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UPDATE ARTICLE

Diverse family dynamics: reproductive, social, ethical, and legal perspectives in Brazil

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Abstract

Objectives: Nowadays, the concept of family encompasses new family structures, based on affectionate and cohabitation relationships, rather than being solely restricted to marriage between a man and a woman and their descendants. This article aims to discuss some social, ethical-legal, and reproductive aspects related to so-called plural families in Brazil. **Methods:** Mini-review of the literature presenting the most relevant information and some peculiarities related to assisted reproduction techniques and legal aspects related to family constitution and civil registration in plural families. **Results:** Assisted reproduction techniques made it possible for some individuals and couples to have biological offspring under conditions where natural conception might pose challenges, resulting in different family configurations. In Brazil, ethical standards for the use of assisted reproduction are regulated by the Federal Council of Medicine (CFM) and the civil registration of individuals resulting from these treatments follows the conditional regulations of the National Council of Justice (CNJ). **Conclusion:** Reproductive medicine has played a crucial role in mitigating prejudice and working towards greater equality between individuals in the formation of their families. However, many challenges and controversies related to ethical-legal aspects still permeate this topic.

Keywords: Diverse Families; Health Services for Transgender Persons; Reproduction; Sexual and Gender Minorities; Single Parent; Transgender Persons

1. Introduction

On June 28th, 1969, the Stonewall Uprising marked the beginning of the LGBT+ movement. Originating in a New York gay bar, this riot, initially seeking basic civil rights, became the starting point fora revolutionary struggle for equality worldwide. Since then, individuals of different gender identities and sexual orientations have been gaining recognition, respect, and representation in various spheres of society.

At the core of this movement, the struggle for reproductive rights and family formation deserves mention. For decades, the patriarchal and religious traditions, dominant in the past, defined the term “family” as the unit formed by the marriage between a man and a woman and their descendants. In this way, so-called plural families, composed of same-sex couples, transgender individuals, single parents, and extended families, among others, continue to face numerous social and legal barriers in fully exercising the right to family to this day.

In the pursuit of greater equality, Brazilian legislation enshrines pluralism and respect for the diversity and autonomy of its citizens. The Federal Constitution of 1988 broadened the concept of family by avoiding adjectives and exclusions in its wording[1]. It guarantees individuals free will regarding family planning, thus encompassing various forms of family formation based on affectionate and cohabitation relationships, rather than being solely restricted to marriage between a man and a woman[1]. Article No.226 stipulates that the family is the foundation of society and should be protected by the State, also addressing the need for parental responsibility[1].

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The recognition of families with diverse conformations is very recent. The stable union between people of the same sex was recognized as a family entity in 2011, when the Federal Supreme Court (STF) granted same-sex couples rights similar to those of heterosexual couples. In 2013, the National Council of Justice (CNJ) approved a resolution that prohibited registry offices from refusing to perform civil marriages between people of the same sex, guaranteeing the right to civil same-sex marriage throughout Brazil[2]. Finally, in 2018, the STF determined that stable unions and civil marriage between people of the same sex should not be subject to legal discrimination.

Given the recognition of new family structures, reproductive medicine has played a crucial role in mitigating prejudices and working towards greater equality among individuals. Assisted reproduction (AR), one of whose main purposes is the facilitation of the procreation process[3], has aided many in realizing the dream of having children under conditions where natural conception might pose challenges. More and more plural families have sought medical assistance to facilitate the formation of their offspring. However, legislation on this issue remains controversial and subject to constant updates.

In Brazil, the ethical standards for the use of assisted reproductive techniques (ART) are regulated by the Federal Council of Medicine (CFM). The most recent regulation is Resolution No. 2.320/2022, published in September 2022[3]. Additionally, the National Council of Justice (CNJ) regulates the civil registration of individuals resulting from these treatments, with Provision No. 83, issued in August 2019, being the current legislation[4]. Below are some legal peculiarities related to the different reproductive possibilities of so-called plural families.

2. Methods

This is a mini-review of the main bibliographical references available in the scientific literature regarding reproductive aspects related to plural families. In this mini-review, we systematically searched the PUBMED database for highly relevant studies published in the last 10 years about assisted reproduction techniques necessary for the procreation of single parents, female same-sex couples, male same-sex couples, transgender individuals, and gender diverse individuals.

Furthermore, we researched the ethical-legal aspects related to plural families provided by Brazilian legislation. A survey was carried out of the main public documents that regulate the practice of assisted reproduction techniques in Brazil, the civil registration the civil registration of individuals resulting from these treatments and the recognition of diverse family unions. The rules for the use of donated gametes, the use of a surrogate uterus and shared pregnancy were emphasized. Extended families (polyamorous) and co-parenting were also included in this review.

3. Results

Different contexts were identified in which ART have been used to favor the formation of plural families. The literature survey on this topic found information on solo parenting, procreation in individuals of the same sex and transgender individuals. In the following lines, some particularities related to assisted reproduction techniques in different family configurations will be detailed.

