






# What does a doctor need to know about breastfeeding and adolescent health and pregnancy?

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## INTRODUCTION

For the World Health Organization (WHO), breastfeeding (BF) should start in the delivery room in the first hour of life, should be maintained in the form of exclusive breastfeeding (EBF) for the first 6 months of life, and after that period, along with healthy complementary feeding, should be maintained for at least 2 years of age<sup>1</sup>.

Among the different medical specialties, traditionally, it is pediatricians, obstetricians, and family and community physicians who act more directly in supporting and helping women during the lactation period, acting as educators and protagonists in interventions during pregnancy, in the immediate puerperium and in the childcare consultations<sup>2-5</sup>. However, it is imperative that every physician, regardless of specialty, has knowledge about BF, as many specialties will require longitudinal follow-up of their patients, allowing the physician to play a fundamental role in planning and supporting BF, such as, for example, support that the general practitioner or occupational physician can offer to working women in the transition between maternity leave and returning to work, one of the critical periods in which lack of guidance can lead to interruption of BF<sup>5</sup>.

This article aimed to address the most current scientific evidence on the benefits of BF on women's health, as well as specific situations that may arise in women's health that contraindicate BF, the few drugs whose use is prohibited during BF and ends by addressing attention integral to adolescent health and pregnancy.

## BREASTFEEDING

### Short-term benefit

Although gestational diabetes mellitus (GDM) tends to resolve after childbirth, in most women, another portion ends up progressing in a few months or years to the onset of type 2 diabetes mellitus (DM2)<sup>6</sup>. In this context, in women with a history of GDM, studies associate BF with improvement in the functioning of maternal pancreatic beta cells in the postpartum period, generating lower glycemic, total, and LDL cholesterol levels and higher HDL cholesterol levels<sup>7-9</sup>. Shub et al. found that among women, with or without GDM during pregnancy, EBF was associated with lower fasting blood glucose concentrations at 6–10 weeks postpartum, after adjusting for possible confounding biases<sup>7</sup>. Tarrant et al. conducted a systematic review involving 13 articles that studied the influence of BF on postpartum glycemic status and eight that compared mean blood glucose values between BF and non-BF participants. Of the 13 studies that compared postpartum glycemic status, nine found that BF reduced rates of glucose intolerance. In eight of the studies, there were mean blood glucose values, and in six of the studies, the fasting plasma glucose was lower in participants who breastfed, with reductions ranging from 3.7 to 7.4 mg/dL<sup>8</sup>.

A recent randomized clinical trial tested whether BF during the oral glucose tolerance test affects glucose and insulin results. For this, 20 women with previous GDM were recruited; each woman performed two OGTTs in the first 3 months after

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delivery, BF the child in one and avoiding BF in the other. Glucose and insulin were measured in four moments. In BF OGTTs, higher values were observed for global glucose and insulin concentrations, glucose and insulin peaks, and individual glucose (at 0, 30, and 60 min) and insulin (at 0 and 60 min) points, but without differences at 120 min<sup>9</sup>.

The act of sucking the nipple-areola region is the most important stimulus for the secretion of oxytocin, which also causes uterine contraction, so that BF accelerates the return of the uterus to its normal size, reducing the occurrence of postpartum hemorrhage, and consequently anemia. In addition, high levels of oxytocin can increase the pain threshold, reducing maternal discomfort and thus contributing to an increase in the mother-infant bond<sup>10</sup>.

The oxytocin released during BF also has lipolytic and anorexigenic effects. Based on this, there will be faster weight loss and a return to pre-pregnancy conditions, with an average monthly reduction of 450 g in maternal weight during BF<sup>11</sup>. A study conducted with 314 Mexican mothers revealed that those who exclusively breastfed for at least 3 months had a weight reduction of 4.1 kg compared to those who did not breastfeed<sup>12</sup>.

As long as there is the lactation period, the high levels of prolactin lead to the inhibition of the hormone gonadotropin, estrogen, and progesterone, leading to the interruption of ovulation and amenorrhea. As long as a woman breastfeeds exclusively on demand, at least eight times a day, and has not menstruated, her protection against pregnancy can reach 96% during the first 6 months. After the return of menstrual cycles, the probability of conception can decrease by 7.4% for each additional month of BF<sup>13</sup>.

