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Contraceptive autonomy: a historical overview

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Abstract

Contraception is the set of methods used to prevent pregnancy. To reduce the number of unplanned pregnancies, access to these methods is essential, as is the respect for contraceptive autonomy. High unplanned pregnancy rates reveal a failure to control the reproductive process and points to a public health problem, leading to a series of problems related to maternal and perinatal reproductive health. This qualitative integrative review selected articles on principlism and protection bioethics to analyze concepts such as autonomy, beneficence, non-maleficence, justice and protection. This study highlights the importance of bioethics in reproductive planning because respecting the individual's decisions means providing adherence and efficacy to the contraceptive method. There was a great limitation in the choice of definitive contraception by pregnant women in the old law that regulated family planning, a fact that will be analyzed in this article.

Keywords: Autonomy. Reproductive rights. Social justice. Bioethics. Family development planning. Health policy.

Resumo

Autonomia na escolha pela contracepção: visão histórica

Contracepção é o conjunto de métodos utilizados para prevenir a gravidez. Para reduzir o número de gestações não planejadas, é imprescindível que haja acessibilidade a esses métodos e, ao mesmo tempo, respeito à autonomia de escolha. Um alto índice de gravidez não planejada revela falha no controle do processo reprodutivo e é um problema de saúde pública, acarretando uma série de agravos ligados à saúde reprodutiva materna e perinatal. Esta revisão integrativa qualitativa selecionou artigos sobre bioética principialista e de proteção a fim de analisar conceitos como autonomia, beneficência, não maleficência, justiça e proteção. Este estudo destaca a importância da bioética no planejamento reprodutivo, pois respeitar as vontades é proporcionar adesão e eficácia ao método contraceptivo. Na antiga lei que regulamentava o planejamento familiar, havia grande limitação na escolha da contracepção definitiva pelas gestantes, fato que será analisado neste artigo.

Palavras-chave: Autonomia. Direitos sexuais e reprodutivos. Justiça social. Bioética. Planejamento familiar. Política de saúde.

Resumen

Autonomía en la elección de métodos anticonceptivos: una panorámica histórica

La anticoncepción es el conjunto de métodos utilizados para prevenir el embarazo. Para reducir el número de embarazos no planificados, es fundamental que haya acceso a estos métodos y, a la vez, respeto por la autonomía de elección. Un alto índice de embarazos no planificados revela un fracaso en el control del proceso reproductivo y constituye un problema de salud pública, acarreando una serie de complicaciones relacionadas con la salud reproductiva materna y perinatal. Esta revisión integradora cualitativa seleccionó artículos sobre bioética principialista y de protección con el fin de analizar conceptos como autonomía, beneficencia, no maleficencia, justicia y protección. Este estudio resalta la importancia de la bioética en la planificación reproductiva, ya que respetar las voluntades es proporcionar adhesión y eficacia al método anticonceptivo. En la antigua ley que regulaba la planificación familiar, existía una gran limitación en la elección de la anticoncepción definitiva por parte de las mujeres embarazadas, hecho que será analizado en este artículo.

Palabras clave: Autonomía. Derechos sexuales y reproductivos. Justicia social. Bioética. Planificación familiar. Política de salud.

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Historical view: contraceptive autonomy

This article aims to analyze, from the bioethics of protection and the principlism of Beauchamp and Childress, whether the basic principles of bioethics have been respected in Brazil regarding the choice of contraceptive method by women in accordance with Law 9,263/1996 [1]. What instigated me to analyze this theme was my personal experience: as a physician who has been working in the public health service for several years, specifically in reproductive planning outpatient clinics, I have always been very concerned about the discrepancy between what is concretely offered to the Unified Health System (SUS) users in relation to the choice of contraceptive method and what is considered ideal.

