

Reproductive technology in Italy between gender policy and inequality. Can we speak of "social infertility"?

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Abstract¹

This article focus on the practices of Medically Assisted Procreation (MAP) or ART (Assisted Reproductive Technology)² related to the process of medicalization of the body, of human reproduction and of everyday life, with a view to the social context in which ART develop. In particular, the Italian context shows some contradictions between the advances in biomedicine and biotechnology and legislative and political conservatism.

This study will therefore consider: a) some theoretical approaches on the relationship between reproductive technology and women's bodies; b) the relationship between

¹ This articles is the result of the author's most recent studies on ART issue. See also Lombardi, De Zordo (2013); Lombardi (2015), (2016).

² Since 1978, the year that marked the birth of Louise Brown and the beginning of the "reproductive technology adventure", the most commonly used definition has been "New Reproductive Technology" (NTR). Later the term "Assisted Reproductive Technologies" (ARTs) was introduced and the two acronyms have remained largely in use in English-speaking countries, where "neutral" terms such as "technology" and "reproduction" are preferred. In Mediterranean countries, with Latin-rooted- languages, the term "Medically Assisted Procreation", is instead commonly used. As often happens, the terminology tends to hide some reality and to eliminate or to assimilate unless the complexity of women's bodies, a fundamental part of the identity of this gender experience. In this paper we use both abbreviations.

Italian policies and social, family and parenting structures; c) the impact of reproductive technologies on gender roles; d) gender inequality, still rooted in the Italian context and facing the challenges of MAP, as well as the persistence of procreative conventional models.

As for the methodology of the study, we have carried out an "integrated study" based on the existing sociological and anthropological international literature and databases³ and on a qualitative research conducted in a local context⁴.

Keywords: reproduction, technology, gender, medicalisation, infertility

1. Reproductive Technologies and Women's Bodies: theoretical approaches

The analysis of the technological reproductive process does not only involve the biological body but also the social and cultural body, expressed through sexuality, parenthood and social, generational and gender relations.

Since the 1960s we have witnessed a process of progressive separation between sexuality and procreation: with the increased use of contraceptives sexuality has become independent from reproduction, while during the second half of the 1970s reproduction has become almost independent from sexuality (Pizzini 1999).

The existence of such techniques, by stirring imagination, encourages different ways to procreate, raise and take care of children (for example single and homosexual parents).

We can thus argue that the advent of MAP highlights three issues:

1. personal and physical relationships to "make" children become more and more obsolete;
2. there is a desire to bring to light what women's womb has hidden for years;

³ EUROSTAT; Istituto Nazionale di Statistica; Registro Nazionale della Procreazione Medicalmente Assistita.

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3. reproduction is separated from the body .

Assisted procreation therefore generates a detachment of the couple from bodily practices and traditional relational strategies linked to procreation. The “artificial” family, no longer based on fertile sexuality – which can be made of a “real” father (the sperm donor), a “scientific” father (the doctor, who replaces the infertile sexual intercourse with a fertile medical act), a “carrying” or “donor” mother - would reduce the social dimension of parenthood to the benefit of biological meanings, which carry with them all legitimization of parenthood. Practices such as artificial insemination with donor sperm or surrogate maternity would not be socially legitimate if they were not carried out in a neutral and aseptic medical environment, and they would be considered adulterous and incestuous. The presence of a doctor gives this kind of transaction the status of a medical act rather than of illegal sexual behaviour; medicine becomes a regulator of social behaviours.

Assisted procreation is also characterised by a paradox: if on the one hand it calls into question physical and blood kinship, on the other it finds its legitimization upon such link, moving filiation “from the social to the individual register”.

Bodies and relationships thus disappear, and seem to become mere means of reproduction. The aim is the product of conception, the embryo, the foetus, the “child in your arms⁵”. The embryo/foetus/child is objectivised and it paradoxically acquires corporeity and rights before it is born, since it is a product of science and therefore separated and separable from the maternal body: the latter disappears in order to emerge as a mere container for the embryo/foetus, who has legal status⁶.