### Long-term benefits

Some studies suggest that the benefit of BF on maternal insulin sensitivity may persist over time. Among them, Ley et al. evaluated 4,372 American women with DM2 and a history of GDM and observed an inverse association between the duration of lactation throughout life and the risk of developing DM2. Compared with not BF, adjusted hazard ratios (HRs) were significantly lower depending on duration with a ratio of 0.73 (95%CI 0.57–0.93) for a cumulative duration of BF greater than 24 months<sup>14</sup>.

There appears to be an inverse dose-response relationship between the duration of BF and the risk of developing cardiovascular disease. In a prospective study, 139,681 women who reported a lifetime history of more than 12 months of lactation were less likely to have various postmenopausal conditions, including hypertension (odds ratio [OR] 0.88,  $p < 0.001$ ), hyperlipidemia (OR 0.81,  $p < 0.001$ ), and cardiovascular disease

(OR 0.91,  $p = 0.008$ ) than women who never breastfed but were not likely to be less obese. When adjusted for BMI, similar relationships were observed. During an average of 7.9 years of study participation, women with a single live birth who breastfed for 7–12 months were significantly less likely to develop cardiovascular disease (HR 0.72, 95%CI 0.53–0.97) than women who never breastfed<sup>15</sup>.

Studies have shown an association between the duration of BF and the consequent protective effect against the risk of breast cancer, probably due to the following mechanisms: lower levels of estrogen during the lactation period reduce the rates of cell proliferation and differentiation, and epithelial apoptosis at the end of the nursing period assists in the destruction of damaged DNA cells. It is estimated that the risk of breast cancer can be reduced by more than 4% for each year of BF<sup>16</sup>.

Compared with never BF, women who breastfed for any length of time were associated with a 22% reduced risk of breast cancer (OR 0.78; 95%CI, 0.74–0.82) and also had a 30% less risk of ovarian carcinoma (OR 0.70; 95%CI, 0.64–0.77)<sup>17</sup>. BF is also associated with a significant reduction in the risk of endometrial cancer (relative risk (RR): 0.77; 95%CI, 0.62–0.96), and each month of BF has been associated with a reduction of 2% RR for endometrial cancer (RR 0.98; 95%CI, 0.97–0.99)<sup>18</sup>.

According to Farland et al., the duration of full and EBF was significantly associated with decreased risk of endometriosis, as for every 3 additional months of full BF per pregnancy, women had an 8% lower risk of endometriosis (HR 0.92; 95%CI 0.90–0.94), 14% lower risk for every 3 additional months of EBF per pregnancy (HR=0.86; 0.81–0.90), and women who breastfed for 3 years or more in total over their reproductive lifetime had a 40% risk lower incidence of endometriosis compared to women who never breastfed (HR=0.60; 0.50–0.72)<sup>19</sup>.

Meta-analysis with six studies, conducted by Chen et al., demonstrated that BF is associated with a lower risk of developing rheumatoid arthritis among women who breastfeed for between 1 month and 1 year (OR 0.783, 95%CI 0.641–0.957,  $p = 0.015$ ) and for more than 12 months (OR 0.579, 95%CI 0.462–0.726,  $p < 0.0005$ )<sup>20</sup>.

The biological and psychosocial effects of BF, such as better stress regulation, may exert long-term benefits for the mother's brain health. A convenience sample of Californian women over 50 years old was recruited through two clinical trials and found that BF women performed better on several cognitive tests in the domains of learning, delayed recall, executive functioning, and processing speed in comparison with women who did not breastfeed, suggesting that BF may have a protective effect for Alzheimer's disease, possibly due to the hormonal effects of estrogens on brain receptors and the insulin sensitivity provided by BF<sup>21</sup>.

Women who breastfed for 15 months or more had a reduced risk of multiple sclerosis compared with those who breastfed for 4 months or less<sup>22</sup>.

