

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

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**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, as well as on its authorship<sup>2</sup>. Since then Brazilian reproductive medicine has been following what is done in other research and educational centres in the world, with a continuous exchange of experience. Reproductive medicine, differently from other medical fields in Brazil, is basically a practice of the private sector, a characteristic which goes against the traditional trends on medical research and education in the country. In general, biomedical innovations are introduced by public or university hospitals. The communication between public and private sector depends mainly on professionals that work in both fields and who transfer the technology. In regard to reproductive medicine, as the techniques have been only used by clinics and private sector services, the relationship with university hospitals has been delayed, if we compared with other specialities. This changing of the traditional trend in biomedical knowledge has set some characteristics to reproductive medicine in Brazil, and more directly, it has imprinted special characteristics to the bioethical debate about the use of such technologies.

In contrast with the early introduction of reproductive techniques in Brazil, especially when compared with other peripheral countries in medicine, the diffusion of the new techniques was not followed by a social or political debate. In the field of anthropological studies, for instance, there were few analyses on feminist perspectives that considered the question, in spite of the Brazilian tradition in reproductive health studies<sup>3</sup>. Most publications on new reproductive technologies referred to the clinical discussion per se or the juridical and religious aspects of it. An analysis of the reasons for such a gap in the feminist studies should be considered, in particular if we contrast it with the fact that such a theme has been one of the main topics in the national media on science and reproduction. The popularisation of the topic was increased in the 90s with the broadcasting of a soap opera on surrogate pregnancy<sup>4</sup>. Still today, it is common to find stories in the Brazilian national press on women pregnant with six embryos or speculation surrounding the future of human reproduction.

Bioethics is not an exception in this national acritical context facing the

reproductive medicine. The few bioethical studies on the topic consider juridical and normative situations, such as womb commercialisation or the embryo reduction, with almost no theoretical or ethnographic analysis related to the Brazilian reality<sup>5</sup>. The clinical-juridical bias in the national legislative debate has been the outcome 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 the 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 are similar in respect to their 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.

In this article, we will analyse the conduct of the Brazilian legislative process regarding new reproductive technologies. Our main counter point is the debate that took place in the United Kingdom, in particular with the publication of the Warnock Report and the suggestions of the Human Fertilisation and Embryology Authority (HFEA)<sup>7</sup>. Among the material analysed, the focus of the attention 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<sup>8</sup>. Aside from the analysis of the legislative process, we include a section on the Justification of these bills, since it is the section where the legislator exposes what he/she believes is the moral support to the bill.

The Warnock Report influence was fundamental in the beginning of the Brazilian legislative process especially to the promulgation of the first medical resolution on the topic. Despite its, we notice that, nowadays, the discussion is deviating from the British debate. The topics that have inspired the execution of the English committee motioned the first discussions in Brazil on new reproductive technologies. This was the case of the discussions on the issue of scientific research on human embryos. Despite the first influence, the topics under debate in the Brazilian Legislative are not the same.

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## The Beginning of the Legislative Process

If we consider the 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. On the first seven years of the use of the reproductive technologies, there was no control on procedures and the data registration was also rare. As previously mentioned about feminist studies, one interesting aspect of this lack of attention to reproductive medicine from the legislative is to compare with the media's interest. Evidence of the extent of the media attention to the topic is the fact that, in 1984, a group of doctors signed a contract with a television network to finance the trip of Australian specialists to Brazil. The objective of the contract was two fold: firstly, the instruction of a small group of Brazilian doctors and, secondly, the opportunity to broadcast the technical procedures involved in in-vitro fertilisation. The contract aimed at recording scenes of the production of the first Brazilian test-tube baby and giving to the communications company the rights to those images. The transmission of the reproductive medicine procedures, however, was abandoned due to the death of a woman, caused by complications in the in-vitro fertilisation (IVF) manipulation<sup>9</sup>.

