

Regulation of assisted reproduction techniques in the resolutions of the Federal Council of Medicine: from gradual liberalization to the pro-life turnaround

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ABSTRACT

The article analyzes the regulation of assisted reproduction techniques in Brazil from the existing regulations in the Civil Code of 2002, the New Biosafety Law of 2005, the CNJ provision 63/2017, and compares the seven resolutions of the Brazilian Federal Council of Medicine issued in 1992, 2010, 2013, 2015, 2017, 2020, and 2021. The focus is to verify how configurations of kinship and personhood (the status of the embryo) are presented in the resolutions. Methodologically it is based on document analysis and the exam of changing rules and it also maps controversies that reveal society's value systems. In view of the legislative omission, it can be seen that the changes in the rules correspond to changes in the Brazilian legislation, but mainly to transformations in society in recent years regarding the recognition of the constitution of new families, the main ones being the access of "homo-affective" couples. One can also perceive the gradual desacralization of the extracorporeal embryo until the pro-life turn in 2021.

KEYWORDS

New reproductive technologies; kinship; status of the embryo; legal regulations

Regulação das técnicas de reprodução assistida nas resoluções do Conselho Federal de Medicina: da liberalização gradativa à virada pró-vida

RESUMO O artigo analisa a regulação das técnicas de reprodução assistida no Brasil, examinando a regulamentação existente no Código Civil de 2002, na Nova lei de Biossegurança de 2005, no provimento CNJ 63/2017 e comparando as sete resoluções do Conselho Federal de Medicina emitidas em 1992, 2010, 2013, 2015, 2017, 2020 e 2021. O foco é verificar como configurações de parentesco e de pessoa (o estatuto do embrião) são apresentadas nas resoluções. Trata-se de pesquisa documental que, analisando a mudança das regras, mapeia controvérsias que revelam os sistemas de valores da sociedade. Diante da omissão legislativa, constata-se que as alterações nas normas correspondem a mudanças na legislação brasileira, mas principalmente a transformações na sociedade, nos últimos anos no tocante ao reconhecimento da constituição de novas famílias, principalmente aquelas relativas ao acesso de casais "homoafetivos". Percebe-se também a dessacralização paulatina do embrião extracorporal até a virada pró-vida em 2021.

PALAVRAS-CHAVE

Novas tecnologias reprodutivas; parentesco; estatuto do embrião; regulações jurídicas

[...] It follows a feeling that the family, having lost the solidness of the 'natural', is more than never, a contractual issue. (Fonseca, 2008: 772).

[...] We encounter the reproductive frontier as a highly political space (Franklin, 2013: 274).

INTRODUCTION

This study addresses the regulation of assisted reproduction technology (ART) techniques, with emphasis on kinship and the status of the embryo, by analyzing the resolutions of the Brazilian Federal Council of Medicine in Brazil. In an article titled *Is Kinship Always Already Heterosexual?*, the philosopher Judith Butler, one of the most influential authors in gender theory, defines kinship as follows:

[...] If we understand kinship as a set of practices that institutes relationships of various kinds which negotiate the reproduction of life and the demands of death, then kinship practices will be those that emerge to address fundamental forms of human dependency, which may include birth, child-rearing, relations of emotional dependency and support, generational ties, illness, dying, and death (to name a few) (Butler, 2003: 221)

The anthropologist Marshall Sahlins, in his turn, in his essay *What kinship is – and is not*, published in 2013, calls kinship the 'mutuality of being'. According to Sahlins, kinfolk "participate intrinsically in each other's existence", they share a "mutuality of being" and are "members of one another" (Sahlins, qtd. in Carsten, 2014). Performative studies of kinship, inspired by Schneider, Carsten's (2014) being one of the leading studies, emphasize criteria such as commensality, co-residence, and nurturing in establishing relations (kinship)¹. This debate has left aside the facts of procreation, which underpin the Euro-American notion of kinship as natural (Strathern, 1992). In the face of these anthropological inquiries, how does another line of kinship studies which assesses medical and legal technologies in the constitution of these relationships position itself? This is the contribution of the present study, which focuses on conceptive reproductive technologies or assisted reproductive techniques, which, by means of technology, do not require sexual intercourse for conception.

Franklin considers that the public endorsement and the widespread celebration of new reproductive technologies reveal a growing degree of consensus about

¹ | This description of performative studies was taken from Warren Shapiro. Available at: <https://anthro.rutgers.edu/faculty/emeritus-faculty/103-warren-shapiro>. Accessed May 24th, 2022.

their desirability and legitimacy (2013:66). Examining *in vitro* fertilization (IVF) helps disclose how gender and kinship technologies, among others, activate the reproductive substance, and not the opposite. IVF materializes reproduction in a technically sophisticated manner, employing technically skilled manipulation (Franklin, 2013: 152). According to Thompson (2005: 5), assisted reproductive technologies require both social and technological innovation to make sense of the biological and social relationships that these techniques forge and deny.

Thompson's ethnographic approach focuses on "making kinship" as opposed to considering a specific fixed type of kin as a natural or cultural fact (Thompson, 2005: 146). Her focus is not on how to make babies but on making parents, driven by an interest in what it takes to become a parent: biomedical interventions, legal innovations, and the work of removing ambiguity from relevant kinship categories (2005: 5). She describes a trend in the United States during her field research in the 1990s: access to assisted reproductive technologies, as well as adoption, was governed not only by the desire of a supposed patient to have a child but also by judgments by others on whether it would be socially appropriate for this person to become a parent. Similar issues can be observed in the regulations to be examined in this article.

Analyzing how the resolutions by the Brazilian Federal Council of Medicine evolve, from the first in 1992 until 2021², shows how the regulation of assisted reproduction techniques gradually transformed based on their reproductive (practices that involve other people's reproductive material rather than the heterosexual infertile couple's) and non-reproductive uses (identification of genetic diseases and embryo donation to research). However, it also regards to, or mostly, access to techniques in response to social modernization processes including sexual and gender identities other than the hegemonic ones.

The present article analyzes the regulation of assisted reproduction techniques in Brazil, by examining the scarce existing regulation and by comparing the seven resolutions by the Brazilian Federal Council of Medicine (CFM) issued in 1992, 2010, 2013, 2015, 2017, 2020 and 2021. The goal is to explore the themes of kinship and the status of the embryo. After following the development of medical techniques, innovation lies in legal technologies, where there has been an expansion of the possibilities of choice (Fonseca, 2008): the CFM resolutions respond to the legal void regarding assisted reproduction in Brazil³. Therefore, it is important to highlight that, except for a small number of articles in the Brazilian Civil Code concerning filiation, the Biosafety Law (research with human embryos), and a provision from the National Council of Justice regarding the issuance of birth certificates, the regulation resides in the resolutions of the Brazilian Federal Council of Medicine, which do not have the force of law. This legal emptiness corresponds to an analytical void:

2 | On September 20th, 2022, the CFM Resolution 2320/2022 was issued, months after the submission of this article. It will, then, be briefly mentioned as for its more pertinent alteration; a detailed analysis, though, won't be possible.

3 | This legal void is not a Brazilian prerogative. In the United States, in face of the absence of federal legislation, the American Society of Reproductive Medicine (ASRM) was a pioneer in issuing medical orientations and still nowadays issues guidelines in an effort to continue to self-regulate (Thompson, 2005).

nothing is found in the Humanities and Social Sciences about the changes in regulation, apart from articles in the field of the Law, which are foreign to the analysis of the social and anthropological realm.

For this study, qualitative methodology in documentary research is employed. The anthropological fieldwork, in this case, focuses on documents, on the resolutions of the Brazilian Federal Council of Medicine, as a means to access controversies in Brazilian society surrounding reproductive technologies in the establishment of kinship (Strathern, 1992; Fonseca, 2011). The research mirrors Giumbelli's approach (2002) to analyze controversies through documentary research, so as to understand conflicting values within a society. Thus, by examining these resolutions, whose initial focus was infertility; we can gain insights into societal demands.

To guide this present analysis of kinship regulation with respect to reproductive governance, I resort to the concept of biopower, outlined by Rabibow and Rose (2006), which should contain some of the following elements: "One or more discourses of truth about the 'vital' nature of human beings, and a set of authorities considered competent to express that truth", "intervention strategies on the collective existence in the name of life and death"; "Modes of subjectivation, through which individuals are led to act upon themselves, under certain forms of authority, in relation to discourses of truth" (2006:29). The resolutions under analysis would be discourses of truth uttered by a competent authority: the Brazilian Federal Council of Medicine. In this sense, in the face of this legal void - the omission of the state itself - a non-state actor, the CFM, proposes ways to regulate professionals and their practices. In agreement with Fonseca, I understand these resolutions within the framework of "new legal technologies," imposing standards in an arena of contested moralities (Vianna, qtd. in Fonseca, 2011).

