual behaviour is marginalised or normalised without exposing governing actors’ stake is through medicalisation (Seckinelgin 2007). This concept describes ‘a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness or disorder’ (Conrad, as quoted in Seckinelgin 2007, 72). This makes issues seem technical and therefore apolitical and is therefore understood as a legitimate form of improving society. Therefore, medical science can be used to separate normal from abnormal behaviour and legitimise interventions to correct the latter without seeming morally loaded (Seckinelgin 2007; Li 2007). Further, the targeting of risk groups may not only associate them with certain medical risks and so-called risk behaviour, but also make them responsible for their condition. Information about certain risk behaviours and how to prevent forms of ill health is accompanied by a moral weight on those who receive this information, and assumptions that patients are capable of avoiding whatever causes them ill health (Seckinelgin 2007). Hence, medical prescriptions can contribute to the normalisation of behaviour and simultaneously make those who engage in such behaviour responsible.

This legitimises their condemnation while ignoring structural factors that made them ill (Seckinelgin 2007; Li 2007).

Against this backdrop, this paper analyses the role of the capacity contract in the governance of adolescent fertility. This entails an examination of whether adolescents are made legible as capable or incapable sexual citizens. The problematisation of adolescent pregnancy follows from how this group is seen by the state. Finally, considering the literature on normalisation and marginalisation of behaviour, I analyse the repercussions for policy.

Methodology

The methods used in this paper are based on the aforementioned theoretical framework. In this section, I explain how I chose the policies to be analysed, collected and analysed my data, and the limitations of my method.

Federal level documents produced between 1989 and 2020 were analysed to understand the construction of adolescence and the state's justifications for addressing adolescents' sexual conduct. These documents pertain to the following adolescent sexual and reproductive health programmes, guidelines and campaigns from this time period.

To address adolescent pregnancy, the Adolescent Health Care Programme (PROSAD) was created in 1989. It defined adolescence as the age between 10 and 19 years and set the aim of curbing adolescent pregnancy. PROSAD's strategies included access to health professionals, contraception, and information on sexual and reproductive health (CSCA 1989). To address this issue at school, the Health and Prevention in Schools Project (SPE) was created in 2003 and was incorporated in the Health in Schools Programme (PSE) from 2007 (MS et al. 2007a). In 2010, the National

Guidelines for Comprehensive Healthcare for Adolescents and Youth in Promotion, Protection and Recovery of Health (abbreviated here as National Guidelines from 2010) were added to these measures (Schaefer et al. 2018). By 2020, the campaign Adolescence First, Pregnancy Later was introduced with the goal of delaying adolescent pregnancy (MS and MDH 2020).

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

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

behaviour via the creation of meaning, these are the most suitable definitions of discourse and discourse analysis for this paper.

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

Further, I also analysed health indicators and surveys from health registries. These included state databases with indicators on adolescent pregnancy from 1994. Some have been retrieved from the Indicators and Basic Data (IDB), a compilation of health indicators from nine different public health databases compiled by the Interagency Health Information Network (RIPSA) covering the years 1996 to 2011. I also analysed registry sheets from the SIAB, SISAB, CadSUS, SISPRENATAL and PEC published up to 2020. The indicators and registries analysed up to 2010 were recommended by the Ministry of Health via the Electronic System of the Citizen Information Service (e-SIC). For the period between 2010 and 2018, I relied on an email exchange with the Department of Strategic Programmatic Actions within the Secretariat of Primary Health Care (DAPES/SAPS).

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

To learn how exactly adolescence and adolescent pregnancies were made legible, I conducted a content analysis of the health indicators and survey questions. I was not interested in the values shown by the indicators, but rather what kind of questions were asked to or about adolescents. I paid attention to what was not assessed or asked to determine what was kept invisible by the state (Brown 2009). Indicators and surveys used by think tanks, universities and non-state institutions were excluded from my analysis, as my research only focused on the data gathered by the state and the documents produced by the relevant line ministries (Rose and Miller 2008).