Along with this process comes the expropriation of reproduction from the body, represented by dissociation, objectivation and interchangeability.

1. Dissociation: between procreation and sexual intercourse; between biological parenthood and filiation (i.e. sperm and ovum donation, surrogacy⁷); between the organs and functions of the female reproductive apparatus, which leads to a break up of the

⁵ An expression which indicates what doctors promise to deliver to the couple (the customer), after a long and insecure period of MAP.

⁶ Article 1 of the MAP Italian legislation: Legge 40/2004.

⁷ It is important to say that surrogacy is not allowed in Italy and in many other European countries. Surrogacy is permitted in UK, Greece and Ireland, albeit with many restrictions (Piga 2013).

maternal function; dissociation of the paternal function which gives way to biologically contestable social fathers and to biological fathers who are not socially recognised; dissociation between the mother and the foetus; dissociation between the time of conception and the start of pregnancy. In this respect, In Vitro Fertilization (IVF), hidden under the umbrella term of “assisted procreation”, is the focal point which transforms the human reproduction representation.

2. The objectification of the body and its functions emerges from the alienation of reproductive functions and organs. The medicine evaluation criteria aim to the functioning of the organs, excluding the body and the person.

3. Finally, the interchangeability of organs (the ovum of a woman inserted into the womb of another woman) and of functions (the gestation of an embryo produced by someone else) are seen as a threat to the integrity of women’s bodies. By this, we mean the complexity of women’s existence, both individual and social, which has possible serious repercussions on the social and relational interaction of individuals (Lombardi 2009, 2013).

Alongside these critical views on reproductive technologies, others provide a positive evaluation of the invasion and/or technological replacement of women’s bodies, which is thus subtracted to social duties considered indefeasible.

Donna Haraway (1995) introduces a new variation in the relationship between the body and the machine, which overcomes old divisions and identifications with regard to gender and other dimensions. According to her, the *cyborg myth* stems from the constructive encounter between body and machine: the word ‘cyborg’ is made of ‘cyber’ and ‘organism’ and means cybernetic organism, indicating a mix of flesh and technology which characterises the body, modified by clutches of hardware, prostheses and other devices (Haraway 1995, 11).

As a consequence, the search for identity is replaced by a search for affinity, which overtakes the phase that made us look for an “us” to be defined and defended, in order to open up unknown opportunities for communication.

According to Donna Haraway (1995), the various critiques of the political system and scientific culture, including the feminist ones, still depend on the idea of

hierarchical dichotomies which have characterised Western thought since Aristotle. It is nonsense to think of our condition in dichotomic terms: we need to construct a world of relationships without identities, we need to propose a new vision of the self, and the cyborg is the self that needs to be elaborated. Communication technologies and biotechnologies are the main tools for the reconstruction of our bodies. These tools incorporate and impose new social relationships for women all over the world. The author here replaces a dichotomic vision with an image which is ideological and reticular and suggests the profusion of spaces and identities and the permeability of borders in the personal and in the political body (Ivi, 68).

With reference to women's relationship with technology, Rosy Braidotti maintains that:

we need to understand that this dimension belongs to us and that starting from its implosion it is perhaps possible to draw different perspectives, by creatively contributing from within to the invention of new universes of signification and of other symbolic orders where technology is not an instrument of power but of satisfaction [of needs] (Braidotti 1996, 33)

But, can we really argue that the body-machine union is a tool that can satisfy needs, freedom of choice and the construction of equalities precisely because it is neutral and abstract, free of bodily ties? The tendency to remove the body experience from the self can be found in different contexts: in virtual communication, in the deconstruction activated by technologies of surveillance, in the breaking apart and putting back together of organ transplants, in medically assisted reproduction (where even sexuality disappears), in genetic research, etc. Bodies, in their wholeness and concreteness, disappear (Lombardi 2009, 186).