In my master's thesis, I evaluated patients' access to intrauterine devices (IUD) in the public health service and concluded that it is still quite restricted in most Brazilian municipalities. Not all health centers offer IUD insertions, a procedure that requires adequate material and technically trained professionals. Some health centers lack of healthcare professionals, suffering with incomplete and high employee turnover, which hinders training. Moreover, despite being one of the most effective contraceptives, IUD demand by users is limited, perhaps due to cultural issues or even the lack of knowledge and introduction to the method by health teams.

The first law created to regulate reproductive planning in Brazil was in force from January 1996 to March 2023, and remained basically unchanged for almost 30 years. At the time, knowledge about bioethics was certainly quite limited, since the field began to take shape in Brazil in the 1990s and it was only in 1995 that the Brazilian Society of Bioethics (SBB) was created, as well as graduate courses in the field.

The current trend is to replace the term "family planning" with the terms "parenting planning" or "reproductive planning," since it does not always concern the family, but the reproductive life of each individual. Reproductive planning is a constitutional right in Brazil, defined as *the set of educational and preventive actions that guarantee the information, means, methods and techniques available for fertility regulation, guaranteeing the freedom to choose the preferred method* [1]. Article 2 of Law 9,263/1996 states that f*amily planning is understood as the set of actions implemented to regulate fertility that guarantee equal rights to the constitution, limitation or increase of offspring by the woman, the man or the couple* [1].

The main objective of reproductive planning is to facilitate the exercise of the individual's sexual and reproductive rights, so that they can decide the ideal time for the arrival of offspring and the desired number of children. This article proposes a historical reflection on women's contraceptive autonomy.

Method

The method used for the composition of this article was exploratory, bibliographic research grounded on a qualitative approach, with an integrative literature review, systematic data collection based on secondary sources, by means of reading to synthesize scientific articles and condense the results.

Keywords and search keys taken from the Descriptors in Health Sciences (DeCS) database were used. The bibliographic survey was obtained via books, government websites, international entities—United Nations (UN), World Health Organization (WHO), Pan American Health Organization (PAHO)—databases–PubMed, Philosopher's Index, Bioethics Literature Database (BELIT), EthxWeb, JSTOR, Scopus, Google Scholar– and digital libraries. Literature that addressed bioethical issues according to the basic principles of Beauchamp and Childress—autonomy, beneficence, non-maleficence and justice—and protection bioethics were included, and articles that addressed exclusively male family planning were excluded.

The following steps were followed: 1) elaboration of the guiding question; 2) search or sampling in the literature; 3) data collection; 4) critical analysis of the included studies; 5) discussion of the results; and 6) presentation of the integrative review. The content was separated into categories and the result was obtained through thematic analysis of the content as proposed by Laurence Bardin.

Unplanned pregnancy and public health

Even today, the number of unplanned, and even unwanted, pregnancies is high, especially among adolescents in greater social vulnerability, which represents a serious public health problem [2]. Unplanned pregnancy can be defined as any pregnancy that was not intended by the individual; unwanted pregnancy, on the other hand, is one that goes against their desires and expectations, inopportune, which occurs at a time considered unfavorable, being responsible for numerous problems related to maternal and perinatal reproductive health.

The main cause of unplanned pregnancy is the low contraceptive use rate, which is evident in less developed countries and is associated with difficulties in accessing health services and their lack of organization [3]. In turn, unwanted pregnancy is considered an indicator of failure to control the reproductive process, which is why the term is widely used in reproductive planning programs to assess the unmet demand for contraception. This includes lack of information and access to all contraceptive methods, contraceptive failure and non-availability of all contraceptives in the public health services [3].

