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Dossier

Reproductive Justice: legacies and contemporary challenges

Reproductive (In)justice and Maternal Health Care: From Rede Cegonha to Rede Alyne

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(In)justicia reproductiva y atención al ciclo gestación puerperio: de la Red Cigüeña a la Red Alyne (resumen: p. 18)

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Gender and race are key determinants of access to healthcare. Reducing maternal mortality has been a persistent challenge in Brazil. Based on documentary analysis and the concept of reproductive justice, this article examines the proposals of Rede Cegonha, Rede de Atenção Materno-Infantil, and Rede Alyne, established since 2011 to improve care during pregnancy, childbirth, and the postpartum period. The study aims to highlight the relevance of reproductive justice as a criterion for women's health policy design, introduce a specific tool for policy evaluation, and apply it to assess how these networks have integrated social determinants of health and their intersections into their frameworks.

Keywords: Maternal mortality. Reproductive justice. Reproductive rights. Social determinants of health. Intersectionality.

Introduction

The persistence of racial disparities in access to rights and healthcare is a fundamental factor contributing to illness and mortality in the Black population. Maternal mortality is no exception. In Brazil, the maternal mortality ratio (MMR) in 2022 was 53.4 deaths per 100,000 births[b]. This number increases to 102.4 deaths when considering only Black women. For White women, the number was 46.6 deaths. Reducing maternal mortality has been a constant challenge for women's health in Brazil. According to the Millennium Development Goals[1], Brazil should have reduced the MMR to 35 deaths by 2015, which would represent a 75% reduction in the level of 141 maternal deaths recorded in 1990. The target was not met. With the Sustainable Development Goals, Brazil's target for 2030 is to reduce maternal deaths to 30 per 100,000 births[2].

[b] The maternal mortality data were produced by the author based on data available from the Mortality Information System (SIM) and the Live Births Information System (SINASC) databases. The result was derived from the ratio of maternal deaths to live births, stratified by race/color group, according to the document Maternal Mortality Ratio – C.3, published by the Ministry of Health.

Although it is evident that specific actions with an ethno-racial focus targeted at combating institutional racism are needed to improve health indicators, the Brazilian government has not adopted race and ethnicity as priority criteria in the design and implementation of public policies, reiterating scenarios of injustice in access to these policies and, often, deepening disparities. The National Policy for the Comprehensive Care of the Black Population, created in 2009, and specialized care for the Indigenous population may be considered exceptions to this rule. However, both policies have not been sufficiently funded, and many health professionals are unaware of their existence, especially of the former[3,4]. In this context, gender, race, and ethnicity, more than targeted policies, must be considered basic criteria to be included in care protocols and in the training of health professionals.

Through documentary analysis, this article examines proposals for care networks established since 2011 and targeted at pregnant women and infants. It analyzes three care networks based on the concept of reproductive justice: Rede Cegonha (RC), Rede de Atenção Materno Infantil (RAMI), and Rede Alyne. These networks were launched during specific administrations of the federal government. Rede Cegonha and Rede Alyne were created by governments of the Workers' Party (PT), a party historically linked to the human rights agenda. RAMI, in turn, was launched by the Liberal Party (PL) government, which was openly opposed to the notion of gender and mindful of human rights. The political context in which the networks were launched may help to understand the adoption of some terms, but it does not fully explain the choices resulting in scenarios of reproductive injustice over the years.

The objectives of this article are threefold: to demonstrate that the concept of reproductive justice is a relevant criterion for public policy design; to introduce a specific tool for policy assessment; and to apply the developed tool to assess how pregnancy, childbirth, and postpartum care networks have incorporated the social determinants of health and their intersections into their frameworks. The main contribution of this article is to advance a model for the analysis of public policies based on the concept of reproductive justice. The model can be applied to the analysis of other public health policies, particularly with regard to sexual and reproductive health.

This article is organized into eight sections, in addition to this Introduction. Initially, we present reproductive justice and its interface with the making of public policies. Then, we describe the study's methodology and present the public policy analysis matrix. Next, we briefly discuss the adoption of healthcare networks, focusing on pregnancy, childbirth, and postpartum care networks. We then address the three networks in specific subsections. Subsequently, we compare the three, highlighting the main elements connected with scenarios of reproductive justice or injustice. In the Conclusion, we revisit the most relevant points discussed in the article and provide suggestions for future research.