### Maternal contraindications to breastfeeding

There are few maternal health conditions in which there is a formal contraindication to BF. Mothers who have infectious diseases such as infection by HIV (human immunodeficiency virus), infection by HTLV (human T-lymphotropic virus), infection by herpes simplex (in the presence of active lesions in the breast), chickenpox (mothers who develop the disease within 5 days before up to 2 days after delivery), and cytomegalovirus (provided the neonate is extremely premature, that is, gestational age at birth <30 weeks or birth weight <1,000 g) should not be breastfed, due to the risk of direct transmission to the child, or in the case of cytomegalovirus and chickenpox, the antibodies that would prevent infection in children are not present<sup>23</sup>.

Mothers who regularly use illicit drugs (marijuana, cocaine, crack, amphetamine, ecstasy, and others) should not breastfeed their children<sup>24</sup>.

In some specific situations such as debilitating infection for the mother, maternal leprosy, invasive systemic maternal infection by *Staphylococcus aureus* or group B Streptococcus, acute phase of maternal dengue infection, occasional consumption of alcohol or illicit drugs, yellow fever vaccine in mothers of children under 6 months of age, or who are undergoing an examination with radiopharmaceuticals, temporary interruption of BF is recommended, and the time that the woman should not breastfeed varies according to each situation<sup>25</sup>.

### Breastfeeding and medication

The number of women who interrupt their children's BF to use medication is still frequent. This may occur because the prescribing physician is unaware of the issue of safety in the use of medications during BF, because the content of medication inserts often recommends not using them in pregnant and lactating women, and the fear that mothers have that a certain medication could harm their child. Nowadays, only a minority of drugs actually contraindicate lactation. In 2010, the Ministry of Health (MS) published the second edition of the manual "Breastfeeding and the use of medicines and other substances," now updated in 2022<sup>26</sup>.

Medications are classified into compatible, judicious, and contraindicated use. It is important that the physician, when prescribing a drug to a nursing mother or if asked about the compatibility or otherwise of a drug, can consult such support material to provide accurate information

## COMPREHENSIVE HEALTH CARE FOR ADOLESCENTS AND PREGNANCY

Comprehensive adolescent health care (AISA) should offer periodic routine and occasional care, when the situation requires it, in order to work on issues related to the prevention of injuries and health promotion, recognizing risk behaviors and/or signs/symptoms that may denote the onset of some disease. The actions of this service should be aimed at reducing vulnerability and risks to physical and emotional health; promoting relationships of trust and self-care; preventing injury and manifesting diseases in adults, but with early onset, diseases related to unprotected sexual activity; and questioning about work, school, citizenship, technology, digital addiction, environment, nutritional aspects, and violence<sup>27,28</sup>.

The AISA should be extended to the entire population aged between 10 and 20 years, with longitudinal and distinct follow-up between the different stages, to be carried out through individualized outpatient care, home visits, and participation in educational groups with the following objectives general: monitor physical growth and development; expand vaccination coverage; promote sexual and reproductive health; promote food and nutrition education; promote safety and accident prevention; promote the prevention of intentional injuries in the home, school, and interpersonal environment; encourage health promotion and prevention of the most common diseases in this age group; promote physical and mental hygiene and the practice of leisure activities appropriate to each phase; and provide socialization, cultural stimulation, and adaptation of adolescents. In this age group, pregnancy is still considered a social and public health problem 28-31 in their social environment, promoting oral health<sup>27-30</sup>.

In Brazil, the pregnancy rate is above the Latin American average in adolescents aged 15–19 years, with this number being 68.4/1,000 adolescents in Brazil, 65.5/1,000 in Latin America, and an average of 46/1,000 in the world. In 10 years, the number of births in children under 19 years in Brazil has decreased by about 40%, but the teenage pregnancy rate is still high, with more than 400,000 pregnant women per year. Only 2% of teenagers who became pregnant continued their studies<sup>27-30</sup>.

For the teenage mother, complications and severity will be greater or lesser according to age, parity, adherence to prenatal care, weight gain, and socioeconomic and cultural factors. The physical consequences are hypertension; anemia, resulting from situations of poverty, malnutrition, chronic malnutrition, and inadequate diet to avoid gaining weight; higher rate of cesareans; urinary and genital infections; maternal mortality (risk increases the lower the chronological age and with successive pregnancies at short intervals); spontaneous and clandestine abortions; toxemia; and dystocia, sexually transmitted infections (STIs)<sup>27-30</sup>.

