SPECIAL ARTICLE

Adolescents' right to contraception without parental consent

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Abstract

Objectives: to discuss the extent to which health professionals consider adolescents' right to access contraceptive methods without requiring the presence and/or authorization of their legal guardians.

Methods: a theoretical-reflective essay based on a narrative review of scientific literature, normative documents, and bioethical references related to adolescents' sexual and reproductive health. This paper is the result of a final project completed as part of the undergraduate medical degree program at the Federal University of Mato Grosso do Sul. Situations that generate ethical, moral, and legal controversies and increase social and health vulnerabilities are analyzed.

Results: the discussion is supported by the principles of professional ethics and bioethics, as well as by the sexual and reproductive rights established in national regulations aimed at comprehensive adolescent health care. The analysis is based on the premise that unrestricted parental consent may limit access to contraceptive methods, thereby increasing the risk of early pregnancies. Based on this evidence, the study emphasizes a welcoming and supportive approach, qualified listening, compliance with professional secrecy, confidentiality, and the adolescent's capacity for discernment as key elements of person-centered care.

Conclusion: professional practice should be grounded in scientific evidence and guided by legal regulations, in order to balance the rights of this population with clinical practice.

Key words *Adolescent health, Contraception, Confidentiality, Personal autonomy, Reproductive rights*

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Introduction

According to Law No. 8.069/1990,[1] adolescence encompasses the transitional stage from 12 to 18 years of age, characterized by intense biopsychosocial changes. Within this period, part of this population also experiences the onset of sexual activity, which has implications for public health demands health promotion policies focused on the prevention of sexually transmitted infections (STIs) and early pregnancy.

The National Adolescent School-Based Health Survey (PeNSE) demonstrated that sexual debut is prevalent in this population, although on a downward trajectory. The percentage of students aged 13 to 17 who reported ever having sexual intercourse decreased from 35.4% in 2019 to 30.4% in 2024. However, among sexually active youth, the early initiation rate (at age 13 or younger) remained high and stable, registering 36.6% in 2019 and 36.8% in 2024.[2,3]

A study conducted using data from the Live Births Information System (SINASC) database, encompassing over 98% of Brazilian municipalities, revealed that among the approximately 8 million births occurred in the period from 2020 to 2022, roughly 13% involved women aged ten to 19 years.[4]

This scenario represents a major public health concern given the risks to the health and well-being of both the mother and the newborn, such as obstetric complications. Notable among these are hypertensive disorders, intrauterine growth restriction, and preterm birth—conditions that increase maternal and infant morbidity and mortality rates. Furthermore, unplanned pregnancy causes social, economic, emotional, and educational impacts that profoundly alter the life trajectories of these young women and their families.[5]

To prevent pregnancy during this stage, the Brazilian Ministry of Health[6] has expanded the availability of long-acting reversible contraceptives (LARCs) through the Unified Health System (SUS). Key methods include the copper intrauterine device (Cu-IUD), the levonorgestrel-releasing intrauterine system (LNG-IUS), and the etonogestrel subdermal implant. Although these methods differ regarding their mechanism of action, duration, bleeding profile, and medical eligibility criteria, they share high rates of effectiveness and continuity of use, making them highly relevant strategies for preventing unplanned adolescent pregnancy.

However, the authors' experience in teaching, research, extension, and matrix support activities with Primary Healthcare (PHC) teams has revealed the persistence of healthcare and institutional barriers to adolescent's access to long-acting reversible contraceptive methods. Notable obstacles frequently observed include a shortage of healthcare professionals qualified to manage these methods, uncertainty regarding the limits of evolving capacities, concerns over confidentiality, and a lack of familiarity with the ethical-legal frameworks that safeguard adolescent care without mandatory parental presence or consent.

To address this reality, the authors develop teaching, training, and permanent education projects aimed at qualifying PHC professionals for contraceptive counseling and LARC management. These initiatives seek to expand access to sexual and reproductive health services and promote care aligned with the principles of comprehensiveness, autonomy, and sexual and reproductive rights.

Despite the relevance of ensuring safe clinical care, as observed in daily practice, an adolescent's biopsychosocial incapacity must not be presumed. Doing so risks undermining their autonomy through the unrestricted requirement of parental consent, without considering the evolving maturity inherent to this age group.