By analysing how adolescents and adolescent pregnancy are made legible, I not only observing adolescents' shifting position within the capacity contract, but also the relationship between legibility and this position. This allowed me to examine how the capacity attributed to a group is operationalised through data gathering and how it subsequently impacts social policy.

Adolescent sexual citizenship in Brazil

This section, and the three that follow, examine how the capacity contract has been employed for the governance of adolescent fertility in Brazil. The empirical evidence suggests that it may have resulted in a narrow and contradictory construction of adolescents and the invisibility of vulnerability factors. This may have impeded a holistic approach to adolescent pregnancy. Thus, the capacity contract fails to achieve its purpose. In this section, I lay the basis for this broader argument by examining how adolescents are made legible and constructed as sexual citizens within the Brazilian capacity contract.

During the 1990s, adolescents were seen as a relatively homogenous group in a stage of 'development characterised by anatomical, physiological, psychological, and social transformations'[1] who were more vulnerable to sexual and reproductive health

risks (CSCA 1996, 5; MS et al. 1993a, 1993b; Horta and de Sena 2010). Any mention of inequalities between adolescents was vague, and policy documents implied that adolescence was 'an evolutionary stage of great vulnerability', regardless of social class, sexual orientation or race (MS et al. 1993b, 23; Jager et al. 2014).

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

This laid the foundation for the construction of adolescents' capacity for self-governance as sexual citizens and the extent to which any sexual and reproductive health policy could consider inequalities between them. The absence of race and gender from these policy documents meant that these aspects of adolescents' realities, which are not purely medical or merely based on income, could not be addressed by policy (Caldwell 2017; Brown 2009). With social factors being overlooked, the PROSAD did not consider potential obstacles for adolescents to follow governmental guidelines aimed at reducing reproduction (Horta and de Sena 2010). The possible effects of this will be elaborated upon in later subsections.

These documents acknowledged differences between adolescents. Further, all spoke of adolescents as citizens with sexual and reproductive rights. However, they framed them as citizens who are in a particular phase of development and therefore require more information to be ready for their sexual life (CSCA 1989, 1996). As such, they were constructed as less capable of agency. This created a notion that the state ought to teach them how to exercise their sexual citizenship (King 1999; Kymlicka and Donaldson 2017). Based on this, the state could justify interventions in adolescent sexual conduct. This discourse implied that adolescents needed information about sexuality to make the presumably right choices which, as I will elaborate later, meant opting against pregnancy (CSCA 1989, 1996; MS et al. 1993a, 1993b).

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

The position of adolescents in the capacity contract changed in the 2000s. Parts of the state apparatus began to view adolescents as heterogeneous citizens with rights and responsibilities (MS et al. 2007a, 2007b). Adolescence remained seen as a phase of development, but there was an awareness that this was a social construct linked to expectations of 'educational attainment and professional preparation' (MS et al. 2007b,

87). Government actors concluded that, as individuals with agency and diverse backgrounds, some adolescents would have more capacity and will to follow public health directives than others (MS et al. 2007a, 2007b). On the other hand, this agency was coupled with a discourse of responsibility. While it remained the role of the state to ensure that adolescents could claim their rights to health equitably, it would also '[stimulate] their responsibility towards their own health' (MS et al. 2007b, 84).

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

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

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

Documents from the 2010s show the Ministry of Health attributing even more diversity, complexity, and autonomy to adolescents, culminating in a conscious effort to see adolescent sexuality free of normal value judgements and consider sexual pleasure (Amuchástegui 2007). Inequality in Brazil and the social determinants of health were often mentioned in Ministry of Health documents and it seems clear to the actors involved that adolescents' realities are complex (DAPES/SAPS 2010, 2016). This autonomy was still frequently tied to responsibilities. Especially the National Guidelines from 2010, which repeatedly stated that adolescents 'must be regarded as a rich potential, capable of influencing the country in a positive manner' (DAPES/SAPS 2010, 5). These Guidelines also reflected other ideas of adolescent citizenship from the 2000s, such as the notion that an adolescent is still 'on the path of becoming a socially sane person'[2] (53). Further, adolescents were seen as subjects with their own opinions, values and views on life that are affected by socioeconomic status and culture (DAPES/SAPS 2010). To 'help adolescents and youth to build their autonomy', a goal similar to the previous decade, one solution was to include adolescents in decisions that affect them (52).

