Emergency contraception and adolescence: responsibility and ethics

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Abstract

Emergency contraception and adolescence: responsibility and ethics

In this paper we discuss particular aspects of the medical care of adolescents, taking into account their particular vulnerability in the social environment they live in and keeping in mind that, through their gradual maturity, they tend to exercise their autonomy in a growing series of independent actions that include the development of sexuality. With this understanding, we will reflect on the ethical aspects of emergency contraception, taking into consideration epidemiological aspects of unplanned pregnancy in the light of traditional principles of bioethics, including the provision of such a resource by the government.

Key words: Contraception. Family planning (Public Health). Pregnancy in adolescence. Adolescent. Bioethics

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Adolescence is a period in which significant discussions concentrate in discussions and eventual consensus, seeking better ways for its goods and fruitful course. As it a great wealth of diverse modifying events in individuals of biological, psychological, and social order, its experiencing is capable to generate different kinds of conflicts, deriving from hyper-dimensioned affective load, as well as little realistic and immature expectations about love and sexuality. *It should be face, given this phenomenon features in our society, as crucial and well defined stage of the growth and development process, whose registered mark is change connect to physical and psychic aspects of human being, inserted in the most diverse cultures* [1].

Biological changes constitute adolescence phase designed as puberty, in which hormonal burst and sexual maturation is included;

the adolescent, among other features, begins to have reproductive capability. Psycho-emotional changes were synthesized by Knobell and Aberastury in the nominated *syndrome of normal adolescence*[1], which describes the search for identity, the grouping trend, the development of abstract thought, humor variations, the singular temporal experience, the progressive separation from parents, and sexuality evolution. *These significant experiences may contribute both youngsters' vulnerability and towards construction of a secure self, and even entrepreneurial, which turns him into protagonist of changes and reconstruction of the future* [2].

Erikson states that adolescents' main task is to establish own and secure identity. However, there is a paradox request of limits*: I need that limits are set to me, but I am warning in advance that I will not respect the* [2]. Sexual structuring is relevant part of this process, since gender roles – female and male – are fundamental from the socio-cultural stand point: experience of sexuality is targeted to genitals, while there is the search for the other, for idealized love, of affective achievement, even if immature [2].

It is worth mentioning regarding this phase issues related to vulnerability and risks. The first one is not youngster's prerogative, but it must be specially visualized during this phase of his development. Risk, in its turn, encompasses both the biomedical point of view and those related to social and behavioral dimensions: *risk is a technical proposition that associates vulnerability concept to damage or undesirable outcome probability. In parallel arises the concept of protecting factor, used basically as prevention mechanism, but it may aim quality of life as well* [3].

It is important to add that risk factor may be present in adolescents themselves, in families, and in society at large, within varied reference groups, among which stands out school, work, group of friends, health, justice, and socio-economical level, cultural insertion, and government policies [3]. To set into context in a broad and comprehensive way the risk-protection binomial in adolescent's care is an unavoidable action searching for better outcomes related to this peculiar age group.

Historical comments

Currently, sexual education is imperative in as much as scourges like precocious pregnancy, abortion and sexually transmitted diseases may be administered in view of its growing practice. In our country, dialogues about the topic both in family and at school are poor and shy.

In Ancient Greece, at the time of Hellenic expansion, girls got married aiming at breeding children for the constant wars. In ancient Hebrew civilization, marriage was considered divine, aiming at reproduction. Virginity should be kept until marriage. With the rise of the Roman Empire, liberality reaches its extreme, that is,

licentious involving all forms of pleasure, inclusively perverse. Woman-object and buying and selling sex becomes real. Later, Christianity restores tradition and previous values like virginity and monogamy.

In the Middle Ages, the valuation related to the topic varies in the different socio-economic levels. For the nobility, virginity was preserved until marriage, while for the liege men, there was stimulus to breed the sooner possible considered the needs for labor hand and warriors. From the 18th Century, desire becomes immoral and circumspection related to sexuality is the word order. Even currently we can see several views and treatments related to teenagers' pregnancy more or less favored in different social classes.