2. Reproductive technologies: the legislative and epidemiological context

During the 20th century, a big change takes place, which relates to the possibility of intervening in the reproductive process right at the beginning, that is during conception and the first stages of insemination. This encompasses a complex web of issues of a

social, ethical, scientific, economic and legislative nature (Lombardi and De Zordo 2013). We need to reflect on these practices and their impact on reproduction, on bodies and on relationships, but also on how they are interconnected with medical and political power and with morality.

Let's first consider the Italian legislation on medically assisted procreation (L. 40/2004) and its article 1 which, indirectly, attributes juridical personality to the embryo⁸ and limits the decisional power of women and couples in relation to the embryo's survival at "all costs"; it thus values women's bodies not in their overall function of *maternage*, but in their biological function of "containers" for the embryo. Is this not a way to establish social and political control over women's bodies? (Lombardi 2009).

Every draft law incorporates specific representations of the body: representations of men's bodies, of women's bodies and their reproductive functions, of the body of the child to be born, and representations of the boundaries and legality in the use of all these (Borgna 2005, 66).

Similarly, art. 4 c. 3 in the same Act bans gamete donation, although a recent judgment by the Constitutional Court has declared this article illegal. Therefore, according to the above article, gamete donation is now allowed, but in fact it is still difficult for couples living in Italy to resort to it; art. 5 states that only stable couples (adult and heterosexual) may have access to MAP: it is therefore evident that the rules indicate and mark the practices and representations of parenthood and family structure.

Moreover, Act 40/2004 creates the National Register of Medically-Assisted Procreation (NRMAP), which annually collects anonymous data for treatment cycles, therapeutic protocols, results and follow-ups of pregnancies and new-borns. The introduction of NRMAP is considered a success in the Italian context because it provides data and useful information on MAP-ART (www.iss.it/rpma).

⁸ According to article 1 of act 40/2004: in order to facilitate the solution of reproductive problems emerging from human sterility or infertility, recourse to medically assisted procreation is permitted, in accordance with the rules of this act of law, «which ensures the rights of all concerned parties, including the embryo» (<http://www.gazzettaufficiale.biz/atti/2004/20040045/004G0062.htm>).

Another important measure implemented by Act 40/2004 is the promotion of reproductive health through the prevention of infertility and the provision of accurate information to women and couples who undergo assisted reproductive technologies. It also aims to promote information campaigns by launching an action plan called ‘National plan for the prevention of infertility’.

In 2013 the NRMAP collected data from 369 infertility centres, 141 (38.2%) of which are public and 228 (61.7%) private, with a varied distribution over the national territory. During that year, 71,741 couples were treated; 91,556 cycles of ovarian stimulation were performed and 15,550 pregnancies resulted from them (16.9%); 11.4% of those pregnancies were lost at the follow-up stage; 12,187 live births resulted from 13,770 monitored pregnancies which equals 13.3% live births out of 91,556 cycles of ovarian stimulation. Regarding the age of the men and women resorting to ART, the mean age is 36.6 for women (34.7 being the European mean age) and 40 for men. The highest number of initiated cycles occurs in the 30-39 year range, which is in line with the average age for having the first child in Italy (www.iss.it/rpma; Lombardi 2015).

It is important to highlight that some recent studies have revealed that age also impacts on male fertility, which begins to decline after age 35, while also increasing the risk of births with genetic or chromosomal diseases (Crosnoe and Kim 2013; Rolland et al. 2013; Fisch and Braun 2008; Hassan and Killick, 2003). These studies contribute to the deconstruction of the stereotype that “men are always fertile” and that they can conceive throughout their life (Lombardi 2015; 2016).

3. Gender differences and the medicalisation of human reproduction

If «medicalisation is the transformation of human conditions into medical problems» (Maturó 2013, 190), infertility medicalisation is the last “step” in the historical process of progressive reproductive medicalisation, which has reached its peak with MAP: from delivery, to pregnancy, to contraception and conceivment. Within this process of progressive medicalisation of everyday life, of bodies, of relationships and of desire

(including the desire for parenthood), infertility is constructed as a problem prone to medical treatment, for which MPA techniques represent the “cure” (Lombardi 2015).

