saúde
EM DEBATE

CASE STUDY

Access to contraceptives and the right to health in Angola: experiences of a woman and pharmacist

Acesso aos contraceptivos e direito à saúde em Angola: experiências de mulher e de farmacêutica

Elisa Dulce João Fundanga Calipi[1], Fernanda Manzini[2], Silvana Nair Leite[1]

DOI: 10.1590/2358-289820241408775I

ABSTRACT This report consists of what Conceição Evaristo calls 'writing and living' – the writing of black women, which mixes with experience, their memories, and the memories of their people, aiming to disturb consciences and echo our stories. The author's 'writing, living and self-seeing' is recognized as the 'writing of the soul', from where each woman writes considering the world she lives in. It aims to briefly reflect on access to medicines, focusing on the access to contraceptive methods in Angola, based on the author's experience. It is a qualitative study, and data were collected through documentary research, field study, and interviews. Content analysis was adopted for data processing. Access to contraceptive methods in Angolan territory is incipient, a result of ineffective public policies and good governance, as well as ineffective external interference. These are reinforced by colonial heritage, which provides approaches in disagreement with local needs. Sexual and reproductive rights must be seen as a political and public health issue inherent to human dignity, beyond the eugenic perspective of birth control.

KEYWORDS Health services accessibility. Right to health. Angola. Contraceptive agents.

RESUMO *Este relato apresenta uma proposta do que a escritora Conceição Evaristo chama de 'escrevivência' – escrita da mulher negra, que se mescla com vivência, relato de memórias e memórias de seu povo, visando incomodar consciências e ecoar nossas histórias. O 'escrever, viver e se ver' da autora é reconhecido como 'escrita da alma', lugar onde cada mulher escreve considerando o mundo que vive, de uma forma integrada. Visa fazer uma breve reflexão sobre o acesso aos medicamentos, tomando o acesso aos métodos contraceptivos em Angola como recorte, tendo em conta a vivência da autora. É um estudo qualitativo e a coleta de dados foi feita por meio de pesquisa documental, estudo de campo e entrevistas. Para o tratamento de dados foi adotada a análise de conteúdo. Identificou-se que o acesso aos métodos contraceptivos em território angolano é incipiente, resultado de políticas públicas e boa governança pouco efetivas, bem como a interferência externa pouco resolutiva. Estes, são reforçados pela herança colonial, que propicia abordagens em desacordo com as necessidades locais. É fundamental que os direitos sexuais e reprodutivos sejam encarados como questão política, de saúde pública e inerente à dignidade humana, para além da perspectiva eugenista de controle de natalidade.*

PALAVRAS-CHAVE *Acesso aos serviços de saúde. Direito à saúde. Angola. Anticoncepcionais.*

[1] Universidade Federal de Santa Catarina (UFSC) – Florianópolis (SC), Brasil.

[2] Escola de Saúde Pública de Florianópolis (ESP-SC) – Florianópolis (SC), Brasil.
manzinifer@gmail.com

This article is published in Open Access under the Creative Commons Attribution license, which allows use, distribution, and reproduction in any medium, without restrictions, as long as the original work is correctly cited.

Introduction

At the age of 19, I went to the gynecologist at a private health service (private clinic) in the municipality of Lobito – Angola, seeking an adequate method of contraception (EDJFC, first author). The physician was an aged Russian. After telling him that I wanted to use contraceptives, he said that I should not resort to contraceptive methods, as I was too young, so I left without any guidance. When I asked the (Angolan) nurse about the conduct, she reinforced the same speech, saying that they do not provide guidance or options of contraceptive methods for young people, and that ideally I would have several children and only then resort to contraception. Frustrated with the health team's advice, I shared this fact with a university colleague, who told me the name of the contraceptive she used and said she had bought it at a local store. So, I did the same and, from then on, I was never interested in going to a women's health service, not even to have access to contraceptive methods in Angola.

Eight years later, having lived in Brazil for ten years, while I studied and graduated in Pharmacy, I had my son and then studied Multiprofessional Residency in Family Health. I returned to Angola for data collection for my master's thesis in Pharmaceutical Assistance. I searched for documents and observations on the forms of access to essential medicines and pharmaceutical services in that country. I was influenced by the training and professional experience as a pharmacist in Brazil, based on the assumption that access to medicines is a citizen's right and a condition for the right to health.