By 2016, adolescents were constructed with even more autonomy and their sexual citizenship was met by the Ministry of Health acknowledging adolescents' right to their sexuality as something that contributes to their wellbeing (DAPES/SAPS 2016; Amuchástegui 2007). Health professionals received instructions to respect adolescents' life goals, while notions that this demographic ought to go to school and be the future of the nation became less prominent. Instead, the Ministry instructed health professionals that, if an adolescent wanted to become pregnant, they would have the right to be

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

Nevertheless, this awareness of heterogeneity and shift towards an ideal of autonomy was not reflected in health indicators and health registries about adolescent pregnancy in the same period. While gendered power imbalances were highlighted in Ministry guidelines and health registries included a question about planned pregnancies from 2014, no patient survey sheet used to gather data about pregnant women and girls asked any question about the potential father. Although the Partner's Prenatal, where pregnant women's partners are asked to take medical exams and accompany the prenatal process, was included in health registries in 2011, no data is gathered about them unless they voluntarily comply (Cofen 2017; SAS 2014; MS 2018, n.d.-b, n.d.-c; DAB 2016, 2018; CNSH 2016). Hence, during the 2010s, the same fragmentation witnessed in the 2000s prevailed. There was an awareness of adolescents' complexities among state officials writing guidelines which was not translated into recognition by those designing surveys (Rose and Miller 2008; Chemmencheri 2015). Regardless of the change in discourse and available data, major aspects of adolescents' lives remained invisible (Brown 2009).

As of 2020, the adolescent sexual citizen finds themselves in a highly contradictory position within the capacity contract. On one hand they lack agency, with the state and the family having legitimised their power to decide sexual and reproductive activities. On the other hand, they are simultaneously addressed with a discourse of choice implying enough agency to negotiate reproduction. The former was

observed first, as, in 2019, the Minister of Health announced the Adolescent Health Booklets would be revised (Tokarnia 2019). The discourse behind this was of a moralist and protective nature, implying that the information on sexual and reproductive health in the Booklets was inappropriate. Bolsonaro's call for parents to rip out the respective pages if they deemed necessary implied a replacement of adolescents' agency and autonomy by domination by the family (Kymlicka and Donaldson 2017; Tokarnia 2019)[3].

The Adolescence First, Pregnancy Later campaign employed a more contradictory discourse, simultaneously diminishing and attributing capacity for agency to adolescents. The campaign specifies that adolescents' parents and caregivers must also be addressed and, when speaking to adolescents themselves, advises them to seek the family for advice and support (MS and MDH 2020). This delegates the governance of adolescent bodies to supposedly benevolent adult guardians (see Clifford 2014; Kymlicka and Donaldson 2017, 2018). At the same time, the campaign text also addresses adolescents with a strong language of choice, with one website literally asking the adolescent reader what their choice is regarding pregnancy during or after adolescence, implying their capacity for self-governance. It also highlights that adolescents have their own cultures and necessities while developing their identities (MS and MDH 2020). On one hand, this campaign attributes power over adolescents' sexualities to their caregivers. On the other, the state simultaneously believes that adolescents can choose to delay a pregnancy if they are provided with information. Nonetheless, while the most recent discourse somewhat homogenises adolescents again, no changes in data gathering have been identified during 2019 and 2020 (SAPS 2020a, 2020b).