So, the first national bill on the issue was only proposed in 1993. It was conducted by the House of Representatives and has two main characteristics: it was the one that most closely represented the interests of the medical class and was directly inspired on the Warnock Report. 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, the need "...to transfer Resolution No. 1.358/92, from the Federal Council of Medicine into law, for its greater use and social support..."<sup>10</sup>. 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 to what is considered the medical professional pattern of conduct. The membership of all doctors to CFM is mandatory. They can only exercise their profession with such affiliation, despite it being a private organism and not the only one defending doctor's interests.

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

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, when regulating the duties and rights of the doctors, also establish the duties and rights of the users of the medical services. In consequence, 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 the medicine should prevail over the 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 or even by 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 on 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 of the topic 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 in the Legislative, the Council Resolution is still an important reference to the regulation but not the central part of the process anymore.

## 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. The tables attached (ATTACH 1) summarise the main proposition of each bill, which will be the reference for the comparative analyses with the Warnock Report and the suggestions of the HFEA for UK.<sup>11</sup>

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## ATTACH I

Subject	Bill no. 1 (1993)
Target Public	Women and infertile couples
Cloning Agreement	Not mentioned From woman and husband
Embryo Transferring	<b>Maximum 4 per trial</b>
Embryo Discarding	Prohibited Prohibited
<b>Embryo Reduction</b>	
Embryo Research	Prohibited
Donation	Confidential
Commercialisation	<b>Prohibited</b>
SUBJECT	Bill no. 2 (1997)
Target Public	Women and infertile couples
Cloning Agreement	Prohibited Only from woman Maximum 4 per trial
Embryo Transferring	
Embryo Discarding	Allowed after 5 years
Embryo Reduction	Allowed in cases of risk to the mother's life
Embryo Research	Allowed with restrictions
Donation	<b>Confidential</b>
Commercialisation	Prohibited
SUBJECT	Bill no. 3 (1999)
Target Public	Married women
Cloning Agreement	Not mentioned Authorisation from woman and husband Maximum 3 per trial <sup>5</sup>
Embryo Transferring	
Embryo Discarding	Prohibited
Embryo Reduction	Allowed in cases of risk to the mother's life
Embryo Research	Not mentioned
Donation	Partial confidential
Commercialisation	Prohibited

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 the medicine of reproduction. *Bill no. 2* is more concerned with the terminology and scientific principles surrounding the 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, similarly to the role of the HFEA in UK. *Bill no. 3* is the one at more advanced stage in terms of Legislative development and it has been 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.

### Warnock Report, HFEA and the Brazilian Bills

In Mary Warnock's initial words when introducing the committee's recommendation "...in recommending legislation, then, we are recommending a kind of society that we can, all of us, praise and admire..."<sup>13</sup>. The admiration, mentioned by Warnock, is not only a contemplative relation with a degree of social ideal, but it is the search for fulfilment of this ideal by means of regulation. Therefore, the law becomes a legitimate and efficient instrument for the imposition of specific social configuration. Some moral premises about the ideal society underlie any legislative process, and this is particularly so in the case of fundamental topics, such as biological and social reproduction. Hence, there is a continuous interplay between moralities that have to be defended by law and those that can be contested. In this comparison with the British case, we will analyse the moral assumptions of three categories that are essential to the debate on new reproductive technologies in Brazil: the status of the child generated by these techniques; the number of embryos transferred in each cycle (as well as embryo reduction); and the issue on women's eligibility to such techniques.