Article 25 of the Universal Declaration of Human Rights states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family [...]"[1]. Corroborating this premise, the 1948 Universal Declaration of Human Rights established the right to health as an essential good for every individual[2], and the 1966 International Covenant on Economic, Social, and Cultural Rights[3], ratifies the right to health as a fundamental human right.

In a study on community perceptions and perspectives on health systems in Africa, respondents defined health as "physical, mental, emotional, spiritual, social, and economic well-being"[4]. Thus, good health and well-being are directly related to factors such as maximizing healthy living, minimizing exposure to risk factors in favor of health and well-being, and minimizing avoidable problems[5].

Reproductive health is based on human rights and consists of having human sexuality and reproduction safely and satisfactorily, where human beings must have the freedom to choose their experiences and decisions[6]. Currently, sexual and reproductive rights represent the commitment of governments to ensure access to health for women in a more targeted way and are referred to in Sustainable Development Goal (SDG) five, on gender equality, proposing the elimination of all forms of violence and harmful practices, as well as ensuring universal access to sexual and reproductive health and reproductive rights. The States are committed to providing better conditions to ensure gender equality[7].

Reproductive rights, as they are known today, were the result of the constant and insistent movement of women who demanded that the United Nations (UN) included this topic in its agenda[6]. After several conferences, the report of the Cairo conference, held in 1994, is considered one of the main milestones in the fight for sexual and reproductive rights, ratifying these as human rights, where freedom and autonomy should be encouraged, as well as the commitment of (public, private and philanthropic) management in the creation, implementation, and maintenance of policies that stimulate the permanent development of these rights[8]. As a way of specifically including African women, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, known as the women's protocol, was ratified and entered into force in 2005[9]. This is seen as an incentive

to promote gender equality, respect for human rights, and the promotion of social justice to women, including the right to make decisions about their bodies[10]. Angola committed to this protocol in 2010[8].

Access to essential medicines is one of the important prerogatives to ensure quality of life. This guarantee is reinforced as the parties strive to reduce discrepancies in the provision of health services while investing sufficient resources in actions such as: encouraging science, technology, innovation, the affirmation of integrated public policies focused on the defense of life[11]. Access to contraceptives is fundamental when talking about sexual and reproductive rights, as it provides economic and social empowerment and decreases maternal and neonatal mortality. However, studies report that this access is unequal when taking into account issues such as color, race, geographic location, nationality, and social class[12-15].

In addition, sociocultural, generational and relational characteristics directly influence the way these health services can be offered. Therefore, stratification leads to an increase in inequalities regarding access to sexual and reproductive health services[12].

From 2010, public policies began to be structured in Angola, after a long period of political instability and great institutional weakness. The National Health Policy describes that health is a human right, and that "the State is committed to ensure the availability of the physical resources of the health system"; however, "within the limits of its capacities [...]"[16]. This description has permeated the content of the country's legislation from the document that created the National Health Service in 1975 (then based on universality and gratuity), a time that marks the liberation from colonial domination to the Constitution of the Republic and the National Health Policy, both updated in 2010 and effective today. The rules and policies mention that health is a right of the citizens, but they do not describe which entity is responsible for guaranteeing access to the right to health[17].

Likewise, current pharmaceutical policies follow the trend of showing the State as a regulator and not a provider in ensuring access to essential medicines[17]. Thus, over the years, the propositions of health legislation for the country have not emphasized the detailed description that access to health and medicines is a fundamental human right and who are the actors responsible for this process[17], which reverberates in significant inequities in the quality of life of populations[18].

Based on this context, the following report and reflection are developed. It aims to briefly reflect on access to medicines, focusing on the access to contraceptive methods in Angola. The report also aims to consider the experience of the first author, an Angolan woman, regarding contraception and the Brazilian healthcare system[19,20].

Material and methods

This is an experience report within the descriptive studies, based on the author's experience while collecting data for the research project for the master's degree in Pharmaceutical Assistance. The experience report aims to describe a professional experience that can contribute to a certain field[21]. Qualitative research aims to understand the aspects of research in its sociocultural dimension and can be expressed through beliefs, values, opinions, representations, and behaviors. It also aims to interpret the meanings of phenomena within natural contexts[22].

Data collection included a documentary search in local institutions, in legislations, ministerial and institutional websites, such as the Ministry of Health of Angola (MINSA) and the Angolan Pharmaceutical Association (OFA) and gray or unconventional literature.