As was shown here, adolescents were initially situated on the vulnerable and 'incapable' side of the capacity contract, which influences and is then confirmed by how they are made legible, creating a circular reasoning. Through changes in discourse, followed by changes in legibility, adolescents moved further to the 'side of the capable' within the contract, being attributed more agency and responsibility. Simultaneously, they became less homogenised. However, the findings from 2020 highlight how the position of a group within the capacity contract is not as simple as moving along a linear progression from incapable to capable of self-governance. On one hand, more aspects of their lives are legible through data. On the other hand, the most recent discourse simultaneously situates adolescents as agents. With enough capacity to delay pregnancy and fulfil their civic duty by acquiring education, but also as a group to be justifiably governed by adult guardians.

As such, the findings of this section seem to show that legibility is based on what the state deems necessary to be seen based on its assumptions. Note, though, that this does not exclude the influence of other factors. The findings in this section also imply that the capacity contract is not only dynamic (Kymlicka and Donaldson 2017), but also contradictory within one moment in time. Adolescents can be placed concurrently on both sides of the capacity contract. In the following sections, I will explore how this has affected the state's approach to adolescent pregnancy. In the next section, I will first analyse how adolescent pregnancy was problematised.

Adolescent pregnancy as health risk

In this section, I build on the previous discussion to examine how an adolescent pregnancy is seen while adolescents change position within the capacity contract. The evidence here contributes to the overarching argument by showing how the capacity contract prevented a holistic understanding of adolescent pregnancy due to its

patronising construction of adolescents.

Adolescent pregnancy was medicalised, especially in the 1990s, making the state treat it as a risk while ignoring structural inequalities behind it (based on Seckinelgin [2007]). It was primarily seen as a health risk for adolescents in the policy documents up to 2000 and in health indicators during the 2000s (MS 2000; DAB 2003). Health professionals were preoccupied with pregnancy between the ages 10 and 19 with the main concern being the higher maternal mortality ratio between those ages. Next to medical concerns, the undesirability of adolescent pregnancy was acknowledged as a social construct linked to the expectation that adolescents go to school instead of reproducing. However, this was often framed as a cultural peculiarity (MS 2000; MS et al. 2007a). The preoccupation with adolescents' health reinforced the notion that they needed protection.

Moreover, in the 1990s, by framing pregnancy as a health risk to adolescent bodies, it was assumed to be inherently unplanned. None of the PROSAD documents analysed considered that adolescents could become pregnant on purpose (CSCA 1989, 1996; MS et al. 1993a, 1993b). As explained in the previous section, adolescents were made legible in a homogenised manner, seen as vulnerable with little capacity for agency, so it was assumed that they could not choose to become pregnant like adults. Further, whether pregnancies were planned was only asked in health registries in 2014 (DATASUS 2008a, 2008b; SIAB n.d.-a, n.d.-b, n.d.-c; Ripsa n.d.; SAS 2014; e-SUS Atenção Básica 2016). Pregnancy was therefore seen as inherently undesired by and for all adolescents and their homogenisation as a group implied that no adolescent could possibly plan a pregnancy (Schaffner 2005; Horta and de Sena 2010; Jager et al. 2014).

Further, adolescent pregnancy was treated as a public health issue rather than a social one. This is explicit in the guidelines for treatment of pregnant adolescents in

2000 where the Ministry of Health stated that ‘adolescent pregnancy, [...] undeniably contributed to the perpetuation of a cycle of poverty and deprivation’ (MS 2000, 8). Instead of addressing adolescent pregnancy as a symptom of structural inequalities, it was addressed as the main problem. Even in government documents pertaining to the SPE from the late 2000s, the reduction of adolescent pregnancy was portrayed as a goal in itself (MS et al. 2007b, 2007a).

