NEW REPRODUCTIVE TECHNOLOGIES, ETHICS AND GENDER: THE LEGISLATIVE PROCESS IN BRAZIL

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ABSTRACT

In this article, I will analyse the conduct of the Brazilian legislative process regarding new reproductive technologies, mainly the moral assumptions of three categories that are essential to the debate: the status of the child generated by these techniques; the number of embryos transferred in each cycle (as well as foetal reduction); and the issue of women’s eligibility for such techniques. The analysis will be a sociological study of the Brazilian legislative debate, using feminist perspectives in ethics as the theoretical reference. The focus will be the bills in progress in the Brazilian National Congress, the public and official declarations of legislators involved in the issue and the regulation of the medical class, which has influenced the legislative process. 

1 I thank Daniel Simeão, the group from the Centro Feminista de Estudos e Assessoria (CFEMEA), and in particular Almira Rodrigues, Patrícia Álvares, from the Conselho Federal de Medicina (CFM), and Teresa Citeli, from the Comissão de Cidadania e Reprodução (CCR) for access to research material. My special thanks also to Marilena Corrêa for discussing the main issues of this paper, to Sasha Roseneil, the director of the Centre of Interdisciplinary Gender Studies, for her friendship and welcome in Leeds, and to John Taylor for his friendship and reading. This article is a partial result of the research developed in the Interdisciplinary Gender Studies, Leeds/UK, between June and September of 2000. I thank the Ford Foundation (Brazil) and the British Council for supporting the research.

2 In summary, the legislative process in Brazil takes the following course: deputies and senators, elected by direct compulsory vote, propose the bills to be discussed and changed by other congressmen/women, by public audiences, etc. The duration of the process varies according to the topic. In the case of reproductive technologies, for instance, the first bill was proposed in 1993 and no consent has yet been reached over the issue. It is possible for similar bills, proposed by different authors, to be in process both in the house and senate, simultaneously. Such is the case of bills on new reproductive technologies. In all, there are three such bills under discussion in the Brazilian National Congress, two of them presently at the House of Representatives and one in the senate.
the legislative process, I include a section on the justification of these bills, since that is where the legislator exposes what he/she believes is the moral support for the bill.

REPRODUCTIVE MEDICINE IN BRAZIL

In 1984, the first baby conceived from artificial insemination was born in Brazil. It was an event that led to great discussion in the country. Since then Brazilian reproductive medicine has been following what is done in other centres in the world, with a continuous exchange of experience. Reproductive medicine, unlike other medical fields in Brazil, is basically a practice of the private sector, which goes against the traditional trends in medical research and education in the country. In general, biomedical innovations are introduced by public or university hospitals. Communication between the public and private sectors depends mainly on professionals who work in both fields and transfer the technology. Compared with other specialties, reproductive technology has not been transferred as rapidly from the private sector to university hospitals. This departure from tradition has made reproductive medicine unique in Brazil, and has affected the bioethical debate about the use of such technologies.

The introduction of reproductive techniques came early to Brazil, compared with other countries on the periphery of medicine, but the diffusion of the new techniques was not followed by a social or political debate. Most publications on new reproductive technologies referred to the clinical discussion per se or the juridical and religious aspects of it. Bioethics is no exception to this national acritical context facing reproductive medicine. The few bioethical studies on the topic consider juridical and normative situations, such as surrogate motherhood or foetal reduction, with almost no theoretical or ethnographic analysis related to the Brazilian reality. The clinical-juridical bias

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in the national legislative debate is the result of leaving reproductive medicine in the hands of doctors and law officials. In contrast with other countries, where the discussion around reproductive technologies has engaged several sectors of society, in a large exercise of democratic debate, the legislative process in Brazil has been controlled and conducted by representatives of the interests of three large classes, in this order of influence: medicine, law and the Catholic Church. The fact is that these three groups have similar basic moral values, which they try to defend through the law. As a result, there is a kind of overlap of interest among these three institutions, reinforcing the argumentative impact of their moral premises.