In other words, we are witnessing a proliferation of syndromes and symptoms to which medicine responds through more and more sophisticated drugs and technological treatments, without successfully investigating the causes of disorder and disease (Maturo 2013). In the field of sexual and reproductive health there are many examples: male impotence, pre-menstrual tension, postpartum depression and other syndromes and diseases related to sexuality and reproduction, included infertility and sterility. More or less effective drugs are offered to men and women to overcome such syndromes and disorders, while very little interest is shown in their extra-biological causes (Lombardi 2015). In actual fact, 36.2% of couples treated with simple insemination and 15.1% of those treated with fresh cycles in 2012 suffered from idiopathic infertility; these rates have significantly increased (respectively + 5.1% and + 1.7%) compared to 2009 (RNPMA 2014). Research has increasingly focused on ART through biomedical interventions aimed at the “functioning” of the reproductive organs, at their efficiency, and at the ability to intervene rather than remove the causes of infertility (*Ibidem*).

Based on these assumptions, gender can be understood as a key factor in the construction of sexual and reproductive pathologies: in fact, there are no medical or pharmaceutical campaigns aimed at women’s sexual problems which may be compared to the campaigns and treatments offered to solve male impotency (Waggoner, Stults, 2010). Studies on the causes of infertility and sterility tend to focus on the pathologies affecting the female rather than the male reproductive system: in actual fact, male reproductive life has not played a big role in the specialized literature while a whole series of pathologies marks the reproductive life of women (pre-menstrual syndrome, post-natal depression, menopause). Still today, in our culture, the male gender is mainly associated with sexuality, while the female gender is associated with reproduction, despite the roles and behaviours of men and women having significantly changed. (Culley *et al.* 2013; Hinton and Miller, 2013; Burnes 2014; Lombardi 2015).

The impact of the lack of the body on the Self is situated in gender roles and social norms, as Clarke *et al.* (2006) maintain while there is a strong cultural expectation of

women's maternity, the male sense of self is potentially related to his role as worker, breadwinner and lover. This means that «female infertility does not cast any doubts on a woman's seductive abilities, while the opposite applies to men: they try to dissociate themselves from the stigma of impotency and seem to want to locate the causes of sterility in the female body. What we can observe is that the medical and technological emphasis on female infertility treatment confirms and reproduces the stereotype» (Lombardi 2015, 120).

In the following patient's narrative, the acceptance of her partner's infertility on her body is shown, while also highlighting the stereotype and the request for "strength" and "potency" addressed to the man:

[...] I feel somehow disappointed... at times betrayed after a long engagement and a quiet marriage. I did not expect to have to face maternity in this way. It is a distant and artificial approach and sometimes it lets emerge in my imagination a less manly image of my husband. If he were "stronger" I would not have to face all this. It is hugely different to have to face a conceivment in this way. It lacks the intimate relationship (1.OS-MM)

The infertile woman also draws her partner's desire on herself:

My womanhood, my being a woman is not so strictly related to maternity. What has led me to consider this opportunity (MAP) is L. [her husband], in order to offer him a psychological chance, for him, because a child is a positive and motivating project (2. OS-MM)⁹

The same social constructions are to be found in institutional representations such as the one in table 1: male infertility is neither classified nor named and this is in stark

⁹ These two narratives are extracts of counselling meetings investigated in M. Mariani's final thesis for the Triennial Master in Professional Counselling (systemic-constructions strand) (2007)

contrast to female infertility which is closely “dissected” and investigated, while male infertility is forgotten even though proper names for it exist in medicine, such as azoospermia, oligozoospermia, criptorchidism, hypospadias, varicocele etc.¹⁰

<i>Female and Male factors</i>	18.4% (8,538)
<i>Tubal factor</i>	10.1% (4,671)
<i>Idiopathic infertility</i>	14.8% (6,854)
<i>Female multiple factor</i>	6.9% (3,204)
<i>Endometriosis</i>	5.4% (2,486)
<i>Ovulation infertility</i>	5.5% (2,539)
<i>Ovarian factors</i>	11.0% (5,130)
<i>Abortions</i>	0.8% (376)
<i>Other factors</i>	0.7% (341)
<i>Male infertility</i>	35.4%