As psychosocial consequences, there is emotional tension, family rejection that increases the probability of developing physical and mental problems; loss of autonomy; partner abandonment; low schooling, associated with low socioeconomic status, being the cause of higher absenteeism in prenatal care; difficulty in returning to school after childbirth due to the fragile support network; and dreams interrupted by the lack of preparation for work, as many drop out of school when they become pregnant and, therefore, lose the opportunity to acquire knowledge and enter the job market<sup>27-30</sup>.

As for the son of a teenage mother, the consequences are prematurity, abandonment, low weight at birth, increase in the infant mortality rate in the first year of life, higher number of hospitalizations, violence, and even BF can be affected. BF should be encouraged for adolescent mothers, making them aware of the benefits for both the child and her (all the same benefits of BF as adult mothers) and the importance of BF to the child exclusively for the first 6 months of life, continuing up to 2 years<sup>30</sup>.

The prevention of untimely pregnancy takes place through sex education, through frank, open, and sincere dialogue with parents, health professionals, and teachers, in addition to contraceptive methods<sup>27-31</sup>.

### Ethical-legal aspects of contraception in adolescence

Contraception can and should be indicated for adolescents, respecting the medical eligibility criteria of the WHO for the use of contraceptives, including for children under 14 years of age, and its prescription is based on technical standards of the MoH and Code of Medical Ethics. However, it turns into a dilemma when deals with adolescents under 14 years of age. If the law is on the one hand, the issue of sexual and reproductive rights is on the other<sup>32-34</sup>.

## REFERENCES

1. World Health Organization. Health topics. Breastfeeding. [cited on Jan 23, 2023] Available from: <https://www.who.int/health-topics/breastfeeding>
2. American Academy of Family Physicians. Breastfeeding, family physicians supporting (Position Paper). 2016. [cited on Jan 24, 2023] Available from: <https://www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/breastfeeding.html>
3. Brazilian Society of Pediatrics. Scientific Department of Breastfeeding. Practical Guide to Breastfeeding. 2020.
4. American College of Obstetricians and Gynecologists Committee on Obstetric Practice; Br Optimizing Support for Breastfeeding as Part

From a legal point of view, in 2009, article 217 was inserted in the Brazilian Penal Code, which establishes the crime of rape of a vulnerable person, “having carnal intercourse or performing another libidinous act with someone under 14 years of age,” with mandatory notification to the Tutelary Council or the Public Ministry. Therefore, the notification must be made even in cases where the relationship is consensual, the parents are aware of it or even when it is a pregnancy desired by the adolescent and her family, not discriminating the age difference between the partners nor the degree of affectivity of the partner couple<sup>32-34</sup>.

Scientific societies have promoted meetings with professionals from the social, health, and justice areas, with the aim of finding possibilities to guarantee adequate assistance in sexual and reproductive health, without failing to propose a reflection on the beginning of sexual life and on the conscious possibility of consider postponing the act.

Special emphasis is given to the importance of the right to information and prevention of pregnancy and STIs, both for those who already have sexual activity and for those who have not yet started it<sup>32-34</sup>.

Recognizing the adolescent as a subject with rights and respecting her as such is essential in order to advance in the challenge of providing comprehensive health care for this population.

## AUTHORS' CONTRIBUTIONS

**RSP:** Conceptualization, Writing – original draft, Writing – review & editing. **LMDL:** Conceptualization, Writing – original draft. **AEBIA:** Conceptualization, Writing – original draft, Writing – review & editing. **DVSB:** Conceptualization, Writing – original draft. **LMN:** Conceptualization, Writing – original draft, Writing – review & editing. **IMDL:** Conceptualization, Writing – original draft.

of Obstetric Practice. *Obstet Gynecol.* 2016 Feb;127(2):e86-92. <https://doi.org/10.1097/AOG.0000000000001318>

5. Dagher RK, McGovern PM, Schold JD, Randall XJ. Determinants of breastfeeding initiation and cessation among employed mothers: a prospective cohort study. *BMC Pregnancy Childbirth.* 2016;16(1):194. <https://doi.org/10.1186/s12884-016-0965-1>
6. Doughty KN, Taylor SN. Barriers and benefits to breastfeeding with gestational diabetes. *Semin Perinatol.* 2021;45(2):151385. <https://doi.org/10.1016/j.semperi.2020.151385>
7. Shub A, Miranda M, Georgiou HM, McCarthy EA, Lappas M. The effect of breastfeeding on postpartum glucose tolerance and lipid profiles in women with gestational diabetes mellitus. *Int Breastfeed J.* 2019;14:46.