Each year, at least 80 million women worldwide experience unplanned pregnancies, and this number has been growing in recent decades. This fact is responsible for the growing number of induced abortions, especially clandestine ones, which increases the risk of morbidity and mortality in women who undergo the procedure. In Brazil, in 1996, the estimated number of abortion cases among young people between 10 and 19 years was 241,392 [4]. In South America, the number of clandestine abortions is around 4 million per year [5]. Unplanned pregnancy is a serious public health issue, as it is responsible for:

- 75% of the school dropout rate among young pregnant women;
- death and complications caused by clandestine abortions and inadequate prenatal care;
- worsening of impoverishment rates and social vulnerability of already vulnerable families;
- baby abandonment, shelter overcrowding and future psychological and social problems;
- childbirth complications; and
- an increase in public spending on prenatal care, childbirth and hospital admissions due to complications resulting from pregnancy and childbirth.

A study called "Birth in Brazil," carried out by the Sérgio Arouca National School of Public Health (ENSP), of the Oswaldo Cruz Foundation (FIOCRUZ), promoted a national survey on labor and birth and monitored 23,984 women in the maternity hospital and their babies between February 2011 and October 2012, in 191 municipalities in Brazil. Among the various results, the numbers regarding reproductive planning stand out [6]:

- only 45% of the women interviewed wanted that pregnancy;
- 9% were dissatisfied with their pregnancy;
- 2.3% reported having tried to terminate the pregnancy; and
- two-thirds of the adolescents stated that they did not want to be pregnant.

According to the study, 55% of Brazilian women and almost 70% of adolescents did not want their pregnancies, numbers that exceed the world average percentage of unwanted pregnancies, which, according to the United Nations, is 40% [7]. The efficiency of reproductive planning can be an important HDI indicator, as it is intrinsically linked to various aspects of human development, such as health, education, and economic well-being.

Another very worrying aspect is the high frequency of reproductive precocity among young people, especially those experiencing greater social vulnerability [8]. In a pluralistic society, it is important that children are planned and born to parents who are prepared [9]. To this end, accessibility and the choice of contraceptive methods are essential and, therefore, constitute a public health issue.

A brief history of contraception

Birth control or contraception is understood as the set of methods used to control fertility via actions, devices or drugs capable of preventing pregnancy [10]. The availability of contraceptive methods is essential to reduce unwanted pregnancy rates.

Brazil is vast, both in geographical extension and in cultural and moral diversity, the latter

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resulting from the presence of native indigenous peoples, Portuguese colonization—which brought with it African slavery—in addition to the immigration of Italians, Germans, Japanese, Arabs, etc. Thus, the country is also home to a multiplicity of religious practices, from Catholicism, brought by the Portuguese colonizers, to religions of African origin, such as Umbanda and Candomblé. For a long time, the State and the Catholic Church played a strong role in social control, with the latter contributing to the castration of female sexuality.

These cultural, religious, social and individual aspects, among other factors, influence the choice of contraceptive method to the extent that they can cause conflicts between moral values and the need to prevent pregnancy, that is, they can generate complex ethical and emotional dilemmas. Since cultural pluralism and moral diversity exert a significant influence on an individual's choice of contraceptive method, recognizing and respecting diversity is essential to ensure equitable access to reproductive health services and to promote informed and autonomous decisions about contraception.

In 1957, a medication was launched in the United States to treat menstrual disorders, which posed a warning about the temporary suspension of fertility in its package insert; it did not take long for the drug to start being used with the objective of attaining precisely this side effect. Its commercialization as an oral contraceptive was approved by the Food and Drug Administration (FDA) in 1960, and thus the contraceptive pill was created, one of the main events responsible for female sexual liberation. From then on, women forsook the traditional role of "housewife" and began to play a more expressive role within society.

Although the use of forms of contraception dates back to antiquity, female emancipation occurred only after the creation of the contraceptive pill, as it is an effective and safe way of avoiding pregnancy, thus giving autonomy for women to decide the ideal moment of motherhood and the number of children they want. With this, women began to exercise their right over their bodies, without having to share her decisions and desires or needing third-party intervention, being a very important advance.