3.1 Single-parent families

Single-parent families are formed by only one parent and their children. Regardless of the gender identity of the parent, AR can enable the independent generation of biological children. In biologically female individuals, oocyte can be obtained through the process of controlled ovarian stimulation and oocyte retrieval, which are then fertilized *in vitro* with donor sperm. Subsequently, the formed embryos are transferred into the uterus, which can belong, for example, to a cisgender woman, a transgender man, or even to a surrogate. In biologically male individuals, fertilization is carried out with donated oocyte and the individual's own sperm, followed by embryo transfer to a surrogate uterus. In other words, the gestational process occurs in a temporary uterus provider[3].

3.2 Dual paternity

Male same-sex couples who wish to have biological children can undergo *in vitro* fertilization using donated oocyte and a surrogate uterus (often referred to as a "gestational carrier" or "surrogate"). It is possible to fertilize oocytes from the same donor with the sperm of each partner, but this process must be performed separately to identify the biological parentage of each embryo, with a prohibition on mixing the sperm from both partners. In addition, the transfer of embryos with different genetic origins into the same uterus is also not allowed[3].

3.3 Dual maternity

Intrauterine insemination (IUI) and *in vitro* fertilization (IVF) using donor sperm are possible techniques for female same-sex couples desiring biological offspring. In IUI, prepared sperm is injected into the uterine cavity after ovulation

monitoring, and oocyte fertilization occurs in the uterine tube. Meanwhile, in IVF, the process involves controlled ovarian stimulation and oocyte retrieval, with fertilization taking place in the laboratory, followed by embryo transfer into the uterus.

Other strategy for female same-sex couples is shared gestation, where the oocytes of one woman are fertilized *in vitro*, and the formed embryo(s) is transferred to her partner's uterus[5,6]. It is important to emphasize that the same sperm can be used to fertilize the oocytes of both women, but the transfer of embryos with different genetic origins into the same uterus in a single transfer is not allowed. Additionally, it is not permitted to mix oocyte from two women for fertilization[3].The implementation of the shared gestation technique has shown similar rates of pregnancy and live births when compared to gestation from autologous oocytes[5,6].

The choice between IUI and IVF varies based on factors such as the woman's age, the presence of patent uterine tubes, and gynecological conditions that may reduce the chances of success in low-complexity treatments, such as endometriosis and low ovarian reserve, among others[5,6].

The practice of home artificial insemination for female couples is contraindicated due to the high risk of biological contamination, infections, socioemotional complications involving aspects of motherhood, future legal issues related to parenthood, and unsecured rights regarding the offspring[7].

3.4 Transgender families

There are limited data on the effects of gender-affirming hormone therapy (GAHT) on reproductive outcomes[8]. Individualized counseling remains the best approach for fertility preservation and fertility treatment in this population. Transgender individuals should undergo ART to preserve their fertility, ideally before initiating GAHT, and use the preserved gametes for later AR through intrauterine insemination or *in vitro* fertilization, for both trans men and trans women[7]. It is crucial to highlight the importance of informing trans women about the potential reproductive system damage caused by GAHT and gender affirmation surgery, as such information can influence the individual's decision regarding fertility preservation[8].

In the case of trans men, discontinuing testosterone use leads to the resumption of menstruation within four to six months, thereby restoring reproductive capacity. Conveniently, oocyte freezing can be performed before GAHT or even during the hormone treatment process without compromising success rates. This is because the exposure to high levels of testosterone in trans men does not seem to interfere with fertilization rates or the development and quality of embryos during the pre-implantation period[9]. For optimal oocyte freezing, it is advised that GAHT be discontinued three months prior to the induction of ovulation; however, recent studies have shown similar rates of oocyte recovery between trans men receiving GAHT and cisgender women undergoing ovulation induction for oocyte retrieval. When a trans man wishes to reproduce, embryos generated from his oocyte and fertilized by his partner's sperm or, in the case of a female partner, by donor sperm, can be transferred to her uterus. If the trans man does not have a uterus, gestation can occur in a surrogate uterus with a relative up to the fourth degree, according to CFM regulations[3].

In trans women, GAHT involves the administration of anti-androgens combined with estrogens, which can temporarily or permanently compromise their reproductive capacity[10]. Therefore, before starting GAHT, it is recommended to offer fertility preservation through sperm freezing to all trans women[11]. Those who did not have the opportunity to freeze sperm before hormone therapy are advised to suspend treatment for a period ranging from three to six months, according to the literature, for spermatogenesis recovery. When these women desire reproduction, they have the option to undergo *in vitro* fertilization or intrauterine insemination using sperm and oocyte from a partner. In the case of a male partner, they can undergo *in vitro* fertilization with their own or their partner's sperm, using oocyte from a donor and a surrogate uterus. In situations where fertility preservation was not performed, or in cases of unsuccessful gamete recovery after the interruption of gender-affirming hormone therapy, the trans individual can pursue parenthood through oocyte or sperm donation.