#### ♦ The Status of The Child

Bill no. 1 and Bill no. 2 do not mention the category 'child', restricting themselves to expressions such as pre-embryo, embryo or fetus. The category 'child' appears with *Bill no. 3*, and probably it was an influence of the latest version of the HFEA *Code of Practice*, where topics such as well being of children were predominant<sup>14</sup>. 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' has recently been taken out of the legislative text (upon suggestion of a group of jurists who assist *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..." (no original emphasis)<sup>15</sup>. The choice of the term 'child', instead of embryo or fetus, is obviously intentional. The emotional impact of the defence of the child's interest, when compared to embryos' or fetus', is much greater, and further, it leaves out the debate on the embryos' status, 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

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semantic use becomes simpler: at the same time that there is no doubt on 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 could be seen in the way in which the bill supports the heterosexual family as the only one eligible for the 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 state..."<sup>16</sup>. *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: "...in 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..." (no original emphasis)<sup>17</sup>. In reality, the strategy of the risk of breaking donors' confidentiality is an efficient solution to control the use of the technique by heterosexual families, 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 child's autonomy regarding the knowledge of his/her biological origins to limit as much as possible the opportunities for single women or homosexual couples of having access to reproductive medicine through the anonymous donation of gametes.

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: "...It 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...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... 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..." (no original emphasis)<sup>18</sup>. The "children of the future" represent the continuity of the moralities defended by the project. 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<sup>19</sup>. 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, 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 and every 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 ethnicity of the reproductive technologies in Brazil, a similar statement of the HFEA recommendation to UK: "...the *Human Fertilisation Act and Embryology Act* (1990) requires that the welfare of the child must be taken into account before any treatment can commence at a licensed centre...", "...including the **need of that child for a father...**" (no original emphasis)<sup>20</sup>. 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.

#### ◆ *Number of Transferred Embryos*

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 an entity which should be protected by law is seldom mentioned. This does not seem to be a legislative gap which is exclusively Brazilian. In the HFEA *Code of Practice*, for instance, there are specific sections on the well being of

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children, donors and clients, but there is no information directed exclusively to the situation of women involved in reproductive medicine. *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..."<sup>21</sup>. Despite *Bill no. 3* mentioning the possibility of health problems to the 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 to rights and reproductive health of women that 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, differently from 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 of punishment prescribed by law - except in cases of risk to the mother's life and pregnancies from rape - the embryony reduction, as well as embryony reduction, have become the main topic of discussion<sup>22</sup>. To have an idea how the discussion on abortion is considered dangerous in the country, more than 80 projects of law have been proposed in the history of the Brazilian National Congress. 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 embryo 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 embryony reduction and some even suggest severe punishments to those practising it. Bills no. 2 and 3, however, consider the possibility of embryony 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 embryony reduction due to multiple pregnancies. During that phase, the medical speech was sovereign in face of the principle of sanctity of embryo life and the discussion

on abortion was replaced by its clinical correlate, embryo reduction.

The medicalisation of embryony reduction was an efficient outlet during the first years of reproductive medicine in Brazil, despite the CFM resolution prohibiting it. The embryony reduction was considered a necessary part of the reproductive treatment and the clinics practising it were not punished<sup>23</sup>. The appeal to other countries' legislation was a common argumentative resource to support the ethicality of the procedure. This was particularly the case of appeals to the recommendations of the *Warnock Report*, where there is no maximum limit of embryos to be transferred in each cycle or even no direct deliberation on embryony reduction (the following part of the *Warnock Report* was especially mentioned: "...though in some sense related, fell outside our terms of reference. Chief among these were abortion and contraception..."<sup>24</sup>). The anti-abortion 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, including the recommendations by the HFEA. One of the senators, when referring to other countries' law 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..."<sup>25</sup>. By "harder and stricter" he refers to the impossibility of embryony reduction or the prohibition of experiments with human embryos, such as cloning.

The consequence of this process is that the question of multiple pregnancies (considered, by the medical literature, one of the main outcomes of assisted reproduction) as well as embryony reduction have been analysed in face of the national legislation on abortion and not as basic issues on women's health or yet as a scientific restriction of the techniques<sup>26</sup>. 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 risk of multiple pregnancy, the prohibition of embryony reduction and the women's health, as interdependent phases of the medical treatment. For those defending religious principles, the prohibition of embryony 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.