It is argued that, although a regulatory framework exists to ensure rights such as confidentiality, informed consent, and evolving autonomy, healthcare practice is often permeated by professional uncertainty and moral influences. These factors not only limit adolescent access to contraceptive methods but also violate legal prerogatives, ultimately contributing to the rise in unplanned pregnancies and their subsequent consequences.

Therefore, this article aims to discuss to what extent healthcare professionals consider the adolescent's right to access contraceptive methods without the mandatory presence or authorization of parents or legal guardians. It is a theoretical-reflexive essay grounded in a narrative review of the scientific literature, regulatory documents, and bioethical frameworks related to youth sexual and reproductive health.

This article is organized into thematic sections to outline, in a concise and systematic manner, the core argumentative axes that guide the discussion. This structure aims to facilitate the reader's understanding by identifying central ideas and articulating the different aspects addressed, without, however, exhausting the topic.

The reflections presented are informed by the authors' academic and professional trajectories in the fields of public health, women's health, and adolescent health. This perspective stems from their involvement in teaching, research, and extension activities within a public university, including training PHC professionals in sexual and reproductive healthcare, contraceptive counseling, and LARC provision.

Complementing this experience is the authors' participation in studies on adolescent health, reproductive health, and vulnerabilities associated with exercising sexual and reproductive rights. In this context, this

manuscript reflects both a normative and scientific analysis of the literature and a continuous dialogue with frontline professionals who face, in their daily practice, challenges related to evolving autonomy and youth access to contraception.

Contraception in adolescence: challenges and opportunities

Contraception in adolescence is an indispensable component of sexual and reproductive health, as it directly prevents unplanned pregnancies and STIs while fostering autonomy and the responsible exercise of sexuality.

However, guaranteeing this right requires more than just making contraceptive methods available. Its fulfillment presupposes a care approach grounded in welcoming and non-judgmental practices, ensuring that this population can make informed decisions regarding their reproductive health. From this perspective, Primary Health Care (PHC) establishes itself as an essential support network for reducing vulnerabilities, promoting equity, and guaranteeing rights.

Among the options available in PHC, LARCs show higher rates of continuity and satisfaction. However, misconceptions, misinformation, and institutional barriers still limit their use.[7]

Expanding access to these methods depends on qualified, person-centered, and evidence-based counseling capable of addressing the safety, reversibility, and benefits of these technologies.[8] In this regard, adolescent-responsive healthcare services that guarantee confidentiality and a welcoming environment are key to enhancing adherence and mitigating inequalities.[9]

Despite LARCs being integrated into SUS supplies, challenges persist regarding stigma, unfamiliarity with sexual and reproductive rights, and weaknesses in service organization. This reality demonstrates that merely offering contraceptives is insufficient to guarantee informed choices, highlighting the need to remove institutional barriers that restrict adolescents' reproductive autonomy.

Overcoming these obstacles is validated by the principles of the SUS outlined in Law No. 8,080/1990, particularly concerning the universality of access, comprehensiveness of care, and preservation of personal autonomy. Therefore, administrative requirements or conditions lacking legal basis must not restrict adolescent access to health promotion, prevention, and care in sexual and reproductive health. Fulfilling this right requires coordinating timely, equitable, and non-discriminatory information, counseling, and contraceptive provision.[10]

However, this legal guarantee still contrasts with daily practice within the services. The authors' experience in education-service integration activities demonstrates that controversies regarding confidentiality, parental involvement, and adolescent access to contraceptive methods remain recurrent in PHC, affecting community health agents, nurses, and physicians alike. This scenario highlights gaps in translating ethical-legal frameworks into clinical practice, contributing to persistent barriers that hinder the full exercise of sexual and reproductive rights during this stage of life.

The ethical-legal framework and the right to confidentiality

At the national level, the Statute of the Child and Adolescent (ECA) safeguards fundamental rights such as dignity, privacy, confidentiality, and informed consent,[1] all of which extend to sexual and reproductive healthcare. From this perspective, parental authority is not absolute and must be exercised in alignment with the adolescent's individual prerogatives, as protected under Article 227 of the Federal Constitution.[11]

Confidentiality is established as an inseparable condition of this care, enabling data protection and prohibiting its disclosure without proper authorization. This premise is anchored in the bioethical principles of autonomy, beneficence, and non-maleficence, and is recognized by regulatory bodies, such as the Federal Council of Medicine (CFM).[12]

Preserving confidentiality builds the therapeutic bond necessary to integrate this population into health services, thereby increasing the demand for care, fostering dialogue about sexuality, and expanding access to contraceptive methods.