Reproductive justice and public policies

The concept of reproductive justice has been developing since the 1990s, bringing together, in an intersectional way, the indivisibility of the human rights of women, sexual and reproductive health, and social justice[5,6]. Derived from reflections within Black feminism, it was named and promoted by Black and Latina activists in the United States in preparation for the Cairo Conference of 1994[5,6]. The concept is intersectional insofar as it recognizes that gender and race determine access to health policies and the protection of sexual and reproductive rights. Therefore, it establishes that health promotion policies must be grounded on three pillars, as defined by Loretta Ross[5,6]: 1. The right to have children and access to family planning; 2. The right not to have children and have access to safe abortion, if necessary; and 3. The right to raise children in safe environments, with access to opportunities and free from violence[5,6].

Fernanda Lopes points out that the three dimensions that constitute reproductive justice are equally important and guide reproductive choices. The author emphasizes that "the ability of any person to determine their reproductive destiny is directly linked to the conditions of their families and community"[7] (p. 1). In other words, reproductive choice is not an individual choice; it is based on the social and collective conditions offered to all population groups, in present perspectives – with access to care, employment and income policies, security, and protection against discrimination – and future horizons, in which well-being scenarios are drawn. The author then concludes that "the concept of reproductive justice materializes in the elimination of socially produced, preventable, or remediable inequalities in the exercise of reproductive rights by different groups of women"[7] (p. 225). She adds that it is not possible to make reproductive choices without guaranteed rights in the midst of a racist, sexist, and cis-heteronormative society.

Reproductive justice has been recognized as a useful concept in academic analyses and as a relevant tool for activism related to human rights and sexual and reproductive rights. Concerning the academy, features like the concept's broad character and openness to new contributions are highlighted, as well as the production of new syntheses with complex lenses open to different perspectives, breaking with essentialisms regarding reproductive choices. Regarding activism, reproductive justice is understood as a praxis of subaltern groups seeking affirmation of their rights and identities[6]. It has been used to evaluate and validate policies adopted by feminist

organizations to guarantee human rights, as is the case of the actions taken by Anis during the Zika virus epidemic[8].

Bilge and Collins[9] argue that, due to its intersectional nature, reproductive justice is, beyond an analytical tool, an instrument of action that demands broader initiatives than health policies to guarantee sexual and reproductive rights and the human rights of women. For the authors:

> [...] reproductive justice considers the guarantee of the physical, spiritual, political, economic, and social well-being of women and girls as part of reproductive health. Recognizing the need for legal protections, reproductive justice aims to transform formal human rights into substantive reproductive rights. Social institutions, especially governments, are required to guarantee social conditions that promote the reproductive rights of women and girls. This may mean addressing issues related to housing, access to clean water, food security, air pollution, and environmental risks[9]. (p. 134)

Thus, the concept of reproductive justice favors the reflection on sexual and reproductive rights to strengthen the framework of rights and supports a perspective that is distant from the maternalism and familism that have recently guided women's health policies, mainly with the advance of far-right governments all over the world[10].

Methodology

Through documentary analysis, this article compares three pregnancy, childbirth, and postpartum care networks created from 2011 onwards. The documents were obtained directly from the Ministry of Health through emails exchanged with the responsible departments, in which access to information contained on the FalaBr platform was requested on April 4, 2025.

The response to the request was issued by two departments of the Ministry of Health: the General Coordination of Women's Health - Comprehensive Care Management Division of the Primary Care Department, and the Hospital, Home, and Emergency Care Division of the Specialized Care Department. The following documents constitute the corpus:

Rede Cegonha

- Ordinance No. 1459/2011, issued by the Ministry of Health;
- Consolidation Ordinance No. 3;
- Parameters for care programming. Section b - Pregnancy, childbirth, and postpartum care network (*Section b*);
- Ordinance No. 1020, issued by the Ministry of Health based on Technical Note 31 of 2012 – CONASS.

RAMI

- Ordinance No. 715/2022, issued by the Ministry of Health;
- Ordinance No. 13/2023, issued by the Ministry of Health;
- Regulatory Impact Analysis (AIR);
- Complement - Regulatory Impact Analysis (C-AIR);
- Ordinance No. 2228, issued by the Ministry of Health.