If the archetype Adam and Eve recalls woman as the temptation agent (the evil), and man as the tempted; nowadays, with the historical evolution, women are making stands as subjects of importance in social organization. Despite this fact, several limitations related to gender still remain – agreed by society based in biological factors.

In view of this complex amalgam of cultural and biological factors that interferes physical and psychologically changes experienced during adolescence, sexual education needs to be designed in order to stimulate youngsters healthy development, leading them toward adulthood in the best possible.

Cecilia Cardinal de Martim, pioneer in this field in Latin America, refers to principles that should conduct it: *a education more to be than to have or to do, an education for forming self-conscience and internal values; an education for love; an education for freedom, and an education for the past, present, and future* [4].

Pregnancy in adolescence

In Brazil, during 2002-2003, almost 700 thousand young girls, aged 10 – 19, became mothers, according to data from the Born Live Information System (Sinasc) [5]. In 2004, the Single Health System (SUS) carried out over 48 thousands curettages in this age group, after abortions, either induced or spontaneous.

According to Ministry of Health (MH) there has been increase in pregnancy in initial adolescence, between 10 and 14 years old [6]. When one considers family income below one minimum wage, fertility rate is 128/1,000; when it is equal or above 10 minimum wages, the rate is 13/1,000. Regarding schooling, the prevalence of pregnancy in adolescence also keeps inverse relation to the amount of years of study [6].

Survey carried out in 1997 on demography and health by the non-governmental organization '*Bem-Estar Familiar*' [Family Well Being] in Brazil, with representative sample from all Brazilian regions, points to this correlating low schooling with pregnancy in adolescence: *54% of adolescents who*

did not have any schooling had been pregnant once; 31.3% of those who had one to three years of schooling; 25.1% of those who had four years of schooling; 18.2% of those who had five to eight years, and 6,4% of those who had 11 years of schooling [6]. Several studies in developed countries show also that precocious maternity is relevant factor to reduce final schooling achieved by young girls. This means that pregnancy is reason for dropping out of school, mainly for those among those who lag in schooling [6].

It is important still to mention data from the Brazilian Institute of Geography and Statistics (IBGE), aiming at quantifying the debate, according to which the number of adolescents in Brazil, in 2000, was around 36 million, which corresponds to one fifth of population. Additionally, according to MH, labor represents the first cause of girls' internship in the public system.

Legislation in Brazil

The Statutes of the Child and Adolescent (ECA), since its publishing in 1990, has been the basis for major conquests in our country. In its Article 4, it sets forth that *it is duty of the family, of community, of society at large, and of public power to ensure, with absolute priority*, *the effectiveness of rights referring to life, health, education, sports, leisure, professionalization, culture, dignity, respect, freedom, and family and community companionship*[7]. Its single paragraph, item *a,* states clearly that *guarantee of priority endowed to the adolescent comprises the priority to receive protection and help in any circumstances*.

Article 15 of ECA states that *the child and the adolescent have right to freedom, respect, and dignity as human being in development process, and as subjects of civil, human, and social rights ensured in Constitution and in legislation*[7]. In Article 16, including item VII, states *that the right to freedom comprises* (...) *to seek for shelter, help, and guidance* [7]. These articles reaffirm vulnerability of the child and of adolescent derived from age factors, underlining their right to protection and support.

One can quote also, for the aims in this discussion, the Federal Law 11,340/06 that sets mechanisms to prevent the high prevalence of home and family violence against woman. This law foresees in its 3rd paragraph in Article 9 that *assistance to woman under household and family violence will comprise access to benefits derived from the scientific and technological development in emergency contraception* (...) [8]. One should bear in mind Federal Law no. 9,263/96, with the same objective, which deals with family planning and *ensures freedom of decision to men, women, or couple to plan their children* [9].