Therefore, the relevance of strengthening strategies such as qualified counseling and expanding access to long-acting reversible methods is emphasized. Conversely, the absence of confidentiality acts as a deterrent, reinforcing vulnerabilities.

It is fundamental that the commitment to confidentiality be explicitly stated during the consultation, including in telemedicine contexts,[13] a modality that has been increasing in sexual and reproductive healthcare, especially in vulnerable territories.

In this regard, it is necessary to outline the ethical-legal criteria that govern exceptions to the maintenance of confidentiality.[14,15] Although confidentiality is a fundamental element of care, professional secrecy is not absolute. The Medical Ethics Code itself allows for flexibility in situations provided by law or in the presence of imminent risk to the patient or third parties.[12] In such cases, the sharing of information must occur proportionally, restricted to what is necessary, and guided by comprehensive protection regulations.

National guidelines and technical opinions ratify that healthcare for adolescents can be provided without

the presence of parents or legal guardians, including the prescription of contraceptive methods, provided that clinical and legal criteria are met.[1,4,16] This understanding strengthens evolving autonomy and informed decision-making.

Based on this context, the authors contend that imposing requirements not stipulated in regulatory frameworks—such as mandatory parental consent for LARC access—can constitute an undue barrier to the exercise of sexual and reproductive rights during adolescence.

This institutional obstruction runs counter to current guidelines, becoming particularly contradictory given the incorporation and dissemination of these methods by the Ministry of Health as effective strategies to expand access to contraception within the SUS. In this regard, restrictions motivated by personal interpretations, moral values, or professional uncertainty tend to compromise equity in care and limit the fulfillment of rights already recognized in public health policies.

To overcome such subjective conduct and ground clinical practice, the ethical-medical framework offers relevant insights, as seen in CFM Resolution No. 2,232/2019.[17] By regulating treatment refusal and patient autonomy, this resolution reinforces the centrality of cognitive capacity and the expression of will in healthcare decision-making. Although it does not specifically address contraception in adolescence, the regulation contributes to the interpretation that assessing decision-making competence must consider individual discernment rather than chronological age alone, offering greater ethical support for a contextualized analysis of evolving autonomy.

However, adolescent autonomy must not be confused with full civil capacity. Given that maturity for decision-making does not depend exclusively on chronological age, the assessment of discernment and decision-making capacity must be conducted in a contextualized, proportional, and individualized manner.[18]

Evolving autonomy,parental authority,and ethical-legal tensions in adolescent contraceptive care

The discussion regarding adolescent access to contraceptive methods without parental authorization requires recognizing that there are legitimate legal and ethical arguments on both sides of the debate. Although the Brazilian legal system recognizes rights related to privacy, confidentiality, and adolescent participation in healthcare decisions, it also imposes statutory duties of protection, care, and guidance upon parents or legal guardians regarding their minor children.[1,11,19]

The primary legal foundation for family involvement lies in the institute of parental authority (*poder familiar*), regulated by the Brazilian Civil Code (Articles 1,630 et seq.). Under this legislation, parents are responsible for directing the upbringing and education of their minor children, representing or assisting them in civil acts, and ensuring their comprehensive protection.[19]

Consequently, a segment of legal scholars and healthcare professionals maintains that decisions related to sexuality and reproductive health should, preferably, involve parents or legal guardians, considering their legal duty of care and protection against situations potentially detrimental to the adolescent's development.[11,19]

In addition to the legal foundation, arguments of an ethical and psychosocial nature are frequently mobilized in favor of parental involvement. It is argued that adolescents are in the process of cognitive, emotional, and social maturation – a circumstance that could limit their capacity to fully evaluate the risks, benefits, and consequences of certain choices. Along this line of reasoning, the presence of parents or legal guardians could strengthen emotional support, enhance protection against situations of vulnerability, and foster shared decision-making considered to be safer.[16]