THE BEGINNING OF THE LEGISLATIVE PROCESS

If we consider the 1984 birth of the first test tube baby a historical landmark in the use of reproductive technologies in Brazil, the beginning of the legislative debate had a late start. The first national bill on the issue was only proposed in 1993 and was conducted by the House of Representatives. It was the one that most closely represented the interests of the medical class. According to its author: ‘… the issue of in-vitro fertilisation, artificial insemination, surrogate motherhood and other correlated, known as assisted reproduction techniques, has worried society on many aspects …’ Therefore, there is a need ‘… to transfer Resolution no. 1.358/92, from the Federal Council of Medicine into law, for its greater use and social support …’. The Federal Council of Medicine (CFM) is a medical class entity that establishes norms for the exercise of medicine in the country. Among other duties, such as the judgement of medical errors, the CFM establishes criteria for what is considered the medical professional pattern of conduct. The membership of all doctors in CFM is mandatory. They can only exercise their profession with such affiliation, despite it being a private organism and not the only one defending doctors’ interests.

The fact that CFM was the first entity to regulate new reproductive technologies in Brazil is not without meaning. Since it is the entity that sets the medical ethics – i.e., the behavioural norms for the exercise of medicine – it has achieved strengths and social legitimacy far beyond its technical and

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administrative duties. Responsibility for the medical ethics code has given to the CFM a supra-moral authority in the field of ethics applied to health. However, the council’s resolutions, while regulating the duties and rights of doctors, also establish the duties and rights of users of medical services. Consequently, the norms of medical professional conduct became the moral parameters for judgement in cases of moral conflict. The way in which the Brazilian legislative process began is not only an example of the moral prestige of the CFM, but it also points to the commonly accepted idea that the technical authority of medicine should prevail over individual values in cases of moral dilemmas. The belief that the mediation of moral conflicts in medicine is a responsibility of the council is largely accepted in the country, and this is especially true among users of medical service and even other professions in the medical field. The premise that medical ethics should be considered the moral pattern for all individuals involved in health services reinforces the medical authority of the national sanitary structure.

Therefore, for the congressman author of the first bill on reproductive technologies, it was at least comfortable to rely on the CFM resolution. In the beginning of the process, it was believed there would be no problems in changing the resolution into a bill, and no complications in it becoming a law. The CFM safeguard, as well as the lack of discussion in the country, would guarantee a quick process. As we will demonstrate, the development of the process was not as easy as expected. It became particularly difficult after the announcement of international scientific experiments with human embryos, which made the topic more attractive to other legislators. With the expanding of the debate, the council resolution was not the central part of the process anymore, though it is still an important reference to the regulation.

THE BILLS

Presently, there are three bills in course in the Brazilian National Congress. In this article, we will describe them according to their proposition order. A congressman proposed Bill no. 1 in 1993; Bill no. 2 was proposed in 1997, and its author was also a congressman; a senator proposed Bill no. 3 in 1999. It is important to point out some general characteristics of each bill. Bill no. 1 is the most superficial of them, probably in consequence of its pioneer. It adopts a general view of the topic, which gives it a certain lightness when compared with Bill no. 3.
It is also the bill which most represents the interests of the doctors involved in reproductive medicine. Bill no. 2 is more concerned with the terminology and scientific principles surrounding reproductive technologies. It refers meticulously to each practice and its medical consequences. It proposes the creation of a ‘National Commission on Assisted Human Reproduction’, a regulating organism to control the future execution of the law, similar to the HFEA in the UK. Bill no. 3 is the one at a more advanced stage in terms of legislative development and it has aroused a great social debate, despite being the last in course. It is the most extensive among the three and the one with the most juridical inspiration.

CHILDREN, EMBRYOS AND WOMEN’S ELIGIBILITY

Bill no. 1 and Bill no. 2 do not mention the category ‘child’, restricting themselves to expressions such as pre-embryo, embryo or foetus. The category ‘child’ appears in Bill no. 3, probably influenced by the latest version of the HFEA Code of Practice, where topics such as the well being of children are predominant. Most of Bill no. 3 represents an incorporation of determinations of the HFEA, in a distinct confusion of duties between the legislative role and what should be determined by the CFM or by a national commission on assisted human reproduction. In spite of the term ‘child’ recently being taken out of the legislative text (upon suggestion of a group of jurists who assisted with Bill no. 3), the justification section mentions: ‘… We call your attention to the fact that in choosing to protect the child, this bill strengthens the responsible parenthood principle …’ The choice of the term ‘child’, instead of embryo or foetus, is obviously intentional. The emotional impact of the defence of the child’s interest, when compared to that of the embryo or foetus, is much greater, and further, it leaves out the debate on

5 HFEA Code of Practice. 4 ed. July 1998. It would be interesting to develop a comparative analysis of the meaning of the category ‘child’ in the Brazilian legislative process with the British category ‘embryo.’ Some observations by Sarah Franklin on the embryo status in the English laws resemble the category ‘child’ in the Brazilian context: ‘… this is why the embryo is ‘special’: it is connected to us … in this sense to debate embryogenesis is to debate humanity …’ (Making Representation: the parliamentary debate on the human fertilisation and embryology act. 1999. In J. Edwards et al., eds. Technologies of Procreation: kinship in the age of assisted conception. 2nd ed. London/NY. Routledge: 141).

the status of embryos, a topic not yet fully explored in the country.