Twelve interviews were conducted with employees of the State Department of Health allocated in different sectors and with different hierarchies. The interviewees were selected according to specific criteria, and different

interview scripts were applied, respecting the specificities of the position. Interviews were recorded and subsequently transcribed and coded using Nvivo® software. To ensure anonymity in the analysis of the results, the participants were code-labeled.

For a better understanding of the situation, an observational survey was carried out from July to August 2019, in the provincial health delegation (State Department of Health) of a province of Angola, where the researcher followed the interviewees for about 100 hours and registered her observations in a field diary. The events of the observation and the progress of the research were registered in a field diary, as well as the researcher's analysis of the events witnessed[23].

The research was approved by the Ethics Committee on Research Involving Human Beings of the State University of Santa Catarina – CEPSH/UDESC (CAAE: 11955719.30000.0118/ Opinion: 3.376.034) and by the provincial health delegation (State Health Department) of the observation site in Angola. All participants signed the Informed Consent Form.

Content analysis, understood as a set of research techniques whose objective is to analyze the meanings and approach of the information contained in the messages, was adopted for data processing[24]. The interpretative analysis modality was used based on the inductive method. According to Lakatos and Marconi[25], this approach aims to lead to conclusions whose content is much broader than that of the premises on which they were based.

Results and discussion

During the observational research, I identified several boxes of Intrauterine Device (IUD) with a short shelf life in the medicine storage and asked one of the employees if it was difficult to distribute them, as there were plenty of them there. On site, there were some inspectors representing the Ministry of Health to evaluate services and infrastructure. One of them immediately responded with the following statement:

> *You have to let it expire anyway, you should not distribute these things, you have to let the children be born and stop copying these things from the West.*

In addition, there were plenty of oral contraceptives in the storage. During the conversation, another person stated that: *"the contraceptives are sent according to the request of the health units or some representative of the province, or municipality"*.

What do these facts show us about access to medicines as a right to health in Angola? What social and contextual values delineate the accessibility and use of contraceptives in that country?

The statements and facts described above aroused reflections and memories of the author as a teenager living in Angola. At what point does the statement mentioned above, coming from a young man, with a high social position, reflect the concern for women's health and/or the influence of the West on the daily life of Angolan women? This occurs in a country where escaping from fatherhood is a social phenomenon and a public health issue that has increased or even gained greater visibility in recent years, resulting in the worsening of social problems such as the increase in school dropout, the maintenance of child labor, child prostitution, the increase in the level of violence, that is, it is directly related to family organization, the degree/level of health and directly affects the quality of life of the population[26,27].

The abundance of contraceptive medicines stored, but out of reach of women, contrasts with the common preconception that the issues of accessibility to medicines in low-income countries have to do with the unavailability of public funding to buy it, or the insufficiency of products from international humanitarian actions[28-32]. The case observed

reveals that, if by chance the coordinator of the health unit also understands that contraception 'is a Western thing' and that children must be born, there will be no contraceptives available in the health units and, therefore, there will be no access to them. Thus, the possibilities of encouraging family planning are nullified and those women who wish to resort to any of the methods offered by the State, as a public health policy, should seek other means. Those who do not have the financial resources, knowledge, or autonomy to do so, will have no access to contraceptive methods.

Based on these reports, it is important to note that sexual and reproductive rights are an inseparable component of human rights; therefore, they are universal and independent of beliefs, social class, race, color, or any personal particularity; they are essential for the physical, emotional, mental, and social well-being of people[33].

In a study on the history of women's health policies in Angola, Rocha and collaborators[34] identified that, over the years, international partnerships were instrumental for the materialization of improvements in the area of women's health, especially investments from the Swedish government. On the other hand, since partnerships are not specific to a population group, much of what was being built was lost or stagnated over time. Possibly, cultural factors such as the condition of subalternity interfered with this conjuncture[34].

The scenario is not yet favorable: in 2017, the maternal mortality rate was 241 deaths per 100,000 live births. Considering that Angola was the 14th worst country in this ranking, it currently occupies the 41st position and is the second-worst country among the African Portuguese-Speaking Countries (Palop) and the Community of Portuguese-Speaking Countries (CPLP), registering about three thousand deaths per year[35]. The country has a fertility rate of 6.16 and 5.96 per woman for the years 2017 and 2020, respectively[36]. The rate may indicate greater difficulty for families concerning food and education of quality, for example, as well as a decrease in the insertion of women in the labor market. Paiva and Caetano[37] report that maternal mortality tends to be a useful indicator to assess the guarantee of a country's reproductive rights, as many of these are preventable. Given this scenario, it is important to note that sexual and reproductive health is a public health issue that goes beyond the decision to have children and, therefore, needs to be treated as a state policy.