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

The state occasionally admitted that adolescent pregnancy was made undesired due to the perception that adolescents were not ready for childbirth and should obtain education, rather than solely for health reasons. State actors themselves admitted that perceiving adolescent pregnancy as undesired *per se* was a social construct based on the modernisation of society and the ideal that adolescents would go to school (MS et al. 2007b). The state therefore made it clear that the society to which it belonged was interested in preventing adolescent pregnancies. However, it still focused on preventing

adolescent pregnancy as a health risk. Thus, the notion of health risks replaced concerns about social roots of adolescent pregnancy as a problem (Seckinelgin 2007).

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

As of 2020, adolescent pregnancy has become medicalised once again, although the visibility of planned adolescent pregnancies remains (SAPS 2020a, 2020b). As its name states, the Adolescence First, Pregnancy Later campaign deems adolescence as an inappropriate age for pregnancy and defines the prevention of unwanted adolescent pregnancy as its goal (MS and MDH 2020). Similar to the PROSAD, this campaign constructs adolescent pregnancy as a health risk that must be prevented, as unintended pregnancies may have negative socioeconomic and health consequences for mothers and babies. It is also explicitly portrayed as a cause for school dropout rates and maternal mortality with one of the campaign images portraying an adolescent girl wearing a graduation gown, emphasising the need for adolescents to choose between parenthood or education (MS and MDH 2020). However, the discourse differs from the 1990s in that it acknowledges that some adolescents choose parenthood by referring

specifically to unplanned pregnancies, incorporating the evidence gained in the 2010s (MS and MDH 2020).

This section highlights the importance of a group's position within the capacity contract for the type of policies formulated to control their sexual conduct. It reinforces the notion that the state may wish to prevent the reproduction of those deemed deviant, undesired, or not ready (Kim 2010; Volpp 2017; Young 1990). I also find that the medicalisation of adolescent pregnancy and assumptions regarding its inherent undesirability coincide with the perception of adolescents as vulnerable, homogenous, incapable of agency and in need of governance by more capable citizens. This may have legitimised a patronising and top-down policy approach, and the lack of legibility of adolescents' more complex lives.

These findings suggest that one's position in the capacity contract may influence the construction and legibility of one's problems, rather than the evidence gained through legibility influencing one's position in the contract. As adolescents are constructed as more capable of agency and responsibility, the problematisation of adolescent pregnancy becomes more nuanced. Meanwhile, planned pregnancies are made legible. The time lag between the change in discourse that indicated adolescents' new position as 'more capable' implies that the discursive construction of a group may not be based on data gathered about them. Rather, what is made visible about a group seems to follow from what the state wants to see. While concerns about adolescent reproductive health and protection are justified and well-grounded in scientific evidence, these findings imply that what the state sees and addresses about a group may rather be based on socially constructed assumptions (Kymlicka and Donaldson 2017).

Education as alternative to pregnancy

Below, I build on the findings from the two aforementioned sections: on the extent to

which adolescents are constructed as capable of choice, and the extent to which the state acknowledges the likelihood of planned pregnancies. I argue that the way in which adolescents and adolescent pregnancy were seen until the mid-2010s and again in 2020 may have justified social policies that marginalised the behaviour of some adolescents. These seem to have allowed the state to ignore its responsibility in increasing adolescents' access to opportunities. Finally, I will show how this can be seen as a consequence of their dynamic position within the capacity contract. Thus, this section contributes to my main argument by showing how the capacity contract prevented the state from addressing adolescent pregnancy holistically.

A major reason for the Brazilian state to discourage adolescent pregnancy has been the idea that adolescents should go to school. As shown in the policy documents from the 1990s to 2010 and again in 2020. Regardless of how much agency is attributed to them, adolescents were made legible as citizens in a phase of development. Other documents linked that with the idea of adolescents as the future of the country (CSCA 1989, 1996; MS et al. 2007b, 2007a; DAPES/SAPS 2010; SAPS 2020a, 2020b). Not only did the Ministry of Health acknowledge that, in Brazilian society, education was expected from that age group, but that was also evidenced in the assumptions and goals of other policies (MS et al. 2007b; Jones 2016; MS and MDH 2020). As explained by Jones (2016), there seems to be an assumption that adolescents' lives are part of a linear progression from childhood to successful adulthood via education. Moreover, as implied by the logic of Brazil's *Bolsa Família* programme, education is assumed to help adolescents and their families lift themselves out of poverty. Adolescents therefore were perceived as a group that needs education to become successful adults. This assumes that education will benefit all adolescents, allowing them to get better employment that translates into social mobility (Jones 2016; Lomelí 2008). However, this is not always