The category ‘child’ is not defined in Bill no. 3 and the efficiency of the term is exactly such ambiguity. In assuming a previous consensus on the meaning, the defence of its semantic use becomes simpler: at the same time that there is no doubt about what is a child and his/her social dignity, the ambiguity of the term allows changes in the original meaning, according to the situation. An example of this process can be seen in the way in which the bill supports the heterosexual family as the only one eligible for reproductive technologies. There is no direct confrontation with the issue of heterosexuality, as the question has not even been discussed. The future social relations of the child are considered the argument for the judgement of which family could be eligible for the technologies: ‘. . . in face of such possibilities, the main issue that emerged from the development of assisted reproduction is precisely its consequences to the child’s filial condition . . .’

Bill no. 3 deliberately mixes filial relations, consanguinity and parenthood, considering them synonymous in order to defend what is supposed to be the child’s interest.

In this context, the child becomes a synonym of parenthood determined by consanguinity of a legitimate filial relation from a heterosexual marriage. The importance of the consanguinity and genetic connection of the child with his/her genitors is so intense that, to discourage the donation of gametes, the text foresees the possibility of breaking the donor’s confidentiality after the child’s majority: ‘. . . [I]n regards to the use of gametes from an anonymous donor, which allows the birth of a child who is legally without a father, the project proposes an effective dissuasive way to allow the child born to exercise his/her right to demand the recognition of paternity, a right that should also be extended to the donor that wishes to claim the paternity of a child . . .’

This strategy is an efficient way of controlling the use of the technique, as few volunteers will donate sperm or egg due to the future identification risk and its juridical consequences. Thus an interesting argumentative evasion is developed: the appeal to the child’s autonomy regarding the knowledge of his/her biological origins is used to limit as much as possible the

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opportunities for single women or homosexual couples to access reproductive medicine through the anonymous donation of gametes.\footnote{It is possible to argue that heterosexual partners would suffer the same restriction, but since most couples do not use sperm or egg donation, this problem will have greater impact on single and homosexual women.}

However, in other parts of Bill no. 3, the ‘child’ is a synonym of human essence, of a certain shared humanity that should be protected against abuses, such as the risk of the use of the technique by single women and homosexuals. In order to defend the sacred status of the child, the text proposes an analogy with the environment:

\[\ldots\text{[I]t is possible to develop an analysis of the risks that children born through the use of assisted reproduction are exposed to, even if there is a lack of scientific postulates and verification that can be accepted by the whole society \ldots}\]

\[\text{Similarly there is a rise of environmental impact, if the relative evaluation of the use of assisted reproduction brings up the possibility of serious risks to the child \ldots the authorisation must be denied or even some mechanisms to discourage the use of assisted reproduction should be envisioned. We believe we should make for the children of the future what is already made today in regard to any innovation that is implemented in the environment: if there are serious risks, the changes will not be implemented, even if they are considered advantageous \ldots}\]


\footnote{Report, Comissão de Constituição, Justiça e Cidadania on the Projeto de Lei no. 90. Senado Federal. Projeto de Lei no. 90, 1999.}

The ‘children of the future’ represent the continuity of the moralities defended by the bill. Just like the environment is the necessary condition for the physical survival of human beings, the heterosexual family – called the ‘complete family’ by the senator responsible for the review of the bill – will continue to be the centre of the social structure.\footnote{Report, Comissão de Constituição, Justiça e Cidadania on the Projeto de Lei no. 90. Senado Federal. Projeto de Lei no. 90, 1999.}

The risk mentioned by the bill is that other family arrangements have access to reproductive technologies and become alternative to the ‘complete family.’ So the defence of the interests of the ‘children of the future’ guarantees the maintenance of heterosexual patterns in the family, as well as the hope that those children will guarantee the continuity of the values.
The fact is the category ‘child’ is related to the defence of patriarchal values, which are jeopardised by the new reproductive technologies. In general, the child represents the masculine interests, which have to be guaranteed by law. The legal instruments established by the bill, in particular the crime section, attempt to ensure the need for a father figure. They block all access to women who are outside a heterosexual union, that is, without a male partner, to reproductive medicine. The presence of the father is a necessary condition to the ethicalness of reproductive technologies in Brazil. However, as we will see further during the eligibility discussion, not all bills propose the need for a father figure in order to have access to reproductive medicine.