In Brazil, for many years, oral contraception, or the pill, was practically synonymous with contraception. Currently, there are several contraceptive methods available on the market, which are grouped according to their effectiveness [11]:

- First line: these are easy to use and highly effective methods, which do not require great motivation or intervention from the user, have an unwanted pregnancy rate of less than 2% during the first year of use, require a lower number of return visits, and guarantee a longer duration of the contraceptive effect. These methods include contraceptive implants, male and female sterilization, and IUDs.
- Second line: these include systemic hormonal contraceptives (oral, vaginal rings, transdermal and injectable patches). This type of contraception depends on user motivation and intervention and, when compared to first-line methods, have higher failure rates, with an unwanted pregnancy rate between 3% and 9% in the first year. It is likely that the high failure rate is due to forgetfulness and changes in intake time, that is, inappropriate use by the user.
- Third line: female and male barrier methods, known as behavioral methods. Regarding the level of dependence, third-line methods depend entirely on user motivation and intervention, so they have very high failure rates, averaging 10% to 20% in the first year. We can include in this group the menstrual cycle calculator, female and male condoms and the diaphragm.
- Fourth line: these are spermicides, which, like the second and third line methods, depend on user motivation and therefore have very high failure rates, around 21% to 30% in the first year of use.

One can thus conclude that the effectiveness of a method is directly proportional to the ease of use and inversely proportional to user intervention.

The IUD is a very effective method, but not yet widely used. The worldwide distribution of IUD users is not uniform: it varies from less than 2% in some countries, such as Brazil, to more than 40% in others, as in the case of Central Asian countries [11]. In Brazil, specifically, there are still

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many myths surrounding the IUD, according to which, for example, it is an abortifacient method or that it causes fetal malformations in case of pregnancy concomitant with use. For this reason, the vast majority of users of the Brazilian public health service still opt for hormonal methods, especially pills, when they want to maintain fertility, or tubal ligation, when they already have established offspring and want a safe and irreversible method.

The creation of Law 9,263/1996

Based on the historical review, it was observed that there was a wave of sterilizations among Brazilian women from the 1970s onwards, which represented 44% of all contraceptive methods. Most women submitted to this contraceptive method were found to be black, low-income and some were extremely young [12]. A few of them were unaware of the irreversible nature of the surgery and opted for sterilization believing that the procedure could be reversed if they were so inclined [12].

The suspicion that it was a matter of demographic control, which is not allowed in our constitution, led to the creation of a joint parliamentary commission of inquiry, formed by deputies and senators, to study the cases and later draft a reproductive planning law. The request for the creation of the commission was precisely due to the fact that the sterilization of women was, at the time, the most used contraceptive method in Brazil. Statistics released by the Brazilian Institute of Geography and Statistics (IBGE) regarding sterilization point to the following: 71% of married or cohabiting women between the ages of 15 and 54 use contraceptives, of which 33% use sterilization and 38% use other methods. If we consider the methods used by women of childbearing age in Brazil, we will see that sterilization represents 44%, being the most used method, followed by the pill, with 41%. For comparison, in developed countries, where 70% of women use some form of contraceptive, sterilization corresponds to 7%. In less developed countries, the percentage rises to 15%. In Italy, it is 1%, in the United Kingdom, 8%, and in Belgium, 5% [12].

In 1996, Law 9.263 was enacted [1], the first that had the objective of regulating reproductive planning. Article 2 of the law states that reproductive planning is *the set of actions for the regulation of fertility that guarantee equal rights of constitution, limitation or increase of offspring by the woman, the man or the couple* [1]. In article 4, it is stated that *family planning is guided by preventive and educational actions and by ensuring equal access to information, means, methods and techniques available for the regulation of fertility* [1]. Article 9 guarantees *the freedom to choose the preferred method* [1]. I highlight the terms “equal rights,” “equal access” and “freedom to choose,” which will be analyzed later from a bioethical point of view.