Sao Paulo Municipal Health Secretariat issued, in 2004, Ordinance 295, that highlights: (...) *the percentage of adolescents users of SUS who get pregnant, many of them unplanned and increasingly younger,*

remains high [10]. A protocol was implemented, in consequence, to supply reversible contraceptives in the basic care units, as well as recommending guidance to adolescents on double protection, that is, to associate a barrier method (male and female condoms) to another method, for example, hormonal. Additionally, the document directs that emergency contraception should be used only in situations like rape, condom or diaphragm rupture, expulsion of intrauterine device (IUD), forgetting two or more progestogen contraceptive pills etc.

The Brazilian Pediatrician Society (SBP) and the Brazilian Federation of Gynecology and Obstetrics Societies (Febrasgo) jointly published, in the same year, their guidelines regarding contraception and ethics in adolescence, which include emphasis to double protection, and respect for eligibility. These guidelines set that physician may prescribe emergency contraception, with criteria and care, because it is an exception resource, to adolescents exposed to eminent risk of pregnancy, under the following situations*: not making use any contraceptive method, failure of contraceptive method in use, sexual violence*[11].

The facts above show the importance that states and societies attribute to continued improvement of programs targeted to inform and to follow up adolescents and youngsters, particularly about issues related to sexuality and reproduction. Such relevance reflects mainly in female adolescents, who, in consequence both of biology and social parameters that are still in force in society (resulting from interpretation made about these physiological mechanism), constitute the most vulnerable group regarding sexual practice undesirable consequences. In this context, a reflection inserts itself *emergency contraception,* considered herein as one of the most legitimate mechanisms to inhibit problems deriving from unwanted pregnancy among adolescents and youngsters.

Contraception and ethics

The Adolescents Unit in the Child Institute of the Clinics Hospital from the University of Sao Paulo Medical School (FMUSP) organized, in 2002, a forum in which emergency contraception (CE) or emergency anti-conception (AE), as it is known also, was discussed among over 50 participants. Among participants, there were pediatricians, gynecologists, lawyers, judges, members of bioethics commissions from universities, members of scientific society, and representatives from Ministry of Health prevention sector. Their conclusions were basis for SBP and Febrasgo recommendations, as well as to Sao Paulo Municipal Health Secretariat Ordinance. Participants did not consider the method as abortive. Major contributions of the event referred to ethical principles, such as *respect to adolescents' autonomy, making them subject of right* [12].

A new forum, in 2005, with analogous participation as the previous one, broadened the debate about the topic, and it ended by suggesting the Federal Council of Medicine (CFM) to deepen the study in a specific technical chamber for recognition of emergency contraception as alternative method to pregnancy in all phases of reproductive life. CFM Resolution 1,811/06 was issued, as result, which establishes ethical standards for use, by physicians, of emergency contraception, which are based in considerations stated in table below.

Table 1. CFM Considerations about emergency contraception (AE)

Source: CFM Resolution no. 1,811, of December 14, 2006. It sets ethical standards for use, by physicians, of emergency contraception, as it does not offend legal norms in force in the country. Official Gazette of the Union, January 17, 2007; section 1:72.

Whereas right is based in the principles of human being dignity and propriates the exercise of responsible paternity;
Whereas is State competence to provide educational, scientific, and material resources for the exercise of this right, being prohibited any coercitive action by public or private entities;
Whereas in Brazil there is a significant number of women exposed to unwanted pregnancy, either because of not using or by inadequate use of contraceptive methods;
Whereas age groups most affected are adolescents and young adults who, often, begin sexual activity before contraception; Whereas prevention of unwanted pregnancy constitutes a good example of responsible sexuality, and that such pregnancy may lead to psychic and social costs, irreversible quite often;
Whereas double protection practice – recommended by the World Health Organization, Ministry of Health, Brazililan Federation of Gynecology and Obstetrics societies< and the Brazilian Pediatrician Society – seeking to include use of male and female condom concomitantly to other contraceptive method, including emergency contraception;
Whereas emergency contraception may by used in any phase of reproductive life, and phase of menstrual cycle in prevention of pregnancy and that, in case of fecundation, there will not be interruption of gestation process;
Whereas the objective of emergency contraception is to avoid pregnancy and that even in the rare cases of failures of methods does not cause harm to gestation process;
Whereas emergency contraception may contribute to decrease unwanted pregnancy and induced abortion.