In African countries, access to contraceptive methods is still admittedly insufficient and that is why the African Union, with its 53 member states, has confirmed its commitment to ensure universal access to sexual and reproductive health services by 2030[38]. The African Union reports that for every additional US$1 spent on contraceptive services, US$2.77 would be saved in the cost of providing better maternal, neonatal, and abortion care. Thus, a full investment would also result in a 78% decrease in the number of unplanned pregnancies, unplanned births, and unsafe abortions, and neonatal deaths would decrease by 71%, while maternal deaths would fall by 60%[38].

Angola has a predominantly young population, with a life expectancy of 63 years for women. The use of contraception by married women aged 15 to 49 years is 14% compared to 63% worldwide. Also, women aged 15 to 49 years represent 19% of all births when compared to women aged 35 years or older, who represent 16%[36].

Today, the concern of women who think about seeking health services focused on family planning is still the same as in 2011: in the interview, the nursing team asks questions such as: 'How many children do you have? How old are you?' And then, if the woman is young (less than 30/35 years old), they ask her to 'call her husband' to see if he is aware of her wishes and authorizes the procedure. In case the woman states that she does not have a partner, they deny the service, because she can get married at any time and her future husband may want to have children immediately. If the woman has never had children,

she is not ‘allowed’ to seek contraception, as in my experience.

There is also the embarrassment that, if requirements for the use of the contraceptive method are met, depending on the occasion, the healthcare providers responsible for authorizing the method in question (usually physicians) on the previous evaluation do not attend the service on that specific day, so it is necessary to attend the facility again, with no guarantees of getting the service you need. In a study on women’s fertility control in Uganda, the author mentions an episode. At a certain point in her life, she was denied access to contraceptives unless she brought a letter from her husband. So, she sat under a tree and scribbled a letter from a fake husband. Then, she had access to what she wanted[39].

Thus, instead of women experiencing sexuality without embarrassment, voluntary motherhood and self-determined contraception, they are subjected to various forms of violence by those who should focus on comprehensive care in an extremely intimate and personal matter[33].

As a consequence, generally the best way to access contraceptive methods without embarrassment is to have an acquaintance within the health service (often in maternity hospitals) who facilitates care, without going through the ordinary procedures, or even who takes the materials (chip or IUD) to be inserted in a private service. Or even with a healthcare provider in your workplace, regardless of distance. It is important to mention that many of these women are literate and have a considerable position within society. But what about those of who have humble conditions and greater needs, such as the culture of the ‘puerperal woman,’ which directly influences their dreams and freedom to do wherever they want?

A study on health inequities in reproductive planning in the Brazilian health system, the Unified Health System (SUS), identified that much of what is offered as contraceptive methods, specifically those designated as long-term reversible hormonal contraceptives, has a stigmatizing and discriminatory feature, under the justification of ‘protecting women in vulnerable situations.’ These inequities prevent actions to expand universal access for all women[12]. When I was pregnant in 2014, I remember having a prenatal appointment at a health unit in Florianópolis (at the time, I was 24 years old). The woman who was registering me asked: ‘Up to what grade did you study?’ She was very surprised when I replied that I was in the fifth year of the undergraduate course in pharmacy, after all, as Carneiro[40] mentions, black bodies are not allowed to be in certain places and/or to have certain positions.

Considering that the right to health involves essential aspects such as inclusion and non-restriction, it implies freedom, equity, and provision of services and all goods related to it without discrimination, so that everybody has access to it, either by its quality, quantity, location[41], many of these prerogatives are not available to the Angolan population when it comes to sexual and reproductive health. Thus, we are denied access to information and freedom of decision about our own bodies, outsourcing the decision to State representatives (healthcare providers and managers) and to men. A study conducted by Tamale[39] states that the narrative of the control of women’s sexual and reproductive rights, in addition to encouraging births, is closely related to an economic and separatist dependence where women are guaranteed unpaid and undervalued activities and men have the right to public life.