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Therefore, for different reasons – religious to some and financial to others – the legislative conclusion has been the same: not to deal with embryony 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 embryony reduction since the defenders of abortion are **serial killers**; because embryony reduction means destruction of embryos that, in fact, is life..." (no original emphasis)<sup>27</sup>.

In face of this context of religious and scientific pressure – on one hand, against to 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 – the women's health is a forgotten part. Groups defending 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 embryony reduction in cases of risk to mother's life significant achievements.

## ♦ Women's Eligibility

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..." (no original emphasis)<sup>28</sup>. *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, using an argumentative support similar to the proposition of the *Warnock Report* and the HFEA recommendation. The new version of the text suggests that only married women or women in a stable union could 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..." (no original emphasis)<sup>29</sup>. Therefore, the bill not only requested the spouse or partner's consent, but it also foresees 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, among other possible explanations, for the step back of *Bill no. 3* in the issue of women's eligibility. The first of them is the degree of opposition and rejection generated by reproductive technologies, considered "anti-natural", "unnecessary" or even "menacing", which are common descriptions used by the legislators responsible for the bills<sup>30</sup>. 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..." (no original emphasis)<sup>31</sup>. In his words, to make the access to reproductive technologies more difficult is an efficient strategy to control something that is considered socially undesirable. Therefore, the next step is to attempt to justify the moral reasons for such rejection of the 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 to guarantee 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 of 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 on the *Justification* section of *Bill no. 3* that states the prohibition of the commercialisation of the uterus, which elucidates this patriarchal uneasiness in 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..." (no original emphasis)<sup>32</sup>. The vulgarity of the term "vanity", in this context, was not by chance. In particular, 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

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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 over the fact that it is necessary to regulate reproductive techniques in Brazil, both in 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. However, some topics must be incorporated, or at least considered, in this final section. 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, clearly influenced by the *Warnock Report*, consider scientific research on embryos. *Bill no. 2*, for instance, is more careful regarding the topic and has a whole section of the legislative text on the topic that is 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 cryo-conservation techniques"<sup>33</sup>. 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 was 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 the Brazilian and the international biomedical research, it is clear that scientific research on human embryos will be an emerging topic in legislative debate on the bills mentioned<sup>34</sup>. Differently from the British case, where the 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, few hospitals that are specialised on 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 the fact that the entrance of reproductive medicine in the Brazilian public health system represents, or not, 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 companies<sup>35</sup>. 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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<sup>2</sup> Some issues discussed on this part were originally developed by Marilena Corrêa and Debora Diniz, in *New Reproductive Technologies in Brazil: a debate awaiting regulation*, in an article presented in the "I International Conference on Ethics and Gender", which happened in Leeds, United Kingdom, in June 2000.

<sup>3</sup> Clearly, there were some feminist voices on the topic. The articles by Marilena Corrêa, who is a doctor and sociologist acting in the field of social reproduction, are good indicators of the potential of the field in Brazil. (Corrêa, Marilena. *A tecnologia a serviço de um sonho Um estudo sobre a reprodução assistida no Brasil*, PhD Dissertation. Instituto de Medicina Social da Universidade do Estado do Rio de Janeiro, Rio de Janeiro, 1997).

<sup>4</sup> In the article, "Saúde Reprodutiva: mídia, ciência e humanidades", Maria Teresa Citeli analyses the relationship between Brazilian media and some specific questions of women's reproductive health. Her research refers to a wide range of data, which includes the four main newspapers in the country. She suggests the category "reproduction", for example, in which one of the new reproductive technologies is involved represents 21% of the total of the material collected (mimeo. 2000: 04).