8. Tarrant M, Chooniedass R, Fan HSL, Del Buono K, Masina S. Breastfeeding and postpartum glucose regulation among women with prior gestational diabetes: a systematic review. *J Hum Lact.* 2020;36(4):723-38. <https://doi.org/10.1177/0890334420950259>
9. Monroy G, Fernández C, Caballé T, Altimira L, Corcoy R. Breastfeeding effect on glucose tolerance assessment in women with previous gestational diabetes mellitus: a randomized controlled trial. *Diabet Med.* 2022;39(11):e14954. <https://doi.org/10.1111/dme.14954>
10. Sattari M, Serwint JR, Levine DM. Maternal implications of bibliography breastfeeding: a review for the internist. *Am J Med.* 2019;132(8):912-20. <https://doi.org/10.1016/j.amjmed.2019.02.021>
11. Lambrinou CP, Karaglani E, Manios Y. Breastfeeding and postpartum weight loss. *Curr Opin Clin Nutr Metab Care.* 2019 Nov;22(6):413-7. <https://doi.org/10.1097/MCO.0000000000000597>
12. López-Olmedo N, Hernández-Cordero S, Neufeld LM, García-Guerra A, Mejía-Rodríguez F, Méndez Gómez-Humarán I. The associations of maternal weight change with breastfeeding, diet and physical activity during the postpartum period. *Matern Child Health J.* 2016;20(2):270-80. <https://doi.org/10.1007/s10995-015-1826-7>
13. Del Ciampo LA, Del Ciampo IRL. Breastfeeding and the benefits of lactation for women's health. *Rev Bras Ginecol Obstet.* 2018;40(6):354-9. <https://doi.org/10.1055/s-0038-1657766>
14. Ley SH, Chavarro JE, Li M, Bao W, Hinkle SN, Wander PL, Rich-Edwards J, Olsen S, Vaag A, Damm P, Grunnet LG, Mills JL, Hu FB, Zhang C. Lactation duration and long-term risk for incident type 2 diabetes in women with a history of gestational diabetes mellitus. *Diabetes Care.* 2020;43(4):793-8. <https://doi.org/10.2337/dc19-2237>
15. Schwarz EB, Ray RM, Stuebe AM, Allison MA, Ness RB, Freiberg MS, Cauley JA. Duration of lactation and risk factors for maternal cardiovascular disease. *Obstet Gynecol.* 2009;113(5):974-82. <https://doi.org/10.1097/01>
16. Qiu R, Zhong Y, Hu M, Wu B. Breastfeeding and reduced risk of breast cancer: a systematic review and meta-analysis. *Comput Math Methods Med.* 2022;2022:8500910. <https://doi.org/10.1155/2022/8500910>
17. Sung HK, Ma SH, Choi JY, Hwang Y, Ahn C, Kim BG, et al. The effect of breastfeeding duration and parity on the risk of epithelial ovarian cancer: a systematic review and meta-analysis. *J Prev Med Public Health.* 2016;49(6):349-66. <https://doi.org/10.3961/jpmph.16.066>
18. Wang L, Li J, Shi Z. Association between breastfeeding and endometrial cancer risk: evidence from a systematic review and meta-analysis. *Nutrients.* 2015;7(7):5697-711. <https://doi.org/10.3390/nu7075248>
19. Farland LV, Eliassen AH, Tamimi RM, Spiegelman D, Michels KB, Missmer SA. History of breastfeeding and risk of incident endometriosis: prospective cohort study. *BMJ.* 2017;358:j3778. <https://doi.org/10.1136/bmj.j3778>
20. Chen H, Wang J, Zhou W, Yin H, Wang M. Breastfeeding and risk of rheumatoid arthritis: a systematic review and metaanalysis. *J Rheumatol.* 2015;42(9):1563-9. <https://doi.org/10.3899/jrheum.150195>
21. Fox M, Siddarth P, Oughli HA, Nguyen SA, Milillo MM, Aguilar Y, et al. Women who breastfeed exhibit cognitive benefits after age 50. *Evol Med Public Health.* 2021;9(1):322-31. <https://doi.org/10.1093/emph/eoab027>