Many women do not even want to access women health services in its entirety. From this perspective, what is the point of promoting support programs for pregnant women and children, such as mosquito nets and nutrition programs, if the decision to be a mother involves a series of actors other than just the parents? How many deaths from ‘non-legal’ abortion attempts occur in the country? What kind of education are our children receiving regarding sexuality? Thus, our right to health is violated daily and in several ways. Therefore, it is clear that the cultural issue of

encouraging birth and the role of women in Angolan society is a field of study that needs to be carefully considered when talking about access to health services and medicines[34,42].

In Brazil, the update of Law no. 14.443/2022 was recently approved with changes in[43] rules on tubal sterilization and vasectomy. The updates include that the age drops from 25 to 21 years old, the authorization of the spouse is no longer necessary to perform the procedure, and the pregnant woman may request tubal sterilization during the delivery period[43]. A national study revealed that 32.7% of Brazilian women use oral or injectable contraceptives, but that most buy them on drugstores. Among the women who were using it, about 1.6 million said they had tried to obtain contraceptives at SUS but without success between 2013 and 2014[13], possibly due to medical prescription requirements or shortages.

Even in a developed country as Brazil, which is understood as democratic, the issue of women's rights still needs to be discussed and is also a public health issue. It is important to note that in Angola, there is no institutionalized document establishing access to contraceptive methods.

Telo[44] makes important observations on reproductive rights, noting that in African countries, it is necessary to consider the cultural component as a guiding thread. Another study states that, in Africa, it is also necessary to consider that family organizations differ greatly from the Eurocentric and Americanized view of what a nuclear and patriarchal family would be[45]. Therefore, the discussion is not only about procreating or not, it involves an entire community with its beliefs related to having children and that, despite being directed mainly to women, men are also required to have a certain number of children and the sooner the better[44]. In addition, the author also refers to the colonialist content in the documents and international aid provided to low- and middle-income countries in the area of reproductive health, which often are aimed at stopping procreation and do not consider the social determinants involved in the process.

A study on pharmaceutical assistance and global health governance in times of COVID-19[46] states that partnerships between States need to consider a 'comprehensive public health approach,' with active participation and inclusion of the various actors, as it reverberates in the reduction of extreme dependence and inequities.

In the specific case of Angola, international partnerships are fragile due to corruption, lack of transparency, and external dependence. This scenario facilitates the condition of vulnerability, such as, for example, in receiving 'aid and donations' without the critical sense and identification of local needs and has a direct influence on the autonomy of the country concerning the provision of health services[17].

Thus, reproductive health has to do with human dignity, especially female dignity. The Guide to Reproductive Health[47] states that reproductive health implies autonomy, safety, and freedom in reproductive and sexual decisions, including the provision of health services, information, and efficient and safe methods for their planning by men and women. In Africa, more than contraception limited by birth control, we need health services that can offer actions that guarantee the right to health considering specificities of class, race, gender, and economic power[48].

In this context, the concept of reproductive justice should be considered, which seeks to revisit the discussion that this is, above all, a political topic and involves an economic, political, and emotional value, so it cannot be associated with a strictly female role[12].

Therefore, women's bodies are controlled by the State, the pharmaceutical industry, the church/religion and society. The State normally defines public policies and, at the same time, decides who, where, how, and when women can access reproductive services; the pharmaceutical industry stimulates the acquisition of certain products, with research

focused exclusively on women and almost not considering men as active individuals in the reproductive and sexual health process; religion determines and dictates rules and behaviors considered right and/or wrong and, finally, society, with the entire construction of structural racism, places itself in the position of defining what represents a morally acceptable standard of living/family as the number of children, the moral obligation to have them, who may not have them, how to educate them[12,14].

The reflection generated by the issue of access to contraceptive methods contributes enormously to broadening the understanding of the issue of access to medicines in Angola or in any other scenario. It is evident that we need to understand medicines as a symbolic object, full of meanings and values[49] that go far beyond the administrative logic of selection, purchase, and distribution. In the case reported in this article, contraceptive drugs and IUDs were expiring and abundant in stock. Therefore, there was no lack of products or financial resources. Likewise, there were also no transportation, storage or other physical structure limitations that could hinder the availability of products. The impediments are related to a social structure, much more complex in terms of interventions and resolution. However, these issues are not considered in any nationally known pharmaceutical policy.

Final considerations

Access to contraceptive methods in a safe and rational manner is essential in guaranteeing women's sexual and reproductive rights. In Angola, access to these is still incipient, because there are numerous barriers, such as structural issues (high rate of corruption, poverty, organization of the health system and poor public policies) and the cultural component, which permeates all actors involved and needs to be understood in its complexity. It is important to note that sexual and reproductive health is not limited only to birth control, rather, its effectiveness consists in guaranteeing human dignity; therefore, it is a non-individualistic agreement.