The category ‘woman’ almost does not appear in the normative vocabulary of the new reproductive technologies, particularly if compared to the category ‘child’ and ‘couple.’ In the three bills analysed, woman as someone who should be protected by law is seldom mentioned. Bill no. 3 was the only one to mention the health of women, in its justification saying: ‘… beyond the physical consequences to women and the juridical ones related to the paternity of a child … there is yet the issue of low effectiveness of those techniques, compared with its high financial, psychological and biological costs …’12 Despite Bill no. 3 mentioning the possibility of health problems for women, the risks were compared to the juridical consequences that men could face in respect to paternity or even financial costs of the treatment. Such lack of consideration for the rights and reproductive health of women who have undergone new reproductive technologies is more noticeable in the debate about the number of embryos to be transferred in each reproductive cycle, as well as the debate on embryo reduction.

In Brazil, as opposed to other countries that have opted for not limiting by law the number of embryos to be transferred in each cycle, this has been a central issue. As the interruption of pregnancy is considered a crime liable to punishment prescribed by law – except in cases of risk to the mother’s life and pregnancies from rape – the embryo transfer, as well as foetal reduction, have become the main topic of discussion.13 The fact that more than 80

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13 The debate on selective pregnancy interruption in cases of foetal health has been intense. Despite the practice being considered a crime, it is estimated that 400 selective pregnancy interruptions have occurred in the country since...
bills have been proposed in the history of the Brazilian National Congress suggests how dangerous the discussion on abortion is considered in the country. Nowadays, there is no bill in course with active reporting, a fact that shows a tendency for bills on abortion to be filed due to the impossibility of a legislative dialogue. This does not mean that the topic has not been arousing heated debate in society, especially among representatives of the religious communities and feminist movements. However, the filing of the bills indicates how dangerous the debate is considered to the legislative track record of a politician.

The foetal reduction question has been a topic of discussion since the beginning of the Brazilian normative process on reproductive medicine, even with the CFM resolution. Bills no. 1 and 2 foresee the transfer of up to four embryos per attempt, whereas Bill no. 3 recently reduced this number to three. All the bills forbid foetal reduction and some even suggest severe punishments to those practising it. Bills no. 2 and 3, however, consider the possibility of foetal reduction in cases where there is no other way of saving the mother’s life. In the first years of reproductive medicine in Brazil, the popular media frequently showed reports on women describing their experience with foetal reduction due to multiple pregnancies. During that phase, medical speech was sovereign in the face of the principle of the sanctity of embryo life and the discussion on abortion was replaced by its clinical correlate, foetal reduction.

The medicalisation of foetal reduction was an efficient outlet during the first years of reproductive medicine in Brazil, despite the CFM resolution prohibiting it. Foetal reduction was considered a necessary part of reproductive treatment and the clinics practising it were not punished. The appeal to other countries’ legislation was a common argumentative resource to support the ethicalness of the procedure. The anti-abortion


14 The overlap between embryonary reduction and abortion was a similar strategy to the one reported by Ana Tereza Ortiz on the practice of ‘depregnation.’ This practice was developed by doctors in the public system in the Dominican Republic. Instead of referring to abortion, which is prohibited by law in the country, doctors in Ortiz’s research defended the ‘depregnation’ of women (Bare-Handed Medicine and its elusive patients: the unstable construction of pregnant women and foetuses in Dominican obstetrics discourse. Feminist Studies 1997; 23: 263–289).
groups took some time to reverse this technological re-symbolisation of abortion by reproductive medicine, though the victory was relatively easy. Nowadays, all the bills in course consider the principle that the embryo’s life is untouchable. The more flexible international legislation on the topic is disregarded; one of the senators, when referring to other countries’ laws mentioned: ‘… there are absurd situations in the world in regards to it. The Spanish bill, for instance, is incredibly violent. On the other hand, Germany, which has experienced outrageous experiments with human beings and with life, has a bill that is amazingly harder and stricter than ours. Or, at least, as strict as ours . . .’15 By ‘harder and stricter’ he refers to the impossibility of foetal reduction or the prohibition of experiments with human embryos, such as cloning.