the case. The quality of education has not always been good enough to make poor adolescents become more productive. Even if they become more skilled, the country's economy has not offered enough jobs for them to employ those skills and earn more (Jones 2016).

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

Especially in the 1990s, 2000s and 2020, the medicalisation of adolescent pregnancy marginalised motherhood before the age of 20 as a risk behaviour, legitimising its undesirability (Young 1990). Regardless of whether the state was offering adolescents good education and better opportunities, the undesirability of this behaviour was legitimised through the medicalisation of adolescent pregnancy.

Hence the state marginalised the behaviour of the disadvantaged, suggested they were responsible, and tried to impose a certain script on their sexuality (Seckinelgin 2007; Carabine 2001; MS and MDH 2020). By medicalising adolescent pregnancy, the state could restrict itself to public health policies teaching adolescents to self-govern instead of confronting the complex interplay of education, employment, and inequality in the whole society (Seckinelgin 2007).

Note that the civic duty towards completing education was present regardless of adolescents' position within the capacity contract. On one hand, their construction with more agency and the resulting capacity for responsibility coincided with the explicit acknowledgement of their civic duty to acquire education. On the other, the need to prevent pregnancy to make adolescents complete their education was also present while they were seen as vulnerable and incapable subjects. This confirms Kymlicka and Donaldson (2017) in stating that children, here including adolescents, do not enjoy lives free of civic duties even under paternalistic governance supposed to protect them from the burdens of responsibility. My findings highlight one way in which the ideal progression into capable adulthood may be operationalised. One of the potential obstacles in the way of this ideal, namely reproduction, is marginalised through medicalisation and social policy. However, adolescents' position within the capacity contract influences the way in which reproduction can be prevented to uphold this civic duty. The invisibility of choice based on the construction of incapable adolescents, as observed primarily in the 1990s, prevents the state from addressing the structural conditions that may lead to said choice. Ironically, the period with the most patronising stance and most drive to protect adolescents from pregnancy gathered the least information necessary for this. The most vulnerable adolescents who chose parenthood out of lack of better options had major aspects of their realities kept invisible.

The invisibility of the father

Like the previous section, this section further demonstrates how assumptions linked to the capacity contract have omitted major vulnerabilities adolescents may face. It contributes to my overarching argument by highlighting how the capacity contract prevents the protection of the group it deems vulnerable, by impeding the visibility of non-benevolent adults. The lack of visibility of fathers shown in this section has led to an approach to adolescent pregnancy which ignored the role of gender beyond adolescence.

As explained above, the health surveys used to record health outcomes of pregnant women and girls have not asked any questions about the characteristics of the fathers of their babies to the pregnant girls themselves. Despite the Partner's Prenatal, there is no registry that includes information about fathers unless they willingly accompany their pregnant partners (DATASUS 2008a, 2008b; SIAB n.d.-a, n.d.-b, n.d.-c; Ripsa n.d.; Cofen 2017; SAS 2014; MS 2018, n.d.-b, n.d.-c; DAB 2016, 2018; CNSH 2016; SAPS 2020a, 2020b). The absence of this information keeps those who impregnate adolescent girls invisible. This not only leaves room for inaccurate assumptions that adolescent girls get impregnated only by adolescent boys, but also hinders adequate policy making (Brown 2009; Hildebrandt and Chua 2017; Scott 1998).