To reduce these barriers, it is necessary to recognize the weaknesses of the health system while thinking about effective government strategies. These should not be limited to the dependence on projects carried out by non-governmental organizations or isolated private institutions, but also consider indigenous actions such as identifying the number of health units that provide access to information and services, the quality of this information, and the qualification of all professionals present in these units. Associated with this, it is necessary to consider the various determinants involved in the process continuously, so that it reverberates in the reduction of inequities and guarantees the integrality of care[50,51].

Thus, it is challenging to continue the study on the nuances involved in ensuring sexual and reproductive health, with accessibility and quality, in the African female community and, more specifically, the Angolan one. And in doing so, one must take into account the violation of rights that these women have been suffering over time, so that interventions are made by them, with them and for them.

Collaborators

Calipi EDJF (0009-0009-8445-431X)* contributed to the project design, data collection, and analysis for the work, writing, and final approval of the version to be published. Manzini F (0000-0002-3047-4632)* and Leite SN (0000-0002-5258-9684)* contributed to the project design, data analysis for the article, critical review of the content and participated in the approval of the final version of the manuscript. ■

*Orcid (Open Researcher and Contributor ID).

References

1. Organização das Nações Unidas. Artigo 25: Direito a um padrão de vida adequado. Brasil: OMS; 2018. [acesso em 2022 mar 20]. Disponível em: https://nacoesunidas.org/artigo-25-direito-a-um-padrao-de-vida-adequado/.

2. Babar Z, organizador. Pharmaceutical Policy in Countries with Developing Healthcare Systems. 1. ed. São Paulo: Adis; 2017.

3. Fundo das Nações Unidas para a População. Pacto Internacional de Direitos Econômicos, Sociais e Culturais. 16 dez 1966. [acesso em 2023 set 20]. Disponível em: http://www.unfpa.org.br/Arquivos/pacto_internacional.pdf.

4. Organização Mundial da Saúde, Escritório Regional da OMS para a África. Sistemas de Saúde em África: Percepções e Perspectivas das Comunidades. Brazzaville: OMS; 2012. [acesso em 2023 abr 20]. Disponível em: https://www.afro.who.int/sites/default/files/2017-06/portuguese---health_systems_in_africa----2012.pdf.

5. Organização Mundial da Saúde. O Estado da Saúde na região africana da OMS: uma análise da situação da saúde, dos serviços de saúde e dos sistemas de saúde no contexto dos objectivos de desenvolvimento sustentável onde estamos onde precisamos de ir. Brazzaville: OMS; 2018. [acesso em 2023 abr 20]. Disponível em: https://iris.who.int/bitstream/handle/10665/275287/9789290341222-por.pdf?sequence=1&isAllowed=y.

6. Fundo das Nações Unidas para a População. Relatório da conferência internacional sobre população e desenvolvimento – plataforma de Cairo. Cairo: FNUAP; 1994. [acesso em 2023 set 20]. Disponível em: http://www.unfpa.org.br/Arquivos/relatorio-cairo.pdf.

7. United Nations. Transforming our world: the 2030 Agenda for Sustainable Development. Genova: WHO; 2015. [acesso em 2022 mar 10]. Disponível em: https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf.

8. Telo FCA. Direitos reprodutivos e (des)colonização: notas preliminares sobre a colonialidade dos direitos reprodutivos. Cad. Gênero Divers. 2019 dez; 5(4).

9. African Union. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. Ethiopia; 2003. [acesso em 2023 abr 20]. Disponível em: https://au.int/en/treaties/protocol-african-charter-human-and-peoples-rights-rights-women-africa.

10. Musoke HD. Direitos sexuais e reprodutivos: uma crítica ao artigo 14 do protocolo dos direitos das mulheres da África. R. Dir. sanit. 2012; 12(3):57-118.

11. Portugal A, Bermudez J. Santos R. Acesso a medicamentos: Direito Humano Fundamental! In: Bermudez J, organizador. Solidariedade ou Apartheid? Lições aprendidas na pandemia. São Paulo: Escola Nacional de Formação e Qualificação Profissional dos Farmacêuticos; 2022. p. 162-5.