Table 1 - Distribution of couples treated with fresh cycles, by cause of infertility - 2013 (number of couples in brackets). Total couples: 46,491. Source: Ministry of Health Report, 2015

We need to reflect on this kind of “forgetfulness” in the National Register Data. In any case we can consider it as a linguistic, cultural and analytical “removal”: the fragmentation and the objectification of women’s bodies (pregnant/non pregnant) are opposed to an indistinct, absent male body, removed from his fertility/infertility and his parenthood (*Ibidem*).

3.1 Medicalisation and the social construction of infertility

Assuming that infertility practices are part of a wider gender structure, rooted in the social construction of health and care, the following paragraph focuses on the case of medically assisted procreation (MAP)¹¹, analysing both the views of experts and medical practices and the narratives of those who experience it¹². This analysis shows that infertility is an experience, socially and culturally constructed, although ART

10 For further investigation of male infertility and its causes, see, among others: Pescetto *et al.* (2009); RNPMA (2012); Parolari and Costantini (2013).

11 In this paper we refer primarily to heterosexual couples who have had access to reproductive technology using partners’ gametes.

12 See: Elia Rosalba (2006), Thesis for University Degree, Milano; Chiara Mambrini (2013), Thesis for University Degree, Milano.

highlights and emphasises only its biological factors: assisted reproductive technology focuses mainly on women's bodies and on their reproductive organs, while the men's role is sidelined, the sperm appears like a substance separated from the male body, which disappears from the MAP scenario. «In assisted reproduction practices, the man is reduced to a mere seed supplier, 'the odd man out' between the doctor and his wife. The male partner is often asked to subject himself to underlying tensions, to accept an impoverished and humiliated sexuality, marked by technical treatment deadlines, regardless of the emotions and the ability of mutual seduction» (Lombardi 2015, 122).

This is the narrative of one man's experience:

when I realized [the fact] that they only wanted a test-tube with my sperm, I felt useless. On one occasion they phoned me as I got back to my office and said "It's not good, we need a new sample". (...) For a man it is very humiliating not to be able to provide the only thing they ask of you (Valentini 2004, 59).

The male control over the reproductive process is however symbolically recovered in the figure of the doctor: reproductive technologies thus operate as a kind of technology that, if on the one hand seems to weaken the role of the male partner in the couple, on the other restores the "intra-gender" and "inter-gender" order .

In fact, while, according to the woman, "three people are involved in a child's conceivment" [the woman, her partner and the doctor], according to the man it is mainly the woman and her doctor who are the actors in the procreative event. The male experience seizes the marginality of his own role in the technological path, although he tries to normalize it (Ventimiglia 1994, 66).

On the other hand, the "desire for motherhood" is strongly emphasized, as we can see in sociological, anthropological and psychological studies (Culley *et al.* 2013), in media representations (Gannon *et al.* 2004; Maturo 2013) and in the medical-scientific discourse: consequently, parenthood responsibility falls on women, by subjecting their bodies to medical treatment even when sterility is medically unexplained, or when it is

the man who is sterile (Lombardi and De Zordo 2013; Lombardi 2015). However, the more closely involvement of women's bodies in MAP practices is not a privilege for them: there are several risks associated with the use of the invasive MAP techniques, which are often not taken into account or not investigated (Parolari and Costantini 2013) and the available scientific studies are still few and inconclusive (Chavkin 2008). This emphasis on the female body has specific social and cultural repercussions on gender relationships, on parenthood and on the different perception and practices of mother- and fatherhood: «MAP social and medical practices seem to converge towards a reproduction of parental and gender stereotypes which do not aim at parity and equality, despite constant changing familial and social structures». (Lombardi 2015, 124). Unexplained infertility¹³ and the way to define and manage it is one of the most emblematic biomedical processes. It really is a problematic issue because it subjects women to strenuous and often risky paths of ART, given the absence of specific or detectable infertility. Gender relationships are greatly affected by the unexplained infertility because of the “culture of fertility/infertility” and its perception. Some narratives of women affected by unexplained infertility highlight their feelings of being unluckier than infertile women, even when they had experienced abortion, because «[...] at least they know that they can [conceive, AG]. Int. 10» (Lombardi and Mambrini 2014).