As seen above, in the 1990s and again in 2020, adolescents were seen as homogenous and vulnerable, so state intervention in the form of medical recommendations was a justified and simple way to promote behavioural change. Nevertheless, by 2020, there was data available to make their heterogeneity visible, although seemingly ignored in the most recent campaign (CSCA 1989, 1996; King 1999; MS and MDH 2020). The invisibility of the father probably contributed to the disregard of the heterogeneity of adolescence as a category as this meant that social

factors leading to planned and unplanned pregnancies were ignored. Gendered issues such as the lack of agency to negotiate the use of contraception were excluded from policy in the 1990s and again in 2020. Moreover, by seeing adolescents as vulnerable, especially in the 1990s, it was justified to construct adolescents as the target group for policies curbing adolescent fertility, ignoring the role of adult men (MS 2000; King 1999). Combined with the medicalisation of adolescent pregnancy and the idea that by giving adolescents information they could avoid that problem, adolescents were made solely responsible for adolescent pregnancy (Seckinelgin 2007).

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

By addressing adolescent pregnancy as a problem pertaining to adolescents, the state ignored how this might be linked to ill-intentioned adults and rape. Evidence from Brazil shows that adolescent girls may engage in sexual relationships with older partners, with age gaps sometimes becoming generational gaps (Brancaglioni and Fonseca 2016). Girls in such relationships are more likely to suffer from intimate partner violence because of power imbalances resulting from the combination of gender, generational and economic inequalities[4] (Brancaglioni and Fonseca 2016; Longfield, et al. 2004; Kaestle, Morisky and Wiley 2002). Besides an increased vulnerability to violence, evidence from other countries shows that girls in relationships with large age gaps have a reduced ability to negotiate the use of contraception (Longfield, et al. 2004; Kaestle, Morisky and Wiley 2002). Note that the Brazilian state does make intimate partner violence perpetrated by adult partners legible when gathering data on violence against children and adolescents[5] (MS 2015). Further, the Ministry of Health was already aware of the role of gender and age in teenagers' ability to negotiate contraception in the 2000s (MS et al. 2007a). However, the invisibility of the father when gathering data about adolescent pregnancy hides pregnancies that may have been the consequence of rape or coercion by adults.

The targeting of adolescents and the invisibility of the father made adolescent girls responsible for their pregnancy, instead of focussing underlying causes, namely gendered and age-related social norms (Seckinelgin 2007). As this was seen as an issue of adolescents, the state coined the idea that adolescents are the sole group responsible for adolescent pregnancy (Brickell 2009). The medicalisation of the issue legitimised this (Seckinelgin 2007). Then, by regulating adolescents' sexual behaviour, the state institutionalised and promoted the idea that adolescent pregnancy is a problem of that age group only (Brickell 2009).

This further demonstrates how situating adolescents on the incapable side of the capacity contract has condemned efforts to protect them. Here, the invisibility of the father and, more generally, of adult men, prevents the state from making the non-benevolent adult legible (see Kimlicka and Donaldson 2017, 2018). As such, assumptions that adults are inherently benevolent guardians cannot be questioned when addressing adolescent pregnancy. Again, the patronising governance of adolescents as incapable subjects prevents the state from gathering information necessary to protect those particularly vulnerable to self-interested adults and, subsequently, from wanted and unwanted pregnancies.

Conclusion

I have analysed the ways in which adolescents were made legible as sexual citizens and how this has shaped policies addressing adolescent pregnancy. There is evidence that legitimises the concern with adolescent fertility as a health issue. However, my findings suggest that the state's approach to adolescent sexual citizenship and pregnancy was a product of assumptions regarding their capacity for self-governance. This is substantiated by how shifts in discourse preceded shifts in legibility, especially explicit between the 2000s and 2010s. Yet this paper does not analyse the factors that contributed to the changes in the position of adolescents within the capacity contract, such as social movements, evidence from non-state actors or other external influences. Further, while my findings suggest a relationship between legibility, a group's position within the capacity contract and policy, I do not mean to suggest that this is a simple relationship exclusively between these variables.