The law, created to protect the “vulnerable” from “mass sterilization” and guarantee reproductive rights, restricted it to some women, especially during the gestation and postpartum period, regardless of vulnerability status, the woman’s desire or the number of children. In addition, the performance of tubal ligation surgery during these periods, if in violation of the law, could be considered an aggravating penalty for the professional who performed it.

Defenders of the method questioned whether childbirth would not be the ideal time to perform it, since the woman was hospitalized, which would minimize issues of access and public expenses with new hospitalizations. However, according to the law, in order to perform tubal ligation women would have to return home and proceed with a new hospital admission after the puerperal period, that is, 42 days after delivery, in the cases of both natural births and cesarean sections. The vast majority of women did not return due to access issues, or even because they had no one to leave their minor children with. And by the time many of them returned to reproductive planning outpatient clinics, they were already pregnant again and once more were prevented from undergoing tubal ligation surgery. This failure in the regulation of reproduction can be associated with multiple factors in the woman’s situation: unprotected sex, incorrect use of contraceptive methods, intolerance to certain methods, failure to negotiate with the partner to use a condom, non-use because she is waiting for sterilization, among other possibilities [3].

Bioethics in reproductive planning

The relevance of bioethics for public policies is now recognized in most countries. Currently, there is a continuous need to integrate bioethics into the processes of public policy-making in order to promote more ethical and fair decisions for society as a whole. Some countries have influential standing bioethics committees [13].

The implementation of moral principles and rules must consider factors such as feasibility, efficiency, cultural pluralism, and political procedures. When moral norms are used to formulate or criticize public policies, one is evaluating whether laws or policies are morally acceptable or not. When moral criteria are applied to analyze public policies, one is examining whether these policies are aligned with fundamental ethical principles. Such an approach can lead to a more comprehensive and in-depth evaluation of public policies, that is, an approach that considers, beyond mere legality, whether public policies and the law promote well-being and justice for all members of society.

There is not always absolute consensus around what is morally correct. Different value systems can lead to conflicting interpretations of the morality of a given law or public policy.

Beauchamp and Childress' bioethical principles

Beauchamp and Childress' principlism, one of the most influential, cited and studied bioethical currents in bioethical research, offers a set of four fundamental ethical principles that can be applied in analysis and decision-making in biomedical and health contexts [14].

1. Autonomy: this principle recognizes the importance of a person's ability to decide what they think is best for them. Respecting autonomy means respecting patient choices and preferences, as long as they are free, informed, based on reason and respect the dignity and freedom of others and the community.
2. Beneficence: refers to the duty to act in the best interest of patients and promote well-being. It is not just a matter of avoiding harm, because beneficence is a positive act, that is, it presupposes action. To stop doing harm is not to practice beneficence—this is what we call non-maleficence.
3. Non-maleficence: it is the duty not to intentionally cause harm to the patient, that is, to avoid unnecessary damage and minimize risks.
4. Justice: the principle of justice concerns distributive justice, that is, the equitable distribution of resources, and entails treating individuals fairly and impartially, ensuring that everyone has adequate access to health care and decisions are made fairly and transparently.

No hegemony exists between the principles. The principlism model is quite relevant to clinical bioethics, however, according to Schramm, it is not applicable to public health dilemmas, as it is based on the morality of physician-patient interrelations [15].

Bioethics of protection

The bioethics of protection, a current created by professors Fermin Roland Schramm and Miguel Kottow, corresponds to a reflective instrument that starts from the observation and analysis of the asymmetry between citizens. It arose from an attempt to adapt the application of bioethics to public health conflicts in Latin America, which is marked by problems that infringe the principle of justice. In Brazil, particularly, many resource allocation and social exclusion issues still exist, with millions of neglected populations and deep social inequalities.

According to Schramm, there is a significant difference between "vulnerable" and "vulnerated." Any human being is subject to momentary vulnerabilities, that is, they may need support and protection as a result of physical, emotional or psychological shocks. The bioethics of protection does not apply to momentarily vulnerable individuals, but to the population of vulnerated people, who do not have training (capability) to carry out their projects and achieve a dignified life, who are deprived of the minimum conditions to take care of themselves independently, who do

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not have the necessary resources to exercise their full autonomy [15].