«Infertility brings with it a profound stigma where the legacy of an ancient gender subordination still survives: infertility has long been considered the sole responsibility of the woman, her dishonour, a deserved punishment for some hypothetical blame. The “barren woman” has always been frowned upon by every social group: she has often been ridiculised, excluded from parties and rituals, avoided, rejected, or looked upon with suspicion and considered dangerous because disobedient to ‘the law of reproduction’» (Lombardi 2015, 124).

These dynamics are still present today, although hidden under different practices and prejudices. For example, in cases of male infertility, the woman often still accepts to

13 Unexplained infertility is infertility that is idiopathic, in the sense that its causes remain unknown even after an infertility work-up, usually including semen analysis in the man and assessment of ovulation and fallopian tubes in the woman.

undergo medical treatment to spare her partner “the shame of infertility”, which in turn drags the insinuation of impotence (*Ibidem*).

4. Social context and family structure

The social and family context in which ARTs are developing should also be considered. The Italian society is characterized by a low fertility rate connected to important changes, such as: the current tension between tradition and change in which the boundaries of gender identity are being redrawn in everyday life; the different and varied family structures; the increased number of unstable families as well as an increasingly uncertain and diversified labor market.

The above mentioned changes are visible in the constant decrease in the rate of marriages (from 4.9 per thousand in 1999 to 3.5 per thousand in 2012) which is among the lowest in Europe (4.2 is the average rate for the EU-28)¹⁴; in the steady increase in civil compared to religious marriages (+ 18% between 1999 and 2012); and in the increase in the age at which people get married (34 for men and 31 for women) and have a child (31.4 for both genders). Social and family changes are also related to fertility rates, which still rank Italy among the countries with the lowest rates in Europe, (1.55 being the EU-28 average rate in 2013¹⁵), although there has been a slight increase (from 1.19 children per woman in 1995 to 1.39 in 2013) mainly as a consequence of rising immigration (Lombardi 2015). Closely linked to the afore mentioned social situation is the fact that Italian women and men have their first child later in life, due to varied factors such as, for example, young people who leave their family of origin later in life (in 2012 52.3% of young men and 35% of young women between age 25-34 were still living with their parents) because their working conditions are precarious and it is very difficult for them to gain economic independence from their parents. The effect of these factors has been amplified in the last five years by an economic crisis which has affected young

14 Eurostat database, 2012

15 Eurostat database, 2013

people in particular (youth unemployment has reached about 40%); the difficulty of balancing work and family life has increased, resulting in women being overloaded. .

The Italian gap, compared to EU goals for 2020, is particularly evident for women's employment rate (-11.9% vs -3.0% of male employment).

The economic crisis has increased gender segregation as a consequence of the fall in qualified female employment and the increase in the number of unqualified jobs. In addition, the low employment rate for Italian women aged 15-64 (55.7% in 2014 vs 64.9% for the EU-28 countries¹⁶) is even lower for mothers: in the 15-49 age group the employment rate is 54.3%, while it reaches 68.8% for women in a couple without children and 77.8% for single women. In actual fact, mothers on temporary contracts are those most at risk of leaving or losing their jobs after having a child (45.7% in 2012 vs 36.3% in 2005)¹⁷.

The unequal labour market conditions are often exacerbated by the gender distribution of housework. In Italy, this task is very difficult, especially for women: 76% of housework falls on women (including employed women with children): e.g., in a couple with the woman aged between 25 and 44, the woman works 53 minutes longer than her partner in an average working day, (9h08 vs 8h15 for men) and even mothers without a job work longer than their partners (8h15 vs 7h48) (ISTAT Report 2011).