These arguments warrant consideration, particularly because comprehensive protection constitutes a structuring principle of policies targeting childhood and adolescence. However, the contemporary interpretation of children's and adolescents' rights rejects the notion that parental authority is absolute. The Federal Constitution, the Statute of the Child and Adolescent (ECA), and international human rights instruments recognize children and adolescents as rights-bearing individuals, endowed with dignity, privacy, and progressive participation in decisions affecting their lives.[1,11,20]

In this context, Article 12 of the Convention on the Rights of the Child establishes that children and adolescents capable of forming their own views have the right to express those views freely in all matters affecting them, with their opinions being given due weight in accordance with their age and maturity. This principle was subsequently deepened by the United Nations Committee on the Rights of the Child, particularly through General Comment No. 4 and General Comment Nº. 20, which consolidate the concept of evolving capacities and recognize adolescence as a stage of progressive acquisition of competencies for autonomous participation in decisions related to one's own health.[20,21,22]

Under this perspective, evolving autonomy does not represent a negation of the family's role, but rather a recognition that comprehensive protection also involves increasing respect for the adolescent's decision-making capacity. As outlined in the aforementioned international standards, the views of children and adolescents must be considered in accordance with their developing maturity.

In the field of sexual and reproductive health, the unrestricted requirement for parental authorization can produce unintended consequences. Concerns regarding a breach of confidentiality are among the main factors that deter adolescents from healthcare services, thereby reducing the search for counseling, STI prevention, and contraceptive methods.[23]

In certain circumstances, mandatory parental involvement can result in the exact opposite of the effect intended by family protection, increasing vulnerabilities and hindering timely access to care.

Given this tension, the solution does not appear to lie in either the absolute prevalence of parental authority or the adoption of an unrestricted conception of individual autonomy. Bioethical literature and professional guidelines converge on the need for contextualized assessments capable of simultaneously considering the adolescent's rights, the family's protective duties, and the specificities of each clinical situation.[16,23,24]

Under this approach, resolving conflicts between comprehensive protection and evolving autonomy must be grounded in objective and individualized criteria. These include the capacity to understand the information provided, the coherence and stability of the expressed decision, the voluntariness of the choice, the absence of signs of abuse, coercion, or sexual exploitation, as well as the nature and risks involved in the proposed intervention.[16,21,24]

Parental involvement should be encouraged whenever possible and compatible with the adolescent's best interests; however, its absence must not constitute an automatic barrier to accessing contraceptive methods when there is sufficient discernment for informed decision-making.[25]

On the other hand, situations involving suspected sexual violence, exploitation, severe psychological distress, impaired decision-making capacity, or significant risk to physical and emotional integrity justify greater protective intervention and the eventual flexible application of confidentiality, while respecting applicable legal and ethical provisions. Under these circumstances, coordinated action with the protective network becomes indispensable to ensure the adolescent's best interests.[1,18]

Thus, analyzing contraceptive care in adolescence requires recognizing that autonomy and protection are not antagonistic principles, but rather complementary dimensions of comprehensive care.

The fulfillment of sexual and reproductive rights depends precisely on the ability of healthcare professionals to balance these dimensions through proportional decisions grounded in scientific evidence, current regulations, and an individualized assessment of each adolescent's needs.

Adolescents aged 12 to 14

In Brazil, the contraceptive care for unaccompanied adolescents is backed by ethical and technical standards, extending even to minors under 14 years of age, in accordance with guidelines from the Ministry of Health,[6] the Federal Council of Medicine (CFM),[12] and the Brazilian Society of Pediatrics (SBP).[16] However, professional conduct must observe the provisions of the Brazilian Penal Code regarding crimes against sexual dignity.[14]

Law No. 12,015/2009, which introduced Article 217-A into the Penal Code,26 criminalizes sexual acts or lewd acts with minors under 14 years of age, regardless of consent and/or the existence of an emotional bond.[14] This understanding is consolidated in national jurisprudence through Precedent 593 of the Superior Court of Justice (STJ),[27] according to which the crime of statutory rape (*estupro de vulnerável*) is established independently of the victim's consent, prior sexual experience, or the existence of an emotional relationship with the perpetrator. Consequently, any sexual contact with minors under 14 years of age is legally characterized as statutory rape and requires a detailed analysis for the adoption of appropriate clinical and protective measures.