The texts – 1,358/1992, 1,957/2010, 2,013/2013, 2,121/2015, 2,168/2017, 2,283/2020, and 2,294/2021 - of the resolutions of the Brazilian Federal Council of Medicine are compared based upon the division of topics, the addition of items over the years, and the main categories used.

New reproductive technologies (conceptive reproductive technologies, medically assisted procreation or assisted reproductive techniques) are biomedical procedures that replace sexual intercourse in the act of conception. These techniques emerged as a response to the involuntary absence of children (Corrêa, 2001). Although initially designed as a solution for infertile heterosexual couples (cf. Corrêa, 2001; Luna, 2007; Tamanini, 2004), their use has spread among individuals whose sexual practices do not generate children due to non-clinical reasons, such as women who have no partners and same-sex male and female couples. In assisted reproduction, reproductive material (gametes: sperm and egg, or embryos) is manipulated outside the body to induce pregnancy. In contrast to insemination, which involves

the manipulation of semen injected into the uterus, in IVF, both gametes are manipulated in a laboratory setting: eggs are extracted through puncture, semen is collected, and fertilization takes place outside the female body. IVF requires an auxiliary technique: embryo transfer, which involves the insertion of embryos into the uterus.

IVF is a technology that unfolds and serves different sets of purposes (Franklin, 2013). Cryopreservation techniques allow for the preservation of reproductive material and the displacement of the act of conception in time and space with regard to the providers of germinal material, by enabling the freezing of gametes and embryos (Tamanini, 2004). These procedures have enabled the anonymity of donors and allow for posthumous reproduction. A more recent innovation, the offer of oocyte vitrification technique, is advertised by clinics as a current procedure⁴, with the discourse of advertising focusing on expanding women's scope of possibilities, such as prioritizing their professional career first (Grudzinski, 2007)⁵. On the other hand, pre-implantation genetic diagnosis (PGD) aims at assessing the quality of the embryo before the transfer when there is suspicion of genetic or chromosomal diseases, but it can also be used for sex selection.

Among the risks of IVF, the CFM resolutions mention multiple pregnancies resulting from the transfer of multiple embryos in the same cycle meant to maximize the chances of pregnancy⁶. Multiple pregnancies carry an increased risk of morbidity and mortality, as well as long-lasting effects on the born babies (Thompson, 2005). The medical recourse would be embryo reduction: selective abortion of one or more embryos. Such a technique is not permitted by the CFM resolutions, which rely on the Brazilian legislation regarding abortion. Another ethical question concerns the fate of spare embryos, generated in a larger number than what is safe to transfer in a single cycle: cryopreservation, donation, use in research, or disposal (Luna, 2007). These questions are related to the instrumental use of the embryo (Franklin, 2013: 311).

New reproductive technologies separate elements of the biological process that were contained within the female body: firstly, they allow for conception without sexual intercourse; secondly, by placing reproductive material outside the female body, these technologies enable the circulation of germinal substances, transcending the heterosexual reproductive couple. Through the external manipulation of gametes and embryos, persons such as sperm donors, egg donors, embryo donors, or gestational carriers emerge in the configuration of kinship (Strathern, 1992). This can be compared to adoption processes or many other forms of kinship arrangements that involve procreation (cf. Héritier-Augé, 1985). In the language of the Law (Leite, 1995), homologous assisted reproduction involves only the genetic material of the couple and their reproductive organs. Heterologous reproduction involves gamete donors, embryo donors, or temporary assignment of the uterus (popularly

4 | Egg freezing was the cover story of *Revista O Globo* in 2009. It mentions women who reportedly used the technique and a clinic that offers the vitrification procedure (cf. Monteiro, 2009).

5 | Confirming that the procedure is not so widely spread in medical clinics, I conducted a search on the Scielo platform regarding oocyte vitrification and found 32 results; among them, 9 were unrelated to animals (botany and ceramics), 21 were from the veterinary field, and only the two most recent articles were from Gynecology. However, one of these articles referred to embryos, not oocytes. The only case was focused on the direct extraction of eggs from the ovary for fertility preservation in a woman with cancer. A new search was conducted via Google: out of the initial ten results, nine were advertisements from human fertility clinics, and only one was a scientific article arguing for the efficacy of oocyte vitrification in humans. However, it reported inferior results when compared to the fresh oocyte success rate (Morishima et al, 2017).

6 | According to Thompson (2005), 5% of babies born from reproductive technologies in the United States are multiple pregnancies of triplets or more.

known as surrogacy). Regarding sperm donation, the bond is recognized based on the intention of fatherhood expressed by the woman's partner, rather than on the biological connection with the genetic donor, the provider of the germinal material. Different meanings are ascribed to clinically identical procedures but contrasting in terms of the intentionality of the individuals involved, which highlights the socially constructed nature of these kinship ties (Strathern, 1992). A woman can gestate the egg of another person: in the case of egg (or embryo) donation, she will give birth to and be considered the mother of the child, even though she has no genetic connection to the child (possibly her partner does). If a woman carries the egg or embryo on behalf of another woman or reproductive couple, she will be the gestational carrier and will give the child away, even if she is the genetic mother (in the case of artificial insemination) or just the gestational mother. In the case of gestational carriers, the partner of another person will be the inseminator and father of the child. In Brazil, maternity is recognized based on childbirth (Tamanini, 2004; Luna, 2007). In other words, the mother is the one who proves to have given birth and leaves the maternity hospital with a certificate of live birth, or, if the birth occurs outside the hospital system, she must provide witnesses to the birth. In the case of surrogacy, there is the possibility of the service being remunerated, as in the case of commercial surrogacy, or involving compensation. Few countries allow for commercial surrogacy (Soderstrom-Anttila et al., 2016)⁷, but even in countries restricted to altruistic surrogacy, some form of compensation is allowed to protect the health of the surrogate, such as health insurance, travel expenses, medical consultations, and treatment (Stuvøy, 2018; Ragoné, 1994).

7 | Israel, Georgia, Ukraine, Russia, India, and the state of California in the United States allow commercial surrogacy, according to Soderstrom-Anttila and colleagues (2016).

It is necessary to confront reproductive technologies with prevailing models of kinship. According to Strathern, the notion of "Euro-American" kinship is a hybrid of nature and culture (1992). This hybrid aspect is explicit in the model for American kinship (in the United States) formulated by Schneider (1968), which serves as a reference for the Western kinship system. Kinship would be composed of two aspects: ties of substance and code of conduct. In Western symbolism, ties of substance are represented by "blood" in the old model, or biogenetic substance: the order of Nature in Schneider's words. Code of conduct refers to the intentional aspect of kinship, the demonstration of bonds through behavior, or the order of the Law, according to Schneider. For Franklin, reproductive technologies will reshape the relationship between substance and code of conduct not just by making the substance object of conduct, but also by making conduct (scientific research) the origin of substance. In addition to new kinships established by the dissemination of shared reproductive substance, the biological relationship with technology itself emerges as "facts of life" through *in vitro* fertilization and embryo research (Franklin, 2013: 66). Subsequent studies by Schneider himself criticized the formulation of kinship as a genea-

logical grid (biological relationships assumed as true) underlying the socio-cultural product called kinship (Schneider qtd. in Franklin, 2013: 170). In this sense, Carsten instead of focusing on what is or is not kinship, intends to move away from the encompassing dichotomy of the “biological” and the “social” (2014). The analysis of the CFM resolutions developed in this study, however, raises the question: Is it possible to move away from this biological-social dichotomy when it structures regulations?

New reproductive technologies allow for the circulation of germinal substances in a way that differs from what would occur in sexual intercourse with procreative intent between a heterosexual couple. This circulation may comprise other individuals rather than the intended reproductive couple in case of gametes or embryo donation and surrogacy (Luna, 2001; 2007, Thompson, 2005; Franklin, 2013). This circulation generates unusual kinship entities and situations of mixing that evoke the logic of purity and danger. In a study on egg donation and surrogacy in the United States, Cussins (1998) proposes a model for analyzing kinship relationships considering the various stages that can or cannot be configured in a kinship network. A stage is opaque (renamed as relational in Thompson, 2005) if it contributes to the establishment of kinship ties and the constitution of personhood, being configured, then, within the kinship web, and transparent (custodial) if it is not (Thompson, 2005). Biological resources, as well as socio-economic factors (who pays for the treatment), legal factors (owners of the embryos), and familial factors (the sperm provider’s partner, the one who planned for the child and will take on him or her) can contribute to this kinship network. Biological and social dimensions can be coordinated in a way that makes a stage relational (opaque), meaning it counts in the configuration of kinship, or custodial (transparent) when it is disregarded. This is the case with egg-providing for pregnancy: a relational stage (opaque) in the case of surrogacy (the egg provider becomes the mother of the child, and the surrogate is an intermediary who carries the pregnancy on her behalf), while it will be a custodial stage (transparent) in the case of anonymous egg donation when the gestational mother is the one who carries the pregnancy. Thus, it is necessary to define what counts or not, as well as the surrounding circumstances, for the establishment of kinship⁸.