The consequence of this process is that the questions of multiple pregnancies (considered, by the medical literature, one of the main outcomes of assisted reproduction) as well as foetal reduction have been analysed in the face of the national legislation on abortion and not as basic issues in women’s health or yet as a scientific restriction of the techniques. This silence in regard to women’s health in the case of multiple pregnancies brings together the interests of the doctors involved in reproductive medicine, as well as of some religious communities. The result of this harmony of interests is the non-discussion of the relationship between the number of embryos transferred per cycle, the risks of multiple pregnancy, the prohibition of foetal reduction, and women’s health, as interdependent phases of the medical treatment. For those defending religious principles, the prohibition of foetal reduction is a crucial question, and, on the other hand, for those practising reproductive medicine, it is important not to show the inefficiency of reproductive techniques. Therefore, for different reasons – religious for some and financial for others – the legislative conclusion has been the same: not to deal with foetal reduction, a crime considered barbaric to some legislators, as one senator stated during a public debate: ‘… we must not persist on the discussion on who does not want to punish foetal reduction since the defenders of abortion are serial killers; because foetal reduction means destruction of embryos that, in fact, is life . . .’16

In the face of this context of religious and scientific pressure – on one hand, against abortion and, on the other, in order to keep the high number of embryos transferred per cycle because of the low efficiency of the technique – women’s health is forgotten. Groups defending the reproductive health of women considered the reduction from four to three transferable embryos per reproductive cycle – a unique suggestion of Bill no. 3 – as well as the non-punishment for foetal reduction in cases of risk to mother’s life significant achievements.

For a long time, this issue was not the focus of legislative discussion. Single and married women were supposed to have the same right to access reproductive technologies, a statement firstly made by the CFM resolution and incorporated in Bills no. 1 and 2. Bill no. 1 considers: ‘… all women, capable in terms of the law, who have requested and whose indication does not exceed the limits of this law, can be subject to assisted reproduction techniques …’; Bill no. 2, on the other hand, is more direct in its indication that: ‘… all capable women, regardless of their civil status, can be a user of assisted human reproduction …’ 17 Bill no. 3, up until recently, had also considered the possibility of single women having access to reproductive technologies, as their marital status was not a basis for their eligibility. Unexpectedly, however, it retreated. The new version of the text suggests that only married women or women in a stable union can have access to reproductive technologies: ‘… benefiting spouses or man and woman in stable union that has requested the use of assisted reproduction with the purpose of reproduction …’ 18 Therefore, the bill not only requests the spouse or partner’s consent, but it also requires the need for a stable union in order to be eligible for the process. This principle is difficult to measure and may generate serious social and moral controversy, in particular with the introduction of reproductive techniques into the public health system.

It is possible to suggest two reasons for the step back of Bill no. 3 on the issue of women’s eligibility. The first is the degree of opposition and rejection generated by reproductive tech-


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nologies, considered ‘anti-natural’, ‘unnecessary’ or even ‘menacing’, which are common descriptions used by the legislators responsible for the bills.\textsuperscript{19} The congressman responsible for the last version of Bill no. 3, when discussing the topic with other senators, expressed his indignation about reproductive techniques in the following way: ‘… the bill reflects the core of the debates and my own view of the problem … it is a commitment with life. I would prefer that assisted reproduction would never occur, but it does, and not only it does but it happens without regulation …’\textsuperscript{20} In his words, to make access to reproductive technologies more difficult is an efficient strategy for controlling something that is considered socially undesirable. Therefore, the next step is to attempt to justify the moral reasons for such rejection of new reproductive techniques.

Children’s protection, as mentioned previously, is the alleged main reason for such repulse to reproductive techniques. However, the defence of children’s interests can be an artifice for guaranteeing certain patriarchal privileges and prerogatives that prevail in the Brazilian society. Furthermore, the eligibility restriction to women in stable unions ensures that, among reproductive medicine practitioners, the male figure will not be discarded. On one hand, the agreed concept of the ‘child’ establishes the need for a father for the composition of the ‘complete family’, on the other hand, the eligibility restriction to those women in stable unions assumes the spouse figure. This last condition immediately eliminates the possibilities of homosexual women using assisted reproduction. There is a passage in the justification section of Bill no. 3 that states the prohibition of the commercialisation of the uterus, which elucidates this patriarchal uneasiness in the face of reproductive technologies and women’s autonomy. The legislation’s ruthlessness – not a mistake in writing – shows the intensity of the fear of the possibility of losing control over women’s reproduction; it states: ‘… a mechanism was established for discouraging women, both the middle-aged ones and those not suffering of infertility, to use assisted reproduction in order to fulfil their vanity of having a son outside the reproductive age or not being subject of undesirable effects of pregnancy …’\textsuperscript{21}