Accordingly, contraceptive requests involving adolescents of this age group require caution and thorough investigation into potential contexts of violence, exploitation, or vulnerability, in addition to compliance with mandatory reporting duties and the immediate activation of the protective network, when applicable.[14,15]

The need for this rigorous investigation is sustained by compelling epidemiological evidence, such as data from the 2019 National Survey of School Health (PeNSE), which reveals that 14.6% of schoolchildren aged 13 to 17 had already suffered some type of sexual violence during their lifetime, a percentage that reached 20.1% among girls. Furthermore, 6.3% of students reported having been forced into sexual intercourse against their will, a proportion that reached 8.8% among the female population.[2]

This reality of child and adolescent vulnerability outlined in schools reverberates in official health data. Records from the Notifiable Diseases Information System (SINAN) and epidemiological bulletins from the Ministry of Health show that adolescents are among the primary groups affected by sexual violence in Brazil.[28] This alignment of indicators corroborates the need for healthcare teams to be trained to differentiate situations involving the autonomous exercise of sexuality from those marked by violence, coercion, sexual exploitation, or statutory rape.[29]

This scenario generates ethical and legal tensions for healthcare professionals.[30] On one hand, there is the

core concern of healthcare delivery; on the other, the responsibility to adopt legal measures, including reporting to regulatory bodies such as the Guardianship Council (*Conselho Tutelar*) and specialized child and adolescent protection police units.

Healthcare organizations recommend that access to care be provided in an ethical, safe, and comprehensive manner. Although the presence of parents or legal guardians during the adolescent's consultation is desirable, prescribing contraceptive methods does not constitute an illicit act. This conduct is legitimate provided that the young patient demonstrates capacity for discernment—following a thorough clinical and psychosocial evaluation—and that the professional complies with comprehensive protection protocols and implements protective measures when necessary, ensuring the complete documentation of all actions in the medical records.[23,24]

It is worth emphasizing that the exercise of parental authority, as provided for in the Civil Code, must coexist with the adolescent's fundamental rights to privacy, dignity, and evolving autonomy. Based on this understanding, a legitimate tension is established between the principle of comprehensive protection and decision-making autonomy, the resolution of which presupposes an individualized analysis and the application of proportionality.[1,11,19]

The unrestricted requirement for parental consent can deter adolescents from healthcare services and increase vulnerabilities, notwithstanding perspectives that encourage a higher centrality of parental authorization. In light of this, preserving confidentiality in specific circumstances constitutes a necessary measure to ensure patient reception, the therapeutic bond, and early pregnancy prevention.[23,31]

The gap between norm and practice: persistent barriers

Despite the regulatory backing, there is a clear divergence between institutional recommendations and clinical reality. Within the healthcare context, this gap begins with the perception of many young individuals who do not fully trust that professional confidentiality will be maintained, which in turn deters them from seeking services and limits their access to proper counseling.

This mistrust is compounded by the insecurity of healthcare teams, who report doubts regarding the legal boundaries of treating unaccompanied minors. This scenario—characterized by a lack of clear institutional protocols and the influence of moral and cultural values—results in restricting practices that contribute to the maintenance of barriers to contraceptive access.[22,29]

In light of these findings, it is advisable to consult the regulatory acts of professional councils (such as resolutions, formal opinions, and technical recommendations), which are instruments that provide ethical and legal backing to clinical practice. Should an impasse persist, it is appropriate to reach out to regulatory and protective bodies, such as the Child and Adolescent Prosecutor's Office and the Public Prosecutor's Office, which can provide guidance to support decision-making.

When the legal standard fails to translate into safe healthcare delivery, the consequence can be the suboptimal utilization of effective contraceptive methods or their incorrect use due to misinformation, thereby exacerbating vulnerability to adverse outcomes.

Reducing inequities in reproductive health therefore requires bridging the gap between norm and practice through investments in intersectoral approaches, professional training, and healthcare service organization.[32]

From this perspective, it is recommended to study the regulations issued by professional councils, the Ministry of Health,[15] and entities such as the Brazilian Society of Pediatrics,[16] and the Brazilian Federation of Gynecology and Obstetrics Associations (FEBRASGO),[25,33] among others.