3.5 Co-parenting

Co-parenting is defined as a situation in which two adults do not wish to maintain a romantic relationship but desire to generate, raise, nurture, and educate a child together. In this sense, a family emerges without necessarily involving a romantic or sexual bond between the parents. From a legal standpoint, in Brazil, there is no specific legislation addressing co-parenting, but there are recommendations for safe co-parenting, such as creating a "child generation contract". This contract can be privately celebrated or formalized through a public deed and will establish, similar to any other parental relationship, the child's registration, shared custody, visitation rights, and child support, among other aspects that ensure the child's rights.

This type of parenting is not outlined in the guidelines of the CFM. Therefore, Assisted Reproduction Clinics lack support to provide reproductive treatment to adults who do not have a civil union or marriage contract, irrespective of their sexual orientation and gender. Thus, it is advisable to seek specific information, legal advice, and consult a specialized AR clinic to assess available options and choose the most appropriate technique. If necessary, an evaluation by the CFM can be sought based on an individual case.

4. Discussion

Although AR provides a multitude of resources for procreation, it is important to highlight that, in Brazil, the use of these techniques is regulated by laws and regulations. In the context of plural families, it is often necessary to use donated gametes and surrogate uterus, as mentioned previously. Furthermore, children resulting from these treatments need to be properly registered. Therefore, below we will discuss the main regulations in this regard.

4.1 Donation of gametes (oocyte or sperm)

Oocyte or sperm can be obtained from anonymous donors, meaning that the recipients of the gametes should not know the identity of the donors, and vice versa. In Brazil, an exception to anonymity is allowed when gamete donation occurs between relatives up to the 4th degree (parents, children, grandparents, siblings, uncles, nephews, and cousins), provided that the use of gametes does not result in consanguinity[3].

4.2 Surrogate uterus

A surrogate uterus requires the fulfillment of certain prerequisites. The temporary uterus provider must be up to 50 years old, have at least one living child, and be a blood relative up to the 4th degree of one of the future parents. If the potential provider has no family relationship, authorization from the Regional Council of Medicine (CRM) must be requested. The temporary uterus arrangement cannot be for profit or commercial purposes, and the reproduction clinic cannot mediate the selection of the provider. In addition, the temporary uterus provider cannot be the oocyte donor if oocytes are needed in the process[3].

From a legal point of view, the following documents are required, as indicated by CFM Resolution No. 2.320/2022[3]:

> a) an informed consent form signed by the patients and the temporary uterus provider, covering biopsychosocial aspects and risks involved in the pregnancy-postpartum cycle, as well as legal aspects of parenthood; b) a medical report attesting to the physical and mental health suitability of all parties involved; c) a Commitment Agreement between the patient(s) and the temporary uterus provider who will receive the embryo in her uterus, clearly establishing the issue of the child's parentage; d) commitment on part of the contracting patient(s) regarding assisted reproduction services, whether public or private, with medical treatment and monitoring, including by multidisciplinary teams if necessary, for the woman temporarily providing the uterus, until the postpartum period; e) commitment to the civil registration of the child by the patients, with this documentation to be provided during pregnancy; and f) written approval from the spouse or partner, if the temporary uterus provider is married or in a stable union.

4.3 Civil registration

For the purpose of civil registration and the issuance of a birth certificate, the presentation of the following documents is indispensable, as provided by Provision No. 63 of the CNJ, Article 175[4]:

> I – declaration of live birth (DLB);II – declaration, with a recognized signature, from the technical director of the clinic, center, or human reproduction service where the assisted reproduction took place, indicating that the child was conceived through heterologous assisted reproduction, as well as the names of the beneficiaries; III – marriage certificate, certificate of the conversion of a stable union into marriage, public deed of a stable union, or decree recognizing the stable union of the couple.

In cases of surrogate uterus use, the presentation of the commitment agreement signed with the temporary uterus provider, clarifying the issue of parenthood, is also required[4]. Due to the need for donated gametes or a surrogate uterus, the names of the donors or the birthing woman will not appear on the birth certificate, establishing no legal kinship and respective legal effects[4]. In same-sex families, the civil registration should appropriately include the names of both parents, without distinction as to maternal or paternal descent[4].

In extended families (polyamorous), *i.e.*, those composed of more than two parents, civil registration is initially carried out in the name of two parents. Nevertheless, after birth and initial registration, socio-affective parenthood is possible, in

which non-consanguineous parentage is recognized and civil registration is made in extended families, allowing individuals to enjoy the same parental rights and duties. The voluntary recognition of socio-affective paternity or maternity of individuals above 12 years old can be authorized by officials in civil registration offices. However, families with children under 12 years of age require that such recognition be through judicial means[12].

5. Conclusion

Different family structures have been increasingly recognized and validated, aiming to provide equal conditions for producing offspring and enjoying the same parental rights and responsibilities. However, there is still a long way to go to ensure full equality and respect for the rights of all people, regardless of sexual orientation. Despite legal and social progress, we still face several challenges in Brazil. Issues such as joint adoption, socioeconomic access to assisted reproduction, ethical-legal aspects and discrimination are controversial topics that must be continuously discussed and updated by society. Regardless of the established or desired family model, it is essential to have a humanized, welcoming, and multidisciplinary approach to address the complexities that permeate the journey of creating plural families.

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PAASN was responsible for the review, design, and last review of the paper.

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