By prioritizing the vulnerated, the bioethics of protection intends to use equity to achieve equality and, thus, respect the principle of justice. The bioethics of protection encompasses two concepts:

1. Bioethics: means "ethics of life" and seeks to guide moral conduct and public policies in the area of health in order to ensure respect for human rights, dignity and the integrity of people.
2. Protection: means giving support to those in need, that is, protecting the vulnerated.

Some aspects of bioethics are important, such as the exercise of personal autonomy, as long as it does not affect the lives of others. The bioethics of protection is a recent proposal in the field of bioethics and refers to the moral problems related to human vulneration. Extreme poverty can subject people to violations of other freedoms necessary to carry out life projects, that is, it can deprive them of the competence to have an objectively and subjectively dignified life [15].

In the bioethics of protection, protective measures are offered that may or may not be accepted by the vulnerated. Those affected are protected so they can develop their potential and capacities until such protection is no longer needed. Therefore, protection should not be confused with paternalism. Protection is not imposed; the vulnerated accepts it if they want. Paternalism, on the other hand, is authoritarian, as it imposes protective measures and can, in the name of the supposed well-being of the other, suffocate them, preventing their ability to make their own choices, keeping them dependent on the choices of others. The bioethics of protection defends, therefore, the right to personal autonomy and prepares the individual to exercise it and be responsible for their actions.

Final considerations

Law 9,263/1996 [1] was the first one created to regulate reproductive planning and of great importance for its implementation and organization in public health. Public services began to offer various scientifically accepted methods of conception and contraception, guaranteeing the right to freedom of choice. To do so, they had to adapt and provide infertility treatment, IUD placement and effect tubal ligation promotion.

Although the law was a great advance, it contained a great limitation for tubal ligation, especially during childbirth or the puerperal period. It is important to note that, in Brazil, with more than 50 million vulnerated, there is enormous social inequality. When a poor, vulnerable and often vulnerated woman is prevented from being submitted to tubal ligation surgery just because she is pregnant, we must question whether her autonomy is being undermined, whether the medical system is failing to practice beneficence and incurring in injustice.

From the perspective of the bioethics of protection, we question whether one is failing to provide something necessary and beneficial and falling short of protecting a vulnerated person. The judgment that an act is morally acceptable does not imply that the law should permit it [14]. However, Law 9,263/1996 [1] itself uses the expressions "equal rights," "equal access" and "freedom to choose," and it is based on that fact that such questions are raised in relation to pregnant women, who for many years have had their rights violated simply for being pregnant.

Furthermore, because it was sanctioned at a time when knowledge of bioethics was poor, the law could violate several of its principles. The current family planning law, Law 14,443 [16], which came into force in March 2023, illustrates this in that it is characterized by greater respect for women's autonomy in choosing definitive contraception. Tubal ligation is now permitted at the time of delivery and in the postpartum period in women over 21 or in those who have two or more alive children. It is necessary that the option for the irreversible method is presented at least 60 days before delivery—as it is a definitive choice, it is important that there is a period for the consolidation of the decision. The new law excludes the need for the spouse's agreement and signature to carry out the procedure, considering individual decision to be enough.

As health professionals, our duty is to offer various means of contraception and enable access to them, as well as to advise against

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early tubal ligation and, in case of opting for surgery, to exhaustively clarify that the method is irreversible, not risk-free and that the greatest complication is regret; however, once this is done, it is up to us to respect individual autonomy and paternalistically. The new law is being complied with and there is currently a great demand for tubal ligation. Perhaps there is a need for future studies to evaluate the effect of the new law on the number of unwanted pregnancies and the rate of regret for opting for the irreversible method.

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Research

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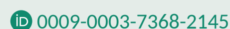

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