Rede Alyne

- Ordinance No. 5350/2024, issued by the Ministry of Health;
- Ordinance No. 5349/2024, issued by the Ministry of Health;
- Ordinance No. 5.530/2024, issued by the Ministry of Health;
- Technical Note issued jointly by the Primary Care and Specialized Care Departments regarding Rede Alyne.

The documents were analyzed and compared using the analytical matrix presented below. Through this process, we aim to understand to what extent the design of the networks and their technical justifications address or reject the perspective of reproductive justice and whether such networks can guarantee greater protection to the human rights of women. At the same time, our objective is to create a tool to analyze public policies that materializes the use of the concept of reproductive justice in everyday life. From this perspective, we developed the matrix presented in Table 1 for this article. Its objective is to make the concept a useful tool for researchers and public managers.

Table 1. Analytical matrix of the pregnancy, childbirth, and postpartum care networks according to reproductive justice criteria.

Axes	Criteria	Does the pregnancy, childbirth, and postpartum care network meet the criteria?*		
		Rede Cegonha	RAMI	Rede Alyne
1 - Access to family planning	Does the policy provide for family planning as part of reproductive life?	Yes	Yes	Yes
	Does the policy offer different contraceptive methods, considering the specific needs of the individuals who seek these methods?	No	No	No
	Does the policy present alternatives for accessing assisted reproductive technologies?	No	No	No
2 - Right to give birth in an assisted, humanized, and violence-free manner throughout the gestational and postpartum periods	Does the policy provide guidelines for access to prenatal and postpartum care?	Yes	Yes	Yes
	Does the policy address cases of obstetric violence?	No	No	Yes
	Is childbirth addressed as a physiological moment?	Yes	No	Yes

3 - Access to safe abortion	Does the policy provide guidelines for humanized, safe-abortion care?	Partially	No	Partially
	Does the policy provide a humanized care network for cases of abortion and legal abortion?	No	No	No
	Is there a provision for conscientious objection by healthcare professionals regarding access to safe abortion?	No	No	No
4 - Social determinants of health	Does the policy address the effects of racial inequalities on health/illness processes?	No	No	Yes
	Does the policy address the effects of income and/or regional inequalities on health/illness processes?	Partially	No	Yes
	Does the policy address the effects of inequalities in sexual orientation and gender identity on health/illness processes?	No	No	No
	Total criteria met**	4/12	2/12	6,5/12

Source: Developed by the author.
* Possibilities of responses: Yes, No, and Partially
** The value corresponds to the number of affirmative responses out of the twelve criteria.

The analytical matrix is structured in four axes and twelve criteria. The four axes – access to family planning; right to give birth in an assisted, humanized, and violence-free manner throughout the gestational and postpartum periods; access to safe abortion; and social determinants of health – are the translation of the three pillars that support the concept of reproductive justice. The axes make it clear that multiple factors must be considered in order to develop a public policy that seeks or engages with the notion of reproductive justice.

The twelve criteria proposed for analysis point to elements that, according to the literature on reproductive health, are the most beneficial for women's health in a context of respect for human rights, in which health is understood not only as the absence of disease, and the social determinants of health are considered an integral part of healthcare. In the matrix, the criteria can be met, not met, or partially met.

Based on the four axes and twelve criteria, we propose that scenarios characterized by greater reproductive justice fully meet most of the criteria. Conversely, the fewer the criteria that are met, the greater the scenario of reproductive injustice.

In the following section, we will present the women's health networks. Throughout the presentation of each one, we will return to the analytical matrix (Table 1) in order to understand whether or not the networks contribute to a scenario of access to health with greater or lesser respect for the human rights of women.

Childbirth and postpartum care networks from 2011 to 2024

A universal, comprehensive, and free healthcare system, with different management levels and serving over 200 million people across five Geographic Regions with more than one hundred macro-regions of health, represents a major challenge regarding the

coordination of initiatives to ensure effective access to high-quality public health[11]. In 2010, considering different demands and the fragmentation of care and management in the Health Regions, and "to ensure that the user receives the set of actions and services they need effectively and efficiently"[12], five thematic healthcare networks, eleven health research networks, and eight health service networks were launched. According to the ordinances that establish them and the documents that provide their guidelines, each of the thematic networks operates with specific funding and protocols aimed at integrating care at the various complexity levels and coordinating municipal services, primary care services, and state and federal health services, including the specialized network[12].