Thus, in plenary session of December 14, 2006, emergency contraception was accepted as alternative method for prevention of pregnancy, as it does not cause harm or interrupt its evolution. It was deliberated that physician has the responsibility to prescribe emergency contraception as prevention measure, seeking to interfere in pregnancy negative impact for adolescents and young adults, and its consequences for public health, particularly reproductive health. For clinical practice, methods currently in use or others that may be consecrated by the scientific community may be employed as long as they do not contradict the Brazilian legislation, that is: in essence, not abortive. Finally, the resolution defines that emergency contraception may be used in all phases of reproductive life[13].

The American Pediatrician Academy refers that previous supply of CE treatment has shown to be effective. Several studies verified that in advance prescription of CE increases the probability of young and adolescent women using it whenever necessary. *Information about CE was provided to British young women, aged 14 to 15 years old, in a large study. Six months after educational intervention, adolescents who received education showed greater probability to refer to correct use of CE, but did not increase its use compared to students who did not get the intervention*[14]. Em In its conclusions, it stresses that CE has the potential even more to decrease unplanned pregnancy rates among adolescents in the United States, and that it is not a teratogenic agent, *It does not have capability to cause disruption of pregnancy already implanted in the womb*[14].

Study carried out in the Municipality of Sao Paulo, and published in 2005 aiming at evaluating CE knowledge and use among young public high school students revealed that methods is known by 59%, and its use by 15% of them[15]. The study found, *regarding double protection concept, that is, concomitant use of condom associated to hormonal method, that among young women with partners who used condoms, many adopted contraceptive pills concomitantly, suggesting that as soon as concern with STD and AIDS is gone (occurring with establishment of trust in fixed, loving, and committed relationship) condom use tends to cease* [15].

The same study shows that information or access to CE did not cause abandonment in utilization of usual contraceptive methods, in which male condoms stands out (most frequently used, with 69.8% of adhesion)[15]. One stresses that WHO, the International Planned Parenthood Federation (IPPF), Family Health International (FHI), the International Federation of Gynecology and Obstetrics (Figo) and regulatory agencies in majority of countries, including the *Food and Drug Administration* (FDA) recommend CE.

The importance of CFM document regarding CE may be verified not just in all

international surveys, but by the fact that, in the same year, the MH published the *Emergency Contraception: questions and answers for health professionals* manual[16], targeted to clarify professionals' doubts about the procedure, which began to be prescribed in the public system. Publishing of this manual by the MH replied to a conflict that arose among health professionals in consequence to the fact that emergency contraception was considered, until then, as a potentially abortive procedure. Such controversy caused significant impact in the professional area, echoing in the whole society. One discusses, next, the major impact factor of the measure, to be or not to be an abortive technique, in light of physiological features of reproductive and pregnancy process.

Physiological features of the reproductive apparatus, fecundation, and pregnancy

One of the major points related to the polemics around emergency contraception consist in the conjecture that, in certain circumstances, it could be a precocious abortive method by preventing implantation of possible already formed blastocyst. At the end of 1960s, when the method started to be used, there was not accrued knowledge regarding its working mechanism. As medication was – and still is – ingested after sexual intercourse and, at the time, one believed that pregnancy started just after it, one deduced that its agent, the pill, could be abortive, acting after fecundation.

Croxatto et all, among other authors, broached about the physiology of menstrual cycle, fecundation, and emergency contraception, as reproduce herein. Although such technical information constitute the basis of mentioned resolution, as well as of the Ministry's manual, one considers as pertinent to present it here, once more, since their streamlining is essential both to sexual education process, which one intends to supply to adolescents and youngster at schools and in health services, and regarding family planning policies themselves.