This educational recommendation proves paramount, given the authors' experience in training initiatives for Primary Health Care (PHC) professionals and sexual and reproductive health services. This field experience indicates that doubts regarding mandatory parental authorization are among the most persistent questions raised by healthcare teams.

It is observed that insecurity regarding the interpretation of ethical and legal standards, compounded by the absence of clear institutional protocols, frequently results in practices that are more restrictive than those provided for in current regulatory frameworks. Although these observations are anecdotal and do not possess a representative character, they illustrate concrete challenges faced in implementing comprehensive healthcare guidelines for adolescents.

Implications for practice and public policy

Sexual and reproductive health promotion in adolescence requires coordinated interventions articulated at different levels of care and management. At the structural level, the need to strengthening intersectoral actions between health, education, and social assistance is emphasized, recognizing that unplanned pregnancy prevention and the promotion of sexual and reproductive rights transcend the boundaries of individual clinical care.[32]

In light of this context, the provision of evidence-based sexual education, combined with timely access to information and contraceptive methods, constitutes an essential strategy for reducing vulnerabilities and health inequities.[15,34]

Within healthcare services, the implementation of existing guidelines depends on the continuous education

of teams to manage the ethical, legal, and clinical issues related to youth care. Professional training must encompass aspects such as confidentiality, informed consent, evolving autonomy, adolescent-centered communication, and the identification of situations involving violence or social and reproductive vulnerabilities.[34,35,36]

Likewise, it is necessary for services to develop clear and institutionally backed clinical protocols capable of guiding decision-making in situations involving conflicts between protection and autonomy. Defining care pathways, ensuring welcoming environments, and reducing administrative barriers can contribute to greater professional security and expand adolescents' access to sexual and reproductive healthcare.[35]

Special attention must be directed toward the organization of Primary Health Care (PHC), given its strategic position as the preferred gateway to the Unified Health System (SUS). Expanding the capacity of services to offer qualified contraceptive counseling, including LARCs when indicated, can foster the materialization of reproductive rights and the development of more equitable care pathways.[32,35]

Finally, conducting research that investigates the perceptions of adolescents, family members, and healthcare professionals regarding confidentiality, parental participation, and decision-making autonomy can contribute to the refinement of public policies and the generation of evidence capable of supporting clinical practices that are better aligned with the needs of this population group.

Final considerations

Brazilian adolescents can access contraceptive methods without parental consent in specific situations. The right to confidentiality, informed consent, and autonomous decision-making is assured provided that the adolescent demonstrates adequate capacity for comprehension, while observing clinical criteria and patients' rights.

However, this legal prerogative faces limitations within healthcare service delivery. Institutional, cultural, and clinical barriers – such as the implicit requirement for parental consent, professional insecurity regarding current legislation, and the absence of clear protocols— hinder regular access to contraception and exacerbate vulnerability to negative sexual and reproductive health outcomes.

In light of this, it is necessary to strengthen the ethical and legal training of healthcare professionals and to implement clinical protocols that guarantee patient reception, confidentiality, and respect for the autonomy of this population. The realization of reproductive autonomy is fundamental to promoting health and improving the quality of comprehensive care, in line with the guiding principles of the Unified Health System (SUS).

Throughout this process, healthcare teams play an important role in expanding access to contraceptive methods, and they must offer patient-centered counseling that is free from stigma. Safeguarding confidentiality is, therefore, an inseparable component of clinical practice, directly associated with increased seeking of family planning services by youth.

Finally, sex education and integrated actions among different sectors are necessary to mitigate the effects of gaps in contraceptive use and to reduce early pregnancy rates. This expanded approach protects rights and strengthens the capacity of adolescents to actively participate in decisions concerning their own bodies and future.

Authors' contribution

Duarte SH: conceptualization, methodology, project administration, supervision, writing – original draft, writing – review & editing.

Kanitz MER, Nunes RO and Terra VE: data curation, investigation, visualization, writing – original draft.

Freitas VV and Oliva RF: data curation, investigation, visualization, writing – original draft, writing – review & editing.

All authors approved the final version of the article and declare no conflicts of interest.

Data availability

All datasets supporting this study are included in the article.

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