8 | The researcher Charis Cussins from the 1998 study started signing as Charis Thompson in the 2005 book. Here are the rules of kinship altering surnames!

LEGAL VOID AND REGULATIONS

In the legal void regarding reproductive technologies in Brazil, their brief mentioning in the Brazilian Civil Code of 2002, the CFM regulations aim at regulating and establishing boundaries. Another legislation that intersects with the CFM regulations concerning reproductive governance, only when it comes to the ma-

nipulation of human embryos, is the New Biosafety Law (Law 11,105/2005), since it authorizes to obtain stem cells from discarded embryos that are nonviable or cryopreserved for up to three years at the time of the law's approval, for research or therapy purposes, besides prohibiting genetic engineering in embryos. The resolutions serve as a source of jurisprudence in the Brazilian justice system. The first baby conceived through *in vitro* fertilization in Brazil was born in 1984. It was only in 1992 that the CFM issued its first resolution on the subject. In 2010, the second resolution was elaborated based on the text of the first, and this went on successively with the others.

Medically assisted reproduction is only addressed in the Brazilian Civil Code of 2002 regarding filiation. Article 1,597 of the Brazilian Civil Code deals with the presumption of children born within marriage. Sections III, IV, and V regulate the following cases:

Article 1,597. Children are presumed to have been conceived during the course of marriage in the following cases:

III - when conceived through homologous artificial insemination, even if the husband is deceased;

IV - when conceived at any time from spare embryos resulting from homologous artificial conception;

V - when conceived through heterologous artificial insemination, provided that prior authorization from the husband has been obtained. (Brazil, 2002).

The Brazilian Civil Code presumes conceived during the course of marriage, children born from assisted reproduction using only the reproductive material of the couple (homologous reproduction), even in the event of the husband's death (which opened the opportunity for posthumous reproduction), and through the use of spare embryos formed with the couple's gametes and artificial insemination with donation, provided there is prior consent from the husband. The authors of the Brazilian Civil Code did not distinguish between artificial insemination and *in vitro* fertilization, taking them as synonyms of assisted reproduction. Therefore, the Brazilian Civil Code presumes parentage when the technique replaces sexual intercourse (as in the case of homologous artificial insemination in section III), it presumes parentage of spare embryos generated with the couple's gametes even outside the period of marital relations (conceived at any time in section IV), and allows for donation,

meaning the introduction of external germinal substance into the couple, only with prior consent in section V. The intentionality in gamete donation to establish filial ties is recognized in comparable terms to what occurs in adoption, where the code of conduct (the dimension of the Law) overrides the ties of biogenetic substance.

The Civil Code comprises laws applied to all in a country, being a general norm of conduct. The resolutions of the Brazilian Federal Council of Medicine, on the other hand, regulate the ethics of medical practice and do not have the force of law. They refer to “an imperative norm” as Rodrigo Pereira (1991) analyzes, enforceable to an entire professional category in Brazil and endowed with “coercive strength and sanctions”⁹:

As the code (resolution) is not a law, in the strict sense, it has an aspect that we could call dynamic, that is, according to the evolution of ideas and the profession itself, some articles can be reviewed, transformed, or reissued (Pereira, 1991: 33).

This observation is appropriate if we consider the dynamic of approval of resolutions on assisted reproduction by the Brazilian Federal Council of Medicine (CFM). The CFM resolutions regulate the use of new reproductive technologies in a more comprehensive way than the Brazilian Civil Code. After 18 years of enforcement, the CFM Resolution No. 1,358/92¹⁰ was modified and fully replaced by the CFM Resolution No. 1,957/10¹¹. After two years and four months, this one was, however, revoked and replaced by the CFM Resolution No. 2,013/2013¹². Then, in May 2015, the CFM Resolution No. 2,121/2015¹³ was published, revoking the previous one. The next Resolution was published in November 2017: the CFM Resolution No. 2,168/2017¹⁴, followed by the Resolution No. 2,283/2020¹⁵ on October 1st, 2020. The Resolution No. 2,294/2021 was published on May 27th, 2021¹⁶. This article will discuss the common elements present in these seven resolutions and pinpoint their differences.

The preamble of the resolutions from 1992, 2010, 2013, 2015, 2017, and 2021 addresses the “ethical norms for the use of assisted reproductive techniques” and their purpose as a “deontological device to be followed by physicians”; to put it another way, they serve as guidelines for medical practice and ethics in Brazil.

The text of the first five resolutions begins with five “considering”, two of which are identical: “the importance of human infertility as a health problem, with medical and psychological implications, and the legitimacy of the wish to overcome it” and “the need to harmonize the use of these techniques with the principles of medical ethics.” The second “considering” brings subtle but significant differences over the years: in the 1992 wording, “the advancement of scientific knowledge already allows solving several cases of *human infertility*” (emphasis added). The term “infertility” is

⁹ | An analysis of the legal system that distinguishes the specificity of professional codes can be found in Pereira (1991), which addresses the Professional Code of Ethics for Psychologists.

¹⁰ | Available at: <https://sistemas.cfm.org.br/normas/visualizar/resolucoes/BR/1992/1358>. Accessed May 25th, 2022.

¹¹ | Available at: <https://sistemas.cfm.org.br/normas/visualizar/resolucoes/BR/2010/1957>. Accessed May 25th, 2022.

¹² | Available at: <https://sistemas.cfm.org.br/normas/visualizar/resolucoes/BR/2013/2013>. Accessed May 25th, 2022.

¹³ | Available at: <https://sistemas.cfm.org.br/normas/visualizar/resolucoes/BR/2015/2121>. Accessed May 25th, 2022.

¹⁴ | Available at: <https://sistemas.cfm.org.br/normas/visualizar/resolucoes/BR/2017/2168>. Accessed May 25th, 2022.

¹⁵ | Available at: <https://sistemas.cfm.org.br/normas/visualizar/resolucoes/BR/2020/2283>. Accessed May 25th, 2022.

¹⁶ | Available at: https://sistemas.cfm.org.br/normas/arquivos/resolucoes/BR/2021/2294_2021.pdf. Accessed May 25th, 2022.

replaced by “reproductive problems” in 2010, a text that is kept in the subsequent resolutions (2013, 2015, and 2017). Thus, the advancement of scientific knowledge is not limited to solving *infertility* but also cases of *human reproductive* problems that may not necessarily be due to clinical infertility. The Resolution No. 2,294/2021 took a more radical approach by shortening the second considering clause to “assist in the processes of procreation,” which increasingly removes the connotation of a problem or disease, by emphasizing the aspect of choice.

This aspect was addressed in the mentioning of the use of new reproductive technologies earlier in this article. The referred change is the main one throughout the text of the 2010 Resolution, but it is not always taken to its full consequences. There is a substitution of considering “that assisted reproductive techniques have enabled procreation under many circumstances, which was not possible through traditional procedures” found in the 1992 and the 2010 resolutions, for “considering that the plenary of the Supreme Federal Court, in the trial session of 5.5.2011, recognized and qualified same-sex stable unions as a family entity (ADI 4,277 and ADPF 132)¹⁷” in 2013. This is a fundamental difference from the previous resolutions, where the CFM, supported by the decision of the country’s highest court, takes to its full consequences what the 2010 Resolution only suggested, ensuring access for same-sex couples. This will solve several issues left unresolved by the previous Resolution. This point remains in the 2015 and 2017 resolutions. The CFM Resolution No. 1,068/2017 introduces two new “considering”:

CONSIDERING the increase in survival rates and cure after treatments for malignant neoplasms, enabling affected individuals to have reproductive planning before interventions that may carry the risk of infertility;

CONSIDERING that women are postponing motherhood and that there is a lower probability of getting pregnant with advancing age; (CFM Resolution No. 1,068/2017)

Age now becomes the main concern, both in terms of social transformations that lead women to postpone motherhood¹⁸ as well as with the increased incidence of neoplasms with the rise in life expectancy in Brazil.

The Resolution No. 2,283/2020 presents two different clauses:

CONSIDERING the necessary observance of the principle of isonomy, enshrined in the Federal Constitution (Article 5, caput);

CONSIDERING the professional autonomy of physicians, as stipulated in Article VII of Chapter

17 | For an analysis of the morality that guided the judgment, see Coitinho Filho and Rinaldi (2018).

18 | One of the dimensions of the postponement of motherhood is the professionalization of women (Viana et al., 2018). Regarding this dynamic in the population of Latin America, refer to Cabella and Pardo (2016).

I, “Fundamental Principles,” of the Code of Medical Ethics (CFM Resolution No. 2,217/2018);

The principle of isonomy will base the inclusion of a new group of patients in the techniques, and the last considering, in its turn, refers to excluding the expression “objection of conscience” from item 2, section II as it considers that this aspect was already contemplated in the code of medical ethics.