12. Brandão ER, Cabral CS. Juventude, gênero e justiça reprodutiva: iniquidades em saúde no planejamento reprodutivo no Sistema Único de Saúde. Ciênc. saúde coletiva. 2021; 26(7):2673-82.

13. Farias MR, Leite SN, Tavares NUL, et al. Utilização e acesso a contraceptivos orais e injetáveis no Brasil. Rev Saúde Pública. 2016; 50(supl2):14s.

14. Fonseca C, Marre D, Rifiotis F. Governança reprodutiva: um assunto de suma relevância política. Horiz Antropol. 2021; 27(61):7-46.

15. Guedes KF, Raimundo VK, Bastos S. Saúde reprodutiva e o acesso a contraceptivos no contexto da pandemia de covid-19. Bis. 2021; 22(2):96-105.

16. Angola. Decreto Presidencial nº 262/10 de 24 de novembro de 2010. Aprova a Política Nacional de Saúde – revoga toda legislação que contra rie o presente decreto. Diário da República. 24 Nov 2010. [acesso em

2024 fev 28]. Disponível em: https://lex.ao/docs/presidente-da-republica/2010/decreto-presidencial-n-o-262-10-de-24-de-novembro/#:~:text=O%20presente%20documento%20de%20Pol%C3%ADtica,e%20os%20respectivos%20Planos%20Operacionais.

17. Calipi EDJF. Políticas Públicas relacionadas ao acesso aos medicamentos em Angola. Florianópolis. [dissertação]. Florianópolis: Universidade Federal de Santa Catarina; 2023.

18. Bermudez JAZ. Acesso a medicamentos: impasse entre a saúde e o comércio! Cad. Saúde Pública. 2017; 33(9):e00123117.

19. Mascarenhas ELO. Produção científica africana e afrocentricidade: beleza, saúde, cura e a natureza holística da ciência africana. [dissertação]. Salvador: Universidade Federal da Bahia; 2021.

20. Remenche MLR, Sippel J. A escrevivência de Conceição Evaristo como reconstrução do tecido da memória brasileira. Cad. Ling. Soc. 2019; 20(2):37-51.

21. Marconi MA, Lakatos EM. Metodologia do Trabalho Científico. 8. ed. São Paulo: Atlas; 2017.

22. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14. ed. São Paulo: Hucitec; 2014.

23. Gil AC. Métodos e Técnicas de Pesquisa Social. 6. ed. São Paulo: Atlas; 2014.

24. Bardin L. Análise de Conteúdo. São Paulo: Edições 70; 1977.

25. Lakatos EM, Marconi MA. Fundamentos de metodologia científica. 7. ed. São Paulo: Atlas, 2010.

26. Kinhama VC. Fuga à paternidade em Angola, província do Cuanza Sul, município da cela, (causas e consequências). REASE. 2022; 8(09):2675-3375.

27. Costa MC, Afonso AC, Campos MAS. A fuga à Paternidade à luz do Ordenamento Jurídico Angolano: Um olhar atento às causas e consequências no município do Mungo – Província do Huambo – Angola. Recima. 2023; 4(1):2675-6218.

28. Khatib R, Mckee M, Shannon H, et al. Availability and affordability of cardiovascular disease medicines and their effect on use in high-income, middle-income, and low-income countries: an analysis of the PURE study data. Lancet. 2016; 13(387):61-9.

29. Sado E, Sufa A. Availability and affordability of essential medicines for children in the Western part of Ethiopia: implication for access. BMC Pediatrics. 2016; 16(40):1-8.

30. Yamin AE, Maleche A. Realizing universal health coverage in East Africa: the relevance of human rights. BMC Int. Health Hum. Rights. 2017; 17(21):1-10.

31. Nnaji C, Wiysonge CS, Okeibunor J, et al. Implementation research approaches to promoting universal health coverage in Africa: a scoping review. BMC Health Serv. Res. 2021; 21(414):1-17.

32. Lohmann J, Brenner S, Koulidiati J, et al. No impact of performance-based financing on the availability of essential medicines in Burkina Faso: a mixed-methods study. PLOS glob. public health. 2022; 2(3):e0000212.

33. Telo SV, Witt RR. Saúde sexual e reprodutiva: competências da equipe na Atenção Primária à Saúde. Ciênc. saúde coletiva. 2018; 23(11):3481-90.

34. Rocha ENSGN, Rodrigues DP, Luchesi LB, et al. Trayectoria histórica de las políticas de salud de la mujer en Angola. Cult. de los Cuid. (Edición digital). 2018; 22(51):38-45.