<sup>5</sup> In the last meeting of the "Comissão de Constituição, Cidadania e Justiça" there were some changes to *Bill no. 3*, which have not yet been incorporated to the version available to the public. The changes were regarding: 1) the number of embryos transferred each cycle (reduced from four to three); 2) the non-punishment for embryonic reduction in case of risk to the mother's life. The full account of the meeting is found in the reports of the Commission previously mentioned. Senado Federal. Secretaria-Geral da Mesa. Serviço de Comissões. Reunião Ordinária da "Comissão de Constituição, Cidadania e Justiça". 14/04/2000.

<sup>6</sup> In fact, most of the bioethical studies on new reproductive technologies are inappropriate uses of the concept of bioethics, instead of careful analysis based on consolidated theoretical references.

<sup>8</sup> In summary, the legislative process in Brazil has 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 course 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 example, that similar bills, proposed by different authors, being in course both in the House and Senate, simultaneously. That is the case of bills on new reproductive technologies. In all, there are three of such bills under discussion in the Brazilian National Congress, two of them presently at the House of Representatives and one in the Senate.

<sup>9</sup> Corrêa, Marilena & Diniz, Debora *New Reproductive Technologies in Brazil: a debate awaiting regulation*. mimeo. 8pp. Reis, A R Gomes A fertilização in-vitro no Brasil - A história contada, as estórias, mimeo (source: Federal Senate Library), Brasília 1985

<sup>10</sup> Câmara dos Deputados. Projeto de Lei n. 3638. 1993: 07. Author: Congressman Luiz Moreira. Commentator: Congressman Marcelo Deda.

<sup>11</sup> A similar table was initially proposed by the Centro Feminista de Estudos e Assessoria (CFEMEA). It is the source of information for the present table. Mimeo. Brasília. 2000.

<sup>13</sup> Warnock, Mary. *Report of the Committee of Inquiry into Human Fertilisation and Embryology*. Department of Health & Social Security. July 1984: 3.

<sup>14</sup> HFEA *Code of Practice*. 4 ed. July 1998. It would be interesting to develop a comparative analyses 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". Edwards, Jeanette et al (eds). *Technologies of Procreation: kinship in the age of assisted conception*. 2 ed. London/NY. Routledge. 1999: 141).

<sup>15</sup> Senado Federal. Projeto de lei do Senado. n. 90. 1999: 23. Author: Senator Lúcio Alcântara. Commentator: Senator Roberto Requião.

<sup>16</sup> Senado Federal. Projeto de lei do Senado. n. 90. 1999: 12. Author: Senator Lúcio Alcântara. Commentator: Senator Roberto Requião.

<sup>17</sup> Senado Federal. Projeto de lei do Senado. n. 90: 08. Author: Senator Lúcio Alcântara. Commentator: Senator Roberto Requião.

<sup>18</sup> Senado Federal. Projeto de lei do Senado. n. 90.. 1999: 14/15. Author: Senator Lúcio Alcântara. Commentator: Senator Roberto Requião.

<sup>19</sup> Report, "Comissão de Constituição, Justiça e Cidadania" on the Projeto de Lei no. 90. Federal Senate. Projeto de Lei no. 90, 1999.

<sup>20</sup> HFEA *Standard Patient Information*. July 1998: 1.

<sup>21</sup> Senado Federal. Projeto de lei do Senado. n. 90. 1999: 21. Author: Senator Lúcio Alcântara. Commentator: Senator Roberto Requião.

<sup>22</sup> The debate on selective pregnancy interruption in cases of fetus health has been

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intense. Despite the practice being considered a crime, nowadays, it is estimated that 400 selective pregnancy interruptions have occurred in the country. Such estimation is calculated through judicial authorisation to abortion due to the fetus incompatibility with extra-uterine life. For an analysis of moralities of the first judicial authorisations in Brazil, see: Diniz, Debora *Selective Abortion in Brazil through juridical warrants*. mimeo. 8pp ("O Aborto Seletivo nos Alvarás Judiciais Brasileiros". In *Bioética*. vol.5, no1, pp.19-24, 1997).