The pregnancy, childbirth, and postpartum care network aims to reduce maternal and neonatal morbidity and mortality, meeting the goals internationally assumed by Brazil[1,2]. Considering the incremental nature of the public policy cycle and based on the sequence of documents on the pregnancy, childbirth, and postpartum care network, it can be stated that, since 2011, it has been organized through three different initiatives, discussed in detail in the following subsections.

Rede Cegonha

Established by Ordinance No. 1459/2011 of the Ministry of Health, the RC is defined as:

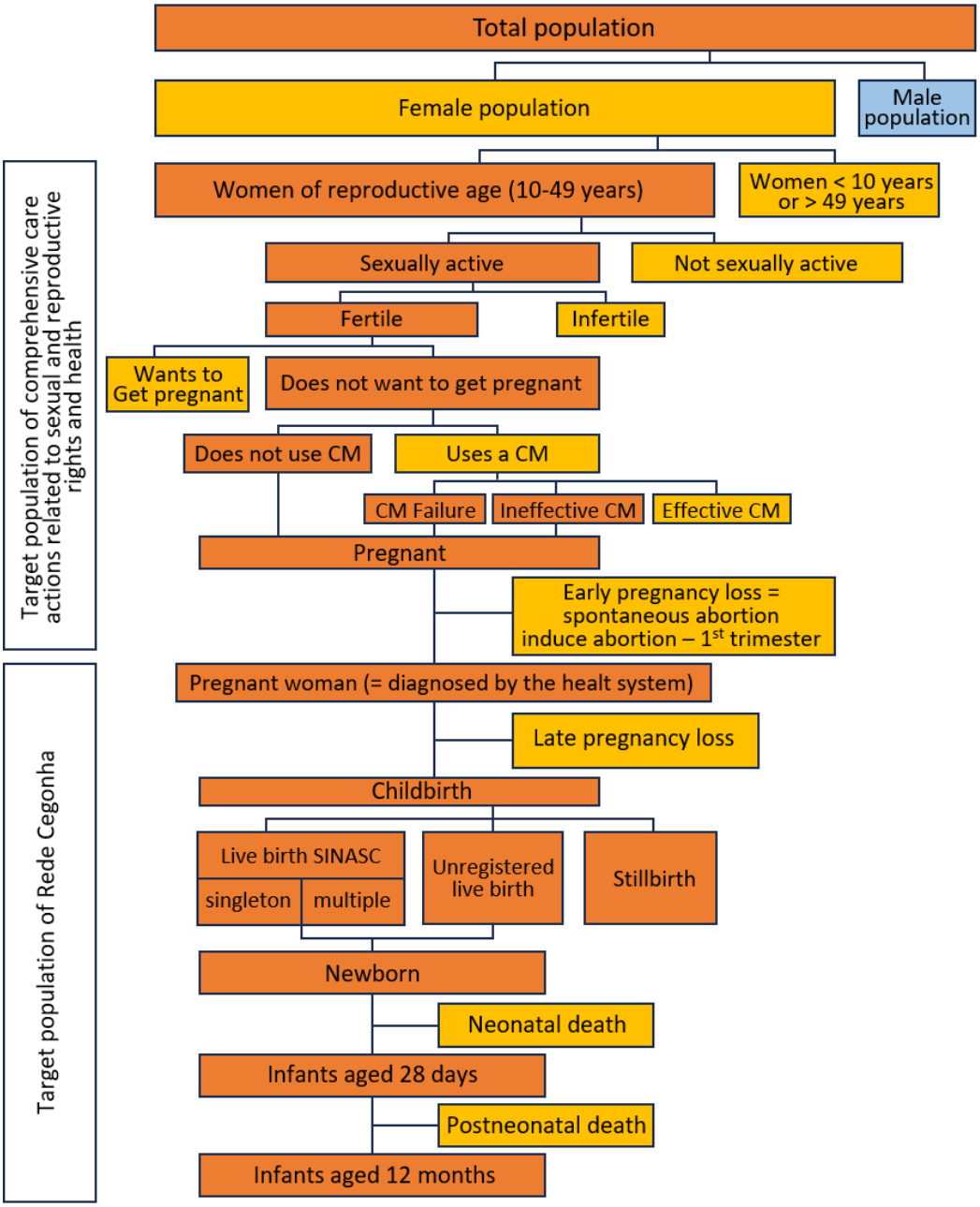
> [...] a care network that aims to ensure women's right to family planning and humanized care during pregnancy, childbirth, and the postpartum period, as well as to guarantee children's right to a safe birth and to a healthy growth and development[13].