Therefore, the low employment rate of women, the precarious work conditions of people in reproductive age; the unequal housework distribution; the insufficient gender policies and the inadequate welfare system are certainly the main factors that causes low fertility rate and high average age to look for a child and, as it is well known, these also are some of the causes of the increasing recourse to ART (Lombardi 2015).

5. Conclusion

¹⁶ Eurostat database (2014).

¹⁷ ISTAT Annual Report (2014).

To conclude, we would like to draw our attention to three significant points that emerge from our analysis of infertility and the impact of ART on gender, and of the social context within which reproductive technologies are developed.

Firstly, the implications of the lack of involuntary offspring are generally very different for women and men, and the social expectations and consequences of infertility are also experienced differently by the two genders (Hinton and Miller 2013): despite the fact that infertility disorders affect both men and women, the issue is neglected in ordinary speech and in much of the medical discourse, and very few studies are carried out on this topic (Culley *et al.* 2013). This does not mean that men do not suffer from reproduction “failure”: «men can experience infertility as a threat to their masculinity and sense of Self» (Hinton and Miller 2013, 247). The diagnosis of infertility impacts on the daily lives of infertile men and on how their masculinity is constructed, questioning patterns of male hegemonic power: as a consequence, infertility opens up possible areas for the reconstruction and renegotiation of men’s identity (Burton 2014; Lombardi 2015; *Ibidem* 2016).

In actual fact, medical discourse encourages men to accept the hegemonic norm rather than an alternative male identity. The requirement to produce spermatozoa in the clinic on demand is central in men’s narratives: very often it is described as ‘awkward’ and ‘humiliating’ (Burton 2014; Hinton and Miller 2013; Lombardi 2015). The same feeling is often described by those men who attend their partner’s childbirth: they suffer on her behalf but they also suffer because they feel powerless, “they can do nothing” (Lombardi 2016). This shows that the male involvement in the reproductive process is not yet complete and begs the question of how and of how many men are prepared to manage the reproductive process, torn between maintaining their “hegemonic masculinity” and their *fathering* role. (Lombardi 2015).

The second point is related to the social context in which ARTs develop. We have seen that Italy is characterized by a low fertility rate, which reflects the current historical phase characterized by a strong tension between tradition and change: the delay in the realization of the parental project is directly linked to the aforementioned

changes and it is a consequence of several social factors rather than of clinical ones [e.g. the difficulty of young people in building their own path of empowerment; the unstable and precarious working conditions; the difficulty of balancing work and family life (ISTAT 2014). All these factors point to a gender condition that is still significantly unequal, with regard to both the labour market and the sharing of family responsibilities and childcare (Lombardi 2015).

Following from the observation of these social and relational dynamics, which are not excluded from welfare policies and the support for parenting and childcare, we suggest that, in addition to the medical factors that determine infertility, there are many social factors intertwined with them that influence each other. For this reason, we can speak of a “social infertility”, which cannot be separated from the socio-political context (Franklin 2015; Lombardi 2015)

The third and final point concerns the future prospects of gender relationships. We have seen that the path to equal rights and responsibilities between genders is still to be achieved in many societies and that the equality process has still got a long way to go (Birembaum-Carmeli and Inhorn 2009; Culley *et al.* 2013; Hinton and Miller 2013; Burton 2014). We have also observed that the development of reproductive technologies and their clinical management tend to reproduce stereotypes and gender roles, emphasising the “female-maternal body” and marginalizing the “male-paternal body” (Lombardi 2015, 2016). Therefore, in agreement with several authors, we think that «it is time for a reappraisal and a more nuanced response to men as reproductive actors» (Hinton and Miller 2013, 250). In this perspective, we believe that men should be more closely involved in the reproductive process: this means offering «services that provide spaces in which to share fears and concerns and express emotions and vulnerability, without the fear of being ‘punished’ because of being male, but also, greater attention to the investigation of the meanings that men themselves attribute to their involvement» (Lombardi 2015, 128).

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