The menstrual cycle is the period starting in the first day of menstruation and ending between 24 and 35 days later, except if there is a pregnancy that interrupts it. Menstruation, the major perceptible mark of this cycle, is consequence of endometrium untying, followed by bleeding that is consequence of the ovary stops producing progesterone. Menstruation occurs approximately 14 days after ovulation, when there is not pregnancy [17].

Ovulation is the process through which the egg leaves the ovary after completing its maturation. The majority of menstrual cycles are ovulatory (approximately 90%), and in them ovulation may occur at any time between the tenth and twentieth second days. For the possibility of pregnancy, the egg must be fecundated within 24 hours after ovulation. If this does not occur, the egg deteriorates, losing capability to form a new individual. Therefore, these characteristics of the egg and the moment in which ovulation occurs establish that fecundation may take place in just one of the 13 days comprised between the 10th and 22th day of the menstrual cycle[17].

Ovulation is essential condition for fecundation, although fecundation does not take place at every ovulation. Fecundation normally takes place in oviduct and, in natural fecundation, in addition to ovulation it is indispensable the existence of intercourse as well in period close to ovulation, in order to promote the meeting between spermatozoid and the egg. Additionally to this *sine qua non* condition, it is important that both, egg and spermatozoid are in good conditions to unite. This only takes place if intercourse coincides with ovulation or if precedes it no longer than five days. Even under such conditions, in half of cases, fecundation does not happen, either because gametes do not meet because they defective or because local conditions are not appropriate for such meeting [17].

In addition to these aspects related to the egg, one should consider also the conditions for the meeting of the egg and spermatozoid as indispensable elements for pregnancy. After an intercourse, spermatozoids may remain in female's body (in condition to fecundate) for up to, approximately, six days. Thus, if intercourse takes place five days before ovulation day, fecundation may occur until the 6th day after intercourse. When intercourse occurs in the same day as ovulation, fecundation may occur in the following 24 hours. From such aspects inherent to the physiology of the egg and spermatozoids, one understands that fecundation may happen at any time within days comprising the 1st and 6th day after intercourse. One may deduce, still, from this that not All individuals start their intrauterine existence in the next day of a sexual intercourse [17].

It is known that a sexual intercourse leaves millions of spermatozoids in vagina. A few hundred go up within minutes to the oviduct, however, observations made in trial animals show that they do not have capability to fecundate. In best conditions, thousands park ar the uterine cervix from where they leave successively in the following days, in groups that displace themselves toward the oviduct. A few spermatozoids, of each group, adhere for hours at oviduct's cells, process in which they acquire the capability to fecundate. Once they untie, they maintain this capability for minutes or a few hours while they seek the egg. Therefore, it is necessary that they new spermatozoids keep arriving replacing the old ones until ovulation occurs. Spermatozoids migration until the location where fecundation becomes effective may occur in the described way, waiting for ovulation, but it does not extend for more than six days after coitus. If spermatozoid can wait for the egg during days, the egg only waits for spermatozoid capable to fecundate for just a few hours. [17].

During, approximately, three to four days after fecundation, woman's body does not have any way to recognize that it carries a new individual in its uterus. Nevertheless, from the 7th day, human blastocyst implants itself in uterus internal wall, giving a hormonal sign to maternal organism (HCG) to continue producing progesterone. In order for it to occur, it is

Necessary that endometrium has become receptive through action of ovary's hormones, estradiol, and progesterone, indispensable both to blastocyst is able to be implanted and to maintain gestation. The maternal body, from implantation, recognizes evidently that there is a new individual in development, and it starts to react to that presence [17].

Still according to Croxatto et all [17], following up 100 couples that have sexual intercourses freely (several times during the month), one notes that in 25 women occur pregnancy in the first month, in 25% of the 75 remaining women in the second month, and successively. The explanation is that, there is not fecundation in 50% of couples, and that half of the 50% of occurring fecundations do not result in gestation because the fecundation products spontaneously eliminates itself before any menstrual delay takes place [17].