Among its principles, the policy recognizes the need to respect human rights; the guarantee of sexual and reproductive rights of women, men, young people, and adolescents, focusing on gender and equity; and the respect for cultural, ethnic, and racial diversity. These elements are aligned with what the concept of reproductive justice advocates as necessary for designing policies aimed at respecting human rights with social justice.

The ordinances that structure the RC[13-15] define its guidelines and forms of funding, incorporating care protocols for high-risk pregnancies, the organization of services such as the Normal Birth Centers (CPN) and the Houses for Pregnant Women, Infants, and Postpartum Women (CGBP), and the material needs for the operation of the services that constitute the RC. The technical document that we analyzed (Section b)[16] establishes care parameters, dimensions the demands for beds and examinations, and estimates methods for calculating the demand to be met based on the population and internationally adopted parameters. For this dimensioning, the document estimates the size of the population targeted by the policy and analyzes the public that benefits specifically from the RC. This provides relevant information for reflections on the Network and its interface with the concept of reproductive justice.

Figure 1, extracted from Section b[16] (p. 5) and translated below, defines the public of the RC, separating the population that should be served by comprehensive care actions related to sexual and reproductive rights and health from that which should be served by the RC. This last group consists of pregnant women diagnosed by the health system, live births, newborns, and children up to 12 months old. In the process of defining the public that can benefit from the RC, contrary to what the ordinances that regulate the creation and operation of the RC stipulate, many people of reproductive age are excluded from this public.

Figure 1. Estimation process of the target population of rede cegonha.



Source: Parameters for care programming[15]. Section b - Pregnancy, childbirth, and postpartum care network (Section b), p. 5.
CM = contraceptive method.

It is important to note that, from the perspective of reproductive justice, people who need support to be able to access assisted reproductive technologies and family planning methods are excluded from the RC public, as well as transgender men and people who need or have had abortions. Thus, when we consider the axes of access to family planning and the right to care within the proposed analytical matrix, a gap becomes evident in the discussion of contraceptive methods and of care for abortion cases, including spontaneous abortions. Concerning the lack of care for abortion cases, the exception is care for high-risk pregnancies, as the specific Ordinance[12] establishes that health professionals must follow the protocols for legal abortion care, safe care for spontaneous abortion, and access to post-abortion counseling services. Therefore, we can state that a scenario of reproductive injustice prevails with regard to axes 1, 2, and 3 of the proposed matrix (Table 1).

In calculating population parameters[13] to estimate the number of beds and professionals for the RC at the territorial level and to plan the delivery of care for high-risk pregnancies, the criteria are the female population of reproductive age, its distribution by states and major regions, the prevalence of diseases involved in high-risk pregnancies, the number of hospitalizations, and comparison with the levels of care in other countries. Markers such as race/color groups, level of schooling, and income of the analyzed women are not considered for calculation purposes, which denotes that the social determinants of health are not taken into account in the parametrization of healthcare actions for women potentially benefiting from the RC. Thus, reproductive injustice also prevails in Axis 4, regarding the framework of the policy adopted by the RC (Table 1).

Evaluations of the RC conducted in 2017[16-18] indicate that there has been significant progress in the quality of childbirth and postpartum care in Brazil since the Network's implementation, with improved qualification and humanization of childbirth[16-18]; a reduction in the interventionist and physician-centered approach to pregnancy, childbirth, and postpartum care[16,17]; and a still incipient reduction in the number of cesarean sections, but with progress towards meeting the guidelines of the World Health Organization (WHO)[16-18]. Among the obstacles to progress and barriers to the consolidation of improvements in maternal mortality rates, racial[18] and regional inequalities in access to healthcare[16,17] still prevail, as well as a lack of knowledge or interest among healthcare professionals[18], causing the discrepancies we saw at the beginning of this article regarding the mortality of Black and White women.