The inclusive nature expressed in the “considerings” is also present in item 1 of section I of “General Principles,” which has been altered over the years:

1 - Assisted Reproductive Techniques (ART) play a role in aiding in the resolution of human infertility problems, by facilitating the process of procreation when other therapies have been ineffective or inefficient in solving the *current infertility situation*. (CFM Resolution No. 1,358/92, item 1 of section I, General Principles) [emphasis added]

1 - Assisted reproductive techniques (ART) play a role in aiding in the resolution of human *reproductive* problems, by facilitating the process of procreation when other therapies have been ineffective or deemed inappropriate. (CFM Resolution No. 1,957/10, item 1, General Principles). [emphasis added]

1 - Assisted reproductive techniques (ART) play a role in aiding in the resolution of human reproductive problems, *by facilitating the process of procreation*. (CFM Resolution No. 2,013/13, item 1)

In this item of the General Principles in the 2010 Resolution, infertility is replaced by human reproductive problems. The 2013 Resolution is more concise and does not mention therapies, only the resolution of problems, which suggests that the latter may not necessarily be clinical. This is maintained in the 2015 and 2017 resolutions. In the 2021 Resolution, a summarized version is adopted: the “role of aiding in the process of procreation.”

Except for the difference regarding infertility and reproduction in item 1, items 3, 4, 5, and 7 of Section I General Principles coincide in the first three resolutions and address the following topics, presented here in a summarized way: 3. Informed consent for patients and donors; 4. Prohibition of selecting the embryo sex except when its health is at risk¹⁹; 5. Prohibition of oocyte fertilization except for procreation²⁰; 7. Prohibition of embryo reduction²¹. Item 6 of the 2010 Resolution, maintained in 2013, brings about an important difference: it limits the number of oocytes or embryos transferred according to the woman’s age (CFM Resolution No.

19 | The prohibition of an embryo’s sex selection, except for health reasons, that is, to avoid the development of gender-related genetic diseases, is one example of a limitation in the Brazilian regulation concerning choice in the establishment of kinship, which aims to keep the technique closer to what occurs in nature (Salem, 1995).

20 | Rule according to the New Biosafety Law of 2005, which prohibits the creation of human embryos without the purpose of reproduction, allowing only the use of spare embryos for stem cell production.

21 | The exclusions of criminal liability in the legislation on abortion in Brazil do not predict this option.

1,957/10), specifying the number of embryos based on age intervals, with a maximum of 4 for older women, while the previous version only established a maximum limit of 4 to avoid multiparity (CFM Resolution No. 1,358/92, item 6, Section I General Principles). In this regard, the 2021 Resolution, in addition to changing the number based on age (two embryos for women up to 37 years old, and three embryos for those above 37), allows only the transfer of up to two embryos that have undergone genetic diagnosis. Item 2, which addresses the use of assisted reproduction provided that there is an effective probability of success without risk to health, present in the 1992 Resolution and maintained in 2010, undergoes an important alteration in 2013 when 50 years old is established as the “maximum age of candidates for assisted reproduction gestation.” The limit on the number of embryos transferred is intended to address declining fertility due to women’s increasing age, and to avoid multiple births in younger women. The increased incidence of twinning is observed in these techniques (Thompson, 2005). On the other hand, the maximum age of 50 years old for candidates suggests two aspects: concern about increased health risks, but also the intention that medicalized reproduction should mimic the limits perceived as natural (cf. Salem 1995).

The 2015 Resolution includes an additional general principle, bringing about a novelty in this regard: a consideration that allows for exceptions to the maximum age limit of 50 years old:

3- Exceptions to the 50-year-old age limit for participation in the procedure will be determined with technical and scientific grounds, by the responsible physician after clarification regarding the risks involved (CFM Resolution No. 2,121/2015, item 3 of Section I General Principles).

This decision allows for flexibility when it comes to age limit, by demanding scientific justifications by the responsible physician, as well as clarification of the risks involved.

As of 2017, a new principle is introduced: “Assisted reproductive techniques can be used for the social and/or oncological preservation of gametes, embryos, and germ tissues” (CFM Resolution No. 2,168/2017, item 2 of Section I General Principles). These techniques go beyond reproduction and allow for better reproductive planning: social preservation refers to the age of healthy individuals who delay reproduction (as observed in the explanatory statement in the Resolution), and the other reason is for health purposes: to preserve against cancer. In 2021, there was a clarifying addition to the mentioned principle: “for medical and non-medical reasons” (CFM Resolution No. 2,294/2021, item 2 of Section I General Principles). This emphasizes the possibility of choice that transcends medicine.

The inclusive aspect arises in item 1 of Section II “Patients of assisted reproduction techniques” in the 2010 Resolution and is maintained in 2013:

1 - Every woman, *capable* under the terms of the law, who has requested and whose *indication* does not deviate from the limits of this Resolution, can be a recipient of assisted reproduction techniques, provided that she has agreed freely and consciously in a document of informed consent.

2 - If married or in a stable partnership, the *approval of the spouse or partner* will be required, following a similar process of *informed consent*. (CFM Resolution No. 1,358/92, items 1 and 2 of Section II “Patients of assisted reproduction techniques”) [emphasis added]

1 - All *capable individuals* who have requested the procedure and whose *indication* does not deviate from the limits of this Resolution can be recipients of assisted reproduction techniques, provided that all participants are in full agreement and properly informed about it, in accordance with the current legislation. (CFM Resolution No. 1,957/10, item 1 of Section II “Patients of assisted reproduction techniques”)

The Resolution No. 1,957/10 encompasses all capable individuals, and in that sense, it explicitly aims, in the section regarding assisted reproduction patients, to transcend divisions resulting from sexual dimorphism and sexual orientation, in terms of access to the techniques²². However, this inclusive character may not apply to all items. When the Resolution was published, television and print media coverage in January 2011 highlighted that it allowed “gay couples” to have access to fertility treatment²³, although the wording of the Resolution was subtle in this regard. At the time, this reflected an increased sensitivity to the demands for access to assisted reproduction as an option for same-sex couples to have children, as evidenced by various studies (Uziel, 2009; Fonseca, 2008; Tarnovski, 2013). This change preceded the decision by the Supreme Court of Brazil regarding same-sex unions (Coitinho Filho and Rinaldi, 2018). On the other hand, the Resolution No. 2,013/13 is explicit regarding access.

22 | Hérietier-Augé (1985) draws various comparisons between new reproductive technologies and kinship arrangements, based on ethnographic data collected from societies that do not conform to the Western symbolic of kinship.

23 | According to the titles: “Gay couples will have access to in vitro fertilization” (Folha de S Paulo, January 6, 2011, p.1) and “Medical Council authorizes same-sex couples to use fertilization” (Éboli, 2011, p. 13)

2 - The use of assisted reproduction techniques is permitted for same-sex relationships and single individuals, respecting the right to the physician's objection of conscience. (CFM Resolution No. 2,013/13, item 2 of Section II “Patients of assisted reproduction techniques”).

Regarding access, the Resolution No. 2,283/2020, the shortest of all, containing only this alteration, brings about an addition in the spirit of inclusion:

2- The use of assisted reproduction techniques is permitted for heterosexuals, same-sex couples, and *transgender* individuals. (CFM Resolution No. 2,283/2020, item 2 of Section II “Patients of assisted reproduction techniques”)

This reveals the inclusive purpose of the Resolution in that it explicitly states that transgender individuals can also have access, in addition to eliminating the caveat regarding the physician’s right to objection of conscience²⁴.

Section II “Patients of assisted reproduction techniques” undergoes an important change in 2015.

3- Shared gestation is allowed in female same-sex unions where infertility does not exist. (CFM Resolution No. 2,121/15, item 3 of Section II “Patients of assisted reproduction techniques”)

This alteration makes the access to same-sex unions explicit, which is not subject to interpretation anymore, as was the case with the 2010 Resolution. The 2017 Resolution defines shared gestation as follows: “Shared gestation is considered a situation in which the embryo obtained from the fertilization of one woman’s oocyte(s) is transferred to the uterus of her partner.” In the 2021 Resolution, the reference to infertility is eliminated. A couple of women can have shared motherhood, meaning one partner gestates the fertilized egg of the other, for affective and non-medical reasons. This is one of the points that underscore the emphasis of more recent resolutions on the dimension of choice in kinship and the rights related to the LGBT population.