The same authors estimate still that after one single sexual act, that has taken place in the second or third week of a menstrual cycle eight out 100 women get pregnant. When levonorgestrel pills are used in the first 72 hours after coitus, just one out 100 women get pregnant – that is, levonorgestrel used this way prevents just 85% of gestations. When used within the first 24 hours post-coitus, its use is almost 100% effective (99,5%). One concludes, then, that if administered after 72 hours, pregnancy rates increases tem fold. Therefore, this method effectiveness is as higher as sooner is used after coitus [17].

When a woman uses levonorgestrel as AE in these first 72 hours, it is possible that she prevents ovulation it it did not occur yet, interfering with migration of new groups of spermatozoids from the uterine cervix to the oviduct or that it affects the adhesion process, and spermatozoids capacity at the oviduct. It is through any of these mechanisms that the pill can prevent fecundation [17].

If, by any chance, fecundation has occurred already when a woman takes the pill, she continues having the same 50% of probability to get pregnant, since, as described, half of the zygotes get lost spontaneously. If zygote is normal and feasible, the pill will not prevent or alter its development. This explains why the method has low effectiveness to prevent pregnancy when used too late.

It is essential to inform that, regarding its abortive effect, the drug composing the pill administered in AE is a synthetic progestin, a molecule similar to progesterone, acting similarly in the organism. The administration of progesterone at a certain moment of the menstrual cycle inhibits ovulation and spermatozoid migration, preventing or making pregnancy difficult. However, progesterone that the ovary produces from ovulation, or that administered after fecundation, favors pregnancy establishment and maintenance. Inclusively, it is in consequence of this property that its name derives, alluding to pro-gestation. Progesterone is not abortive, even if administered in high doses. On the contrary, it is essential to pregnancy [17].

Emergency contraceptive pills action mechanism is not understood completely yet. In order to clarify it, difficult and expensive investigations are required due to ethical, logistic, and technical realities that need to be overcome. Available data in scientific literature does not provide any evidence that levonorgestrel prevents pregnancy through a mechanism that implies in embryo eliminations, either before, during, or after its implantation. Neither there is evidence that it will not do it ever. As thoroughly described, ovulation inhibition or change in spermatozoid migration are so far the sole proven mechanisms [17].

Final considerations

One of the factors about emergency contraception comprehensively discusses is the *security* provided by the possibility of a next day pill could not redound in lesser attention to traditional methods, including carelessness in using condoms. Nevertheless, the time to prescribe CE may be an excellent opportunity to open paths and initiate guidance to those adolescents who, knowingly, start their sexual experiences increasingly precociously. In view of a situation of eminent danger of unplanned pregnancy, for which emergency contraception is sought (and understood by involved adolescents as "savior" measure), it is reasonable to suppose that it there may be also greater opening for new information and guidance that provide future sexual experiences with lower level of insecurity and risk. This context favors professional educational approach.

Brazilian legislation ensures the right to contraceptive methods. Sexual and reproductive rights, including information and choice of contraceptive method for family planning has its guarantee in Article 226, paragraph 7, of the 1988 Constitution [18]. Federal Law 9.263/96, on family planning, sets forth in its Article 9 that *it is the responsibility of the State to offer all conceptive and contraceptive methods and techniques scientifically accepted, and that do not set risk for people's life and health, ensured freedom of option* [9].

The Ministry of Health, in 2006, made available – *distributive justice* – one more means to avoid unwanted pregnancy: the emergency contraceptive method, whose correct usage may, additionally to prevent it, reduce, and consequently, the severe damages related to pregnancy interruption caused by badly undertaken interventions - beneficence.

According to Helena Pereira de Melo's teachings when explaining about bioethics, the right to health and bio-right, *ethics is a system of rules through which human being guides his personal and social life, and bioethics includes reflection on accrued knowledge*[19]. She adds that bioethics is a set of concerns and practices, it participates in the characteristics of post-modern knowledge, which is the opening to methodological plurality, to resort for different methods, languages, and objective of the several areas of knowledge[19]. She adds, still, *that in current societies there is not a common moral to all citizens, coexisting*

several theories, like the utilitarian, neo-contractualism, deontologic, personalism, whose applications lead to different solutions for a ethical-legal conflict[19].