Thus, considering the proposed matrix, the RC fully meets three reproductive justice criteria, partially meets two, and does not meet seven criteria, resulting in a situation of reproductive injustice despite the advances mentioned in the literature (Table 1).

Rede de Atenção Materno-Infantil (RAMI)

The RAMI was established by Ordinance No. 715/2022, issued by the Ministry of Health on April 4, 2022. The issuance of the ordinance proposing to replace the RC stems from the diagnosis that there is a regulatory problem that determines an excess of maternal and neonatal mortality, with the RC functioning in a "precarious manner

and with major flaws in the effectiveness of the care delivered to pregnant women"[19] (p. 1). Among the principles of the RAMI, the mention of human rights, equity, and respect for cultural, ethnic, and racial diversity stands out. The reference to sexual and reproductive rights is replaced by family planning and responsible sexual behavior. The mention of gender is also suppressed, which is symptomatic of what Louzada et al.[20] point out as a repressive attack on policies targeted at gender equality, aiming to dismantle and revoke them.

According to the Regulatory Impact Analysis (AIR), the problems of the RC derive from a fragmented network, random incentives for services, absence of well-defined funding criteria, concentration of actions and services in some regions, isolated qualification strategies without proof of effectiveness, and poor monitoring of the use of the transferred resources[19] (p. 9). The document also mentions the need for qualified health professionals and the performance of society, "which fails to claim its rights"[19] (p. 4), and, due to this, is assisted by ineffective and excessively costly public policies[19]. Unlike the RC, the RAMI would bring greater efficiency in the use of public resources, something considered central in a scenario of fiscal constraint[19] (p.16).

The documents that structure the RAMI reveal a change in the design parameters of childbirth and postpartum care, emphasizing medical-hospital care and indicating a process centered on care provided by maternity hospitals and services with more than 500 births per year. One of the diagnoses present in the RAMI framework is that the high maternal mortality rates in Brazil derive from the lack of infrastructure in small services, which are incapable of offering professionally oriented childbirth care. Thus, instead of expanding services such as the Normal Birth Centers, the RAMI intended to incorporate them into the hospital environment and guarantee the existence only of centers located inside or near hospitals, without the possibility of adding new services.

While the RC focused on the physiological processes of childbirth and the debate surrounding the need to reduce the number of cesarean sections performed in Brazil, the RAMI advocates an interventional model with different low- and high-risk outpatient services that enable, for example, "to have adequate structure and staff for safe vaginal and cesarean deliveries, whether elective or immediate"[21], emphasizing the number of consultations provided by doctors and reducing the presence of obstetric nurses[22].

The emphasis on the interventionist model centered on hospitals and specialized care, which makes the parameters of childbirth and postpartum care regress[23,24], the lack of social participation, and the disrespect for the participatory spheres of health policies, such as the Tripartite Intermanagement Committee, Conass and Conasems[22], contrary to what is presented in the AIR and C-AIR documents, are the main criticisms made to the RAMI.

Regarding the data produced to justify the adoption of the RAMI, the AIR document compares maternal mortality rates between the major Brazilian regions and between countries longitudinally, in order to demonstrate the timid progress in the decline of maternal mortality. However, the study does not discuss differences in mortality rates between groups of women and addresses briefly, without presenting

data, the effects of poverty on women's health. Furthermore, the study does not comment on the increase in maternal mortality in the context of the COVID-19 pandemic, even though the data indicate a significant growth in maternal mortality in Brazil between 2018 and 2021: from approximately 52 deaths/100,000 births to 126 deaths/100,000 births[19].

Considering the axes and criteria of the matrix (Table 1), the RAMI fully meets two criteria – family planning and guidelines for prenatal, childbirth, and postpartum care – and does not meet the other ones, which denotes an extremely challenging scenario regarding reproductive justice, especially if it were fully implemented over a long period, which did not occur because it was discontinued in January 2023 through Ordinance No. 13/2023 of the Ministry of Health.