In a field study conducted in 2002 (Luna, 2007), a doctor reported having denied a request from a same-sex couple due to the lack of support in the Resolution No. 1,058/92, although she would not have objected if it had been a request from a homosexual man who brought a female friend to be his partner in reproduction. Turte-Cavadinha (2013), in a field study conducted before the approval of the CFM Resolution in 2013, already mentioned the interest of lesbian couples in using the ROPA technique (reception of oocytes from the partner) which allows for gestation involving both partners and without a legal father, which would provide security for the couple. In interviews, lesbian couples express interest in the ROPA technique “as a promoter of an ideal of a child biologically conceived by both mothers, just as in sexual reproduction with heterosexual couples” (Vitule et al., 2015: 1176), and there are registered cases of couples who used the technique before the 2013 Resolution authorized it. Thus, the formulation of the CFM rules follows the changes in practices

24 | The right to objection of conscience has been encouraged by conservative religious sectors to engage their activism in a “religious citizenship” that opposes sexual and reproductive rights (Vaggione, 2017).

of fertility clinics that offer the service. The legal dimension of this bond is explicit in Fonseca's account (2008) regarding the acknowledgement of this type of co-parenting in 2003 by a family court in the state of New Jersey (United States), in that both mothers' names appear on the birth certificate. This acceptance is subject to controversy when contrasted with the reality in France, an advanced country in terms of social customs, which until recently prohibited access to reproductive technologies for same-sex couples (Amorim, 2019), a position divergent from other countries in Europe. However, the new bioethics law passed in France in 2021 allowed for the parental project of couples comprised of a man and a woman, two women, and single women (Barry et al., 2022)²⁵.

"Section III - Regarding clinics, centers, or services that apply assisted reproduction techniques" has maintained the same text since 1992 and establishes the following requirements: control of materials; the obligation to maintain a permanent record of pregnancies; and a permanent record of diagnostic tests. The 2013 Resolution adds an important item: "4 - The records must be available for inspection by the Regional Medical Councils," which is maintained in the 2015, 2017, and 2021 resolutions. This item implies a growth in control over the centers that provide these services, an example of reproductive governance that affects human reproduction centers.

Section IV addresses "donation of gametes or embryos" and has identical wording in the 1992 and 2010 resolutions, with two additions in 2013. Item 1 prohibits any profit or commercial nature of donation. Items 2 and 3 establish the confidentiality of the identity between donors and recipients and restrict access to information solely for medical purposes and to physicians, ensuring the protection of the donor's identity. Item 4 establishes the obligation of assisted reproduction clinics and services to keep a record of clinical data and phenotypic characteristics. Item 5 proposes a limit on the number of births of children of different sexes by the same donor in a region with one million inhabitants²⁶. Item 6 assigns the responsibility to the medical unit for selecting donors, ensuring phenotypic and immunological similarity and compatibility between donors and recipients. Finally, the last item, item 7, prohibits a member of the medical team from participating as a donor in assisted reproduction programs. Some items of this Section IV were established in 1992 without changes, indicating their consolidated value: the prohibition of commercial nature in these transactions of reproductive material²⁷, the confidentiality of donors' and recipients' identities (with a caveat added in the 2021 Resolution)²⁸, the limit on births by a donor in a given region as a measure to prevent involuntary incestuous relationships among individuals born from donations. The registration of donors' clinical data materializes the medicalization of genetic inheritance, and by extension, the medicalization of kinship (Finkler, 2000). The demand for phe-

25 | Other introduced changes were the possibility for adults born from assisted reproduction to access the identity of the donor and the option for autologous gamete cryopreservation without medical justification (Barry et al., 2022).

26 | According to research conducted by Machin (2022), which assessed the market of sex cells in Brazil, due to legal gaps and the absence of specific legislation, there are many ambiguities, besides the forces of the medical market putting altruistic rules under tension, the overall control of clinics is not possible, as there is a lack of conditions to monitor compliance with these limits.

27 | In summary, resistance to commercialization corresponds to the attempt to keep the market separate from children and family (Stuvøy, 2018).

28 | The point remains, but with a caveat, as the 2021 Resolution made an exception by allowing the possibility of gamete donors relatives. The anonymity of gamete and embryo donors, a rule that remained unchanged from the first CFM Resolution 1,358/92 until the 2021 Resolution, was demanded in Germany and Norway, but not in the United States and England (only in the case of self-insemination), according to a comparative table elaborated by Allebrandt (2007). This shows how the dimension of choice and knowledge is differently articulated by the legislation and regulations of different countries. More recent work by Rosana Machin shows a trend towards abolishing donor anonymity, considering the rights of children conceived through medically assisted reproduction (2016).

notypic similarity refers to practices as ancient as the secrecy of adoption, enabled by resemblance and now repeated in the dynamics of assisted reproduction (Costa, 2004). Beyond the secrecy of donation, the requirement for phenotypic and immunological similarity and compatibility, or the effort to match physical characteristics, represents the social manipulation of genetic origins, in the words of Salem (1995). In this sense, phenotypic similarity symbolically replaces the transmission of genes (Costa, 2004).

In the 2013 Resolution, Section IV has nine items: the new item 3 establishes the maximum age for gamete donation as 35 years old for women and 50 years old for men. A final item allows for shared egg donation, when the donor and recipient (both experiencing reproductive issues) share the biological material as well as the financial costs, giving preference to the donor over the produced material. The 2015 Resolution keeps the text of this section identical except for Item 9, which restricts gamete donation to males and to shared egg donation. The 2017 Resolution has an alteration in Item 9 and once again allows for “voluntary gamete donation.” The last item regulates shared egg donation, a common practice in clinics recorded in field reports (Luna, 2007), used to circumvent difficulties in accessing treatment due to the price of clinical and laboratory assistance, while others would need egg donation and would be able to afford to subsidize the treatment of the donor partner (Correa and Loyola, 2015). The 2021 Resolution represents an important break from the principle of anonymity in gamete donation (Salem, 1995), in that it allows for donation among relatives up to the fourth degree (parents/children, grandparents/siblings, uncles/nephews, cousins). It establishes both age limits for gamete donation: 37 for women and 45 for men, except when the material is frozen, and the duty to inform recipients about risks to the offspring. The second break refers to the choice of the donor, which was previously concentrated in the hands of medical professionals seeking resemblance, but now user choice in gamete or embryo banks is granted. Lastly, it ensures that transferred embryos come from a single source.

The following section, “V. Cryopreservation of Gametes and Embryos,” addresses the freezing of germinal material by assisted reproduction services, defining in Item 1 the elements that can be cryopreserved: sperm, eggs, and embryos, and in Item 3 stating that spouses must express in writing the fate of the embryos in case of divorce, serious illness, death, or if there is a desire for donation. Item 2 highlights an important difference from the Resolution No. 1,358/92, which prohibited the disposal of spare embryos and allowed the patient to decide how many embryos should be transferred fresh and how many should be cryopreserved. The Resolution No. 1,597/10 allows for the cryopreservation of only viable spare embryos, which remains in the 2013 Resolution. However, the 2013 Resolution presents a significant alteration: the possibility of discarding frozen embryos that have been stored for

five years or more, at the patient's discretion. There is reference to the possibility of donating frozen embryos to stem cell research. Regarding this matter, a subtle difference is identified in the 2015 Resolution, in that it states in Item 4 that "The use of embryos for stem cell research is not mandatory, as predicted by the Biosafety Law." The emphasis in these two resolutions is the disposal of embryos at the "patient's" discretion, not solely for donation to research.

The Resolution No. 2,168/2017 introduces significant changes to Section V:

4- Cryopreserved embryos that are three years or older may be discarded if it is the expressed wish of the patients.

5- Cryopreserved embryos that have been abandoned for three years or more may be discarded.

Sole paragraph: Abandoned embryos are those for which the responsible parties have violated the pre-established agreement and cannot be located by the clinic. (CFM Resolution No. 2,168/17, items 3 and 4 of Section V - "Cryopreservation of gametes or embryos")

The excerpt regarding donation for stem cell research is removed, as this fate was restricted to embryos already cryopreserved at the time of the approval of the New Biosafety Law. In accordance with this law, the time limit for embryo cryopreservation is reduced from 5 to 3 years, and the term "abandoned embryo" is introduced, authorizing the clinic to discard embryos when those responsible for the embryo's fate cannot be located²⁹. On the other hand, the 2021 Resolution takes a pro-life turn by limiting the number of generated embryos to eight and emphasizing the uncertainty regarding their viability. It also requires judicial authorization for disposal at the parents' request or in cases of "abandonment" (items 4 and 5). Both conditions impose stricter rules to make disposal more difficult.

²⁹ | Allebrandt (2018) demonstrates in an ethnographic study how an assisted reproduction clinic seeks the "genitors" of embryos to avoid accumulation of cryopreserved embryos.

2-The total number of embryos generated in the laboratory shall not exceed 8 (eight). Patients will be informed to decide how many embryos will be transferred fresh, as determined by this Resolution. Viable spare embryos shall be cryopreserved. Since there is no prediction regarding viable embryos or their quality, the decision shall be made after this stage.

4- Cryopreserved embryos that are three years or older may be discarded if it is the expressed wish of the patients, subject to judicial authorization.