<sup>23</sup> The overlap between embryony reduction and abortion was a similar strategy to the one reported by Ana Tereza Ortiz on the practice of 'depregnate'. 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 research defended the 'depregnation' of the women ("Bare-Handed Medicine and its elusive patients: the unstable construction of pregnant women and fetuses in Dominican obstetrics discourse" In *Feminist Studies* 23, n. 2 (Summer 1997): 263-289.

<sup>24</sup> Warnock, Mary. *Report of the Committee of Inquiry into Human Fertilisation and Embryology*. Department of Health & Social Security. July 1984: 5.

<sup>25</sup> Senado Federal. Secretaria Geral da Mesa. Serviço de Comissões. Reunião Ordinária da Comissão de Cidadania e Justiça. 12/04/2000:5.

<sup>26</sup> On the topic, see for instance: Serour, Gamal I.; Aboulghar, Mohamed; Mansour, Ragaa, et al. "Complications of medically assisted conception in 3.500 cycles". In *Fertility and Sterility*, vol. 70, n. 4, October 1998: 638-642.; Martin, Peter M; Welch, Gilbert H. "Probabilities for Singleton and Multiple Pregnancies after in vitro Fertilization". In *Fertility and Sterility*, vol. 70, n. 3, September 1998: 478-481; Addor, Véronique; Santos-Eggimann, Brigitte; Fawer, Claire-Lise; Paccaud, Fred; Calame, André. "Impact of Infertility Treatments on the Health of Newborns". In *Fertility and Sterility*, vol. 69, n. 2, February 1998: 210-215; Roest, Jan; van Heusden, Arne; Verhoeff, Arie; Mous, Harold; Zeilmaker, Gerard. "A Triplet Pregnancy after in vitro Fertilisation is a Procedure-Related Complication that should be Prevented by Replacement of two embryos only". In *Fertility and Sterility*, vol. 67, n. 2, February 1997: 290-295.

<sup>28</sup> Câmara dos Deputados. Projeto de Lei n. 3638. 1993: 02. Author: Congressman Luiz Moreira. Relator: Congressman Marcelo Deda. House of Representatives. Bill no. 2.855. 1997: 07. Author: Congressman Confúcio Moura. Relator: Congressman Jorge Costa.

<sup>29</sup> Senado Federal. Projeto de lei do Senado. n. 90. 1999. Author: Senator Lúcio Alcântara. Commentator: Senator Roberto Requião. Federal Senate. General Secretary of the Board. Commission Services. Ordinary Meeting of the

"Comissão de Constituição, Cidadania e Justiça". 12/04/2000.

<sup>30</sup> Senado Federal. Projeto de lei do Senado. n. 90. 1999. Author: Senator Lúcio Alcântara. Commentator: Senator Roberto Requião.

<sup>33</sup> Câmara dos Deputados. Projeto de Lei no. 2.855. 1997:05. Author: Congressman Confúcio Moura. Commentator: Congressman Jorge Costa.

<sup>34</sup> 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 person. This law, however, is not referenced in the bills (Corrêa, Marilena & Diniz, Debora. *Novas Tecnologias Reprodutivas no Brasil: um debate à espera de regulamentação*. mimeo. 8pp. 2000).

<sup>35</sup> On the topic, see, for instance: Wallach, Edward. "Cost-Effective Treatment of the Infertile Couple" In *Fertility and Sterility*, vol. 70, n. 6, December 1998: 995-1005; Griffin, Martha; Panak, William F. "The Economics Cost of Infertility-Related Services: an examination of the Massachusetts infertility insurance mandate". In *Fertility and Sterility*, vol. 70, n. 1, July 1998: 22-29; The Ethics Committee of the American Society for Reproductive Medicine. "Shared-Risk or Refund Programs in Assisted Reproduction". In *Fertility and Sterility*, vol. 70, n. 3, September 1998: 414-415.

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