Unplanned pregnancy has been faced with pragmatic superficiality of decision such as abortion or quick marriage, suppressing dialogues, and using authoritarianism that does not educate or does not add much. Emergency contraception, well understood, technically and ethically, additionally to availability, its usefulness is evident in preventing family conflicts and unties, aiming at more commitment, security, and stability for the future of this generation, and for future generations. *Sexual education proposal should have freedom, responsibility, and commitment, with information working as instrument so adolescents from both sexes may ponder about decisions, and to make most suitable choices. Guidance about CE should constitute part of the contraceptive guidance as a whole, whose task, in adolescence, is hard, mainly because one should consider own psychosocial features of this age group* [12].

The great target of reflection about humanity and bioethical thought is the dignity of the individual by its own nature, and not just for its physical, mental, social, and moral meaning in the planet. Scientific progresses occur in great speed and, often, they precede detailed, comprehensive, and lasting ethical analysis. Research that seeks conquests, pursuits efficiency, efficacy, and effectiveness. Obviously, use optimization is ethical imperative already, but scientific discovery should be delivered always to post or new attentive considerations that are based in prudence and discernment – aiming the best for the subject (agent of right), for the individual (agent of dignity), and tor the entire society, even if strict ethical rules for research have been adopted preliminarily

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To reflect once more on CE technical and ethical features, in view of real vulnerability of adolescence, has, for this author, connotation of continued and growing responsibility that should surround health care with all of its generalities and minutiae. All possibilities for scientific progress should be broadly investigated, and its applications, usefulness, and employment discussed comprehensi-vely, plural, and successively, aiming possible and dynamic consensus in view of the multiplicity of analysis and reflections. The ultimate objective is human being's benefit with minimum losses, with focus on individual's dignity, his self-determination, and justice for society's collective good. When these principles are set in clear, frank, and transparent way, funding the sustaining pillars of democratic disputes, we are in front of a magnific educational process for humanity.

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Resumen

Contracepción de emergencia y adolescencia: responsabilidad y ética

En este trabajo se discuten los aspectos específicos de la atención médica a los adolescentes, teniendo en cuenta la especial vulnerabilidad de ellos en el entorno social en lo cuál viven, y considerando que, a través de la progresiva madurez, tienden a ejercitar su autonomía por la creciente sucesión de acciones propias que incluye el aflorar de su sexualidad. Con esa comprensión, vamos a reflexionar sobre los aspectos éticos de la contracepción de emergencia, observando los aspectos epidemiológicos de los embarazos precoces y no planificados, a luz de los principios tradicionales de la bioética, incluyendo la disponibilidad de este recurso por los poderes públicos.

Palabras-clave: Anticoncepción. Planificación familiar. Embarazo en adolescencia. Adolescente. Bioética.

Resumo

Este trabalho discute aspectos peculiares da assistência médica aos adolescentes, ponderando sua particular vulnerabilidade no meio social em que vivem e tendo em mente que, por meio de sua progressiva maturidade, tendem a exercitar sua autonomia numa sucessão de ações próprias que inclui o aflorar da sexualidade. Com esse entendimento, é formulada a reflexão sobre aspectos éticos da contracepção de emergência, considerando aspectos epidemiológicos de gravidez precoce e não planejada à luz de princípios clássicos da bioética, incluindo a disponibilização de tal recurso pelo poder público.

Palavras-chave: Anticoncepção. Planejamento familiar. Gravidez na adolescência. Adolescente. Bioética
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References

1 Saito MI. Adolescência, cultura, vulnerabilidade e risco: a prevenção em questão. In: Saito MI, Silva LEV, Leal MM. Adolescência: prevenção e risco. 2ª ed. São Paulo: Atheneu; 2008. p.41.
2. Op.cit. p.42.
3. Op.cit. p.43.
4. Op.cit. p.104.