5- Cryopreserved embryos that have been abandoned for three years or more may be discarded.

ed, subject to judicial authorization. (CFM Resolution No. 2,294/2021, items 2, 4, and 5 of Section V - "Cryopreservation of gametes or embryos")

Even though it is not possible to analyze the CFM Resolution No. 2,320/2022 here, the most important changes for the argument of this article concern embryos. The maximum limit on the number of generated embryos was removed, a point that had been heavily criticized for hindering the chances in the treatment of individuals with fertility issues. If this may seem to mitigate the pro-life turn, the exclusion of items 4 and 5 from Section V - Cryopreservation of gametes or embryos clearly attests to this stance: there is no longer prediction for the disposal of viable embryos³⁰. The only mentioning of disposal or use for research relates to embryos diagnosed with genetic diseases (according to Section VI - Preimplantation Genetic Diagnosis of Embryos).

The regulations surrounding the extracorporeal embryo either depersonalize it and diminish reverence towards it, or represent it as a person, as seen in the case of "abandoned" embryos. Franklin (2013: 311) warns about the instrumental use of the extracorporeal embryo, whereas Thompson discusses the "embryo tale," revealing the larger meanings attributed to embryos outside the body and bringing up the tensions between the sacred and the profane (2005: 247). In the realm of reproductive technologies, embryos are treated as "proto-persons" (Ibid.: 250) and can be considered sacred as long as they keep the intrinsic value of promise: the potential for development (Ibid.: 259). In the 2021 Resolution, judicial authorization is the requirement that makes the disposal more difficult, preserving embryonic life. This point confirms the clash between the sacred and the profane mentioned by Thompson, illustrated in the accusation by pro-life sectors that equate the destruction of embryos to genocide. Hence, the same embryos can be object of adoption campaigns and are at the center of regulatory battles regarding their use or disposal (Ibid.: 262-65). These battles are evident in the current Resolution (2,320/2022), which consolidates a pro-life turn by preventing the disposal of viable laboratory embryos, which aligns with the anti-abortion movement in Brazil and is proposed in projects such as the Statute of the Unborn (Luna, 2019).

Section VI addresses the diagnosis and treatment of embryos. The strict rules established in the 1992 Resolution remained in the Resolution No. 1,957/10. According to item 1, the intervention must aim to assess the viability of the embryo or diagnose diseases, and it requires the informed consent of the couple. Item 2 restricts therapeutic interventions to treat diseases and requires the informed consent of the couple. Item 3 establishes 14 days as the maximum time for *in vitro* development. The Resolution No. 2,013/13 has less restrictive wording: it does not require the informed

30 | As summarized in the news on the CFM (Federal Council of Medicine) portal, the main changes of the 2022 resolution are: "The new criteria promote a review of the number of embryos generated in the laboratory, clarify the minimum age for gamete donation, and open the possibility for women unrelated to the couple to provide their uterus for gestation." Note published on September 20th, 2022 at 14:17. Available at: <https://portal.cfm.org.br/noticias/cfm-publica-atualizacao-das-regras-para-reproducao-assistida-no-brasil/>

consent of the couple and reduces reverence towards the embryo. The wording of the Resolution No. 1,057/10 states that this type of diagnostic intervention “shall not have any other purpose” than assessing the viability of the embryo (in item 1) or for therapeutic purposes (in item 2), it “shall have no other purpose than treating a disease or preventing its transmission, with real guarantees of success.”

The reverence towards the embryo is minimized in the CFM Resolution No. 2,013/13, which includes in item 2 the possibility of selecting embryos compatible with any child of the couple affected by a disease whose treatment is either stem cell or organ transplantation, revoking the item that allowed genetic diagnosis only to treat the embryo itself and introducing the possibility of its use for the generation of donor siblings, a point observed in many cases (Luna, 2004; Franklin, 2013). In this regard, the new Resolution no longer treats the extracorporeal embryo as a subject that is an end in itself, a moral agent in the Kantian sense that self-determines (Fagot-Largeaut, 2004), and allows its generation with the purpose of serving as an instrument for something else, a point criticized by pro-life movements, particularly the Personalist Bioethics of the Catholic magisterium (Luna, 2010).

The CFM Resolution No. 2,121/2015 significantly alters item 1, adding that in cases of “genetic alterations causing diseases,” embryos may be “donated to research or discarded.” The reverence towards the embryo diminishes over the years, as well as the possibility of its manipulation increases. While the 2013 Resolution allows for the selection of compatible embryos for a disease “that has stem cell or organ transplantation as an effective treatment modality,” in item 2 of Section VI, the 2015 Resolution limits it to “stem cell transplantation, according to current legislation.” In this case, the change seems to follow not only ethical standards but also the technical and clinical realization of these therapy attempts. The Resolution No. 2,294/2021 restricts the disclosure of the sex of embryos to cases of sex-linked diseases and alterations in the sex chromosomes.

From the Resolution No. 1,358/92 to 1,957/10, Section VII regarding surrogate gestation (temporary uterus donation) also remains unchanged. The text establishes as a condition for such procedure the existence of a medical problem that prevents or contraindicates gestation in the genetic donor. Item 1 limits who can act as a surrogate: 1. Temporary surrogates must be related to the genetic donor within the second degree of kinship, with other cases subject to the authorization by the Regional Medical Council (CRM). Item 2 prohibits any form of profit or commercialization in temporary uterus donation. It is important to note that this item 1 of Section VII was not updated in 2010 to be inclusive like the previous sections of the same Resolution. The keeping of this restriction on the practice of surrogate gestation limited the access of same-sex couples to the authorization from the CRM. Even considering those who engage in heterosexual practices, the rule does not accommodate

cases where there is no second-degree female relative in the genetic donor's family. Another problematic aspect is the misunderstanding of the concept of second-degree kinship.

There are significant changes in the following Resolution. In response to almost all of these issues, the CFM Resolution No. 2,013/13 introduces a series of changes in Section VII – about Surrogate Gestation. The first change is to allow surrogate gestation in the case of same-sex unions. The second is to expand the degrees of consanguineous kinship up to the fourth degree, to include relatives of both partners as possible temporary uterus donors, and to specify what kinship means (first degree - mother; second degree - sister/grandmother; third degree - aunt; fourth degree - cousin), while maintaining the age limit of 50 years old. Besides, it introduces a final item that regulates many procedures, by requiring documentation: an informed consent form signed by the patients (genetic parents or same-sex couple) and the temporary uterus donor; a medical report on the suitability and psychological profile of the surrogate; a description of the medical aspects; a contract between the patients and the surrogate establishing the child's filiation; "the biopsychosocial aspects involved in the pregnancy-postpartum cycle"; "the inherent risks of maternity"; the impossibility of terminating the pregnancy except in cases predicted by law; guarantee of medical treatment for the temporary uterus donor until the postpartum period; guarantee of the child's civil registration by the patients (genetic parents); written approval from the spouse of the surrogate if married or in a stable union. This list of documents will be altered in the following Resolution.

The 2015 Resolution modifies item 3 regarding the required documents in the patient's medical records. 3.2: The report with the psychological profile is now required for all parties involved, not just the surrogate. Other modified items include: 3.3. Commitment Agreement among the patients and the temporary uterus donor, establishing the child's filiation; 3.4. Guarantee, by the patients contracting assisted reproduction services, of medical treatment and monitoring for the woman who will temporarily donate her uterus until the postpartum period; 3.5. Guarantee of civil registration for the child by the patients (genetic parents) - documentation to be provided during pregnancy.

Several items that were vaguely formulated in the 2013 Resolution are specified in the 2015 Resolution, which shows the rationalization of legal procedures for surrogate gestation. The Resolution No. 2,168/2017 renames the section to VII - "Regarding surrogate gestation (temporary uterus loan)." Then, it is no longer a "temporary donation," but a "temporary uterus loan," characterizing the act as a loan rather than a donation. The other change pertains to the definitions of kinship: "consanguineous kinship up to the fourth degree (first degree - mother/daughter; second degree - grandmother/sister; third degree - aunt/niece; fourth degree - cousin)." The

pairs “mother/daughter” for the first degree and “aunt/niece” for the third degree are included, implying reciprocal relationships. This indicates the possibility for a daughter to lend her uterus to her mother, or a niece to her aunt, while the wording of the 2013 Resolution assumed the older individual would assist the younger one. The generational aspect is brought up, by acknowledging the possibilities of later motherhood for women who have already borne children.