Nevertheless, it is relevant to consider that even the criteria met by the RAMI have problems in their form, insofar as they are distant from the perspective of sexual and reproductive rights and advocate responsible sexual behavior, which is defined neither in the ordinances nor in the technical documents. Regarding pregnancy, childbirth, and postpartum care, the emphasis on physiological processes and on the physician to the detriment of pregnant people allows an increase in the frequency of obstetric violence, which once again amplifies reproductive injustices.

Rede Alyne

Rede Alyne is defined by Joint Technical Note No. 220/2024-DGCI/SAPS/MS DAHU/SAES/MS as an initiative targeted at updating the RC, adapting the installed network to "new technologies, services, and epidemiological scenario, to address ethnic-racial and local-regional inequalities associated with the persistence of maternal and infant morbidity and mortality indicators in Brazil"[25] (p. 1). The diagnosis on maternal mortality identified the following challenges:

> [...] the high preventable maternal mortality; the increased percentage of premature births; disparities between the federative units; the effects of racism on access to and quality of care, observed in the higher mortality in the Black and Indigenous population; difficulties for achieving a qualified monitoring; and the underfunding of the Rede Cegonha[25]. (p. 1)

Regarding its principles, Rede Alyne reiterates the principles of the RC, but innovates by proposing the "promotion of equity, observing ethnic-racial inequities" and "the protection and promotion of the family-infant bond, especially for homeless people"[26]. In addition to homeless people, the provision of care for incarcerated individuals is also envisaged. As for its objectives, Rede Alyne also innovates by focusing on the reduction of mortality among Black and Indigenous populations and prioritizing the fight against ethnic-racial inequalities. Thus, concerning the axes of the analytical matrix in light of the concept of reproductive justice, Rede Alyne takes the social determinants of health into account, providing healthcare in a scenario of reproductive justice.

Regarding Axis 2, the right to childbirth care, Rede Alyne is the only one that meets all three criteria, with particular emphasis on the mention of obstetric violence. In this respect, the Normal Birth Centers are understood as an effective strategy to reduce this type of violence. Axis 3, concerning access to abortion and abortion care, is the one that shows the poorest response. That is, access to safe abortion has not yet been addressed systematically, despite abortion being one of the main causes of maternal mortality in Brazil.

Rede Alyne is still in the early stages of its implementation and, although it shows promise in building its foundations on those of the RC, which has already been implemented and evaluated, some of its instruments and proposals are innovative, broadening the conception of the childbirth and postpartum care policies. Among the networks analyzed here, it is the only one that mentions the National Policy for Comprehensive Women's Healthcare (PNAISM) in its documents, which could enhance its capacity to score among the axes if the PNAISM had strategies for implementing safe abortion and family planning. However, the relationship between the PNAISM and the pregnancy, childbirth, and postpartum care networks needs to be better explored, as the women's health policies and networks compete for the same funds, with a tendency towards substitution rather than complementarity when it comes to comprehensive women's care, and focus on the pregnancy-puerperium cycle[27-29].

Pregnancy, childbirth, and postpartum care networks and reproductive justice

The analysis of the three childbirth and postpartum care networks revealed a scenario of reproductive injustice, with improvements brought by the Rede Alyne proposal. The weakest points are access to family planning and safe abortion. The networks only focus on abortion in cases of spontaneous abortion in high-risk pregnancies. For the other cases, there are no indications of what should be done, even though abortions can occur even in desired pregnancies.

The silence regarding family planning, in turn, is symptomatic of the lack of governmental commitment to a relevant aspect of reproductive health. Although briefly mentioned in the RC and Rede Alyne, it is operationalized only through a calculation used to estimate the number of IUD implants for the women who would be treated in the RAMI. None of the networks addresses the issue effectively through the offer of different contraceptive methods, from condoms to long-acting hormonal methods. Brandão et al.[30] demonstrate that there are no substantial initiatives produced by the Brazilian National Health System (SUS) for promoting access to contraceptive methods, and some initiatives offered at the state level generally have a selective and often eugenic character, controlling the reproduction of socially vulnerable women, usually homeless women or adolescents. The initiatives lack social participation processes and a broad debate led or at least featuring those most affected by the decision to use the methods: the women users of the SUS.