22. Portaccio E, Amato MP. Breastfeeding and post-partum relapses in multiple sclerosis patients. *Mult Scler.* 2019;25(9):1211-6. <https://doi.org/10.1177/1352458519830588>
23. Committee on Infectious Diseases, American Academy of Pediatrics. In: Kimberlin DW, Barnett ED, Lynfield R, editors. *Red Book: 2021. Report of the committee on infectious diseases.* 32nd ed. Itasca, IL: American Academy of Pediatrics.
24. Brazilian Society of Pediatrics. Scientific Department of Breastfeeding. Use of drugs and other substances by women during breastfeeding, 2017.
25. Brazilian Society of Pediatrics. Scientific Department of Breastfeeding. Infectious maternal diseases and breastfeeding - Update, 2022.
26. Brazil. Ministry of Health. Secretary of Health Care. Department of Programmatic and Strategic Actions. Breastfeeding and use of medications and other substances. 2nd ed. Brasília: Editora do Ministério da Saúde, 2014. [cited on Feb 03, 2023] Available from <https://www.gov.br/saude/pt-br/assuntos/saude-de-a-a-z/s/saude-da-crianca/publicacoes/amamentacao-e-use-of-medicines-and-other-substances-2nd-edition/view>
27. Azevedo AEBI, Bermudez B, Fernandez B, Ferreira H, Hagel L, Goldberg T, et al. Adolescent consultation: clinical approach, ethical and legal guidelines as a tool for the pediatrician. *Adolesc. Saude, Rio de Janeiro;* 2018. p. 73-85. Available from: [http://www.adolescenciaesaude.com/detalhe\\_artigo.asp?id=761](http://www.adolescenciaesaude.com/detalhe_artigo.asp?id=761)
28. Azevedo AEBI, Reato LFN. *Adolescence handbook- 1. Ed – Barueri, SP: Manole;* 2019.
29. Azevedo AEBI, Eisenstein E, Fernandez B, Goldberg T, Ferreira H, Guimarães P, et al. Teenage pregnancy prevention. Rio de Janeiro, 2019 - (Practical update guide - scientific document) Available from: [https://www.sbp.com.br/fileadmin/user\\_upload/Adolescencia\\_-\\_21621c-GPA\\_-\\_Adolescent\\_pregnancy\\_contraception](https://www.sbp.com.br/fileadmin/user_upload/Adolescencia_-_21621c-GPA_-_Adolescent_pregnancy_contraception)
30. Azevedo AEBI, Eisenstein E, Fernandez B, Goldberg T, Ferreira H, Guimarães P, et al. Contraception in adolescence. Rio de Janeiro 2018 (Orientation manual - scientific document). Available from: [https://www.sbp.com.br/fileadmin/user\\_upload/20290c-GPA\\_-\\_Contraception\\_in\\_Adolescence](https://www.sbp.com.br/fileadmin/user_upload/20290c-GPA_-_Contraception_in_Adolescence)
31. SBP. Scientific Department of Adolescent Medicine and Scientific Department of Breastfeeding. *Adolescence and breastfeeding;* 2020.
32. Azevedo AEBI, Reato LFN, Rehme MFB. Ethical, bioethical and legal aspects of adolescent care in pediatric treaty of the SBP section: bioethics. 5th ed; 2021.
33. Rehme MFB, Cabral ZAF, Monteiro DLM, Herter LD, Araujo ESP, Cunha A, et al. 2nd Forum on ethical and legal aspects in adolescent care. *Female.* 2020;48(2):70:81.
34. Federation of Gynecology and Obstetrics Associations (FEBRASGO), Brazilian Association of Obstetrics and Gynecology of Childhood and Adolescence (SOGIA), Brazilian Society of Pediatrics (SBP). Care for adolescents under 14 years of age: clarification Alert - Federal Law No. 12,015/2009. *FEMALE* 2021;49(1):25-8.