The vulgarity of the term ‘vanity’, in this context, was not by chance, especially if we consider that there were few direct references to women such as this in the legislation. Women are the focus of male control in the name of a possible and unexplained ‘vanity’, contrary to children that deserve their defence due to their social fragility and vulnerability. Therefore, it is the law’s duty to limit such excess of female ‘vanity’, according to the legislators’ words.

SOME POSSIBLE DEVELOPMENTS IN THE LEGISLATIVE DEBATE IN BRAZIL

There is almost a consensus on the fact that it is necessary to regulate reproductive techniques in Brazil, both with respect to access and the professional practice related to it. Due to such social expectation and the development of the legislative process, there is no doubt there will be national regulation in the near future in the country. Attempting to project future legislative debate, it is possible to foresee two emerging topics. The first is the scientific research on embryos and the second the issue of allocation and priorities of health resources, in particular with the availability of reproductive medicine in public services. Some reasons should be considered to justify the emergence of both topics.

Bill no. 1 and no. 2 consider scientific research on embryos. Bill no. 2, for instance, is more careful regarding the topic and has a whole section of legislative text on the topic, called ‘From Investigation to Experimentation’, which says: ‘… human gametes can be subject of basic or experimental investigation, exclusive for the improvement of obtaining, oocitos maturation and egg crio-conservation techniques …’22 However, Bill no. 3 adopted the opposite perspective, as it discards the discussion, and does not even mention the problem. It seems as if it is not within the bill’s scope to debate it, or even as if it is not essential to the country at the moment. Some topics, such as cloning, have been left on the margin of the legislative discussion on new reproductive technologies (they have been inserted in specific bills in progress at the Brazilian National Congress), in spite of the fact that the three bills mention the prohibition on the use of reproductive medicine for cloning human beings. Since there is a great harmony between Brazilian and international biomedical

research, it is clear that scientific research on human embryos will be an emerging topic in legislative debate on the bills mentioned.\textsuperscript{23} Different from the British case, for example, where scientific research was considered a fundamental question from the beginning of the legislative process, in Brazil this question has been treated separately.

The second emerging topic is related to the introduction of reproductive medicine into the public health system. Probably, this will be one of the most difficult issues in the national legislative debate surrounding the question. Up to the present moment, the debate on reproductive technologies in the country has been immersed in some specific values, such as the reproduction of the heterosexual family and the kinship link. Such bias was a result of the dilemmas faced by practitioners and users of the technique. In general, these groups of people have similar moral values. Reproductive medicine was a service and a group of techniques that were only accessible to those users of private health services, i.e. people able to pay the high financial cost of the treatment. However, there has been pressure, particularly from doctors who wish to legitimise the field of reproductive medicine in the country, towards offering new reproductive technologies also in the public health system. In some Brazilian cities, a few hospitals that specialise in women’s health are now offering this type of service. It is a topic worthy of ethnographic studies, especially if compared to the services and costs of private reproductive medicine.

Regardless of whether or not the entrance of reproductive medicine in the Brazilian public health system represents a step towards democratisation of scientific knowledge (a topic undergoing intense debate in several sectors of Brazilian society and fundamental to Bioethics), the immediate consequence of such technological transfer will be the issue of health priorities. The question of which should be the priorities in the field of women’s reproductive health stands out. Nowadays, the cost/benefit relationship of reproductive technologies is one of the most heated topics in reproductive medicine around the world, especially because it deals with the interests of health insurance

\textsuperscript{23} Bio-technology Law, no. 8.974/1995, among other issues, regulates ‘… the experiments with human embryos, reproductive cells, genetic material …’ It proposes the principle of unavailability of biological material and of persons. This law, however, is not referenced in the bills (Corrêa and Diniz, \textit{op. cit.} note 2).
companies. It will be a topic that cannot be ignored in Brazil, where the need and inequalities of the national sanitary system are immense. However, this issue has been avoided in the legislative debate, since the movement for the introduction of reproductive medicine in the public health services has been conducted by doctors who are interested in the ultimate institutionalisation of the technique.

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