35. E-global Notícias em português. Angola: Mortalidade materna registra três mil vítimas por ano. E-global. 2023 mar 10. [acesso em 2023 mar 10]. Disponível em: https://e-global.pt/noticias/lusofonia/angola/angola-mortalidade-materna-regista-tres-mil-vitimas-por-ano/#:~:text=A%20posi%C3%A7%C3%A3o%20de%20Angola%20tem,lugar%2C%20tendo%20subido%2027%20lugares.

36. Population Reference Bureau. World Population Data Sheet: middle-africa. 2021. [acesso em 2023 mar 10]. Disponível em: https://interactives.prb.org/2021--wpds/wp-content/uploads/2021/08/2021-world--population-data-sheet-middle-africa.pdf.

37. Paiva CCN, Caetano R. Avaliação de implantação das ações de saúde sexual e reprodutiva na Atenção Primária: revisão de escopo. Esc Anna Nery. 2020; 24(1).

38. Guttmacher Institute. Investimento na Saúde Sexual e Reprodutiva na União Africana. [acesso em 2023 mar 9]. Disponível em: https://www.guttmacher.org/pt/fact-sheet/investing-sexual-and-reproductive-health--african-union#:~:text=As%20pol%C3%ADticas%20da%20Uni%C3%A3o%20Africana,as%20pessoas%20que%20deles%20necessitam.

39. Tamale S. Controle da Fertilidade das Mulheres em Uganda: Perspectivas sobre religião, direito e medicina. Sur - Rev. int. direitos human. 2016; 13(24):117-28.

40. Carneiro AS. A construção do outro como não-ser como fundamento do ser. [dissertação]. São Paulo: Universidade de São Paulo; 2005.

41. UN Committee on Economic, Social and Cultural Rights. General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4. [acesso em 2023 mar 20]. Disponível em: https://www.refworld.org/docid/4538838d0.html.

42. Goldenberg T, Stephenson, R. Applying a deviance framework to understand modern contraceptive use in sub-Saharan Africa. PLoS ONE. 2019; 14(5):e0216381.

43. Brasil. Lei nº 14.443, de 2 de setembro de 2022. Altera a Lei nº 9.263, de 12 de janeiro de 1996, para determinar prazo para oferecimento de métodos e técnicas contraceptivas e disciplinar condições para esterilização no âmbito do planejamento familiar. Diário Oficial da União. 2 Set 2022.

44. Telo FCA. Direitos reprodutivos e (des)colonização: notas preliminares sobre a colonialidade dos direitos reprodutivos. Cad. Gênero Divers. 2019 dez; 5(4):199-218.

45. Oyèrónké O. Conceituando gênero: os fundamentos eurocêntricos dos conceitos feministas e o desafio das epistemologias africanas. 2004. [acesso em 2023 mar 20]. Disponível em: https://filosofia-africana.weebly.com/uploads/1/3/2/1/13213792/oyèrónké_oy?wùmí_-_conceitualizando_o.

46. Ribeiro AA, Ricardi LM, Pontes MA, et al. Assistência Farmacêutica e governança global da saúde em tempos de Covid-19. Saúde debate. 2022; 46(133):501-17.

47. Fundo de População das Nações Unidas Brasil, Johnson & Johnson Foundation. Guia para saúde sexual e reprodutiva e atenção obstétrica: Informações, orientações e metodologias ativas para profissionais da Atenção Primária à Saúde. Brasília, DF: Enlace; 2022.

48. Musoke HD. Direitos sexuais e reprodutivos: uma crítica ao artigo 14 do protocolo dos direitos das mulheres da África. Rev. Dir. sanit. 2012; 12(3):57-118.

49. Lefebvre H. O Direito à Cidade. São Paulo: Editora Moares; 1991.

50. Lemos A. Direitos sexuais e reprodutivos: percepção dos profissionais da atenção primária à saúde. Saúde debate. 2014; 38(101):244-53.

51. Souza KV, Tyrrell MAR. Os fatos & atos relacionados ao (difícil) exercício dos direitos sexuais e reprodutivos: em recortes, o processo de viver de um grupo de mulheres de classes populares. Texto contexto – enferm. 2007; 16(1):47-54.

Received on 06/29/2023
Approved on 10/03/2023
Conflict of interests: non-existent
Financial support: non-existent

Responsible editor: Maria Lucia Frizon Rizzotto