I have also analysed the construction of adolescent pregnancy as a problem linked to adolescents' perceived capacity for agency. Here, I found that the general trend in Brazil has been that the more the capacity contract justified the paternalistic governance

of adolescents as sexual citizens, the less the state saw the factors that contributed to (un)planned adolescent pregnancy. Medicalisation and invisibility of choice hid how a perceived lack of better alternatives could contribute to particularly vulnerable adolescents choosing parenthood. Further, the fixation on the incapable adolescent needing protection kept adults invisible. This confirms Kymlicka's and Donaldson's (2017) criticism that the capacity contract assumes adults are benevolent.

This paper offers empirical evidence to support claims for abandoning the capacity contract as a means to theorise citizenship. It endorses previous criticisms of the capacity contract that highlight how it does not guarantee children and adolescents a life free of civic duties and how adult citizens are not inherently their benevolent protectors (Clifford 2014; Kymlicka and Donaldson 2017, 2018). This has been exemplified by the role given to education as preferred alternative to pregnancy and by the invisibility of the potential involvement of adult men in adolescent pregnancies. Further, my analysis of the shifting positions of adolescents within the capacity contract imply that it fails to achieve its purpose. In the Brazilian context, this contract seems to translate into a narrow approach to social policy that misses important factors of vulnerability. By essentialising and homogenising adolescents and dismissing their agency, their own choices and assessments of what they need are made invisible. Thus, the capacity contract legitimises the patronising governance of adolescent sexual conduct without considering how adolescent agency works (King 1999; Li 2007). Scholars and policy makers working with groups typically constructed as incapable must therefore not dismiss these groups' perceptions of what they need and what could contribute to their wellbeing. As highlighted by the governance literature and confirmed by my findings, a crucial first step in this direction is ensuring the legibility of these groups' desires (see Scott 1998).

Within this line of thought, Kymlicka and Donaldson (2017) call for further research on mechanisms for ensuring that the wishes and needs of the 'incapable' are considered. However, my evidence shows that making these groups' complex lives visible is not straight forward. First, what governing actors deem necessary to see seems to be linked to discursively constructed assumptions about the group and problem to be addressed. This implies a discursive nature of the capacity contract, wherein it can reproduce itself by creating knowledge about a certain group. If a group is assumed to lack capacity for self-governance, certain factors pertaining to their lives, such as their own desires, may be deemed irrelevant to be made legible. Moreover, even if more characteristics of a group are made visible, my evidence from 2020 shows that this does not guarantee that policies will be based on all data available to the governing actor. This confirms Chemmencheri (2015) in highlighting that legibility does not inherently translate into redistribution. The evidence that those deemed incapable make their own choices is not enough for governing actors to consider those choices. Nonetheless, my evidence has also shown that this reproduction of the capacity contract can be broken, as evidenced by the shift in approach to adolescent fertility in the 2010s. Therefore, future research should enquire what factors prevent the capacity contract from determining the legibility of citizens. It should explore the conditions under which governing actors do not dismiss evidence on the agency of groups typically constructed as incapable.

Notes

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

[2] Alternative translation: 'on the path of becoming a socially healthy person'

[3] As of November 2020, it is not possible to download the Booklets through the Ministry of Health's website, despite their text still urging users to do so (MS n.d.-a).

[4] In 2019, 62% of suspected perpetrators of reported sexual violence against children and adolescents were adult males, although partners and ex-partners form a smaller portion of suspects for reported sexual and general violence (Waiselfisz 2012; ONDH 2019). However, it is likely that coercion and rape may not be recognised as such due to gender and generational roles. These may result in acts of violence being interpreted as displays of affection (Brancaglioni and Fonseca 2016).

[5] The registry sheet on interpersonal violence and self-harm from the Information System for Notifiable Diseases (SINAN) gathers data on the age of the perpetrator at least since 2015, whereas older versions from 2008 and 2006 did not (MS 2006; 2010b; 2015).

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