As there is no specific guideline or program currently in place, and since the networks constitute the main initiative for comprehensive women's healthcare, it is high time that abortion and contraceptive care were given greater prominence. Table 1 presents the number of criteria met by each network, considering the twelve criteria established as parameters. The table indicates that, in its framework, Rede Alyne is the one that most closely aligns with a scenario of reproductive justice. It is a very recent initiative with a central concern for ethnic-racial and regional inequalities. It is also based on the advances achieved by Rede Cegonha in terms of humanizing care and reducing morbidity and mortality. It remains to be seen whether the advances it proposes will be implemented in the care provided for pregnant women, women in labor, and postpartum women on a daily basis.

Conclusion

The analysis of the three networks reveals a scenario of reproductive injustice that persists throughout the period, resulting from the lack of a more regular approach to the axes of reproductive justice, mainly the access to abortion. Furthermore, it is important to highlight that the effects of racial inequalities on access to public policies have not been systematically addressed, nor has institutional racism, which affects how Black, Indigenous, and Quilombola women and children are treated within health services. This has adverse repercussions, including excess morbidity and mortality. Analysis from the perspective of reproductive justice strengthens the need to adopt intersectional criteria when considering health policies for women. One point that requires further reflection is the lack of a comprehensive approach to women's health, as the focus is on a typical pregnancy-postpartum cycle when access to health policies and sexual and reproductive health is considered.

The proposed matrix proved to be useful as an analytical tool for the selected health policies. Further research can examine its applicability beyond the documents that structure the care networks, analyzing their implementation and assessing the progress made by the networks in the territory. In addition, considering that the Cegonha, RAMI, and Alyne networks exclude a large part of the population from their beneficiary public, it would be interesting to understand how the matrix can be applied to actions outlined in the PNAISM and whether these actions are aligned with the childbirth and postpartum care networks or not. This is a rich research agenda that has profound effects on how people define their reproductive choices, access public policies, and experience their human rights.

Considering the persistence of maternal mortality and the multiple scenarios of disrespect for the human rights of women, it is necessary to intensify the use of the concept in the design of public policies, making it a praxis also in the worldview of health managers. This can be achieved through the dialogues and cooperation historically constructed between women's movements, Black women's movements, and governments to advance health policies[20,27,29,31,32].

Data Availability

The contents underlying the research text are non-handwritten contents.

Conflict of interest

The author have no conflict of interest to declare.

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Gênero e raça desempenham papel fundamental no acesso à saúde. A redução da mortalidade materna tem sido um desafio perene da assistência à saúde às mulheres no Brasil. Usando análise documental e com base no conceito de justiça reprodutiva, este artigo analisa as propostas de redes de assistência a gestação, parto e nascimento criadas a partir de 2011: Rede Cegonha, Rede de Atenção Materno-Infantil e Rede Alyne. Os objetivos do artigo são: demonstrar a relevância do conceito como critério para o desenho de políticas de saúde para as mulheres; apresentar uma ferramenta específica a ser aplicada para avaliação de políticas públicas; e aplicar a ferramenta desenvolvida para avaliar como as redes de assistência ao parto e puerpério têm incorporado os determinantes sociais de saúde e suas interseccionalidades a seu desenho.

Palavras-chave: Mortalidade materna. Justiça reprodutiva. Direitos reprodutivos. Determinantes sociais de saúde. lnterseccionalidade.

Género y raza desempeñan un papel fundamental en el acceso a la salud. La reducción de la mortalidad materna ha sido un desafío perenne de la asistencia a la salud de las mujeres en Brasil. Usando el análisis documental y con base en el concepto de justicia reproductiva, este artículo analiza las propuestas de redes de asistencia a la gestación, parto y nacimiento creadas a partir de 2011: Red Cigüeña, Red de Atención Materno-infantil y Red Alyne. Los objetivos del artículo son: demostrar la relevancia del concepto como criterio para el diseño de políticas de salud para las mujeres, presentar una herramienta específica para aplicarla en la evaluación de políticas públicas y aplicar la herramienta desarrollada para evaluar cómo las redes de asistencia al parto y al puerperio han incorporado los factores determinantes sociales de salud y sus interseccionalidades en su diseño.

Palabras clave: Mortalidad materna. Justicia reproductiva. Derechos reproductivos. Determinantes sociales de salud. lnterseccionalidad.