5. Datasus. Live birth, technical notes [Internet]. Brasilia, Brazil: Datasus; 2010 [accessed: 14 January 14, 2010]. Available at: http://tabnet.datasus.gov.br/cgi/sinasc/nvdescr.htm.
6. Guimarães EMB. Gravidez na adolescência: fatores de risco. In: Saito MI, Silva LEV, Leal MM. Adolescência: prevenção e risco. 2ª ed. São Paulo: Atheneu; 2008. p.421.
7. Brasil. Lei nº 8.069, de 13 de julho de 1990. Dispõe sobre o Estatuto da Criança e do Adolescente e dá outras providências. Diário Oficial da União 16 de jul. 1990; seção I:13563.
8. Brazil. Law no. 11,340, of August 7, 2006. Creates mechanisms to inhibit household and family violence against woman, in terms of Paragraph 8, of Article 226 of the Federal Constitution, on the Convention to Eliminate All Forms of Discrimination Against Women, and the Inter-American Convention to Prevent, Punish, and Eradicate Violence Against Woman; sets forth on the creation of Courts of Household and Family Violence against Woman, Alters the Penal Process Code, the Penal Code, and the Criminal Execution Law, and provides for other measures. Official Gazette of the Union, August 8, 2006; section I:1-41.
9. Brazil. Law no. 9,263, of January 12, 1996. Regulates Paragraph 7 of Art. 226 of the Federal Constitution that deals on Family Planning, sets forth penalties and provides other measures. Official Gazette of the Union, August 20, 1997; section I:17989.
10. Sao Paulo. Ordinance no. 295, of May 18, 2004, of the Municipal Health Secretariat. Institutes the Protocol to provide reversible contraceptives in the Health Primary Care of the Municipality of Sao Paulo, aiming at expanding and making agile the supply of methods to SUS users in safe way, and with suitable follow up. Official Gazette of the Municipality of Sao Paulo, May 18, 2004:22.
11. Brazilian Pediatrician Society. Brazilian Gynecology and Obstetrics Federation. Contracepção e ética: diretrizes atuais durante a adolescência [Internet]. Adolescência e Saúde jun. 2005 [accessed in July 12, 2010]; 2(2):8-9. Available at: http://adolescenciaesaude.com/ detalhe_artigo.asp?id=168.
12. Leal MM, Saito MI. Anticoncepção e adolescência. In: Lopes FA, Campos Júnior DC. Tratado de pediatria. Barueri: Manole; 2007. p. 405-16.
13. Brazil. Federal Council of Medicine. Resolution no. 1,811, of December 14, 2006. Establishes ethical standards for use, by physicians, of emergency contraception, as it does not offend legal norms in force in the country. Official Gazette of the Union, January 17, 2007; section 1:72.
14. American Pediatrician Academy. Adolescents Committee. Guidance standard: emergency contraception de. Pediatrics (Portuguese edition) 2006;10(4): 249-60.
15. Andalaft Neto J, Figueiredo R. Uso de CE e camisinha entre adolescentes e jovens. Rev Sogia-BR [Internet]. abr-jun. 2005 [acesso 15 jan. 2010];6(2):[11p.]. Disponível: http://www.redece.org/Artigo%20Figueiredo%20e%20Andalafti%20AMPLIADO.pdf.
16. Emergency contraception: questions and answers for health professionals. Brasilia:

Ministry of Health, Health Care Secretariat, Department of Strategic Programmatic Actions, Woman's Health Technical Area; 2006.
17. Croxatto HB, Ortiz ME, Muller AI. Mechanism of action of emergency contracepcion. Steroids 2003;68:1095-8.
18. Brazil. Constitution. 1988. Constitution of the Federative Republic of Brazil. Federal Senate; 1988.
19. Melo HP. Bio-law Unit of the Bioethics and Medical Ethics Service of Medical School of the University of Porto. PowerPoint presentation: Bioethics, health right, and bio-law. Brasilia: Federal Council of Medicine; 2008. (Personal communication: Class for doctoral program in Bioethics of Medical School of the University of the Porto/ Federal Council of Medicine).

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