For comparison, here are the most relevant points of Provision No. 63/2017 from the National Council of Justice (CNJ)³¹ regarding birth certificate issuance, whose Section III addresses assisted reproduction. In the case of same-sex unions, adjust the registry to the names of the ascendants; a declaration from the technical director of the human reproduction service stating that the child was conceived through heterologous assisted reproduction and indicating the names of the beneficiaries (Article 17). In this Article 17, I highlight three paragraphs: paragraph 1: In the case of surrogacy, “the name of the surrogate mother, as stated in the declaration of live birth, shall not be included in the birth certificate.”, instead, a commitment form signed by the temporary uterus donor, clarifying the filiation, should be presented; paragraph 2 refers to posthumous assisted reproduction and it requires “prior authorization specifically from the deceased person for the use of preserved biological material.”; “paragraph 3: The knowledge of biological ascendance shall not imply the recognition of a kinship bond or the respective legal effects between the donor and the child conceived through assisted reproduction”. I emphasize the last paragraph for privileging the contractual and intentional aspect of legally recognized kinship, ensuring that gamete and embryo donors are not legally attributed as parents by law, as addressed in paragraph 1 concerning surrogacy. The publication of this Provision (November 14, 2017) and the CFM Resolution No. 2,168/2017 (November 10, 2017) occurred almost simultaneously. The norms established by CNJ Provision 63/2017 are also in accordance with the CFM resolutions at the time.

31 | Available at: <https://atos.cnj.jus.br/atos/detalhar/2525>. Accessed May 25th, 2022.

Back to the CFM resolutions, once again, the 2021 Resolution is innovative: it requires that the “temporary uterus donor” have at least one living child³². It also prohibits the clinic from intervening in the selection of the donor, in the same item that prohibits any commercial aspect of the practice. To simplify, a medical report from all parties involved is required, removing the psychological profile requirement.

32 | This recommendation also appears in the ASRM (Soderstrom-Anttila, 2016).

The final section of the Resolution No. 1,957/10, considered the most controversial item according to the press, and maintained in the following resolutions, deals with *posthumous* reproduction: VIII - posthumous assisted reproduction, according to which “Posthumous assisted reproduction does not constitute an ethical offense as long as there is prior specific authorization from the deceased for the use of the cryopreserved biological material, *in accordance with current legislation*.” The CFM (Federal Council of Medicine) drew inspiration from the “current legislation”:

sections III and IV of Article 1,597 of the Brazilian Civil Code described above. Section III allows conception through artificial insemination without a donor even if the husband has died, and section IV considers those born at any time when it comes to spare embryos formed solely from the reproductive material of the couple. The Civil Code does not clarify whether the spouse should be alive at the time of fertilization or embryo transfer. The CFM Resolution No. 1,957/10 merely requires prior authorization from the deceased regarding the cryopreserved material. In this sense, the Resolution takes the law's loophole to its ultimate consequences. It does not take into account the effect of death on the status of a person, who becomes incapable of building family ties.

A final section IX is added to the Resolution No. 2,013/13 and kept in all the following resolutions. It predicts that exceptional cases will depend on the authorization from the Regional Council of Medicine.

The 2021 Resolution may allow many interpretations. It both increases the possibility of choice (choice of donors among relatives) and restricts this choice by imposing that the surrogate mother already have living children, in addition to reinforcing the prohibition of sex selection. In the explanatory statement of the aforementioned Resolution, there is a justification, based on jurisprudence, for the alteration regarding the possibility of presenting relatives as gamete donors: there had been court decisions in this regard. On the other hand, the measures that limit the generation of embryos in the laboratory or require judicial authorization were initially based on the medical code of ethics approved during the rise to power of conservative governments³³. It is important to highlight that during the Bolsonaro government, there were the most number of amended resolutions (three: 2020, 2021, and 2022) within the shortest period of time, in contrast to previous governments (2010: Lula; 2013 and 2015: Dilma³⁴; 2017: Temer). It is possible to speculate whether the favorable position of the CFM leadership towards President Bolsonaro had an impact on the Technical Chamber, resulting in a pro-life turn after an uninterrupted sequence of resolutions since 2010 that relativized the sanctity of the extracorporeal human embryo³⁵. The 2022 CFM Resolution, excluding the possibility of discarding viable embryos, confirms the alignment with the anti-abortion bias of the Bolsonaro government.

FINAL CONSIDERATIONS

Among the many implications of the biomedical reproductive technology for identity and kinship, what is most striking is the potential to subvert identity and categories of kinship that biomedicine was initially designated to affirm and repair

33 | The code of medical ethics was approved on September 27th, 2018 (at the end of the Temer government), but it came into effect 180 days later, under the Jair Bolsonaro government. Embryos are mentioned only in Chapter III, Article 15, which prohibits "creating embryos for research," "creating embryos for the purpose of sex selection, eugenics, or to produce hybrids or chimeras," showing an intention to restrict spare embryos: fertilization "should not systematically lead to the occurrence of supernumerary embryos."

34 | The 2015 Resolution was published 2 years and 4 months after the previous one of 2013. The 2013 Resolution was mainly driven by the Supreme Federal Court's judgment to recognize stable unions between same-sex individuals with the same legal status as marriage, as stated in the 4th considering. In contrast, the 2015 Resolution basically specifies points left ambiguous in the previous resolution without major changes.

35 | Note 35 on page 23..

(Thompson, 2005: 267). Thus, these technologies are both highly conservative as well as socially and technically innovative.

The trajectory of changes in the resolutions suggests that the sequence of amendments aligns with the observed trend in the US context, shifting from the idea of the best interests of children to the expansion of a reproductive rights idea revolving around parental choice (Thompson, 2005: 7).

Analyzing all the resolutions over the years since 1992 and their amendments allows us to observe some trends in reproductive governance, which are already perceptible in the 2010 Resolution, with its openness to societal demands, which are beyond medical issues. Overall, the 2013 Resolution shows a greater concern for time, establishing limits for the age of access for candidates to assisted reproduction, gamete donors, and surrogate mothers. There is an emphasis on regulating open issues, such as clinic oversight and procedures for registering children born through surrogacy. The resolutions of 2015 and 2017 basically come to rectify any gaps left by the main alterations made in the 2013 Resolution.

A significant change can be observed regarding the status of the extracorporeal embryo: the resolutions of 2010, 2013, 2015, and 2017 tend to relativize the absolute right of the embryo to life, which was implicit in the 1992 Resolution that hindered its disposal and assumed the permanent freezing of unused embryos, even if non-viable. This hindrance to embryo disposal resembles the position of the Catholic Church in defense of life, which even refuses *in vitro* fertilization, taking it in general as a crime (Sales, 2014; Luna, 2010). When only the cryopreservation of viable embryos is required in 2010, and in the 2013 Resolution it is allowed, by the will of the “patients,” the disposal of frozen embryos after five years, reduced to three years in the 2017 Resolution, or their use in stem cell research, the extracorporeal embryo produced in the laboratory is treated as an object and not as an entity endowed with rights as demanded by pro-life movements (cf. Luna, 2010). This new situation in Brazil partially reenacts what has been happening for years in England, where more radically, the “parents” of frozen embryos after five years are required to choose between transfer to themselves, donation to other couples, donation for research, or disposal of these entities (Franklin, 2013; Luna, 2001), and this could have become routine in Brazilian clinics, as pointed out by Allebrandt (2018), if not for the resolutions of 2021 and 2022. This relativization of the embryo as an individual, a being that is an end in itself, is confirmed by the possibility of using preimplantation genetic diagnosis to generate donor babies compatible with sick siblings. On the other hand, showing how this process encompasses tensions and contradictions, the term “abandoned embryo,” which emerged in the 2017 Resolution, goes in the opposite direction by personifying this entity, by likening it to a child.

Regarding the establishment of kinship relationships, the difference in rules

35 | On the CFM portal, there is the contact with the president and the list of demands presented along with the new code of medical ethics. Cf. “In presenting the new Code of Medical Ethics, CFM makes requests”. Available at: <https://portal.cfm.org.br/noticias/ao-apresentar-novo-codigo-de-etica-medica-cfm-faz-pedidos-ao-presidente-jair-bolsonaro-em-nome-dos-medicos/>. Accessed May 17th, 2022. During the pandemic, journalistic articles commented on the CFM's pro-Bolsonaro position, even regarding the prescription of drugs proven to be ineffective in the name of medical autonomy, which contrasted with the criticism of several medical associations. Such was the participation of the CFM's representative in the Covid CPI, one of the CFM's vice presidents and a Bolsonaro supporter. Cf. Eduardo Gonçalves. Doctor Vice-president of the Federal Council of Medicine is a Bolsonaro supporter affiliated with the PSL. Emmanuel Fortes, from CFM, campaigned for the use of chloroquine and tries to join politics. *O Globo*, October 9th, 2021. Available at: <https://oglobo.globo.com/politica/medico-vice-presidente-do-conselho-federal-de-medicina-bolsonarista-filiado-ao-psl-25231622>. Accessed May 19th, 2022. In a live of May 7th, 2020, with a publication edited by the news portal *Metrópolis*, later shared on the social network Twitter by Fernando Haddad, the president of CFM speaks of the alignment of the entity with the Bolsonaro government and with the Ministry of Health for having met all the requests made, emphasizing that there is “dialogue” (he was received 5 times in 1 year and four months of government), in addition to criticizing President Dilma and Minister Alexandre Padilha for the “popularization of medicine”: “We will not recover the damage of the government of President Dilma and Minister Alexandre Padilha. We will have approximately one million five hundred thousand doctors. It is the popularization of medicine”. Available at: <https://t.co/Bx4xFewjmU> https://twitter.com/Haddad_Fernando/status/1446535800817082373?s=20. Accessed May 19th, 2022.

concerning gamete and embryo donation and gestational surrogacy deserves a closer analysis. Anonymity and identity secrecy of genetic material providers are required in the former case, while in the latter, the demand is for the woman who agrees to gestate on behalf of another to be a close relative of one of the reproductive partners. There is a dynamic between what threatens kinship relationships, requiring distance on one side and controlled proximity on the other. If the model proposed by Cussins (1998)/Thompson (2005) affirms that some steps in the establishment of kinship can be recognized or not, Salem's analysis (1995) unravels the underlying principles of this logic that governs the difference in rules. When the norms require the anonymity of the genetic material (gametes and embryos) donors, the need to conceal these kinship ties affirms the primacy of natural over social bonds or "the intrinsic frailty of socially established bonds" (Salem, 1995: 60), which would represent a human intervention strategy aimed at masking the very intervention in nature (reproduction) (Salem, 1995: 59). In the case under examination, one should question why equal anonymity is not required for gestational surrogacy as it is for gamete and embryo donation. One initial reason could be pragmatic: the difficulty of finding a woman willing to carry a pregnancy on behalf of another. Therefore, in the initial Resolution No. 1,358/92, the CFM required proximity and kinship relations with the genetic donor (mother) to discourage commercialization of surrogacy services. However, there is a reason in the symbolic of kinship beyond practicality. The existence of different rules suggests a hierarchy among different biological kinship bonds, where the genetic bond is considered a truer relationship than the act of gestation itself. Therefore, when a woman suggests that her sister should be a donor, the clinic would refuse it according to ethical norms (until the 2021 Resolution), while the cooperation of that sister as a surrogate is allowed and recommended. This hierarchy that prioritizes genetic bonds contradicts Brazilian legislation, as in it maternity is established by birth. The "truth" of genetic ties begs anonymity for gamete donors in bioethical regulations on assisted reproduction.³⁶ With such hierarchy, the relationship established through pregnancy between the surrogate and the fetus is equated to a social relationship, of secondary value when compared to natural bonds. Despite the implications of *in vitro* fertilization, in the vocabulary used to refer to kinship and filiation relationships the expressions "biological father" and "biological mother" are kept for gamete providers, stemming from the adoption debate. This is evident in a bill (PL 120/2003) that addresses paternity investigation for individuals born through assisted reproductive techniques³⁷. The bill aims to ensure that "a person born through assisted reproductive techniques has the right to know the identity of their biological father or mother" (qtd. in Diniz, 2003: 15). The expression "biological mother," as an equivalent to the "genetic mother" or gamete provider, contrasts with the term "gestational mother" as if gestation did not involve

36 | The importance of genetic bonds assumed as the truth of kinship also appears in a different context: the attitude of judges demanding proof of kinship through DNA testing (Fonseca, 2011) as a factor above any testimony of social bonds.

37 | The entire content of PL 120/2003 authored by Roberto Pessoa (at the time PFL-CE) is available at <https://www.camara.leg.br/propostas-legislativas/104774>. Accessed Jun 5th, 2023.

a biological relationship, which is another sign of hierarchy among the bonds.

Revisiting Cussins' argument (1998) about the configurations of the kinship web coordinating in distinct ways, if, according to the law, maternity is based on whom gives birth and paternity, by the mother's partner, these rules create, on the one hand, a favorable circumstance for regulating kinship relationships in egg and sperm donation practices; but, on the other hand, a complicated situation for gestational surrogacy cases. An example is male or female couples who choose the same gamete donor to ensure that their children are genetic siblings (Fonseca, 2008), as the case in the news in 2012 of a male couple from Recife who had one child and kept frozen embryos for the birth of the "biological child" of the partner³⁸. These examples show the importance of the creation of consanguinity in our context, such as the recurring fantasy among young lesbians in Brazil of having the partner's brother as the sperm donor (Grossi, 2003). On the other hand, Vitule and colleagues (2015) identified that male couples, fearing a legal dispute, might prefer adoption to avoid involving a third person, the biological mother, who would have legal rights to maternity. This contrasts with female couples who prefer options that allow for pregnancy.

Another sign of change is the offering of the technique called ROPA (reception of oocytes from the partner) by the clinics themselves, targeted at female couples (Turte-Cavadinha, 2013; Vitule et al, 2015). This medical technique is associated with legal technologies included in the recent CFM resolutions. In this case, the dimension of choice supersedes the hierarchy between genetic and gestational kinship, so that both partners are legally recognized as mothers. In terms of gender, this representation places one woman in the male role of inseminator, in the sense of providing the seed or gamete for the other to conceive (Strathern, 1991), but what seems to interest the couples is the communion of substance in reproduction as a symbol of love (Schneider, 1968). The change in the 2021 Resolution, which allows to include relatives as gamete donors, reinforced the possibility of achieving the communion of substance through the technique, even if it involves genetic material from donors within the family, as seen in the news "The first twins born to a gay couple in Brazil; they have genetic material from both father's: Robert's semen and Gustavo's sister's egg generated Marc and Maya in the womb of a surrogate cousin, Lorena."³⁹ There, the genetic material of one parent was mediated by the sister's egg. As an example of a transparent or custodial tie, according to Thompson's theory, this instrumental connection allows for generation but does not imply a relationship, which is why it is not considered incestuous by those involved in the reproductive arrangement.

In Brazil, legal regulations on assisted reproduction are scarce. The analysis of the different contexts of use of new reproductive technologies suggests underlying cultural values that affect the establishment of kinship configurations, revealing the

38 | The couple obtained eggs from an anonymous donor and relied on the collaboration of the cousin of one of them for the transfer of the uterus, as well as got the double paternity registration for the child by the Family Court. Cf. LINS, Letícia. "Couple obtains unprecedented double paternity: PE entrepreneurs, together for 15 years, counted on the help of a cousin, who offered to be a surrogate". *O Globo*, March 31, 2012, O País, p. 18.

39 | Cf. "The longest and most exciting day of our lives". *O Globo*, 26 Feb. 2022, p. 10.

tension between the given and the constructed dimensions, between what is possible to choose or bonds to activate and what seems the injunction of an external natural law. Bodies reproduce themselves and subjects negotiate their options to establish kinship in the face of the possibilities offered by techniques, and formal or informal regulations existing in the context (Fonseca, 2011). Such are the clandestine surrogacy arrangements, as well as the decision regarding access to techniques regarding age, existence of stable or living partners, sexual orientation, among other aspects. The first major restriction is the limited availability of assisted reproduction in public services and its high costs in private clinics (Corrêa and Loyola, 2015). Next, it is necessary to analyze the values that underpin access to procreation technologies.

Considering that in Brazil, a resolution on assisted reproduction was only issued in 1992, eight years after the birth of the first baby using this technology in 1984, and that this resolution remained unchanged for 18 years until 2010, it is evident that altering these resolutions has become a routine practice, registered in 2010, 2013, 2015, 2017, 2020, 2021, and 2022. This updating indicates the need for adjustments related to changes in the Brazilian legislation (such as the New Biosafety Law) or to the interpretations that the Supreme Federal Court gives to Brazilian laws (such as the recognition of same-sex unions), or to the new code of medical ethics, or even to the jurisprudence regarding gamete donation. Moreover, it is also associated with the process of modernization of society's values and liberalization of customs, with progressive individualization. Hence, the interest in recognizing the intricacies of the use of reproductive technologies by same-sex couples, which has been altered since the 2010 Resolution, even before the Supreme Federal Court's decision, and continues to progress with each new resolution. What was unacceptable in 2002, when I conducted fieldwork, is now regulated in 2015 concerning shared motherhood. There is an increase in the possibilities of choice, in tension with the idea of natural determination of kinship, or paraphrasing Fonseca (2008: 772), in the face of the feeling that the family has lost the solidity of the natural, the question would be contractual, signaling the increase of choice in the field of laws.

In the legal void on assisted reproduction in Brazil, the CFM resolutions emerge as the competent authority to address matters regarding life (Rabinow and Rose, 2006) and the reproductive frontier becomes a political space (Franklin, 2013) with a pro-life bias encouraged by the rise of conservative forces in the government. These regulatory battles revolve around the use and disposal of embryos (Thompson, 2005), as evidenced in the resolutions of 2021 and 2022, prohibiting embryo disposal and consolidating the pro-life perspective aimed at re-sanctifying the embryo as a person and a subject of rights.

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